Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Co-Commissioning Primary Care Services

Governing Body meeting

J

4 December 2014

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Is your report for Approval / Consideration / Noting

Approval

Are there any Resource Implications (including Financial, Staffing etc)?

Not at this point

Audit Requirement

CCG Objectives

4.6 Contractual restraints facing member practices resulting in an inability of practices to deliver and expand service provision

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached?
This paper focusses on the potential to alter organisational arrangements so at this stage an EIA is not required

PPE Activity

How does your paper support involving patients, carers and the public?
No change

Recommendations

The Governing Body is asked to approve the following recommendations:

- That for the financial year 2015/16 the CCG's preferred co-commissioning model is that of level 1, Greater involvement in primary care decision making with NHSE; and
- That, should our wider commissioning agenda require an increased level of co-commissioning in-year, such a submission will be made at that time.

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1 Introduction

At its November meeting the Governing Body discussed an update on the proposed Co-Commissioning arrangements of Primary Care (General Medical Services) and, in recognising that further guidance was awaited, asked for a further paper to be presented and discussed once the new guidance had been issued.

This paper outlines the content of the guidance which has now been received; assesses the opportunities and risks of each co-commissioning level and seeks Governing Body's approval of the preferred level of Co-commissioning for Sheffield CCG for the financial year 2015/16.

2 Aims of Co-Commissioning

The stated overall aim of co-commissioning is to develop better integrated out-of-hospital services based around the diverse needs of local populations.

For many CCGs 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.

Co-commissioning is one of a series of changes set out in the *NHS Five Year Forward View* as it sets out the need to break down traditional barriers in how care is provided. It calls for out-of-hospital care to become a much larger part of what the NHS does, and for services to be better integrated around the patient. Co-commissioning is a key driver of this by enabling greater collaboration between commissioners across local health economies and wider geographical and organisational footprints.

3 Proposed Co-Commissioning Models

Three standard models for the co-commissioning of primary care have been offered to CCGs by NHSE, principally for reasons of governance and administrative efficiency. These are:

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. The terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in respective regulations and cannot be varied under any co-commissioning arrangement. Co-commissioning will exclude all function relating to individual GP performance management.

Model 1 – Greater Involvement in Primary Care Decision-Making

Under this model CCGs would be enabled to collaborate more closely with their area teams to ensure the strategic alignment across of decisions across the local health economy. Both parties will also need to engage with local authorities, local HWB and communities in primary care decision making. With no formal accountability for decision making CCG conflicts of interest are not increased.

Model 2 – Joint Commissioning Arrangements

This model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team via a joint committee arrangement. This model is designed to give CCGs and area teams an opportunity to more effectively plan and improve the provision of out-of-hospital services and would enable pooling of funding for investment in primary care.

The functions covered in this option include:

- GMS,PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breech/remedial notices and removing a contract);
- Newly designed enhanced services;
- Design of local incentives schemes as an alternative to QOF (see below);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decision on ‘discretionary’ payments (eg returner/retainer schemes).

In joint commissioning arrangements individual CCGs and NHSE always remain accountable for meeting their own statutory duties with regards to Primary Care Commissioning.

It is for both parties to agree the full membership of their joint committees, however the guidance states that in the interests of transparency and the mitigation of conflicts of interest a local HealthWatch representative and a local authority representative of the HWB will have the right to join the joint committee as non-voting attendees.

Model 3 – Delegated Commissioning Functions

This model offers CCGs the opportunity to assume full responsibility for commissioning general practice services, whilst NHSE will legally retain liability for the performance of primary medical care commissioning. To that end NHSE will require robust assurance that their functions will be effectively carried out. Similar to model 2 above the functions to be included are:

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

With regard to governance of this model it is recommended that CCGs establish a primary care commissioning committee. CCGs will be required to ensure that the committee is chaired by a lay member and have a lay and executive majority. As with Model 2 above HealthWatch and a local authority representative from the local HWB will have the right to join the committee as non-voting attendees. The governance developed around this model will need to be particularly mindful of potential conflicts of interest. Further guidance on the governance requirements is awaited.

4 Local Flexibilities for Incentive Schemes and Contracts

Under delegated (Model 3) arrangements CCGs would have the ability to offer GP practices the opportunity to participate in a locally designed contract as an alternative to national QOF or directed enhanced services (DES), ie using the allocated funds in a different way. This option could be jointly explored by NHSE and the local CCG under the model 2 joint commissioning arrangements and would not be permissible under a model 1 arrangement. Regardless of co-commissioning level, any such arrangement can only be put in place with the agreement of each practice and in consultation with the LMC. CCGs will continue to have the ability to put in place local commissioned schemes using their own commissioning funds.

For 2015/16 Sheffield CCG has no plans in place to alter the national QOF or DES arrangements. The Sheffield LMC have advised that they would not be supportive of any such move.

5 Approvals Process and Timescales

For Model 1 – Greater Involvement in Primary Care -no formal approvals process is necessary

For Model 2 – Joint Commissioning - CCGs and area teams are to complete a proforma and provide supporting information for joint arrangements by 30 January 2015. Supporting information must include the proposed governance structure and CCG's constitution amendment request.

Regional moderation panels will consider applications by early February 2015, with arrangements being implemented by 1 April 2015.

For Model 3 – Delegated arrangements- CCGs and area teams are to complete a proforma and supporting information for delegated arrangements noon 9 January 2015.

Regional moderation panels will consider applications on 15 & 16 January 2015, with a National moderation panel (in late January) making recommendations to a new NHS England committee. This committee will sign off of delegated proposals in Feb 2015.

Where proposals are not recommended for approval, an appropriate plan will be developed between the CCG and area team, supported by regional teams, to further develop proposals or establish joint arrangements for 15/16.

CCGs will sign a legally binding agreement to confirm the detail of how NHS England will delegate its general practice functions to CCGs.

Relevant delegated funds will be transferred to CCGs by 1 April 2015.

Delegated arrangements will be monitored as part of the CCG assurance process. NHS England is developing a revised approach for the 15/16 CCG assurance framework.

6 Changing a Co-Commissioning Arrangement form 2015/15 Onwards

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.

CCGs are urged to continue to discuss any plans to change their co-commissioning model with their area team. New proposals for joint committees can be considered in-year through 15/16, and joint committees can consider progressing to joint budgets

Conversely if things are not going well, arrangements can be rolled back by mutual agreement. This should be discussed through the assurance process

7 Constitutional Changes

Proposals for joint and delegated commissioning arrangements will require an amendment to a CCG’s constitution. Model statements have now been produced for CCGs to consider in order to request their constitutional change. Other minor individual CCG constitutional amendments may also be required in relation to these commissioning arrangements .
As membership organisations, CCGs must consult with their members on any proposed constitutional changes and also have a duty to consult with relevant stakeholders, such as local authorities, on constitutional changes.

The deadline for constitution amendment requests has been extended from 1 November 2014 to 12 noon on 9 January 2015. A further extension is in place till 30 January 2015 for constitution amendments that relate solely to joint commissioning arrangements.

8 Conflicts of Interest

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. This is being developed in partnership with NHS Clinical Commissioners and with formal engagement of Monitor and HealthWatch.

9 Support and Resources for Co-commissioning

NHSE has been clear that there is no possibility of additional administrative resources from area team to support CCGs co-commissioning aspirations and that CCGs can have access to the existing area team's primary care commissioning staff resources to deliver their responsibilities. Those CCGs which are looking to take on greater responsibility for co-commissioning primary care services are either looking to increase their capacity to deal with the increased workload and/or feel their current structure will be able to absorb the workload required. This is not the case within Sheffield CCG, at this point in time.

10 Progressing Co-Commissioning Within South Yorkshire and Bassetlaw

A number of project teams comprising LAT and CCG reps) have been established within the SYB area which cover:

- Financial baselines and future access to Capital and Revenue growth
- Operational Commissioning Models
- Supporting Quality Assurance

The agreed high level next steps are:

Timeline	Action
End November	Publish baseline spend for 2014/15
Early December	Develop initial proposals for operational commissioning models and quality assurance
Mid December	Finalise with each CCG proposed EoI, governance arrangements, committee footprint, staffing resources and commissioning plans
Mid December	Allocations for 2015/16 published along with conflict of interest guidance.
9 January	EoI for delegated commissioning submitted
30 January	EoI for joint commissioning submitted.
February – March	Mobilisation

11 Initial Considerations of Each Project Group

- Finance: The group has agreed a consistent set of principles regarding funding splits and budget management. Allocations and assumptions have not yet been shared with CCGs as allocations to area teams and CCGs will not be known until mid-December at the earliest, after which time a full assessment of the related risks can be made. Risk sharing proposals are being developed and whilst this is particularly relevant for those CCGs seeking delegation or pooling arrangements the implications on all CCGs are yet to be fully understood.

- Operational Commissioning Models: This group is looking to understand more fully the detailed functions currently undertaken by NHSE, with particular regard to Primary Care Contracting, and therefore the likely functions to be assumed under co-commissioning arrangements. Concurrent with this is an analysis of the current and future staffing levels within the wider Yorkshire and Humber footprint and the potential support on offer to CCGs. The group has agreed some principals around the support to be offered to CCGs, ie that is should be proportionate to number of primary care contracts within a CCG and not the co-commissioning level being

sought. Plans are in place to work through a number of possible scenarios to explore how each would be managed within each model.

- Supporting Quality Assurance: this group has developed a proposed way of working within the new arrangements and these are currently being considered by the SYB CCGs. The group's assessment of the functions and responsibilities within each co-commissioning level are included within Appendix 1. A supporting assessment of how the current NHSE staff would support the functions within each model is now needed.

12 Considerations Specific to Sheffield

The stated aims of co-commissioning of primary care as outlined in section 2 of this paper strongly echo with hose of Sheffield CCG. However the way in which Sheffield is looking to achieve them differs to the approach being sought in many other areas.

Integrated Commissioning/BCF: Sheffield's ambition regarding the integrated commissioning approach between the CCG and the Local Authority is well rehearsed. Many of the services changes we would like to see happen in local setting are enshrined within our developing joint approach, eg wraparound services to support primary care service delivery to at risk patients. Other CCGs might wish to use co-commissioning arrangement to promote such change locally, rather than via their BCF arrangements. So, whilst some CCGs may actively seek model 2 or 3 to progress this work there is, at this point in time, little merit in terms of health gain to Sheffield patients to be gained via this approach.

Integrated Provision: To support the ambition within our integrated commissioning intentions there is an equally ambitious integrated provider agenda emerging within the city. Over recent years the Right First Time initiative has enabled the FTs of the city to meet and discuss provider solutions to key issues. Over the last few months work has been taking place to enable general practice in its provider role to develop its collective voice and to engage with the city's providers to support and develop integrated provider solutions.

The emerging GP Provider Board (GPPB) is starting to work with the city's providers in a more integrated way and to explore how full pathways, not just specific elements, can be seamlessly delivered by such collaborative working. Whilst in time it might be desirable for practices to consider the elements of their core contracts which need to change to enable a more appropriate response to pathway delivery, it is not a pressing issue at this juncture.

The contractual and financial challenges facing general practices are not insignificant and morale within practices remains low. The national rules regarding equalisation of finances, core contract delivery etc will remain in place regardless of a CCG's co-commissioning level and so due consideration needs to be given as to whether the CCG's supportive role in encouraging practices to engage with the integrated provision agenda which is being welcomed by the GPPB will be detrimentally affected in the CCG also assuming a contract/performance monitoring responsibility on NHSE's behalf.

Membership Engagement: Models 2 and 3 both require a change to the CCG constitution, which in turn require the CCG to seek the views of member practices. Set timescales are tight and prohibit a meaningful engagement process to be undertaken by early January.

Many practices have expressed frustration with the current contractual arrangements and approach adopted by NHSE. However, this in itself is not sufficient reason for the CCG to seek increased responsibility – particularly as there is no increase in capacity to improve upon the current approach. The key imperative must be to use this tool where it can be used to improve the health gain of Sheffield patients. In seeking wider engagement with practices the CCG must be able to clearly articulate the benefit to patients of the preferred co-commissioning model will bring.

13 Approach of Other CCGs

As stated above some CCGs are welcoming of the co-commissioning models which give them more responsibility for commissioning Primary Care Services as it is a means of supporting their out of hospital agenda in a way their local BCF arrangements do not. This may be particularly so where a CCG has finances available next year to invest further in primary care services.

Other CCGs are viewing the move towards delegation as something of inevitability, not least due the signal within the Five Year Forward View of the need to break down the traditional barriers of how care is provided (and therefore contracted for). As a result some are taking the view that they will pursue an increased responsibility sooner rather than later.

It is worth noting, however, that the decision each CCG is being asked to take is in relation to the co-commissioning responsibility it is seeking for the financial year 2015/16, with the ability to seek increased responsibility in-year if that is deemed necessary.

In Sheffield our ambition for the whole system is such that it is difficult to assess where co-commissioning of primary care services in 2015/16 genuinely fits. It may be prudent therefore for Sheffield CCG to express model 1 (Greater involvement in Primary Care decision making) as its preference for co-commissioning in 2015/16, with the caveat that should our wider agenda require an increased level of responsibility in order to move forward that an in-year submission will be made to NHS England.

14 Recommendations

Governing Body is asked to discuss the content of this paper and to consider for approval the following recommendations:

- That for the financial year 2015/16 the CCG's preferred co-commissioning model is that of level 1, Greater involvement in primary care decision making with NHSE; and
- That, should our wider commissioning agenda require an increased level of co-commissioning in-year, such a submission will be made at that time.

Paper prepared by: Katrina Cleary, Programme Director

On behalf of: Ian Atkinson, Accountable Officer

25 November 2014

Appendix 1 Supporting Quality Assurance in Co-commissioning Using the RASCI Model (demonstrating accountability and responsibility for each of the co-commissioning options)

Option 1 Greater Involvement in primary care decision making

	Host Local Authority	Host CCG	Host Area Team	CQC	Professional Committee e.g. LMC	Professional Regulator i.e. GMC
	ANYTOWN LA	ANYTOWN CCG	SY&B			
General Practice Commissioning		S	A /R			
Pharmacy, Eye Health and Dental commissioning		S	A /R			
Design and Implementation of local incentive schemes	C	S	A /R		C	
Contract Management		S	A /R			
MHPS		S	A /R		I	I
Quality Surveillance		S	A /R			
CQC non compliance		S	A /R	R		
Complaints		S	A /R			
Safeguarding	I	S	A /R			
Serious Incidents		S	A /R	I	S	
Primary Care Development		R	A /R			

Responsible	(Doer) The organisation assigned to do the work
Accountable	(Buck stops here) The organisation making the final decision with ultimate ownership
Supporting	(Here to help)The organisation that will support the quality assurance functions
Consulted	(In the loop) The organisation that must be consulted before a decision or outcome is taken
Informed	(For your information) The organisation which must be informed that a decision or action has been taken

Option 2 Joint commissioning arrangements

	Host Local Authority	Host CCG	Host Area Team	CQC	Professional Committee e.g. LMC	Professional Regulator i.e. GMC
	ANYTOWN LA	ANYTOWN CCG	SY&B			
General Practice Commissioning		R	A /R			
Pharmacy, Eye Health and Dental commissioning		R	A /R			
Design and Implementation of local incentive schemes	C	R	A /R		C	
Contract Management		R	A /R			
MHPS		S	A /R		I	I
Quality Surveillance		R	A /R			
CQC non compliance		R	A /R	R		
Complaints		R	A /R			
Safeguarding	I	R	A /R			
Serious Incidents		R	A /R	I	S	
Primary Care Development		R	A /R			

Responsible	(Doer) The organisation assigned to do the work
Accountable	(Buck stops here) The organisation making the final decision with ultimate ownership
Supporting	(Here to help)The organisation that will support the quality assurance functions
Consulted	(In the loop) The organisation that must be consulted before a decision or outcome is taken
Informed	(For your information) The organisation which must be informed that a decision or action has been taken

Option 3 Delegated commissioning arrangements

	Host Local Authority	Host CCG	Host Area Team	CQC	Professional Committee e.g. LMC	Professional Regulator i.e. GMC
	ANYTOWN LA	ANYTOWN CCG	SY&B			
General Practice Commissioning		R	A /S			
Pharmacy, Eye Health and Dental commissioning		R	A /S			
Design and Implementation of local incentive schemes	C	R	A /S		C	
Contract Management		R	A /S			
MHPS		S	A /R		I	I
Quality Surveillance		R	A /S			
CQC non compliance		R	A /S	R		
Complaints		R	A /S			
Safeguarding	I	R	A /S			
Serious Incidents		R	A /S	I	S	
Primary Care Development		R	A /S			

Responsible	(Doer) The organisation assigned to do the work
Accountable	(Buck stops here) The organisation making the final decision with ultimate ownership
Supporting	(Here to help)The organisation that will support the quality assurance functions
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