**Agenda Item No. 8**

CITY OF WOLVERHAMPTON COUNCIL

# Health and Wellbeing Board

29 July 2015

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| **Report title** | Update on Primary Care Co-Commissioning | |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing | |
| **Wards affected** | All | |
| **Accountable director** | Steven Marshall | |
| **Originating service** | Wolverhampton CCG) | |
| **Accountable employee(s)** | Steven Marshall<br>Email | Director of Strategy & Transformation<br>steven.marshall3@nhs.net |
| **Report to be/has been considered by** | Wolverhampton CCG Governing Body | 14 July April 2015 |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1. Provide appropriate feedback to the CCG

**Recommendations for noting:**

The Health and Wellbeing Board is asked to note:

1. The contents of the report

## 1.0 Purpose

This paper outlines the content of the guidance received to date, assesses the opportunities and risk of each co-commissioning level and its preferred option of level 2 (joint Commissioning) for Wolverhampton CCG

## 2.0 Background

2.1 Primary Care Co-Commissioning is one of a series of changes set out in the NHS Five Year Forward View. It offers CCGs a choice of three levels of co-commissioning primary medical services with NHS England, which following the Health and Social Care Act 2012, has overall legal responsibility for primary care commissioning.

The expected benefits for patients and the public include:

- Improved access to primary care and wider out-of-hospital 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

2.2 Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

2.3 Primary care co-commissioning is the beginning of a longer journey towards place based commissioning – where different commissioners come together to jointly agree commissioning strategies and plans, using pooled funds, for services for a local population.

2.4 The three levels of co-commissioning offered to CCGs by NHS England are:

**Level 1: Greater involvement in primary care decision-making** – Greater involvement in primary care co-commissioning is simply an invitation to CCGs to collaborate more closely with their NHS England teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy.

**Level 2: Joint commissioning arrangements** – A joint commissioning model enables one or more CCGs to assume responsibility for jointly

commissioning primary medical services with their NHS England sub-region. There are two possible models:
**Joint committee**: a joint committee makes a decision on matters in the scope of the joint committee, which could include NHS England's functions and CCG's functions.

**Committees in common: "**committees in common" come together but they make individual decisions. Multiple joint committees could meet as "committees in common" if they choose to.

**Level 3: Delegated commissioning arrangements** – Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning.

2.5 The table below provides a summary of the responsibilities for primary care functions across each level of co-commissioning:

| Primary Care Function | Greater Involvement | Joint Commissioning | Delegated Commissioning |
|---|---|---|---|
| General Practice commissioning | Potential for involvement in discussions but no decision-making role | Jointly with sub-regions | 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 incentive schemes | No | Subject to joint agreement with sub-region | Yes |
| General practice budget management | No | Jointly with sub-regions | Yes |
| Complaints management | No | Jointly with sub-regions | Yes |
| Contractual GP practice performance management | Opportunity for involvement in performance management discussions | Jointly with sub-regions | Yes |

| Medical performers' list, appraisal, revalidation | No | No | No |
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## 3.0 Progress, options, discussion, etc.

3.1 From April 2015, 86 CCGs took up 'joint commissioning' responsibilities and 63 CCGs took up 'delegated commissioning' responsibilities.

3.2 Wolverhampton CCG applied in January 2015 for joint commissioning of primary care services, but the application was deferred by NHS England at regional level to allow the CCG more time to improve its financial stability. The ambition for applying for co-commissioning was:

- To promote the development of seamless, integrated out-of-hospital services through a shift of investment from acute to primary and community services
- To achieve greater alignment of primary and secondary care commissioning, improving efficiency across patient pathways and greater synergy between commissioning budgets
- To improve access to primary care and wider out-of-hospital services by bringing services closer to patients
- To facilitate opportunities to improve proactive care planning for patients (including self-management of chronic conditions), patient outcomes and experience
- To reduce unplanned hospital admissions as a result of exacerbations of long-term conditions
- Enhance the quality of decision-making and support to GPs in referral to secondary care

3.3 These ambitions for co-commissioning still hold true as the rationale for re-applying. However, following the review of the CCG's Practice Support Visit Programme in 2014/15, there is a measured need to strengthen the joint approach to improve the *quality* and *performance* of Practices, where identified as in need of development, against key deliverables eg. Access to care, care management and general performance to targets.

3.4 The functions of each level of co-commissioning are described below:

**3.4.1 Greater Involvement in Primary Care Decision-Making.** Under this model CCGs would be enabled to collaborate more closely with NHSE to ensure the strategic alignment of decisions across the local health economy. Both parties will also need to engage with local authorities, local Health & Wellbeing

Boards and communities in primary care decision-making. With no formal accountability for decision-making, CCG conflicts of interest are not increased.

3.4.2 **Joint Commissioning Arrangements** enables CCGs to assume responsibility for jointly commissioning primary medical services with NHSE via a joint committee. This model is designed to give CCGs and NHSE an opportunity more effectively plan and improve the provision of out-of-hospital care and enable pooling of funding for investment in primary care. The functions covered include:

- GMS, PMS and APMS contacts, monitoring contracts, taking contractual action such as issuing breach / remedial notices and removing a contract
- Newly designed enhanced services
- Design of local incentives schemes as an alternative to QOF
- The ability to establish new GP Practices in an area
- Approving practice mergers
- Making decision on discretionary payments (eg return / retainer schemes)

3.4.3 **Delegated Commissioning Arrangements** offers CCGs the opportunity to assume full responsibility for commissioning general practice services whilst NHSE will retain responsibility for the performance of primary care medical commissioning. The functions covered are similar to joint commissioning, with more autonomy.

## 4.0 Financial implications

4.1 Co-commissioning will have an impact on the workforce capacity of the CCG. There is no uplift in CCG running costs to accommodate the extra responsibilities of co-commissioning so any adjustment to staffing structures must be contained within the current running cost limits

## 5.0 Legal implications

5.1 Risks would need to be managed in respect of governance, conflicts of interest, workload vs staff capacity and engagement / liaison with NHSE

## 6.0 Equalities implications

6.1 None identified

## 7.0 Environmental implications

7.1 None identified

## 8.0 Human resources implications

8.1 Approp, rait Staffinglevels need to be identified by the CCG

## 9.0 Corporate landlord implications

9.1 None

## 10.0 Schedule of background papers

10.1 N/A