NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group
Governing Body
Paper Summary Sheet

For: PUBLIC session ☒ PRIVATE session ☐

Date of Meeting: 22 November 2016

For: Decision ☒ Discussion ☐ Noting ☐

Agenda Item and title:	GOV/16/11/10 CCG Application for Delegated Commissioning of Primary Care
Author:	Victoria Stanley, Commissioning Manager, Out of Hospital Tracey Strachan, Associate Director, Out of Hospital
Lead Director/GP from CCG:	Jo Cullen, Director of Primary and Urgent Care, Group Director West Wiltshire
Executive summary:	This paper requests Governing Body approval for the CCG to apply to NHS England by 5th December 2016 to take full delegated commissioning responsibility of primary medical services for Wiltshire CCG, subject to the outcome of the membership ballot undertaken by the LMC during November 2016. NHS England is explicit that there is no additional administrative resources going to CCGs who apply for this full delegated commissioning 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. The CCG and NHS England will agree a transition plan to support the transfer of responsibility by function during 2017/18.

Primary Care Contract Tasks to be Delegated

Operational management of General Practice Commissioning including:

• Administer the national DES/QOF locally • Application for closed lists • Branch surgery closures • Practice list reviews • Boundary changes	• Termination of contracts • Practice mergers/federation • Contract variations e.g. PMS to GMS • APMS contract review • PMS premium usage	• Retainer approvals • Locum reimbursement approvals • Christmas and New Year planning • Dispensing Services Quality Scheme (DSQS) • Safeguarding Policy, Procedures and Process

Operational management of services commissioned on behalf of practices including:

• Interpreter and translator services • Occupational health • Violent Patient Scheme (including security services)	• Clinical Waste Contract • NHS Shared Business Services (SBS)/Capita

	STP guidance for Primary Care[1] says that the STP should be setting out plans to make progress by 2020 in the key areas of: • support and grow the primary care workforce • improve access to general practice in and out of hours • transform the way technology is deployed and infrastructure utilised • better manage workload and redesign how care is provided Delegated commissioning status will support these plans.
Evidence in support of arguments:	CCG Strategic Plan Five Year Forward View General Practice Forward View
Who has been involved/contributed:	Clinical Executive Wessex Local Medical Committee Primary Care Operational Group Primary Care Joint Commissioning Committee
Cross Reference to Strategic Objectives:	Links to delivery of the Wiltshire CCG Strategic Five Year Plan
Engagement and Involvement:	An LMC run ballot of Wiltshire CCG membership is running from 3rd November to 17th November. It asks the membership to vote 'yes or no' to the following question: *Do you support the CCG applying to take delegated commissioning responsibility for primary medical services from April 2017? YES/NO*
Communications Issues:	Engagement will be necessary with a wide range of stakeholders via the Primary Care Operational Group, Joint CCG – NHS England Co-commissioning Committee and other forums including Healthwatch, patient representatives, and the Local Authority.
Financial Implications:	As part of this application process, the CCG will need to undertake 'due diligence' on the implications and CCG resources required to take on delegated commissioning functions and responsibilities. NHS England have reaffirmed that no resources of funding or staff would transfer as a result of delegated commissioning as this contributes to the 30% reduction in running costs over the next 3 years for NHSE. However staff have been identified that will be 'aligned' to the CCG during the period of transition. Further work is required to assess the risks and cost the service that would be offered to BaNES and Swindon CCGs through a Service Level

[1] https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-aide-memoire-pc.pdf

	Agreement for hosting the transactional duties across the STP area. This will be covered in a future paper. The CCG needs to assure itself that the budget being delegated from NHS England is commensurate with Primary Care expenditure including any commitments to deliver savings targets (QIPP targets). 'The Wiltshire CCG GP Services allocation for 2016/17 is £59.7m which includes 3.57% growth and £810k additional allocation for Dispensing Doctors Adjustment.'
Review arrangements:	The CCG has a monthly Primary Care Operational Group, currently chaired by the LMC and with the CCG and NHS England represented; and a quarterly Primary Care Joint Commissioning Committee held in public. Under the new arrangements a Primary Care Commissioning Committee would be set up, initially meeting monthly.
Risk Management:	A paper detailing the risks and benefits of both applying and not applying was presented to the Governing Body in private on the 27th September 2016.
National Policy/ Legislation:	In 2014, as part of the Five Year Forward View, NHS England announced that CCGs would be able to have greater involvement in commissioning primary care services i.e. co-commissioning that aims to support the development of integrated out-of-hospital services based around the needs of Wiltshire people. It is part of a wider strategy to join up care in and out of hospital.
Public Health Implications:	None identified
Equality & Diversity:	No adverse impact identified. This proposal covers all Wiltshire CCG member GP Practices and all registered patients with a Wiltshire CCG GP practice.
Other External Assessment:	NHS England, Wessex Local Medical Committee, Healthwatch and Wiltshire Council are represented on the Primary Care Joint Commissioning Committee.
What specific action re. the paper do you wish the Governing Body to take at the meeting?	The Governing Body is asked to ratify the decision to proceed with applying for delegated commissioning responsibilities for primary medical services from April 2017, subject to the outcome of the membership ballot. An option to host transactional responsibilities on behalf of Bath and North East Somerset (BaNES) and Swindon CCG's across the STP footprint is being developed, and will be the subject of a future paper should all three CCGs agree to apply for full delegated commissioning responsibility.

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DELEGATED PRIMARY CARE COMMISSIONING

Background

In May 2014, Simon Stevens invited CCGs to consider applying for a role in co-commissioning primary medical care. CCGs were asked to submit expressions of interest to develop new arrangements for co-commissioning such services by June 2014, setting out how the proposals fitted with the CCG's five year strategic plan.

In April 2015 after due consideration the CCG decided that given the fundamental role that primary care is planned to take at the centre of our more community based integrated health and social care model, it should pursue a joint commissioning arrangement with NH England

Recent figures show that 114 CCGs have now moved to delegated commissioning and early indications show that 90-95% of all CCGs will have moved by April 2017.

Primary care commissioning is a key enabler in developing seamless, integrated out of hospital services based around the needs of local populations. It is seen as a driver for the development of new models of care, such as multi-specialty community providers and primary and acute care systems.

The opportunity to take delegated responsibility of primary medical services offers the CCG and its membership the chance to expand its role within primary medical services commissioning without prejudice to practice entitlements, which are negotiated and set nationally. This will allow Wiltshire CCG to increase its local influence on the future strategy of primary care and hold more power to drive the development of the GP Forward View and its associated funding streams, thus supporting General Practice sustainability. It will also enable the CCG to align incentives with wider health and social care planning, improving the potential for to develop an integrated primary care based out of hospital service. Finally, it will increase the ability to tackle variations in the quality in primary care, improving patient experience and new models of care.

A paper detailing the risks and benefits of applying for full delegated commissioning status was discussed at the Governing Body (in private) on the 27th September 2016.

Benefits and Risks

Key benefits and risks that have been identified of full delegation (as per the recent BMA guidance as attached as Appendix 1) are:

Benefits

- Opportunities for GPs in CCGs to have direct leadership to influence the development of and investment in general practice. This should allow for timelier 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 Quality Outcome Framework (QOF) and Directed Enhanced Services (DES), 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 Sustainability and Transformation Plans (STP).
- 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.

Risks

- 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 Care Quality Commission (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

Governance arrangements

Under delegated commissioning, the CCG will form a Primary Care Commissioning Committee. The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers for the commissioning of primary care in accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended). Essentially, the Committee will become responsible for a number of statutory duties including the duty in relation to quality of primary medical services

This includes the following activities:

• General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider of Medical Services (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 and Directed Enhanced Services);
• Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
• Decision making on whether to establish new GP practices in an area;
• Approving practice mergers; and
• Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

In performing its role, the Committee will exercise its management of the functions in accordance with the delegation agreement entered into between NHS England and NHS Wiltshire CCG, which will sit alongside the terms of reference.

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Resources

Primary care commissioning is currently delivered by NHS England Area Teams / Sub Regions covering a large geography normally spanning several CCGs, and also covering all parts of primary care (including pharmacy, dental, optometry) not just limited to general practice. The CCG and NHSE would agree a transition plan that demonstrates how in year the responsibility transfers by function so by 1st April 2018, NHS England would have completely handed over

Funding

As part of this application process, the CCG will need to undertake 'due diligence' on the implications and CCG resources required to take on delegated commissioning functions and responsibilities. Further work is required to assess the risks and cost the service that would be offered to NHS Bath and North East Somerset (BaNES) and Swindon CCGs through a Service Level Agreement for hosting the transactional duties. This will be covered in a future paper.

The CCG needs to assure itself that the budget being delegated from NHS England is commensurate with Primary Care expenditure including any commitments to deliver savings targets (QIPP targets). The Wiltshire CCG GP Services allocation for 2016/17 is £59.7m which includes 3.57% growth and £810k additional allocation for Dispensing Doctors Adjustment.

Summary

The CCG has had a Joint Committee operational since April 2015, working with NHS England and the Local Medical Committee. Should the Governing Body now support the CCG to take delegated responsibility of commissioning primary medical services, a Primary Care Commissioning Committee will be formed which will report to the Governing Body, ensuring that there are robust systems and processes in place for monitoring, managing and assuring the quality and safety of primary care medical services and for driving continuous service improvement.

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Appendix 1: Update on co-commissioning of primary care: guidance for CCG member practices and LMCs (BMA, November 2016)

GPC
co-commissioning Guic

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Equality Impact Analysis – the EIA form

Title of the paper or Scheme: CCG Application for Delegated Commissioning of Primary Care

For the record	
Name of person leading this EIA: Jo Cullen	Date completed: 14.11.16
Names of people involved in consideration of impact	
Name of director signing EIA: Jo Cullen	Date signed: 14.11.16

What is the proposal? What outcomes/benefits are you hoping to achieve?

This paper requests Governing Body approval for the CCG to apply to NHS England by 5th December 2016 to take full delegated commissioning responsibility of primary medical services for Wiltshire CCG, subject to the outcome of the membership ballot undertaken by the LMC during November 2016.

Delegated commissioning status will also support STP plans and the operational management and resilience of general practice.

Who's it for?

The proposal covers services commissioned from all member GP Practices and their registered patients in Wiltshire CCG.

How will this proposal meet the equality duties?

It covers all registered patients.

What are the barriers to meeting this potential?

None identified.

2 Who's using it? Refer to equality groups

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)?

All Wiltshire registered patients covering the full range of protected characteristics will be covered within this service.

How can you involve your customers in developing the proposal?

General Practitioners, Practice managers and other practice staff have constantly input into the shaping of this proposal.

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)

None at this stage

3 Impact Refer to dimensions of equality and equality groups

Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation and if appropriate: financial economic status, homelessness, political view

Using the information in parts 1 & 2 does the proposal:

a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is? How can this be mitigated or justified?

None identified

What can be done to change this impact?

N/A

b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for other groups?

None identified

Does further consultation need to be done? How will assumptions made in this Analysis be tested?

No.

4 So what? Link to business planning process

What changes have you made in the course of this EIA?

None have been made

What will you do now and what will be included in future planning?

An LMC run ballot of Wiltshire CCG membership is running from 3rd November to 17th November. It asks the membership to vote 'yes or no' to the following question:

Do you support the CCG applying to take delegated commissioning responsibility for primary medical services from April 2017? YES/NO

As part of this application process, the CCG will need to undertake 'due diligence' on the implications and CCG resources required to take on delegated commissioning functions and responsibilities.

When will this be reviewed?

Both in-year and at the end of every financial year

How will success be measured?

Various methods of which will be identified through local and nationally mandated measures.

EMBEDDED PAPER - APPENDIX 1

BMA

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

British Medical Association
bma.org.uk

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.

November 2016

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**.

Contents

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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