Agenda item 7 **Attachment** 4

NHS
Surrey Downs
Clinical Commissioning Group

Title of paper	Co-Commissioning: Surrey Downs CCG preferred model and application to NHS England	
Meeting:	Governing Body	
Date:	19th Dec 2014	
Author	Kate Taylor/Karen Parsons	
email		
Exec Lead	Karen Parsons	
Purpose	To Agree	✓
	To Discuss	
	To note	

Development

Co-commissioning of Primary Care has been offered to CCGs in 3 models. These have been taken to each of our 3 GP Commissioning localities for discussion and the membership have voted on the preferred model via Survey Monkey (closing date 18th Dec). The LMC have also been consulted with regards future state of Primary Care commissioning.

Executive Summary and Key Issues

There are risks and opportunities linked with all three models of co-commissioning. There is general consensus that Primary care commissioning will come back to CCGs during 15/16 in some form and there is agreement that SDCCG should be involved in the process in order to influence direction of travel. However the financial risk (inheriting Primary Care budgets in deficit) involved with Delegated co-commissioning (model 3) is deemed too great to go for this option at the present time.

Recommendation(s)

The Governing Body is asked to agree to support SDCCG expression of interest in Joint Primary Care Co-commissioning.

Attachments

None

Implications for wider governance

Quality and patient safety

Co-commissioning would give the CCG greater influence over whole system commissioning and ensure quality issues and patient safety are not flagged up separately to fragmented commissioning bodies but are dealt with cohesively.

Patient and Public Engagement

The CCG has been tasked with engaging membership practices and local Area Teams in this first round of engagement to understand local commissioner views on direction of travel. Views of patients and the public will be central to any actual commissioning undertaken under the new model.

Equality Duty

This is national policy and equality impact will be assessed initially at national level.

Finance and resources

Co-commissioning comes with no delegated resource form the Area Team. Joint co-commissioning will involve the setting up of a joint committee between Area Team and CCGs including the joint working around disaggregating budgets and workstreams in 15/16. Delegated co-commissioning would mean the CCG inherits Primary Care budgets in deficit

Workforce

Currently no staff are transferring form the Area Team. The CCG has set up a Primary Care programme of work which has staff aligned to the development of Primary Care networks under the existing Primary Care strategy.

Information Governance

This will be worked through at a national level with the complexities of NHS England still retaining responsibility for payments etc. to practices and the need for CCG to assure performance before payments are authorised..

Conflicts of interest

In joint co-commissioning there is no conflict of interest risk as the Area Team are joint committee members. In delegated co-commissioning there are conflict of interest issues which would be mitigated, in accordance with national guidance, by the establishment of a Primary Care sub-committee with Lay membership. In

addition SDCCG would secure independent clinicians to sit on the committee to safeguard clinical input to commissioning.

Communications Plan

Following the membership vote and GB sign off the submission will be circulated to all practices and submitted as per national guidance. Communications plan will then focus on updating wider stakeholders and ensuring any processes which may change are clearly mapped out and communicated to stakeholders. i.e. patient complaints.

Risk and assurance

Joint co-commissioning is deemed the model which gives the CCG most assurance over the move towards CCGs taking back Primary Care commissioning and is a relatively risk averse choice. Assurance has been given from national and regional teams that Area Teams' capacity cannot be a factor to disagree with Joint Co Commissioning.

Co-commissioning: proposed model of co-commissioning to submit to NHS England

Introduction

Primary Care is currently commissioned by NHS England through Area Teams and Primary Care Co-Commissioning is an offer from NHS England for CCGs to get involved in the commissioning of primary care.

NHS England's Co-commissioning vision is to give "*commissioning GPs more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services*" [1]. It is, "*The beginning of a journey towards place based commissioning*" [2]whereby local services are commissioned by local accountable organisations. This paper provides a summary and background of events leading up to a recommendation for SDCCG to submit an expression of interest in 'Joint Commissioning' arrangements

1. Background

In June 2014 SDCCG submitted an initial expression of interest for full delegation in lieu of further clarification and guidance being made available in the autumn of 2014.

Following a wide scale response from CCGs the national team revised guidance and have now issued 3 models for CCGs to express an interest in being part of (Figure 1).

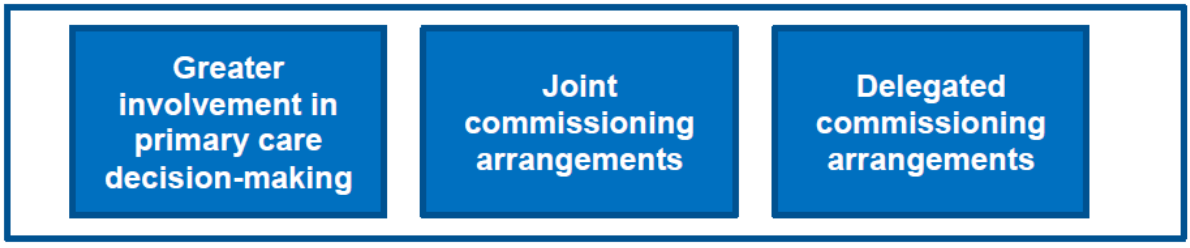

Figure 1

Co-commissioning ***aims*** to:

- recognise the local knowledge of CCGs which the Area Teams do not have or cannot maintain
- break down barriers in tiers of care
- increase out of hospital provision by enabling CCGs to invest in Primary and enhanced Primary Care

There will ***be potential benefits for patients and the public***:

[1] (5 year forward view, Oct 2014)
[2] (Next steps towards primary care co-commissioning, Nov 2014)

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

2. Co-Commissioning models

CCGs have been presented with 3 models of co-commissioning from which to choose:

- Model 1: Greater involvement in primary care decision-making
- Model 2: Joint Commissioning arrangements
- Model 3: Delegated commissioning arrangements

Equally, there is a 4th option open to CCGs to 'do nothing', however, both CCG and LMC recognise that this is not a viable option for the reasons stated below:

- co-commissioning is clearly the national direction of travel and the CCG should place itself in a position to influence as far as possible.
- the restructure of NHS England means Primary Care will in all probability increase the remoteness of commissioning for primary care (reduction in Area Teams' numbers).
- CCG will not be able to access wider funds to align to its Out of Hospital transformation work and could ultimately be subject to directives on which model to take as policy changes and co-Commissioing becomes mandatory for all CCGs

3. Appraisal of Co-Commissioning models

Annex 1 provides an overview of each model in terms of benefits, risks and national thinking. In summary:

Model 1: Greater involvement in primary care decision-making

This model means the CCG would meet with the Area Team more frequently and be surveyed quarterly by the National team at NHS England to ensure the 2 bodies are working well together. The CCG previously had Quality and Contract meetings with the Area Team however these were discontinued by NHS England. There is a lack of clarity over how this informal engagement with the Area Team could help and support the transition and improvement to full delegated primary care co-commissioning.

Model 2: Joint Commissioning arrangements

This model of Co-commissioning would see the Area Team and CCG setting up a formal joint committee where both parties had sign off commissioning decisions. It is likely that some functions would be delegated under this model for ease/capacity issues at the Area Team (i.e. enhanced services) as the two bodies work together to disaggregate work-streams and budgets throughout the year. The Area Team's role in this model mitigates conflict of interests and financial risk as the Area Team will retain budgets and liability whilst sharing some decision making.

Model 3: Delegated commissioning.

In this model all functions (excl. the performers list and potentially the Premises portfolio) would be delegated to CCGs. This would mean local influence over investment and in the longer term, the chance to develop local quality schemes and move away from national QOF measures (by membership agreement). Whilst this model is simpler in some terms than joint commissioning- whereby joint committees and governance must be worked through- this model comes with financial risk. Budgets for Primary Care have been set at 14/15 plan and, given current overspend on Primary Care budgets, these will be delegated in deficit.

4. Proposal and Next Steps for SDCCG Submission for Joint Co-Commissioning

The CCG would like to submit an expression of interest to undertake Joint Co-Commissioning with a view to moving to delegated commissioning once financial risk is mitigated and practices have clearer answers as to how conflicts of interest are managed and the process for management of primary care contracts. It is understood that a move to delegated could happen in year if required.

Surrey Downs CCG would like to submit an expression of interest in Joint Co-Commissioning from April 2015. The LMC supports SDCCG in their initial proposal to submit an expression of interest in the Joint Co-Commissioning model (Level 2);

"Remaining at Level 1 may not enable the degree of support for Primary Care that Level 2 does seem to allow, that level 3 carries potential risks that have not yet been clarified. Colleagues should take this into account when making their decision as to which level of co-commissioning to support" (LMC, Dec 2014)

We have spoken to key stakeholders in our area:

- Council of Members 20th Nov- presented overview with agreement to take information and more detailed discussions at each of the 3 GP Commissioning Locality Meetings.
- LMC discussions and formal meeting 9th Dec- agreed support for Joint co-commissioning.

- Locality feedback Thurs 4th, Fri 5th and Thurs 11th December at GP commissioning locality meetings- general consensus that Joint Co-commissioning is the model we should start with moving to delegated once details/financial risk is better understood.
- Survey Monkey vote is out to each practice to confirm membership's choice (one vote per practice) – close date 18th December. (verbal update at GB)
- Co-commissioning event with Area Team Fri 12th December.

Following the membership vote and sign off from Governing Body the CCG will submit an Expression of Interest in co-commissioning. Completed submissions must be signed by Area Teams then submitted to regional teams; 9th Jan for Delegated commissioning and 30th Jan for joint commissioning.

Proposals for joint and delegated commissioning arrangements will require an amendment to a CCG's constitution. If this is the only constitution amendment request it can be made in the usual way and a copy submitted with the proposal (so delegated commissioning **9 January,** joint commissioning **30 January**). Assurance has bene received that these amendments can be submitted in draft if timescales do not allow full sign off in time for the tight deadlines. All other constitutional amendment requests should have been submitted through the normal route by **6 January 15.**

Delegated arrangements – **noon on 9 January**, with both CCG and NHS England sections complete – to england.co-commissioning@nhs.net

Joint committee proposals – **5pm on 30 January**, with both CCG and NHS England sections complete – to england.co-commissioning@nhs.net

Recommendations:

Governing Body to approve SDCCG submission for expression of interest for Joint Commissioning of Primary Care

Annex 1: Summary of 3 Primary Care Co-commissioning Options

Model	Benefits to CCG	Risks to CCG	Direction
Option 1: GREATER INVOLVEMENT IN PRIMARY CARE COMMISSIONING i.e. Meet with AT more and complete quarterly surveys on how commissioning is going	• Minimal change and limited resource implications • No need to change constitution etc. in short timeframe • No performance management which could safeguard CCG practice relationship	• No provider relationship with Primary Care • No access to more funds • Limited influence over change or progress • Reductions in AT resource could impact CCGs anyway	• National: No CCG has indicated this will be chosen as an option • LMC: this option given no access to wider funds from which to build on and offers limited chance to improve current issues • Guidance indicates this is unlikely to help and will change imminently help and will change imminently
Option 2: JOINT COMMISSIONING i.e. Set up a shared joint CCG and Area Team committee where CCG can respond and 'localise' AT decisions through shared forum	• More access to funds via pooled budgets and/or directions of funds • Influence over out of hospital commissioning • No conflict of interest as AT have joint decision making • Streamline contact and claims processes for practices • Shared risk and joint working on moving towards delegation • Time to work through accurate budgets and processes	• AT's capacity to support joint committees • Complex decision madding with additional parties to be worked out • Joint sign off on issues could delay change but no more so than currently	• National event feedback is that a majority of CCGs are going for this option • LMC: Given SDCCGs size and established plans this is the supported option for co-commissioning • Guidance suggests this is a sensible middle ground for Year 1 given risk inherent in Option 3 (Delegated co-commissioning
Option 3: DELEGATED COMMISSIONING Ie. All functions and budgets delegated to	• More access to funds via poled budgets/direction of funds • Streamline contract/claims processes	• Conflict of Interest: will be a risk mitigated by new GB committee but must ensure clinical commissioning	• National: very few CCGs are going for this option • LMC: A step too far with financial risk

CCG excl. performers list and potentially premises	for practices – create central responsive body • Align funding to strategic plans for OOH care • Quality Improvement: flexibility over local incentive schemes (can move away from QOF by agreement with membership) • Can commission for whole system care along pathways	• Financial Risk: budgets set at 14/15 plan and are overspent at M6. Overspend etc. inherited • Financial risk: limited confidence in AT figures submitted • Resource: no overheads/running costs delegated	and lack of clarity for practices over decision making • Guidance: indicates this would be preferred by AT who have capacity issues but practicalities are complex