

### What is Co-Commissioning?

Currently, hospital and community services are commissioned by CCGs, while primary care services are commissioned by NHSEngland, and Social Services by Local Authorities.

NHSE London Region is encouraging co-commissioning arrangements across London's CCGs and potentially local authorities.

Co-commissioning is one of a series of changes set out in the NHS Five Year Forward View, which emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. Co-commissioning is seen as a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations, driving the development of new integrated out-of-hospital models of care, such as multispecialty community providers and primary and acute care systems.

Co-commissioning will give CCGs the option of having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained.

Although co-commissioning remains optional it is clear that CCGs and wider groupings of commissioners at Strategic Planning Group level are being actively encouraged to embrace the opportunities that NHS E feels this development provides. There is no one size fits all, with co-commissioning offered at three models:

**Level 1 (or Model A)** – Greater involvement in primary care decision-making

**Level 2 (or Model B)** – Joint Commissioning – enables decisions

**Level 3 (or Model C)** – Delegated Commissioning – enables decisions

Level 1 (or Model A) does not enable decision-making on GP contracts and so has no conflicts of interest.

### How will your practice be affected by these changes?

Co-commissioning has the potential be a mechanism for GPs as members of CCGs to have greater influence over the commissioning of services, including the ability to enhance the funding and provision of general practice, for the benefit of the profession and patients.

However, it is important for your practice to be aware that co-commissioning levels 2 and 3 also enable CCGs to hold and manage the core GP contract of their members, with powers to issue breach notices and terminate contracts. This is a major change to the way general practice is commissioned and performance managed and could have significant consequences.



**Use our Practice Impact of Change Tool in this guide to make sure you do not sleepwalk into anything that impacts negatively on your practice and on the values of General Practice.**

# GP RESILIENCE GUIDE : PRIMARY CARE CO-COMMISSIONING

## TAKE CONTROL

### As a GP provider and CCG member, what should I do?

CCGs must submit proposals by 30 January 2015 (joint commissioning) and 9 January 2015 (delegated).



**Understand the different co-commissioning models and their implications for your practice as in this guidance, as well as NHS England Next Steps.**

*Consider the potential benefits and risks of each option/model.*



**Consult your LMC on your CCG's plans NOW.**

*What commissioning arrangements are neighbouring CCGs seeking?*

*How will these changes affect the local health economy?*



**Know your rights, and your CCG's responsibilities.**

*Be aware that CCGs are membership organisations who must consult with their members and secure their support before submitting co-commissioning proposals. GPC believes this should take the form of a formal democratic vote of member GPs/practices.*

*Any CCGs granted level 2 or 3 commissioning arrangements must update their constitutions – this MUST be done in collaboration with member practices.*



**Engage with your CCG Board. Discuss with them:**

*What do they see as specific proposed benefits of co-commissioning?*

*How will they performance manage member GP contracts?*

*What will membership of 'joint committees' and 'primary care commissioning committees' be?*

*How will CCGs manage and mitigate the risks of Conflicts of Interest (COI)?*

*Under joint and delegated commissioning arrangements, where do practices go for arbitration (what frameworks is your CCG putting in place)?*



**Know your constitution: this applies to partners and sessional**

Any CCGs granted level 2 or 3 commissioning arrangements must update their constitutions – this must be done in collaboration with member practices (see submission deadline above).

Remember this is not a one off "all or nothing" decision. CCGs can opt for co-commissioning models later in 2016/17 and beyond and therefore they must not feel pressurised to pursue any particular option now.



**As GP providers and members of CCGs, you have the power to determine which level of co-commissioning your CCG governing body takes on.**



**Know your rights. Key points for CCG member practices and LMCs.**

1. All GP practices in England are members of a CCG (this is a statutory requirement).
2. As membership organisations CCGs are accountable to their members; members can vote to have CCG Board dissolved, or an individual Board member removed.
3. CCGs must consult their membership before making any decisions about co-commissioning and/or amending constitutions and before submitting proposals to NHS England; this must be done with the agreement of member practices.



**Make sure you have been consulted properly.**



**Use the opportunity to question and challenge to achieve the assurance you need to make an informed decision.**

4. The CCG deadline for submissions this time around, including amending constitutions, is:
  - 30 January 2015 (for joint commissioning)
  - 9 January 2015 (for delegated commissioning)

CCGs need not rush – this is not a “one off” opportunity; CCGs can wait until 2016/17 before they seek to take on board greater co-commissioning responsibility.

### What won't CCGs be able to do under Co-Commissioning?

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.

### What will CCGs be able to do under Co-Commissioning?

CCGs will not have direct power to performance manage individual GPs, BUT, it is regrettable that core contract management will now largely fall within the remit of CCGs.



**Use the GPC's Assessment of Co-Commissioning and the Co-Commissioning opportunities and risks analyses in this guide.**

# GP RESILIENCE GUIDE **TAKE CONTROL** • GPC ASSESSMENT OF CO-COMMISSIONING

	Opportunities for Practices	Risks to Practices
Greater Involvement	<p>CCGs have more influence in the development of general practice without any of the risks of having any direct responsibility or accountability.</p> <p>Opportunity to build on gains made since the introduction of CCGs without the need for restructuring.</p> <p>May allow CCGs to take a significant advisory and consultative role to NHS England without the risk associated of responsibility.</p>	<p>Commissioning decisions remains slow and fragmented.</p> <p>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 and for patients).</p> <p>CCGs have minimal influence over national strategy – will not be able to design local incentive schemes to replace QOF and DES.</p> <p>Risk of further deterioration in the quality of GP commissioning with remote, recently merged sub-regional NHS England teams.</p>
Joint Commissioning	<p>Opportunity for significant new and increased influence over GP commissioning agenda.</p> <p>Ability to design local schemes to replace QOF and DESs.</p> <p>Could create better collaboration with neighbouring CCGs as they work together in one joint commissioning group with the AT.</p> <p>CCGs (and member practices) relatively less exposed to COI issues compared to full GP commissioning responsibility.</p>	<p>Risk that joint structures will have no real accountability to individual CCGs (and member practices).</p> <p>Local schemes to replace QOF and DESs may result in increased workload as practices likely to still be expected to adhere to QOF indicators (which will be monitored); local negotiations could undermine the national contract.</p> <p>Increased exposure to COI (whether real or perceived) related to CCGs role in procuring services from members (and their own practices).</p> <p>Tensions between CCGs Board and member practices related to COI arising from CCGs jointly commissioning, holding and managing GP contracts.</p> <p>Could worsen tensions where historic relationship between member practices and CCG is poor or dysfunctional.</p>
Delegated Responsibility	<p>Opportunity for GPs in CCGs to have direct leadership to influence the development and investment in general practice.</p> <p>CCGs will be best placed to commission primary/ community/secondary care in holistic and integrated manner.</p> <p>Ability to design local schemes to replace AOF and DESs.</p> <p>CCGs will have more power to drive forward the development of the GP provider models and the 5 year forward view agenda.</p>	<p>Unclear whether CCGs will have sufficient capacity, expertise (or will be large enough) required to deliver since CCGs will not be provided with any additional resources (and AT becoming more distant) – likely to weaken influence of GP member practices.</p> <p>CCGs commissioning, holding and managing GP contracts could worsen tensions where historic relationship between member practices and CCG is poor or dysfunctional.</p> <p>Local schemes to replace QOF and DESs may result in increased workload as practices likely to still be expected to adhere to QOF indicators (which will be monitored); local negotiations could undermine the national contract.</p> <p>Increased exposure to COI (whether real or perceived) related to CCGs role in procuring services from members (and their own practices).</p> <p>Paradoxically the COI issue could therefore lead to less true influence by GPs, practices and CCGs in commissioning of general practice.</p>

## GP RESILIENCE GUIDE • PRIMARY CARE CO-COMMISSIONING TAKE CONTROL • OPPORTUNITIES AND RISKS ANALYSIS

There are issues and risks which need to be mitigated. However, we consider that primary care co-commissioning may be helpful in addressing a number of the key concerns that practices are experiencing. These concerns include in particular the workforce crisis, the potential to establish primary care teams around practice populations, the need to invest in the infrastructure of primary care including premises and the need to secure ongoing, recurrent funding for primary care.

### Opportunities

- As General Practice is under such great pressure to meet growing patient demands, CCGs could direct resources to meeting priorities for access, and support shift of work from secondary care.
- Increased support for development of infrastructure to support a strong General Practice, building on core values with GPs at the centre of healthcare system.
- Support a shift from commissioning for secondary care to commissioning for primary care.
- Enable and support new collaborative ways of working for General Practice.
- Support the primary care development agenda.
- Resources should be able to be more effectively directed to support infrastructure.
- CCGs should be able to invest in primary care, breaking down the current paralysis as NHS E/CCGs are unable at present to tackle priority issues.
- Implementation of effective governance and decision making processes, which are lacking in some CCGs.
- Support for positive commissioning, rather than activity-based contracting.
- CCGs should be able to focus on service and pathway design.
- Potential for positive horizontal rather than vertical integration could therefore benefit primary care and reduce fragmentation.
- CCGs should be better able to support core pay and rations functions relating to General Practice.
- CCGs able to support equitable distribution of services and resources.
- Enable effective inter-provider/MDT working with General Practice as a core building block.
- Unified commissioning/budgets would enable CCGs to effectively direct resources from hospital savings.

### Risks

- CCGs taking on full primary care contract management including performance management, and/or primary care core funding allocation/management.
- CCGs 'policing' their colleagues which may damage relationships or lead to conflicts of interest and performance management of individual GPs.
- Lack of definition of budgets across organisations with financial pressures hampering financial shifts.
- CCGs need to work within existing budgets at the moment with no extra funding.
- Scope of current contracting, competition and procurement processes may hamper financial shifts.
- Risk management shifts to GPs with limited risk sharing from CCGs.
- CCGs may become PCT-like commissioners, distant from their membership.
- Limited resources may impair the ability to innovate, develop and deliver.
- Removal or reduction in GP autonomy with moves to contract from provider networks or federations, including core work.
- Shift of core GMS, PMS, APMS contracts to local commissioning arrangements may reduce the ability to influence policy nationally.
- Short timescales and a lack of consistency causing different approaches.
- Inducement to give up practice autonomy.
- Stratification of healthcare and service provision.