	Health and Well-Being Committee **29th January 2015**
Title	**Primary Care Co-Commissioning**
Report of	Maria O'Dwyer Director of Integrated Commissioning Margaret Chirgwin – Primary Care Strategy Programme Lead Barnet CCG
Wards	All
Date added to Forward Plan	December 2014
Status	Public
Enclosures	Appendix 1: NHS Letter from NHSE to Local Authority CEOs and HWBB Chairs -Update on Primary Care Co-Commissioning 18th Dec Appendix 2: London Councils to London Borough Leaders Health and Social Care Portfolio Holders and HWBB Chairs
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Summary

In late September an NSH England (NHSE) document released provided further information on Co-Commissioning, additional guidance was issued on 14th of November. Clinical Commissioning Groups (CCGs) are requested to put forward proposals by end of January 2015 for Joint Commissioning and earlier if Delegated Commissioning was the preferred option. Following internal and public discussion Barnet CCG Governing body in the December 2014 Committee meeting agreed to support in principle the proposal to join with other North Central London (NCL) CCGs and put in a **Joint Commissioning** proposal. The Guidance requires the CCG to review and confirm membership support including support for the necessary changes to the **CCG constitution** and a commitment to proceed towards joint commissioning arrangements and the setting up of a joint committee. From Jan –Feb 2015 the CCG will be committed to engage across NCL to engage with practices, HWBBs Healthwatch and Patients.

The proposed plan is that a Joint Committee would come into existence in shadow form in April 2015 and run in shadow until 1st October 2015 initially as Level 1 "greater involvement"

arrangements. From October it will start to operate formally as a Joint Committee under level 2 joint arrangements. This provides more time for constitutional changes to be put in place by March 2015. The terms of reference and membership of this Committee is currently under discussion.

This paper seeks the support and engagement of Barnet HWBB on it's in principle decision to develop a proposal to take Joint Co-Commissioning forward at the end of Jan 2015. The Board is requested to discuss how the HWBB will participate in a Joint Committee across NCL .The Board is also requested to consider the role of Public Health in this discussion, and feedback any views/considerations to the NCL lead for Primary Care (Chief Officer for Islington).

Recommendation

1. **The Health and Wellbeing Board is requested to note and support Barnet CCG's decision to develop a proposal to jointly co-commission with the other 4 NCL CCGs**
2. **Consider and discuss how the Health and Wellbeing Board will participate in Joint Co-Commissioning Committee across NCL**
3. **Consider the role of Public Health in Joint Co- Commissioning and feed any views /considerations into to NCL ongoing discussions**

1. WHY THIS REPORT IS NEEDED

1.1 Health and Social Care Act 2012 introduced substantial changes to the way the NHS in England is organised, in particular it created CCGs. It defined the responsibilities which did not include responsibility for the primary care contracts (GP, Pharmacists, Opticians and Dentists) which were previously managed by the PCT. However, on 1st October 2014 changes were made to the Act to allow CCGs to take on joint responsibility with NHS England (NHSE) for these contracts thus moving us back towards most of the responsibilities that the PCT held.

1.2 Initially Co-Commissioning is about the contracts NHSE holds with General Practice but in later years is likely to include the contracts with Opticians, Pharmacists and Dentists. So Barnet CCG, with our NCL CCG partners, are considering taking on joint responsibility with NHSE for:

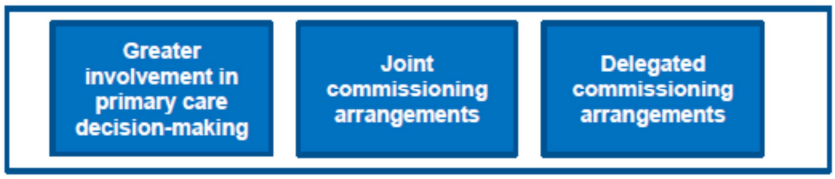
- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");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

1.3 It will not include individual GP performance management (medical performers' lists for GPs, appraisal and revalidation).

1.4 **The Options**

Model Zero: Do not get involved at all. However we do not think that this is really an option.

Or one of three options:



1.5 In June 2014 the 5 North Central London (NCL) CCGs put in a proposal to Jointly Commission with NHSE.

1.6 Following a discussion at the Committee and amongst the other NCL CCGs we believe that the best option for the CCG is to join again with the other NCL CCGs and put in a **Joint Commissioning** proposal.

Summary of Co-commissioning functions under each option

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	Yes
Pharmacy, eye health and dental commissioning	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role
Design and implementation of local incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, revalidation	No	No	No

1.7 **Key Issues for Practices as Providers**

1.7.1 In many ways very little should change from a practice or patient point of view – the same NHSE staff as at present will do the daily management of contract.

1.7.2 However, there should be an improvement of the management of enhanced schemes with more local clinical involvement in their development and implementation. The CCG will be integral to decision making about things such as establishing new GP practices and the approval of Practice building developments, thus ensuring a sustainable General Practice provision for our population. These decisions will be taken across all five NCL CCGs in partnership with NHS England.

1.8 **Key Issues for the CCG and Practices as Members of the CCG**

1.8.1 Whatever option Barnet CCG takes on there are unlikely to be any new resources allocated to the CCG to do the work of managing the contracts and supporting practices with issues related to their primary care contracts – sharing the support work across the 5 CCGs will be more efficient and therefore we believe this is a better option than if we did any form of Co-Commissioning alone.

1.8.2 As CCG Governing Body is made up of mainly GPs the change in commissioning arrangements may give rise to further questions in relation to conflict of interest, however Barnet CCG are cognisant of this conflict and have processes in place to monitor such issues currently. Managing conflict of interest issues across the 5 CCGs will lend itself to reduce actual and perceived conflicts. There is further NHSE Guidance on how to manage this in the background papers.

1.9 **Constitutional Changes**

1.9.1 Changes to the CCG's constitution will be required and in order for the CCG to proceed with Co-Commissioning we will need agreement from GPs – the first change will be to add a few paragraphs to take on joint responsibility for the agreed areas (the first box above) and create the necessary Joint Commissioning Committee with NHSE and the other four CCGs. The second required change is to add the Terms of Reference for this committee as an annex to the constitution. Annex C and D (see background papers) give suggested wording. The CCGs as above will work on these to agree the final wording taking all CCGs views into account.

2. REASONS FOR RECOMMENDATIONS

2.1 Option 2 is being recommended because this is the one that the 5 NCL CCGs are all willing to sign up to at this time. It was felt that there was not enough information in November/December 2014 on Option 3 which is ultimately where the NCL CCGs would like to be but only when there is clear understanding of the risks involved and how these may be managed effectively.

2.2 The NCL CCGs are seeking to only have a Joint Co-Commissioning Committee in Shadow from April 1st 2015 to give enough time to develop full

membership and other stakeholder support for co-commissioning and to move to full joint commissioning and then to full delegated co-commissioning at a pace that ensures risks are minimised and benefits to the population maximised. There is an expectation that HWBB will participate in Joint Co-Commissioning (please see documents from NHS England and London Councils for further information).

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 **Model 0 – not in the NHSE proposal but CCG could decide to focus on our statutory responsibility to improve the quality of primary care and leave NHSE to be responsible for the GMS/PMS/APMS contracts.** Still work to coordinate with other primary care commissioners (PH England, Borough PH, NHSE) but no responsibility beyond improving quality.

3.1.1 This option was not believed to be a possibility and as the present situation has not been working well in particular with lack of information sharing and coordination of effort.

3.2 Co-commissioning as a single CCG or with a different combination of CCGs was considered but dismissed because so much work was undertaken last year to develop a joint proposal and it is unlikely to deliver efficiencies in the system.

3.3 **Model 1 – Greater Involvement – to be locally agreed with the Area Team**

3.3.1 This option was believed to be likely to entail increased level of work for the CCG without the gains of formal involvement in decision making.

3.4 **Model 3 - Delegated Arrangements – proposal due by 9th January**

3.4.1 This option was felt to be one the CCG would want but the lack of sufficient detail and the need for a fully developed proposal by 9th January made this option not feasible at this time in light of understanding impact and risk within the time frame.

4. POST DECISION IMPLEMENTATION

4.1 There is significant work currently underway at the moment to agree across the NCL CCGs the structure and functions of the Joint Co-commissioning Committee and the changes that will be needed to all 5 CCG Constitutions. As soon as the proposed Constitutional changes are available, The CCG will engage with each Member Practice and request that they confirm that they are happy for these changes to be made. We will need a 75% supporting vote to do this but are recommending that this is the only viable option available to the CCG. To date current engagement is supportive.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 This supports the CCG's Primary Care Strategy and the CCGs statutory requirement to ensure the ongoing development of the quality of primary care services provided to the population of Barnet.

5.1.2 This supports all 4 the Health and Well Being Strategy themes because General Practice and primary care more broadly has a role to play in each theme with a particular theme on theme 1 and 4:

1. Preparation for a healthy life – that is, enabling the delivery of effective pre-natal advice and maternity care and early-years development;
2. Wellbeing in the community – that is creating circumstances that better enable people to be healthier and have greater life opportunities;
3. How we live – that is enabling and encouraging healthier lifestyles; and
4. Care when needed – that is providing appropriate care and support to facilitate good outcomes and improve the patient experience.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 This has financial implications for within the NHS (between the CCGs and NHSE) but should have no negative impact on service provision. It is hoped that there will be synergies that mean that more resources will become available for service provision to the Barnet population.

5.3 **Legal and Constitutional References**

5.3.1 The Health and Social Care Act 2012 established health and well-being boards as forums where key leaders from the health and care system work together to improve the health and well-being of local communities. The Health and Well-being Board plays a key role in the local commissioning of health care, social care and public health through developing and overseeing a Joint Strategic Needs Assessment (JSNA) and Health and Well-being Strategy

5.3.2 The terms of reference of the Health and Wellbeing Board , as set out in part 15 of the Constitution, Annex A ; include the tasks of jointly assessing the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies. A further role includes considering all relevant commissioning strategies from the CCG and the NHS Commissioning Board and its regional structures to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration. A further duty is to promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health.

5.3.3 The Recommendations therefore, as set out in this report appear to be in accordance with applicable law and guidance, and what is set out in this report appear to be appropriate recommendations for the HWBB to consider.

5.4 **Risk Management**

5.4.1 The risks of Co-Commissioning are complex in particular around perceptions of and actual conflicts of interest. Managing conflicts of interest: statutory guidance for CCGs was released 18th December 2014 and is attached. Co-commissioning across the 5 NCL CCGs will help to reduce these potential conflict issues. The Guidance will also inform the proposed makeup and functions of the Joint Co-Commissioning Committee.

5.4.2 There is an additional risk in the failure to engage appropriately with member practices to change the constitution

5.5 **Equalities and Diversity**

5.5.1 There is no impact on Equality and Diversity issues.

5.6 **Consultation and Engagement**

5.6.1 There will be a process of engagement with member practices to seek the appropriate support to amend and make the necessary changes to the CCG constitution.

6. BACKGROUND PAPERS

6.1 Proposed next steps towards primary care co-commissioning: an overview Dr Amanda Doyle, Ian Dodge, Ivan Ellul and Julia Simon September 2014 - http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf

6.2 Next steps towards primary care co-commissioning: Annex C: Model wording for amendments to Clinical Commissioning Groups' constitutions 10th November 2014 - http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/annx-c-mod-wrd-amends.pdf

6.3 Next steps towards primary care co-commissioning: Annex D: Model terms of reference for joint commissioning arrangements including scheme of delegation 10th November 2014 - http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/annx-d-mod-tor-jnt-comms.pdf

6.4 Managing conflicts of interest: statutory guidance for CCGs: NHSE Commissioning Strategy Directorate. First published: March 2013. Update released 18th December 2014 - http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf