Report to: Board **Meeting Date:** 26 November 2015

Agenda No:	15			
Report Title:	Primary Care Co-Commissioning			
Written by:	Interim Project Director for Primary & Immediate Care			
Purpose of Report:	To seek Board approval from the Mid Essex CCG to make formal application to move to joint commissioning of Primary Care Services from 1 April 2016.			
How does this issue link to the CCG's Strategic Objectives?				**Please Tick**
Strategic Objective 1	To improve quality and outcomes for all and keep patients safe			✓
Strategic Objective 2	To meet the financial challenge through responsible use of resources			✓
Strategic Objective 3	To achieve transformation, innovation and integration of services			✓
Strategic Objective 4	To ensure there is full practice engagement informing commissioning			✓
Strategic Objective 5	To ensure public confidence in commissioned services			✓
Strategic Objective 6	To ensure the CCG has the necessary governance, capacity and capability to deliver all our duties and responsibilities			✓
Approval Route: **(List Groups/Committees that have reviewed this document).**	**Group/Committee**			**Date**
	Audit Committee			9/11/2015
Have any financial implications been signed off by the Chief Finance Officer? (**Please Tick**)		**Yes**	**No**	**N/A**
			The CFO will be consulted on the proposed amendments	
Have the following Assessments been carried out? (**Please Tick** P) NB: Board members may request a copy of the relevant Assessment from the Head of Corporate Governance, if required.		**Yes**	**No**	**N/A**
Equality Impact Assessment				✓
Quality Impact Assessment				✓
Privacy Impact Assessment				✓
Procurements Only: Has the Procurement Checklist been completed? (**Please Tick** P)		**Yes**	**No**	**N/A**
				✓
Patient & Public Engagement:	A comprehensive engagement programme has been completed with membership practices and the wider stakeholder community including all practices, Healthwatch and Local Authority.			
Significant Risks identified:	The necessary amendments to the Conflicts of Interest Policy and the establishment of a Joint Commissioning Committee will assist the CCG to manage conflicts of interest.			
Recommendations and decision/actions required by the Board:	The Mid Essex CCG Board is asked to: • Note the consultation process and outcome • Note the contents of the report and support the proposal to move to Joint Commissioning from 1 April 2016. • Endorse the amendments to the CCG's constitution • Note the Audit Committee's approval of the amendments to the Conflicts of Interest Policy. • Endorse the proposed draft Terms of Reference for a Joint Co-Commissioning Committee with NHS England and North East Essex CCG • Endorse the use of the proposed procurement template .			

1. INTRODUCTION

In May 2014, NHS England invited Clinical Commissioning Groups (CCGs) to come forward with expressions of interest to take on an increased role in the commissioning of GP services. The intention was to give CCGs more influence over the wider NHS budget and enable local health commissioning arrangements that can deliver improved, integrated care for local people, in and out of hospital.

CCGs were asked to take forward one of the following co-commissioning models:

- Full delegated responsibility for commissioning the majority of GP services
- Joint commissioning responsibility with NHS England
- Greater involvement in GP commissioning decisions.

Following discussion by the Mid Essex CCG Board, it was agreed at this time that the CCG should limit itself to the 'greater involvement' model in order to enable the CCG to focus upon delivery of its in-year efficiency savings and a balanced long term financial plan.

A further invitation by NHS England to CCGs not yet participating in joint or fully delegated commissioning was issued at the beginning of the 2015/16 financial year as part of a general thrust to increase CCG uptake nationally. This offer was discussed by the CCG Board at an informal development session on 16 July 2015 and it was agreed to commence a dialogue with member practices to establish whether they were supportive of increasing the CCG's involvement in primary care co-commissioning.

Since that time there has been considerable discussion with practices including a formal consultation process, practice visits and focussed sessions at the GP Shutdown in November.

1.1 Joint Commissioning

Under this model CCGs may either form a joint committee[1] or "committees in common" with their area team in order to jointly commission primary medical services. 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 must ensure that any governance arrangement they put in place does not compromise their respective ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making. It should be noted that currently Mid Essex and North East Essex are in discussion with regards a joint CCG and NHS England Joint Commissioning Committee.

The process for applying for joint commissioning is via an informal discussion with the NHS England local team, following which a proforma agreement (Appendix 1) is signed by both parties and submitted to NHS England confirming a 'go live' date of 1 January 2016 or 1 April 2016. Mid Essex CCG is proposing to submit an application to NHS England for a "go live" date of 1 April 2016 submitting its formal application by 1 January 2016.

[1] *Following the passing of a Legislative Reform Order (LRO) by parliament, CCGs can now form a joint committee with one or more CCGs and NHS England where they were previously prohibited from doing so.*

1.2 Delegated Commissioning

Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. As with joint commissioning, CCGs will continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation.

In accordance with its constitutional thresholds, the CCG determined that it would only pursue an application for joint and/or delegated commissioning where there was a response rate of at least 50% of member practices with 75% of respondents in support of more formal involvement. Mid Essex CCG made the decision not to move to fully delegated commissioning as a consequence of the response to the initial membership consultation.

2. GOVERNANCE ARRANGEMENTS

2.1 Constitution

In order for CCGs to progress to co-commissioning there is a requirement that their constitutions are updated. The changes used by the Mid Essex CCG are those provided under the national guidance to enable consideration of the move to co-commissioning. CCGs are only able to submit twice yearly Constitution revisions (June and November 1st). The proposed amendments were presented to the CCG's Audit Committee and distributed to practices for comment and approval. In correspondence seeking approval from practices, it was made clear that the changes to the Constitution were not a precursor to an agreement to move towards to co-commissioning but merely an enabler.

The final version was submitted to the National Review Team in line with the required timescale of 1 November 2015 together with an impact assessment and self-certification letter from the Accountable officer. It should be noted that the proposed amendments are completely aligned to national guidance and can be viewed as Appendix 2.

2.2 Consultation

The CCG has consulted widely with member practices and other stakeholders with regards proposals to progress to joint commissioning. Appendix 3 is the original consultation document distributed to practices and the wider stakeholder group including Local Authority, Health Watch and the Local Medical Committee. The outcome of the original consultation did not achieve the required 75% sign up and the process was therefore put on hold. For clarity 14 practices wished to wait and see, 18 practices advised that they were happy to progress and 13 practices failed to respond. Practices were advised of the outcome of the consultation and notified that the CCG would not be progressing further with co-commissioning.

Following the initial consultation, correspondence was received from both the Regional and National teams setting out a proposed direction of travel for primary care and in particular a move by CCGs to progress with co-commissioning. The Regional letter was shared with primary care and the proposal to move towards joint commissioning (not delegated) was presented to member practices with the opportunity of a practice visit and focussed sessions planned at the GP Shutdown. The shutdown was followed by a letter alongside a question and answer sheet with further invitation for a practice visit or the opportunity to contact the CCG for any further clarity.

Considerable thought was given to the next stage of the consultation process. It was noted that there had been a lot of consultation and correspondence sent to practices. In addition there was the GP shutdown, and when asked for early feedback, practices appeared to support the move to joint commissioning.

There were 41 practices in attendance at the GP shutdown and as a consequence it was felt more appropriate to seek practices support for co-commissioning by exception to signal if they did not wish to progress, rather than once again take time out of their already busy workload and respond to express their support of the proposal, particularly frustrating if they had already given their agreement on a number of occasions.

For information a copy of the letter and Q&A sheet provided to practices can be viewed under Appendix 4.

However, following discussion with the LMC the CCG agreed to undertake a full consultation and wrote again to practices with an extended timeline with a requirement for practices to respond demonstrating either support (Yes) or unsupported (No).

From this process 45 practices were eligible to apply as North Chelmsford HCC and Silver End were excluded as contracts are held by existing practices and including them would have effectively given the partnerships concerned two votes. Thirty five practices responded (77.8%) but one practice did not commit. Eligible responses were therefore 34. In total 26 practices have voted “yes” which equates to 76.5% and 8 practices registered a “no” which equates to 23.5%.

This outcome meets the requirements of the CCG Constitution with over 50% response and, from these responses, 75% approval of the proposed change.

2.3 Conflicts of Interests Policy

As part of the CCG’s application for joint co-commissioning of primary care services, the CCG is required to ensure that its Conflicts of Interest Policy is amended to take account of the relevant provisions of the NHS England document ‘Managing Conflicts of Interest: Statutory Guidance for CCGs’ relating to co-commissioning, available at http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf

The CCG has reviewed and amended its Conflict of Interests policy to reflect the mandatory guidance expanding to meet the requirements for CCGs taking on joint commissioning responsibilities and has been approved by the Audit Committee and referred to in the Policy update being provided to Board on 26 November 2015.

The guidance states that CCGs must ensure that it records all procurement decisions made in respect of primary medical services and details how any conflicts were managed that arose in the context of these decisions. A model procurement template has been developed by NHS England which the CCG is proposing to use for recording these decisions (Appendix 5); a summary of which will be publicly available in the same way as the Register of Conflicts of Interests.

2.4 Joint Commissioning Committee

Within the guidance and governance arrangements there is a requirement for CCGs to establish a Joint Commissioning Committee to oversee decision making and is a composite of CCG and NHS England. In joint commissioning arrangements, the joint role of NHS England in decision-making will provide an additional safeguard in managing conflicts of interest. However, CCGs should still satisfy themselves that they have appropriate arrangements in place in relation to conflicts of interest with regard to

their own role in the decision-making process.
The arrangements for primary medical care decision making do not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest. They apply to decision-making on procurement issues and the deliberations leading up to the decision.

Once again the CCG has used national guidance in the development of the attached draft terms of reference for this group. The Board will be aware that the draft Terms of Reference are for a Joint Commissioning Committee which will include Mid Essex CCG, North East Essex CCG and NHS England. It is anticipated that these will require further update as the Committee is established and develops. The draft Terms of Reference can be viewed as Appendix 6.

2.5 Opportunities/Benefits of Joint Commissioning

As part of the co-commissioning application process the CCG has produced a benefits document to demonstrate the local opportunity aligned to the development and implementation of co-commissioning. This can be viewed as Appendix 7.

2.6 Assurance

It should be noted that the Audit Committee Chair and Accountable Officer will be required to provide direct formal attestation to NHS England that the CCG has complied with the mandatory Conflict of Interests guidance as part of the application process for delegated commissioning.

NHS England has also determined that as part of the 2015/16 Assurance Framework for CCGs specific additional assurances will be required from all CCGs that have taken responsibility for delegated functions. For co-commissioning functions (and out-of-hours services), CCGs will be required to prepare a quarterly self-certification of compliance against five key areas:

- Governance and the management of potential conflicts of interest
- Procurement
- Expiry of contracts
- Availability of services, and
- Outcomes.

For delegated arrangements and out-of-hours services, the self-certification will be required to be signed off by the CCG governing body. For joint commissioning arrangements the self–certification will be signed off by the joint committee of the CCGs and NHS England.

3. RECOMMENDATIONS

The Mid Essex CCG Board is asked to:

- Note the consultation process and outcome
- Note the contents of the report and support the proposal to move to Joint Commissioning from 1 April 2016.
- Endorse the amendments to the CCG's Constitution
- Note the Audit Committee's approval of the amendments to the Conflicts of Interest Policy
- Endorse the proposed draft Terms of Reference for a Joint Co-Commissioning Committee with NHS England and North East Essex CCG
- Endorse the use of the proposed procurement template

Appendix 1

Delegated Commissioning: Submission pro forma and checklist to apply to commence on 1st April 2016

It is strongly recommended that CCGs begin working with the corresponding NHS England DCO at least 6-8 weeks in advance of submission to ensure that all the necessary internal processes, information and documentation is updated and approved in advance.

NHS England will provide the offer of support to all CCGs to take forward the co-commissioning arrangement of their choice except in cases where the assurance process has raised significant concerns in respect of current capacity and/or capability to enter into a delegated commissioning arrangement.

As with the 2014/15 process, regional panels will meet to review the proposals and make recommendations to a national panel on which proposals should be taken forward. CCGs will be notified of the outcome of their application by the end of the year.

Further information on the application and approvals process can be found here.

From: <CCG Name> and <NHS England DCO title>

To: england.co-commissioning@nhs.net and 'NHS England Regional Primary Care Co-Commissioning contact'

Subject: Application for <CCG Name> to begin delegated commissioning arrangements on 1 April 2016.

Dear colleagues,

This is to confirm that <CCG Name> is applying to begin delegated commissioning of primary medical services with NHS England on 1 April 2016. NHS England is requested to progress the application to the regional panels for consideration.

We are pleased to confirm that the CCG has met the following requirements and that satisfactory evidence of this has been provided to the NHS England DCO:

Delegated Commissioning Checklist	
<CCG Name> has set out clearly defined objectives and benefits of the arrangement	Y / N
CCG Constitution or proposed constitutional amendment has been updated in line with the guidance (and this has also been approved by the NHS England regional office and sent to england.co-commissioning@nhs.net prior to this submission).	Y / N
Governance documentation has been updated in line with the NHS England guidance (delegated terms of reference)	Y / N
CCG has reviewed its conflicts of interest policy in line with NHS England's managing conflicts of interest statutory guidance. The DCO confirms the CCG meets the required conflicts of interest management thresholds.	Y / N
CCG IG Toolkit meets level 2 criteria as a minimum	Y / N

The CCG's current assurance level (as at Q2 of 2015/16 or equivalent) for each of the five assurance component *(Key: Outstanding, Good, Limited Assurance, Not Assured)*	Well led organisation	O/G/LA/NA
	Delegated Functions, if previously engaged in joint commissioning	O/G/LA/NA
	Finance	O/G/LA/NA
	Performance	O/G/LA/NA
	Planning	O/G/LA/NA
	Additional Comments:	

I hereby confirm that <CCG Name> membership and governing body have seen and agreed to all proposed arrangements in support of taking on delegated commissioning arrangements for primary medical services on behalf of NHS England for 2016/17. NHS England is requested to progress the application to the regional panels for consideration.

Signed by <CCG Name> Accountable Officer
Signature (scan/electronic version required):
Print Name:
Position:
Date:

Signed on behalf of <CCG Name> Audit Committee Chair
Signature (scan/electronic version required):
Print Name:
Position:
Date:

Signed by NHS England Director of Commissioning Operations
Signature (scan/electronic version required):
Print Name:
Position:
Date:

Please note section 2 removed from this checklist as to be used only if progressing to fully delegated commissioning with transfer of budgets.

Appendix 2

Proposed changes to Mid Essex CCG Constitution

6.5.2 **Joint commissioning arrangements with NHS England for the exercise of NHS England's functions**

(a) The CCG may wish to work with NHS England and, where applicable, other CCGS, to exercise specified NHS England functions.

(b) The CCG may enter into arrangements with NHS England and, where applicable, other CCGS to:

- Exercise such functions as specified by NHS England under delegated arrangements;
- Jointly exercise such functions as specified with NHS England.

(c) Where arrangements are made for the CCG and, where applicable, other CCGS to exercise functions jointly with NHS England, a joint committee may be established to exercise the functions in question.

(d) Arrangements made between NHS England and the CCG may be on such terms and conditions (including terms as to payment) as may be agreed between the parties.

(e) For the purposes of the arrangements described at paragraph (b) above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

(f) Where the CCG enters into arrangements with NHS England as described at paragraph (b) above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

(g) The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph (b) above.

(h) The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

(i) Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

(j) The governing body of the CCG shall require, in all joint commissioning arrangements that **the Chair of the Joint Commissioning Committee** of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

(k) Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year after the expirationof the six months' notice period.

Appendix 3

NHS
Mid Essex
Clinical Commissioning Group

CO-COMMISSIONING IN PRIMARY CARE

A discussion paper for GP practices on a proposed way forward

Foreword

In May 2014, NHS England invited Clinical Commissioning Groups (CCGs) to express an interest in taking on an increased role in the commissioning of GP services. The intention is to give CCGs more influence over the wider NHS budget and support local health commissioning arrangements that can deliver improved, integrated care for local people, in and out of hospital.

There are three co-commissioning models that CCGs can operate within. The three models are:

- **Model One:** Greater involvement in GP commissioning decisions
- **Model Two:** Joint commissioning responsibility with NHS England
- **Model Three:** Full delegated responsibility for commissioning the majority of GP services

Mid Essex CCG is currently been operating model one - greater involvement in primary care decision making.

However, in response to national trends and current challenges within the local healthcare system, Mid Essex CCG together with the support of all practices, would like to propose a move towards joint commissioning and full delegated responsibility.

This document sets out the differences between the models; the opportunities going forward and things to carefully consider. It also tells you which model we would prefer to go for in light of the assessment we have made. The timescales for this project are incredibly tight. If we are to propose a change in the way we co-commission primary care in mid Essex, the deadlines for our submission to NHS England are:

- For joint commissioning by 30th September 2015
- For full delegated responsibility by April 2016

We need your views on whether you agree with us, or whether you believe we should approach this differently. Please consider the information in this document and send us your thoughts by Monday 31 August 2015. If you would like a visit to your practice or CCG attendance at any of your local meetings please do not hesitate to ask.

Caroline Dollery
GP and Chair of MECCG

Caroline Rassell
Accountable Officer MECCG

The national picture

Nationally, since April 2015, 64 CCGs have taken on full delegated responsibility for commissioning general practice, whilst 87 CCGs have joint commissioning responsibilities with NHS England.

For those CCGs that haven't yet submitted a proposal or are waiting to hear the outcome of a submission, NHS England continues to provide support to help them achieve a commissioning model that works best for them.

A change in co–commissioning - what will it mean in mid Essex?

Mid Essex CCG is currently operating model one – greater involvement in GP commissioning decisions.

In essence this means that MECCG has greater involvement in primary care decision making and participate in discussions about all areas of primary care including:

- Primary medical care;
- Eye health;
- Dental and community pharmacy services

Provided that NHS England retains its statutory decision-making responsibilities and there is appropriate involvement of local professional networks.

However, it appears that a move towards models two and three are a matter of "when not if". In keeping with this forming national direction and the pace of change on co-commissioning, we need to consider a move towards either joint commissioning or full delegation.

The section below describes both models and how they operate.

Model Two – Joint commissioning responsibility with NHS England

What is it?

A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their NHS England area team, either through a joint committee or "committees in common".

How will it operate?

Joint commissioning arrangements give CCGs and area teams an opportunity to more effectively plan and improve the provision of out-of hospital services for the benefit of patients and local populations. Joint committees will cover:

- 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 ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (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).
- Joint commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation).

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.

Under this arrangement the funding for GP Primary Care remains with NHS England. As such there is no exposure for the CCG to financial risk through over-performance against available budget.

Model Three - Full delegated responsibility

What is it?
Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. **Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively**.

NHS England will remain responsible for the management of individual GP performance and contract termination. CCGs will continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation.

How will it operate?
CCGs that take on delegated commissioning responsibilities have access to a fair share of the area team's primary care commissioning staff resources to deliver their responsibilities and:

- Area teams retain a fair share of existing resources to deliver all their ongoing primary care commissioning responsibilities.
- There will be no nationally prescribed model: this will be a matter for local dialogue and determination. However, NHS England is committed to supporting local discussions in any way deemed helpful, and the current Primary Care Co-Commissioning Programme Oversight Group will continue to operate during the implementation period to help address practical issues.

Funding arrangements
With regards the funding arrangements for delegated authority, this involves the transfer of all identified GP Primary Care budgets from NHS England to the CCG. The methodology utilised for identifying the budget to transfer varies between spend area, with current understanding summarised below

- Contract – budgets allocated for this component are based upon actual value of existing arrangements for GMS, PMS and APMS contracts
- Enhanced Services – depending on the service these are either funded at
    - total signed-up value for those where entitlement is calculated on a per head of population basis (for those practices who have signed up to the ES), or
    - previous years payment levels for those where entitlement is on a unit of activity basis
- QOF – budgets allocated on current years aspiration levels (influenced by previous years achievement)
- Premises – current actual costs incurred under the premises directions, plus an element of additional funding for developments currently in the 'pipeline', plus a share of the centrally held pot
- Other/Discretionary non list based payments – budgets transferred calculated on an apportionment of NHS England's local available budgets

A change in co-commissioning – Strengths and weaknesses

All of the models described represent a fundamental shift in the way primary care is commissioned in mid Essex. Having engaged with several practices already, the CCG has been able to form a view on how we would like to proceed which we believe fits the needs of our local GP members. However, we want to gauge how much support this direction of travel has or whether you, as part of our GP membership, believe we should be going another way.

In December 2014, the BMA Co-Commissioning Update illustrated the potential opportunities and threats for Practices in a table – we've reproduced it in this document so practices can see, at-a-glance, some of the relative strengths and weaknesses of the models. *NB: Where COI is identified this means conflict of interest.*

	Opportunities for practices	Threats to practices
Greater Involvement	CCG's 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 CCG's without the need for restructuring. May allow CCG's to take a significant advisory and consultative role to NHS England without the risk associated of responsibility	Commissioning decisions remains slow and fragmented. CCG's (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). CCG's 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	Greater and direct influence in the development of and investment in general practice. Ability to design local schemes to replace to QOF and DES's. Could create better collaboration with neighbouring CCG's as they work together in one joint commissioning group with the AT. CCG's (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) and managing members contracts. Tensions between CCGs board and member practices related to COI arising from CCG's jointly commissioning, holding and managing GP contracts. Could worsen tensions where historic relationship between member practices and CCG is poor or dysfunctional.
Delegated	Opportunity for GP's in CCGs to have direct leadership to influence the development and investment in general	Unclear whether CCGs will have sufficient capacity, expertise (or will be large enough) required to

	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 5 year forward view agenda.	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) and managing members' contracts. Paradoxically, mitigating the COI issue could therefore lead to less true influence by GP's, practices and CCGs in commissioning of general practice.

The way forward?

For several months, the CCG has been working on all the options for primary care co-commissioning to gather initial views of our member practices, as well as gain assurances on the potential impacts of each model in our area.

As an organisation we wanted to better understand the way each model works and how it could work locally here in mid Essex.

Given the options, and the national trends in co-commissioning, we believe that the best way forward for the CCG's GP Member Practices is to **support the development of co-commissioning with an application for joint commissioning to be established from October 2015 with a move to fully delegated arrangement from April 1st 2016 (financial risk permitting).**

We believe that, given the national trends, the timescales involved and the local situation within Mid Essex CCG, this would be the best direction of travel. However, we need to know if our GP Members support this, or whether you believe we should go in a different direction.

Your views count

We want to make sure all practices have the opportunity to consider the options and let us know whether you support our preferred option for the future.
Please can you complete the form attached below and either return it by email to Adam Cronin at adam.cronin@nhs.net or post to:
Adam Cronin - Co-Commissioning
Wren House, Hedgerows Business Park, Colchester Road, Chelmsford, CM2 5PF

A change in co-commissioning – Your choice form

Name of GP practice:
Preferred Option:

Please tick the box next to your selected option:

Option One: We support the MECCG view to support the development of co-commissioning with an application for joint commissioning to be established from October 2015 with a move to fully delegated arrangement from April 1st 2016 (financial risk permitting) and are happy for this to be progressed.	☐
Option Two: We **DO NOT** support the MECCG view to support the development of co-commissioning with an application for joint commissioning to be established from October 2015 with a move to fully delegated arrangement from April 1st 2016 (financial risk permitting) and believe it should not be progressed.	☐

By signing below I confirm that I have been given the authority to respond on behalf of the GP Practice named above:
(Signature) .....

(Print name) .....

Please return your form to the Co-Commissioning team via post or email:

Email: adam.cronin@nhs.net
Post: FAO: Adam Cronin
Wren House, Hedgerows Business Park, Colchester Road,
Chelmsford, CM2 5PF

Appendix 4

Letter to all senior Partners & Practice Managers with Q&A Fact Sheet

Dear Colleague

Re: Co-Commissioning in Mid Essex

Following further discussions at the GP Summit last week, we are writing to you for a final time regarding the proposal for Mid Essex CCG to move towards joint commissioning with NHS England with effect from April 2016.

As a membership organization, MECCG is fully committed to ensuring that its practices are suitably briefed and in possession of the salient facts that will enable them to take an informed view on whether or not to support the proposal. In order to assist this process, we have produced a Question and Answer sheet, which we hope will provide clarity for any outstanding issues or concerns you may have. This sheet has, in the main, been generated from questions raised at recent practice meetings and/or the GP Summit last week.

We have now contacted you on a number of occasions, not only to seek your views on joint commissioning but also to update you on the progress of the debate. The table below provides a brief summary of the efforts we have made to consult with you and obtain your thoughts and comments:

22nd July 2015	Co-commissioning document was taken to the Mid Essex Primary Care Forum to gauge opinion and to seek advice as to consultation process.
7th August 2015	A five week consultation period asking practices for their views and level of support with regards mid Essex progressing with Co-commissioning. The documentation circulated for consideration during the consultation period was accompanied by an offer to visit any practices or sub-localities on request and this was taken up by one GP collective.
8th September 2015	Brief update/summary at GP evening event to launch the Demand Management LES.
14th September 2015	Summary of consultation shared with practices.
13th October 2015	Letter sent to practices from MECCG attaching a copy of NHS England (Regional Team's) request for the CCG to consider progression to joint commissioning from April 1st. MECCG repeated its offer to visit practices and sub-localities for further discussion, with one practice and a GP collective responding.
29th October 2015	Letter to practices regarding consent for the Constitution changes that would be required to enable CCG to progress with co-commissioning in the event of practice agreement to proceed.
November 4 2015	Workshops at GP Summit to discuss both opportunities and challenges of co-commissioning.

Given the degree of consultation already undertaken, and in view of the additional feedback received at the GP Summit, the CCG will not undertake another full consultation and is therefore proposing to consult by exception, i.e. **the CCG will assume that you are supportive of progression towards joint commissioning unless we hear from**

you to the contrary.

The CCG Board is clear that any major decision such as this requires 75% of our member practices to consent to the proposal as stated in the CCG's Constitution. If we receive sufficient responses against joint commissioning, the CCG will not proceed further at this stage.

As discussed at the GP Summit last week, the timescales are tight. In order to comply with the proposed NHS timeline of submission by January 1st 2016, we need to receive your feedback by close of play on Wednesday November 18th. In the event that we receive majority agreement to proceed, this will allow the CCG Board to approve the application at its next meeting on 26th November 2015.

Attached is a Q&A sheet. If you would like further clarity or have other questions, please do not hesitate to contact Melanie or Waseem in the primary care team at melanie.crass@nhs.net or 01245 459478. We are happy to visit to discuss co-commissioning and how practices could get involved should they wish to do so.

We will provide feedback to practices on the outcome of this exercise and next steps.

Yours sincerely

Mid Essex Clinical Commissioning Group
Questions & Answers for move towards Co-commissioning

What is joint commissioning?	Mid Essex CCG is proposing to work jointly with NHS England on the future commissioning of primary care services. In essence, this means that we will participate in commissioning, contracting and performance discussions and decisions with NHS England. As described at the GP Shutdown, this will enable the CCG to be engaged with all primary care discussions and be able to support practices experiencing difficulties or particular challenges at an earlier stage. To provide the necessary governance, and particularly to manage conflicts of interest, a Joint Commissioning Committee will be established with membership from NHS England, Mid Essex CCG and (potentially) North East Essex CCG.
What does it cover?	The Joint Commissioning Committee will oversee: • GMS, PMS and APMS Commissioning and Contracting • Newly designed enhanced services, whether Local Enhanced Services (LES) or national Directed Enhanced Services (DES); including the shift to locality based commissioned outcomes and the development of local QOF arrangements • Decision making on whether to establish new GP practices in an area • Approving practice mergers • Making decisions on 'discretionary' payments • Strategic developments around Primary Care Estates and Premises Development • Primary Care Workforce Development
What are the financial implications? • Will the primary care budget be used to subsidise shortfall in funding elsewhere or to fund secondary care services? • Will practices be responsible for funding any shortfalls in the CCG budgets? • Will the CCG be able to provide additional financial support to practices if we progress to co-commissioning ? • Why do we not move to fully delegated commissioning and hold the budget now	• Absolutely not: the primary care budget is ring fenced and will not be used to subsidise or pay for secondary care over- performance. • Absolutely not • The CCG will work in partnership with member practices, Chelmer Health and NHS England in seeking additional primary care development monies. However, there will be no immediate available funding for practices as a consequence of co-commissioning. • Before transferring the primary care budget, the CCG is keen to work with NHS England to understand fully the current allocation for Mid Essex and be clear about both opportunities and risks associated with that transfer. By progressing initially with joint commissioning the CCG will have the opportunity to influence primary care commissioning with no financial risk.
What are the legal implications?	Concerns have been expressed as to whether the move to co-commissioning is legal in relation to the Health and Social Care Act. Particular concern has been expressed with regards to conflict of interest. The CCG is currently working with NHS England and North East Essex CCG to establish a Joint Commissioning Committee to manage the risk of conflict of interest. The CCG is also reviewing and updating its Conflict of Interest policy in line with national guidance.
What impact is there for practices?	There should be no impact or additional work created for practices as a consequence of co-commissioning unless practices wish to become involved. The impact will be felt by the CCG, which is currently reviewing its infrastructure to support both Primary Care Development and Co-Commissioning.
What are the	• An opportunity for the CCG to exert, through the establishment of a joint commissioning

opportunities?	committee, formal influence over decision-making with regards to the commissioning and contracting of primary care services within Mid Essex • An opportunity for the CCG to work with NHS England on the development of local Enhanced services and the potential development of local QOF arrangements. • An opportunity for the CCG to be advised of issues and to support practices at an earlier stage.
What are the risks?	• There are concerns around the maintenance of the CCG's relationship with practices in the event that we move to co-commissioning. However, as identified above it is hoped that any potential effects will be minimised through the development of a co-commissioning committee. As a matter of note, NHS England will retain overall responsibility for primary care contracts and will manage individual poor performance issues. • The question of conflict of interest has been raised many times and is clearly a matter of real concern. However, it is anticipated that this risk can be mitigated by the establishment of the Joint Commissioning Committee (including North East Essex CCG).
Will it really make any difference?	Yes, the Team at the CCG believes that it will make a difference. While we recognise that progress nationally has been slow we believe that it will give the CCG a genuine opportunity to influence events and to be involved at an earlier stage in the event of problems or issues within the Mid Essex locality. In addition, the CCG's view is that progress to co-commissioning and consequent acknowledgment of a formal working partnership between MECCG and NHS England will facilitate a more positive response to bids for funding.

Appendix 5

Procurement template

[To be used when commissioning services from GP practices, including provider consortia, or organisations in which GPs have a financial interest]

NHS Mid Essex Clinical Commissioning Group

Service:	
Question	**Comment/Evidence**
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities? How does it comply with the CCG's commissioning obligations?	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposals?	
How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available? Have you recorded how you have managed any conflict or potential conflict?	
Why have you chosen this procurement route? ≠	
What additional external involvement will there be in scrutinising the proposed decisions?	
How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	

Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
How have you determined a fair price for the service?	

Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	

Additional questions for proposed direct awards to GP providers	
What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

[≠] *Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and guidance (e.g. that of Monitor).*

Mid & North East Essex Clinical Commissioning Groups

Primary Care Joint Commissioning Committee

Terms of Reference

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would jointly commission primary medical services.

2. The NHS England and Mid Essex and North East Essex CCGs joint commissioning committee is a joint committee with the primary purpose of jointly commissioning primary medical services for the people of Mid and North East Essex CCG localities.

Statutory Framework

3. The National Health Service Act 2006 (as amended) ("**NHS Act**") provides, at section 13Z, that NHS England's functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

Role of the Joint Committee

4. The role of the Joint Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England.

5. This includes the following activities:

- 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 ("Local Enhanced Services" and "Directed Enhanced Services"); including the shift to locality based commissioned outcomes
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers;
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

- Primary Care Strategic development and implementation including provision of

sustainable primary care and the delivery of individual NHSE and CCG Transformation Programmes.
- Primary Care Estates and Premises Development
- Primary Care Workforce Development, (Training, Recruitment and Retention)
- Considering future contracting arrangements for integrated primary and community services.

6. In performing its role the Joint Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Mid Essex CCG and NHS North East Essex CCG, which will sit alongside the delegation and terms of reference.

Geographical Coverage

7. The Joint Committee shall consist of the NHS England EAST Area Team and the following CCGs:

    - NHS Mid Essex CCG;
    - NHS North East Essex CCG

and will undertake the function of jointly commissioning primary medical services for Mid and North East Essex.

Membership

8. The Joint Committee shall consist of:

    - Three representatives from each CCG, which must include at least one Lay Member, and can include the CCG Chair, Chief Officer and Lay Member;
    - Three representatives from NHS England's EAST Area Team, as follows: the Medical Director, Area Director and Head of Primary Care (or a named deputy of appropriate seniority for any of these representatives);
    - The membership will meet the requirements of each of the named CCGs' constitutions.

9. The Chair of the Joint Committee shall be elected, by the members of the Joint Committee present at its first meeting, from the Lay Members selected by the CCGs listed in paragraph 8 above to represent them on the Joint Committee.

10. The Vice Chair of the Joint Committee shall be elected by the members of the Joint Committee present at its first meeting from the CCG Lay Member representatives.

11. When electing to the positions of Chair and Lay Vice Chair in accordance with paragraphs 11-12 above.

12. Non-voting attendees will include:

    - CCG Directors of Commissioning
    - CCG Directors of Primary Care (or equivalent)
    - CCG Medical Directors
    - CCG Directors of Finance
    - Nominated representative from Essex Health Watch
    - Nominated representative from Essex Health and Well Being Board
    - Nominated representative from Essex Local Medical Committee

Meetings and Voting

13. The Joint Committee shall adopt the Standing Orders of NHS Mid Essex CCG and NHS North East Essex CCG insofar as they relate to:

    - Notice of meetings;
    - Handling of meetings;
    - Agendas;
    - Circulation of papers; and
    - Conflicts of interest

14. Each CCG member of the Joint Committee shall have one vote (6 in total) with NHS England having a weighted vote (6 in total). The Joint Committee shall reach decisions by a simple majority of members present, but with the NHS England Area Director / Medical Director having a second and deciding vote, if necessary). Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view

15. Where a decision is to be made relating to the exercise of NHS England functions in respect of a single CCG, such a decision shall be made between that CCG and NHS England (with NHS England having the casting vote), with the remaining CCGs abstaining from the decision in question

16. The Joint Committee will be quorate if the following are in attendance and the provisions regarding lay and executive majority for conflicts of interest management are complied with:

    - Two voting representatives from each CCG listed in paragraph 8 above, one of whom must be the Chair or Vice Chair; and
    - Two voting representatives from NHS England.

17. The Committee shall meet once a month (subject to agreement at the first meeting of the Committee).

18. Meetings of the Joint Committee:

    a) Shall, subject to the application of 18(b), be held in public.

    b) The Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

19. Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

20. The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

21. Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the joint committee in which event these shall be observed.

22. The [TBC] shall act as Secretary to the Joint Committee.

23. The Secretariat to the Joint Committee will:

    a) Circulate to all members, the minutes and action notes of the Joint Committee within 3 working days of the meeting.

    b) Present the minutes and action notes to the EAST NHS England Team and the governing body of each of the CCGs listed in paragraph 8 above.

24. These Terms of Reference will be reviewed from time to time, reflecting the experience of the Joint Committee in fulfilling its functions and the wider experience of NHS England and CCGs in primary medical services co-commissioning.

Decisions

25. The Joint Committee will make decisions within the bounds of its remit.

26. The decisions of the Joint Committee shall be binding on NHS England and the following CCGs:

- NHS Mid Essex CCG
- NHS North East Essex CCG.

27. Decisions will be published by both NHS England and NHS Mid Essex and NHS North East Essex CCGs.

28. The secretariat will produce an executive summary report which will presented to NHS England EAST and the governing bodies of Mid and North East Essex CCGs each month for information.

Key Responsibilities

29. See paragraph 5 above.

Review of Terms of Reference

30. These terms of reference will be formally reviewed by NHS England EAST and Mid and North East Essex CCGs within six months of establishment and in April of each year, following the year in which the joint committee is created, and may be amended by mutual agreement between NHS England EAST and Mid and North East Essex CCGs at any time to reflect changes in circumstances which may arise.

[Signature provisions]

Schedule 1 - List of Members – to be populated once membership agreed

Appendix 7

Benefits of Primary Care Co-commissioning within Mid Essex

Mid Essex CCG has consulted with its member practices on whether to undertake joint primary care commissioning arrangements with NHS England with then the intention to move to fully delegated commissioning or whether to take a "sit and wait approach" to understand further developments within primary care.

When consulting with practices, the direction of travel in which the CCG needed to move with co-commissioning changed and as result now needs to align itself with neighbouring CCGs and undertaking joint commissioning.

This paper outlines the benefits to patients of Co-commissioning

1. Transforming Care for Vulnerable Elderly

Linked to our Better Care Fund (BCF) plan and the CCG's overarching Live Well Strategy co- commissioning will support achieving greater integration of health and care services within our localities. The CCG will use co-commissioning as an opportunity to operate a more cohesive out-of-hospital care model that brings together general practice (with GP clinical leadership and accountability), community health services, mental health services and social care to provide more joined-up services and improved outcomes.

Benefits to patients are set out in Box 1 below;

Box 1: ME CCG Model for Frailty – Patient Benefits
• We will focus on the highest need patients, those at risk of decline; with robust patient identification (risk stratification processes) • Care will be oriented around the needs of the patient, spanning primary, secondary and social care • Each patient's care will be led by a confident General Practitioner, who has full accountability for their patients' outcomes and overall budget • There will be identification of patients for review at an enhanced MDT to develop a care plan to reduce unscheduled care and improve quality of care for each patient.

The CCG will as part of its overarching vision for the delivery of integrated primary and community services (MCPS) look to provide a new model of contracting which will enable the delivery of services, the type of contract is still to be considered but may be in the form of an APMS , Lead Provider or Alliance Model.

2. Transforming Immediate Care

Using **co-commissioning** we would be better placed to deliver on our commitment that sees 'patient's home' as the main location where healthcare will take place – a more efficient location for creation of added value in health care.

The management of Long Term Conditions (LTCs) in the home will be our primary focus. We will use opportunity that co-commissioning presents to review QOF and Enhance Services models to introduce incentives that will support LTC, self-management,

facilitated by technology centrally monitored and linked to general practice, enabling the home to safely be the location for higher acuity health care under GP supervision.

We will use co-commissioning to support the development of enhanced/extended access to primary care, likely at a locality rather than individual practice level. A hub and spoke approach is likely linked into existing models of provision including the Primary Care service in the A&E Department at Broomfield together with the three out of hours sites located across the Mid Essex economy.

Box 2: Transforming Immediate Care – Patient Benefits
• Patient will receive high quality clinical care to manage their long term conditions in the community and primary care • Patients will be given support to live as independently as possible and maximise their quality of life • Streamlining of immediate care services for person-centred co-ordinated care with extended access and progress towards seven day working. • Patients will experience reduced emergency visits, outpatient referrals for patients and reduced pressure on surgical waiting lists

3. Personalised and Preventative Care

A preventative and personalised care approach within ME CCG will use co-commissioning opportunities to focus on structuring care provision proactively around patients' needs within primary care.

Our aim is to engage with patients before they get seriously ill or if ill already, to tailor care to reduce acute episodes. We will pursue technology opportunities that will shape the design and delivery of the preventative and personalised care agenda in primary care over the next 5 years. Primary care and GP clinical supervision is essential to adoption of new technologies. Examples include remote consultations and telemedicine. The main benefits of this approach will be the shift to improved wellness, a reduction in the acuity of care and an overall improvement in outcomes and efficiency in care delivery. We feel that having the ability to influence new Local Enhanced Services will help us to incentivise these developments.

Box 3: Personalised and Preventative Care – Patient Benefits
• This approach will drive a wellness agenda across ME CCG and ensure we are treating patients proactively to avoid or delay acute episodes through app-driven wellness, self-care, smart homes and assisted living technologies. • We will be treating patients in the comfort of their homes, and tailoring care to individual patient's needs through telemedicine and remote consultations • There will be greater efficiency in care delivery through the use of case managers, patient coordinators, predictive analytics, technology-enabled new work models and interoperability between care systems

4. Significantly improve Quality in Primary Care

By using co-commissioning opportunities to develop sustainable high standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reduce unwarranted variations in quality, and, where appropriate, provide targeted improvement support for practices.

We would use all quality metrics available to support this work stream including outputs from Patient Survey and the analysis of Patient Complaints.

The CCG is also currently in discussions with the GP Provider Arm to run a project looking at primary care sustainability including quality and member practice capacity to deliver our strategic goals and achieve improvement in the outcome indicators. This work would be completed during 2015/16-2016/17 to inform a longer-term strategy to improve primary care quality and reduce variation in patient outcomes across our two localities

Box 4: Quality in Primary Care – Patient Benefits
• Improved levels of patient satisfaction with the services they receive in general practice across both our localities • Opportunity for CCG to work with NHS England with regards decision making for primary care commissioning and contracting alongside PC Estates Development, workforce and the strategic development of primary care. • Patients will receive high quality experience across all our practices for the core elements of day-to-day practice - including, diagnosis, referral and prescribing; non-clinical aspects of quality - including, access to care and patient engagement; and areas where the role is shared with others - for example, maternity and end-of-life care.