REPORT TO:	Health Policy and Performance Board
DATE:	13th January 2015
REPORTING OFFICER:	Simon Banks, Chief Office
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Developing a NHS Halton CCG response to *Next steps towards primary care co-commissioning*
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 On 10th November 2014 NHS England, in partnership with NHS Clinical Commissioners, published *Next steps towards primary care co-commissioning*. The document aims to provide clarity and transparency around co-commissioning options, providing CCGs and area teams with the information and tools they need to choose and implement the right form of co-commissioning for their local health economy. NHS Halton CCG needed to decide by 9th January 2015, the level of primary care co-commissioning the organisation wishes to undertake with NHS England.

2.0 RECOMMENDATION: That the Health Policy and Performance Board are invited to review this paper and receive a verbal update from NHS Halton CCG.

3.0 SUPPORTING INFORMATION

3.1 In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. There has been a strong response from CCGs wishing to assume co-commissioning responsibilities. NHS Halton CCG submitted an expression of interest in co-commissioning of primary care services in June 2014.

3.2 NHS England now wants to harness this energy and address the frustrations CCGs have expressed in the current primary care commissioning arrangements, to more effectively shape high quality local services. The purpose of *Next steps towards primary care co-commissioning* is to give CCGs an opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each model, including associated functions; governance arrangements; resources; and any potential

risks, with advice on how to mitigate these. The document then sets out the steps towards implementing co-commissioning arrangements, including the timeline and approvals process.

3.3 Co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. The *Five Year Forward View* emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will drive the development of new integrated out-of hospital models of care, such as multispecialty community providers and primary and acute care systems.

3.4 Co-commissioning will give CCGs the option of having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained. Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities; and
- A better patient experience through more joined up services.

3.5 Co-commissioning could also lead to greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services. Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

3.6 Primary care co-commissioning is the beginning of a longer journey towards place based commissioning – where different commissioners come together to jointly agree commissioning strategies and plans, using pooled funds, for services for a local population. From 1 April 2015 NHS England will be extending personal commissioning through The Integrated Personal Commissioning (IPC) programme. The IPC programme aims to bring health and social care together, identifying the totality of expenditure at the level of the individual, giving people more control over how this is used and enabling money to be spent in a more tailored way. Furthermore, from 2015/16 CCGs will have the opportunity to co-commission some specialised services through a

joint committee. NHS England has also been encouraging CCGs and local authorities to strengthen their partnership approach so they can jointly and effectively work to align commissioning intentions for NHS, social care and public health services.

3.7 *Next steps towards primary care co-commissioning* gives clinical commissioning groups (CCGs) the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements. The document has been developed by the joint CCG and NHS England Primary Care Commissioning Programme Oversight Group in partnership with NHS Clinical Commissioners.

3.8 Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

3.9 There are three primary care co-commissioning models CCGs could take forward:

- Greater involvement in primary care decision making.
- Joint commissioning arrangements.
- Delegated commissioning arrangements.

3.10 The scope of primary care co-commissioning in 2015/16 is general practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

3.11 Under joint and delegated arrangements, CCGs will have the opportunity to design a local incentive scheme as an alternative to the Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DES). This is without prejudice to the right of GMS practices to their entitlements, which are negotiated and set nationally. In order to ensure national consistency and delivery of the democratically-set goals for the NHS outlined in the Mandate set for us by the government, NHS England will continue to set national standing rules, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF and IT intra-operability.

3.12 In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest. In delegated arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

3.13 With regards to governance arrangements, draft governance frameworks and terms of reference for joint and delegated arrangements on behalf of CCGs have been developed. CCGs are encouraged to utilise these resources when establishing their governance arrangements.

3.14 A significant challenge of primary care co-commissioning is finding a way to ensure that CCGs can access the necessary resources as they take on new responsibilities. Pragmatic and flexible local arrangements for 2015/16 will need to be agreed by CCGs and area teams.

3.15 Conflicts of interest need to be carefully managed within co-commissioning. Whilst there is already conflicts of interest guidance in place for CCGs, this will be strengthened in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. A national framework for conflicts of interest in primary care co-commissioning will be published as statutory guidance in December 2014.

3.16 The approvals process for co-commissioning arrangements will be straightforward. The aim is to support as many CCGs as possible to implement co-commissioning arrangements by 1 April 2015. Unless a CCG has serious governance issues or is in a state akin to "special measures", NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs who wish to implement joint or delegated arrangements will be required to complete a short proforma and request a constitution amendment. The approvals process will be led by regional moderation panels with the new NHS England commissioning committee providing final sign off for delegated arrangements. The timescales for submissions are:

- Joint commissioning – 30th January 2015
- Delegated commissioning, noon, 9th January 2015

4.0 POLICY IMPLICATIONS

4.1 NHS Halton CCG has been required, within short timescales, to

consider the three models of co-commissioning that have been presented to the organisation. It is arguable that the first of these approaches, greater involvement in primary care co-commissioning, simply reflects where the organisation was at its inception – collaborating closely with our area team to ensure that decisions taken about healthcare services are strategically aligned across the local health economy and assisting NHS Halton CCG in fulfilling the duty to improve the quality of primary medical care. NHS Halton CCG therefore had a choice of two approaches, joint commissioning or delegated commissioning.

4.2 Joint Commissioning

4.2.1 A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". 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. Within this model CCGs also have the option to pool funding for investment in primary care services.

4.2.2 In 2015/16, joint commissioning arrangements will be limited to general practice services. The functions joint committees could cover are:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("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).

4.2.3 Joint commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS CCGs could either form a joint committee or "committees in common" with their area team in order to jointly commission primary medical services. With regards to joint committees, due to 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. NHS England's scheme of delegation is being reviewed and will be revised as appropriate to enable the formation of joint committees between NHS England and

CCGs i.e., where NHS England invites one or more CCGs to form a joint committee.

4.2.4 A model terms of reference for joint commissioning arrangements, including scheme of delegation has been developed by NHS England. This model applies to the establishment of a joint committee between the CCG (or CCGs) and NHS England. If CCGs and area teams intend to form a joint committee, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures. The joint committee structure allows a more efficient and effective way of working together than a committees-in-common approach and so this is the recommended governance structure for joint commissioning arrangements.

4.2.5 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. Arrangements should also comply with the conflicts of interest guidance.

4.2.6 The effectiveness of joint arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. NHS England and CCGs need to ensure that any governance arrangements put in place enable them to collaborate effectively.

4.2.7 It is for area teams and CCGs to agree the full membership of their joint committees. In the interests of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the joint committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

4.2.8 CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of

their committees. It will be important to retain clinical leadership of commissioning in a joint committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.2.9 CCGs and area teams may wish to consider implementing a pooled fund arrangement under joint commissioning arrangements as per section 13V of Chapter A1 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Establishing a pooled fund will require close working between CCG and area team finance colleagues to ensure that the arrangement establishes clear financial controls and risk management systems and has clear accountability arrangements in place.

4.2.10 The funding of core primary medical services is an NHS England statutory function. Although NHS England can create a pooled fund which a CCG can contribute to, the CCG's contribution must relate to its own functions and so could not relate to core primary medical services. However, CCGs are able to invest in a way that is calculated to facilitate or is conducive or incidental to the provision of primary medical care and provided that no other body has a statutory duty to provide that funding.

4.3 Delegated Commissioning

4.3.1 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. Naturally, CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation.

4.3.2 NHS England and NHS Clinical Commissioners have agreed that a standardised model of delegation would make most sense for practical reasons. CCGs have expressed a strong interest in assuming the following primary care functions which will be included in delegated arrangements:

- 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).

4.3.3 Delegated commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management. CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.3.4 NHS England has developed a model governance framework for delegated commissioning arrangements in order to avoid the need for CCGs to develop their own model. The recommendation is that CCGs establish a primary care commissioning committee to oversee the exercise of the delegated functions. A model terms of reference for delegated commissioning arrangements including scheme of delegation has been developed. If CCGs intend to assume delegated responsibilities, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures.

4.3.5 A formal document which records the delegation of authority by NHS England to CCGs will be issued once the approvals process is completed. In delegated commissioning arrangements, CCGs will remain accountable for meeting their own pre-existing statutory functions, for instance in relation to quality, financial resources and public participation. CCGs must ensure that any governance arrangement they put in place does not compromise their ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making.

4.3.6 It is for CCGs to agree the full membership of their primary care commissioning committee. CCGs will be required to ensure that it is chaired by a lay member and have a lay and executive majority. Furthermore, in the interest of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the delegated committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

4.3.7 CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of

stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. Furthermore, it will be important to retain clinical involvement in a delegated committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.4 Implications for NHS Halton CCG

4.4.1 Co-commissioning is now firmly established as a direction of travel within the NHS. The guidance recognises that CCGs are at different stages of their developmental journey and are facing a variety of local challenges. Therefore it is likely that the appetite to take on further responsibilities for primary care co-commissioning will vary across the country. It is nonetheless clear that NHS England wants CCGs to enter into joint commissioning arrangements for 2015/16 before taking on delegated responsibilities for 2016/17. At the NHS Halton CCG Governing Body on 4th December 2014 it was recommended an expression of interest should be submitted for the organisation to assume delegated commissioning for 2015/16.

4.4.2 Both models, joint commissioning and delegated commissioning, involve the establishment of the appropriate governance mechanisms to support impartial decision making, engage with the local population and avoid conflicts of interest. The establishment of a set of governance arrangements for joint commissioning would be as time consuming as for delegated commissioning. Furthermore, if joint commissioning were to be pursued, another iteration of changes in governance would need to follow for delegated commissioning. It cannot be guaranteed that NHS England would have sufficient numbers of people to attend a joint committee, which could impair the ability of such an arrangement to function effectively. Joint commissioning would also involve an additional set of governance beyond the Governing Body, whereas delegated commissioning could be more easily established around existing arrangements. In terms of governance arrangements, it is therefore suggested that it would be more appropriate and efficacious to take on delegated commissioning from 2015/16.

4.4.3 A significant challenge involved in implementing primary care co-commissioning is finding a way to ensure that all CCGs can access the necessary resources as they take on new co-commissioning responsibilities. This challenge exists whatever model NHS Halton CCG decides upon.

4.4.4 Primary care commissioning is currently delivered by teams covering a large geography normally spanning several CCGs, and also covering all parts of primary care not just limited to general practice. There is no possibility of additional administrative resources being deployed on these services at this time due to running cost

constraints. It is arguable that NHS Halton CCG is already complementing and potentially supplementing these existing arrangements with our own resources, the development of the strategy for general practice services in the borough being one example. In short, NHS Halton CCG is already engaged in a *de facto* joint commissioning arrangement and it would not take a significant amount of redesign to deliver delegated commissioning.

4.4.5 Pragmatic and flexible local solutions will need to be agreed by CCGs and area teams to put in place arrangements that will work locally for 2015/16. These local agreements will need to ensure that:

- 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.

4.4.6 Whether NHS Halton CCG pursues joint or delegated commissioning, a conversation will be needed with the area team regarding accessing support through their existing primary care team. Again, it would be preferable to have such a conversation once. Given the limited size of existing primary care teams, potentially only part-time capacity would be available for individual CCGs taking on delegated commissioning responsibility, so it may be that collaborative arrangements between CCGs would be desirable to achieve greater critical mass. Staffing models for these arrangements will vary across the country and will require careful discussion to ensure that the practical, legal and staff engagement issues are clearly understood. We understand that the majority of CCGs in Cheshire and Merseyside, which will be the geography served by the new Area Team, are exploring delegated commissioning and will be potentially 'fishing in the same pond' for resources. NHS Halton CCG needs to be an active participant in these discussions alongside like-minded CCGs.

4.4.7 NHS England will ensure transparency in sharing financial information on primary care with CCGs. All CCGs will have the opportunity to discuss the current financial position for all local primary care services with their area team. CCGs will be provided with an analysis of their baseline expenditure for 2014/15 broken down between GP services and other primary care services by the end of November 2014. Final decisions regarding allocations for 2015/16 will be made by the NHS England Board in December 2014.

4.4.8 NHS England recognises that it will be challenging for some CCGs to implement co-commissioning arrangements, especially delegated

arrangements, without an increase in running costs. Whilst it is not within their gift to increase running costs in 2015/16, NHS England will keep this situation under review. CCGs should discuss with area teams options for sharing administrative resource to support the commissioning of primary care services.

4.4.9 In delegated arrangements, CCGs will receive funding for known future cost pressures within current allocations e.g. net growth in list sizes. In such circumstances, there may be a linked efficiency requirement which will need to be delivered in order for budgets to balance. Furthermore, if supported by clear strategies, CCGs would also have greater flexibility to "top up" their primary care allocation with funds from their main CCG allocation. Delegation would therefore give NHS Halton CCG greater control than joint commissioning in terms of resource allocation, which would enable the delivery of any aspirations for revised care models that emerge from our *Strategy for General Practice Services in Halton* or in response to *Five Year Forward View*.

4.4.10 NHS England is taking steps to move towards a fair distribution of resources for primary care, based on the needs of diverse populations. The GMS Minimum Practice Income Guarantee (MPIG) will be phased out by April 2020, and a review of local PMS agreements is underway as set out in the Framework for Personal Medical Services (PMS) Contracts Review. Area teams should ensure that any decisions relating to future use of PMS funding are agreed with CCGs. We envisage that CCG and primary care allocations will continue to move towards a fair distribution of resources and reflect inequalities, as in the current CCG formula. As part of any delegation of primary care commissioning responsibilities, area teams will provide details of any differential funding levels across localities. Again, it is arguable that a delegated model would give NHS Halton CCG more influence over the future use of PMS funding.

4.5 <u>Decision Making</u>

4.5.1 At the time of writing, NHS Halton CCG is preparing to make a firm decision as to which of the three co-commissioning options the organisation should pursue. It will be recommended to the CCG's Governing Body on 4th December 2014 that a submission for delegated commissioning should be developed, rather than a submission for joint commissioning. This document needs to be completed and submitted by noon on 9th January 2014.

4.5.2 The guidance states that, as membership organisations, CCGs should fully engage with their members when considering co-commissioning options. It also suggests that it would be of benefit it the CCG and local stakeholders such as patients, local authorities, Health and Wellbeing Boards and HealthWatch had an open and

inclusive conversation about options and possible arrangements.

4.5.3 Unfortunately the time frame within which NHS Halton CCG Governing Body needs to make a decision is not conducive to meaningful engagement with member practices or other partners. The paper that went to the NHS Halton CCG Governing Body on 4th December 2014 therefore proposed that a draft submission supporting delegated commissioning is drawn up and comments invited from member practices and other key partners by 19th December 2014. The submission would also be discussed at the NHS Halton CCG Service Development Committee on 10th December 2014 with clinical and practice leads and at the Governing Body Development Session on 18th December 2014. The final submission would be ratified by the Governing Body on 8th January 2015.

4.5.4 The Health Policy and Performance Board will be given a verbal update on the outcomes of this work.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Co-commissioning will need to be delivered within existing programme and running cost allowance budgets. There may be opportunities for pooled or delegated budgets and other resources depending on the model followed.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None as a result of this report.

6.2 Employment, Learning & Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

None as a result of this report.

6.4 A Safer Halton

None as a result of this report.

6.5 Halton's Urban Renewal

None as a result of this report.

7.0 RISK ANALYSIS

7.1 The greatest risk arising from co-commissioning is the ability of NHS

Halton CCG to deliver additional commissioning responsibilities with existing resources.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 NHS Halton CCG will be required to ensure that it is compliant with the duties upon public bodies under the Equality Act 2010 as co-commissioning develops.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Five Year Forward View, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/.

NHS England and NHS Clinical Commissioners, *Next steps towards primary care co-commissioning*, NHS England, Gateway Reference 02501, 10th November 2014, www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf.