NHS
Mid Essex
Clinical Commissioning Group

# CO-COMMISSIONING IN PRIMARY CARE

## A discussion paper on a proposed way forward for MECCG

## 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.

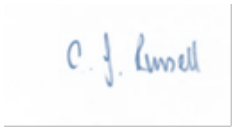
Nationally, it appears that momentum is steadily gathering for CCGs to take on more primary care commissioning responsibilities. We believe we have a unique opportunity to benefit from the resources, guidance and help that is available to CCGs who wish to take on more of these responsibilities.

However, the window of opportunity is extremely small. We believe it's vital that, with the support of our member practices, we act now in order to maximise the benefits that are available to those CCGs indicating they want to move in this direction.

This document sets out the differences between the models; the opportunities going forward and things to carefully consider. As we've said before, 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 would welcome your views on what we are proposing and invite you to let us know any questions, queries or comments you may have by no later than Tuesday 1st September 2015.



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 participates 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 in this direction.

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:

- 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.

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.

## A change in co-commissioning – Strengths and weaknesses

All three models described represent a fundamental shift in the way primary care will be commissioned in mid Essex. Having engaged with several practices already, the CCG has been able to form a view on how we might 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 believe we should opt to wait and see if there are further developments.

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 you 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.<br><br>Opportunity to build on gains made since the introduction of CCG's without the need for restructuring.<br><br>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.<br><br>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).<br><br>CCG's have minimal influence over national strategy – will not be able to design local incentive schemes to replace QOF and DES.<br><br>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.<br><br>Ability to design local schemes to replace QOF and DES's.<br><br>Could create better collaboration with neighbouring CCG's as they work together in one joint commissioning group with the AT.<br><br>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).<br><br>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.<br><br>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.<br><br>Tensions between CCGs Board and member practices related to COI arising from CCGs jointly commissioning, holding and managing GP contracts.<br><br>Could worsen tensions where historic relationship between member practices and CCG is poor or dysfunctional. |

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|---|---|---|
| **Delegated Responsibilities** | Opportunity for GP's in CCGs to have direct leadership to influence the development and investment in general practice.<br><br>CCGs will be best placed to commission primary/community/secondary care in holistic and integrated manner.<br><br>Ability to design local schemes to replace QOF and DESs.<br><br>CCGs will have more power to drive forward the development of new GP provider models and the 5 year 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.<br><br>CCGs commissioning, holding and managing GP contracts could worsen tensions where historic relationship between member practices and CCG is poor or dysfunctional.<br><br>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.<br><br>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.<br><br>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, what our options are in relation to timing and how they 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).**

Given the national trends, the timescales involved and the local situation within Mid Essex CCG, we believe that opting for this approach would minimise any risks that would be incurred in awaiting further developments. If the CCG opts to wait, it could mean that we miss out on a number of resources, guidance, help and support that will be offered to those CCGs who take on greater responsibility.

However, we need to know if you support our view, or whether you believe we should await further developments.

## Gathering your views

We want to make sure all MECCG member practices have the opportunity to consider the options and let us know whether they support our preferred option for the future. However, we would value your input too.

We have asked Member Practices to indicate their preference and to let us know their view by September 1st 2015. We will let you know the outcome of this piece of work.

If you have any questions about this document, or if you would like to express an opinion on what you think is the best option then please feel free to email Adam Cronin at MECCG adam.cronin@nhs.net with your opinions.