BMA

Update on co-commissioning of primary care: guidance for CCG member practices and LMCs

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This paper is an update of previous GPC (general practitioners committee) guidance for GP practices and LMCs (local medical committees) about options for your CCG (clinical commissioning group) to take greater commissioning control (called "co-commissioning") including the commissioning and performance management of general practice contracts. Since the previous guidance, 114 of the 209 CCGs in England have assumed delegated commissioning responsibilities. If your CCG is thinking of doing the same it is important that you understand these changes and their implications. As a practice it is important you are aware of what is happening in your area so you can exercise your rights as a member to democratically influence the decision of your CCG.

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Key points for CCG member practices and LMCs

1) Make sure you understand the different co-commissioning models and their implications for your practice, including the benefits and risks of each model.

2) Engage your CCG Board. Discuss with them:
   - What do they see as the benefits of delegated commissioning in your area?
   - What are their views on holding and performance managing member GP contracts?
   - What will the membership of "joint committees" and "primary care commissioning committees" look like? [See 'What do the different co-commissioning models mean' for more information on these]
   - How will CCGs manage and mitigate the risks from conflicts of interest?
   - What frameworks is your CCG putting in place for arbitration processes?

3) CCGs must consult their membership and obtain a mandate from members before making any decisions about co-commissioning and before submitting proposals to NHS England. GPC thinks this should take the form of a formal democratic vote of member GPs/practices.

4) CCGs should have consulted their LMC well in advance of making any decisions about co-commissioning.

5) Any CCGs taking forward delegated commissioning must update their constitutions, in collaboration with member practices.

6) **If these steps have not taken place then your CCG should not be going forward with delegated commissioning.** The deadline for applying for delegated commissioning in April 2017 is **5 December 2016**.

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What is co-commissioning?

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

This was first introduced in November 2014 in the document *Next steps towards primary care co-commissioning* for CCGs to take up from April 2015. NHS England offered each CCG the opportunity to adopt one of three commissioning models:

- Model A: Greater involvement
- Model B: Joint commissioning
- Model C: Delegated commissioning

In the first year 63 CCGs took on full delegation, with another 51 CCGs opting for it the following year. At present the number of CCGs who have opted for some form of co-commissioning are:

- Model B: Joint commissioning – 60 CCGs
- Model C: Delegated commissioning – 114 CCGs

The list of CCGs and details of which co-commissioning model they are using is available here. We have assumed that the 35 remaining CCGs will have adopted model A by this point and will be working closely with their NHS England regional team.

At present, CCGs are not obliged to apply for any of the co-commissioning models. Before making any decisions and before submitting proposals to NHS England, CCGs must consult their membership and obtain a mandate from members. GPC believes that this should take the form of a formal democratic vote of member GPs/practices.

This is supported by the NHS England application pro forma requiring the CCG Accountable Officer and Audit Committee Chair to confirm that the '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 2017/18.' If CCGs do not properly follow this process, including allowing enough time to consult with members, it is questionable whether any changes are valid and can be implemented.

Any CCGs taking forward co-commissioning must also update their constitutions, in collaboration with member practices.

It is critical that CCGs consult their LMC well in advance of any decision about co-commissioning and, if they decide to take it forward, involve them fully in the process.

What won't CCGs be able to do?

CCGs – regardless of the commissioning model adopted – will not have any additional powers over the performance management of individual GPs, including the medical performers' list, appraisal or revalidation.

CCGs will not have any additional powers over the commissioning of dental, community pharmacy and eye health. NHS England are exploring options for expanding co-commissioning into wider primary care areas in the future.

What do the different co-commissioning models mean?

1. Model A: Greater involvement

Greater involvement in primary care co-commissioning is an invitation to CCGs to collaborate more closely with their NHS England regional teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy. This level involves no CCG decision making on GP contracts and no conflicts of interest.

We would expect all CCGs to be at least at this level.

2. Model B: Joint commissioning

A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their NHS England regional team.

The functions **joint committees** cover are:

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

Within this model CCGs and NHS England regional teams can create a pooled funding arrangement to increase investment in primary care services.

Governance: Joint commissioning requires a "joint committee" or "committees in common" to make commissioning decisions. This could be with one or more CCGs and the NHS England regional team. It is for regional teams and CCGs to agree the full membership. Representatives from the local Healthwatch and Health and Wellbeing Board also have the right to join this committee as non-voting members.

NHS England's guidance on conflicts of interest does not go into a lot of detail with regards to mitigating conflicts of interests for the joint commissioning model. They expect that 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 their role in the decision-making process. See the governance section for the delegated commissioning model for more detail on what this could look like.

How to apply: There is no longer a formal approval process for joint commissioning; arrangements should be taken forward locally. The next go-live date for joint commissioning is 1 January 2017. All agreements and documentation should be in place before this point.

3. Model C: Delegated commissioning

Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the liability for the performance of primary medical care commissioning so will expect assurance that its statutory functions are being discharged effectively. This requires good communication between the CCG and the NHS England regional team. NHS England suggests CCGs taking on delegated commissioning consider collaborating or merging with other CCGs to receive requisite support.

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

These are the same functions that that the joint committee has responsibility for in the joint commissioning model. The **main difference here is that the responsibility and decision-making for these functions lies solely with the CCG**, as opposed to jointly with the NHS England regional teams. This means that primary care investment decisions that fall within the functions above will not require approval by the NHS England area team.

Within this model CCGs have greater flexibility to "top up" their primary care allocation with funds from the main CCG allocation.

NHS England is explicit that there is no possibility of additional administrative resources going to CCGs who apply for this model. However, they accept that pragmatic and flexible local solutions need to be agreed by CCGs and regional teams to ensure that CCGs have access to a fair share of the regional team's primary care commissioning staff resources. It is important to hold them to account over this.

Governance: Delegated commissioning requires CCGs to create a PCCC ("primary care commissioning committee") to oversee the exercise of delegated functions. It is for CCGs to agree the full membership of this committee. However, it is required to have a lay Chair and lay majority within both the committee and the executive. Representatives from the local Healthwatch and Health and Wellbeing Board also have the right to join this committee as non-voting members.

NHS England's guidance on conflicts of interest recommends that CCGs do not have voting rights on the PCCC. One way to ensure that this doesn't limit clinical involvement in commissioning is by having GPs from other CCG areas and non-GP clinical representatives (such as the CCG's secondary care specialist and/or governing body nurse lead) as voting members on the committee. The CCG may wish to consider a reciprocal arrangement with other CCGs to enable effective, but not conflicted, clinical representation within the committee.

GPC recommends that LMCs also have a seat on the PCCC.

How to apply: The deadline for submissions for delegated commissioning in April 2017 is **5 December 2016**. CCGs should already be having discussions with their NHS England regional team and finance leads. They should also have consulted their membership, as well as their LMC, well in advance of making any decisions about co-commissioning and/or amending constitutions. GPC thinks this should take the form of a formal democratic vote of member GPs/practices.

Conflicts of interest

Whilst moving to a joint or delegated commissioning structure undoubtedly raises issue around conflicts of interests, there are ways of mitigating these by putting in place specific measures in the CCG constitution. **CCGs must consult with member practices about any necessary changes to their constitutions.**

In order to avoid conflict of interest issues, CCGs need to put in place measures that are robust, transparent and command confidence amongst member practices. This needs to happen from day one, and needs to be regularly reviewed given the changing policy environment. It is important that they involve the LMC throughout this process. As a minimum we believe that GP members of CCG boards must not be involved in any investment or performance management decisions affecting member practices.

As a number of CCGs have already started delegated commissioning there are examples of how this can be done successfully. Your NHS regional team should be able to work with your CCG to make sure arrangements are satisfactory.

GPC have published specific guidance covering conflicts of interests in co-commissioning, which includes suggested changes to CCG constitutions.

In June 2016, NHS England published revised statutory guidance on conflicts of interest, specifically aimed at CCGs exercising delegated authority.

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

	Opportunities	Threats
Greater involvement	– CCGs have more influence in the development of general practice without any of the risks of direct responsibility or accountability. – Removes the risk of increased conflicts of interest.	– Commissioning decisions remain slow and fragmented. – CCGs (and practices) are less able to make changes to general practice services than those who have decided to take on greater responsibility (widening gap between practices). – CCGs have minimal influence over national strategy – they 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, regional NHS England teams – Inconsistent with the direction of travel for place-based plans that support the needs of the local area.
Joint commissioning	– Greater and direct influence in the development of and investment in general practice. – Ability to design local schemes to replace QOF and DESs. – Could create better collaboration with neighbouring CCGs as they work together on joint commissioning groups. This is consistent with wider policy on increased collaboration across localities through initiatives like STPs (sustainability and transformation plans). – CCGs (and member practices) are relatively less exposed to conflict of interest issues compared to full delegated responsibility. – CCGs may not have the management capacity for the workload involved in delegated commissioning.	– Risk that joint structures will have no real accountability to individual CCGs (and member practices). CCGs must ensure that they are a significant and equal partner. – Local schemes to replace QOF and DES may result in increased workload as practices are likely to still be expected to adhere to QOF indicators which are also monitored as part of the CQC inspection process. – Increased exposure to conflicts of interest (whether real or perceived). – Could worsen tensions where the historic relationship between member practices and CCG is poor or dysfunctional. – NHS England regional teams are remote and do not have the necessary local knowledge to use resources in the most effective way.
Delegated responsibility	– Opportunities for GPs in CCGs to have direct leadership to influence the development of and investment in general practice. This should allow for more timely decision-making for practices. – CCGs are best placed to commission primary/community/secondary care in a holistic and integrated manner. – Ability to design local schemes to replace QOFs and DESs, which are aligned with local strategic intentions. – CCGs will have more power to drive forward the development of new GP provider models and the five year forward view agenda. – It fits with wider strategy to develop place-based commissioning to best support the needs of local populations. – Offers opportunities to improve out-of-hospital services and support a shift in investment from the acute to primary and community care setting. This is something that is being put forward in most STPs. – Ability to make redesign decisions across a portfolio of providers and so across pathways of care tailored to local need. Opportunity to be more patient focussed in commissioning.	– It can be an additional strain on resources for CCGs, which will inevitably have an impact elsewhere in the system. – CCGs commissioning, holding and managing GP contracts could worsen tensions where the historic relationship between member practices and CCG is poor or dysfunctional. – Local schemes to replace QOF and DES may result in increased workload as practices are likely to still be expected to adhere to QOF indicators which are also monitored as part of the CQC inspection process. – Responsibility for any deficit including outstanding legacy payments/debts as well as secondary and tertiary care overspends and deficits. – Even more exposure to conflicts of interest (whether real or perceived). – Paradoxically, the strict governance structure required to mitigate the conflicts of interest issue could lead to less true influence by GPs, practices and CCGs in commissioning general practice. As GPs continue to work at scale this will become even more of an issue [See 'Policy environment update' for more information on this].

FAQs

Are any other changes to commissioning likely?	Yes. NHS England has been clear that co-commissioning reforms were the first step towards turning CCGs into organisations which may use a capitated budget to deliver care to defined populations.
Is it true that CCGs are also soon to be commissioning specialised services?	Specialised services are still commissioned by NHS England, although they are taking a more collaborative approach with CCGs. It is possible that this will change in the future.
How will local incentive schemes/ contracts align with national arrangements?	Any migration from a national standard contract could only be affected through voluntary action. CCG Boards cannot compel practices to change from a national contract to a local contract. National monitoring for all QOF indicators via CQRS (Calculating Quality Reporting Service) will continue (practices should be mindful that this may put them at risk of doing new work without stopping any QOF obligations).
Will there be a formal process for CCGs developing local incentive schemes or enhanced services?	No. There will be no formal approvals process for any CCG wishing to develop a local QOF scheme or local alternative to a DESs. Any proposed new incentive scheme should be subject to consultation with the LMC, and must be able to demonstrate improved outcomes, reduced inequalities and value for money.
Are CCGs bound by national regulations and/or directions with regards to the GMS/PMS contract?	Yes. The terms of GMS contracts – and any nationally determined elements of PMS and APMS contracts – will continue to be set out in the respective regulations and directions and cannot be varied by CCGs or joint committees.
Are CCGs bound by national plans for MPIG (Minimum Practice Income Guarantee) and PMS reviews?	Yes. CCGs will be required to adopt findings from PMS and MPIG reviews. Any locally agreed schemes will need to reflect the changes agreed as part of the review.
Do CCGs who take on additional responsibility have access to additional resources?	No. There is no possibility of additional administrative resources being deployed to CCGs. Pragmatic local solutions will need to be agreed by CCGs and NHS England local teams.

Policy environment update

Since the guidance was first published in December 2014 there have been a number of changes to the environment that co-commissioning takes place in. These may affect the way that CCGs and practices are thinking about co-commissioning. This section sets out some of these changes and considers how they might relate to co-commissioning.

Working at scale

Since our previous guidance the number of GPs working at scale has continued to increase. In a recent BMA survey 43% of GPs in England reported that their practice had joined a federation or network. Whilst we support this development, it creates additional risks of conflicts of interest issues for co-commissioning. There is a risk that the line between practices as members of a CCG and practices as providers within GP networks/federations or local integrated care systems will become increasingly blurred. For example, some networks could in theory cover an entire CCG area.

In June 2016, NHS England published updated statutory guidance on conflicts of interest, taking on board learning from the first wave of CCGs to opt for delegated commissioning. This should help provide CCGs with the necessary toolkit to put in place measures to restrict and negate conflicts when making decisions on matters of primary care commissioning. Recently, NHS England have established a cross system task and finish group, which the BMA has a representative on, with the aim of strengthening conflicts of interest management across the NHS. Once this has concluded it is possible that NHS England's guidance will need to be updated.

GP forward view

In April 2016, NHS England published the general practice forward view, setting out a general programme of support for general practice over the next five years. This strategy follows strong lobbying and calls for action from GPC, including our paper on 'Responsible, safe and sustainable: our urgent prescription for general practice'. As part of the GP forward view, NHS England have committed to invest a further £2.4bn a year by 2020/21 into general practice services, representing a 14% real terms increase. They have also committed £508 million for a five year sustainability and transformation package. This includes a £56 million practice resilience programme starting in 2016/17, £206 million for workforce measures and £246 to support practices in redesigning services. For more information on the potential opportunities for general practice from the GP forward view see our 'Focus on the NHS England General Practice Forward View' and 'Focus on funding and support for general practice'.

CCGs have been asked to submit a GPFV plan to NHS England on 23 December 2016. These are expected to reflect local circumstances but must, at a minimum, set out: how access to general practice will be improved; how funds for practical transformational support will be created and deployed to support general practice; how ring-fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed. It is important to hold your CCGs to account over these plans.

The additional flexibility delegated commissioning gives CCGs puts them in a better position to create and carry out these plans. It will also make it easier for practices to hold CCGs to account over their support for general practice over the next five years, as they will be responsible for making decisions over the funding of general practice rather than either a remote NHS England regional team or a joint committee where it is unclear who has ultimate responsibility.

New care models

When co-commissioning was first introduced the five year forward view had recently been published. It promoted several new care models that break down traditional divides between primary, secondary, and community care and between health services, social care and mental health services. One example of these models is a MCP (multispecialty community provider), a new type of integrated provider that has general practice at its heart and combines the planning, budgets and delivery of primary and community care. It delivers care to the whole population, based on the registered lists of GP practices, using integrated, multi-disciplinary teams. Three different voluntary MCP contractual options are currently in development.

Since then, these models have been developing and the first few are expected to "go live" during 2017. However, for these models to successfully bring about transformation they need to be matched by an equally integrated locality-based commissioning model. CCGs are responsible for the majority of healthcare commissioned services so, to work most effectively with integrated provider models, they need to have access to the full range of commissioning possibilities, including primary care.

The delegated model provides the greatest flexibility to do this in a way suited to local need as CCGs have the ability to choose how to invest from their whole budget. In the joint model, there is the option to set up a pooled budget arrangement with NHS England but there will need to be agreement across the "joint committee" or "committees in common" about how this money is spent.

For example: A CCG commissions district nursing services from its community provider. In the delegated model, the CCG could consider pooling the funding for this service with its primary care funding and arrange for district nursing services to be commissioned as part of primary care linked to GP practice nursing. This arrangement would work well for GP services that might be offering some wider primary care services within their practice or network.

Place-based systems of care

Another important development is the creation of STPs (sustainability and transformation plans), new place-based planning systems. Health and care organisations within 44 footprint areas, covering the whole of England, were tasked with creating these STPs during 2016. Among other things, STPs are expected to outline how integration across healthcare and with local authority services, including public health and social care, will be improved.

This move towards offering more integrated care is likely to involve changing the traditional payment mechanisms used across the system. Capitated payments are one way that CCGs might approach this, particularly for patients with several complex long term conditions. Capitated payment means paying a provider or group of providers to cover the majority of the care provided to a target population, across different care systems. This is slightly different to the model currently used for primary care budgets where the payment goes to a single provider and only covers primary care activity. If there is a move to more patients having capitated budgets across wider systems of care, including primary care, then CCGs having responsibility for the majority of the health budget puts them in a better position to manage this.

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