The NHS Five Year Forward View and

Next Steps Towards Primary Care Co-Commissioning

NHSE has Published Two Important Policy Documents that Affect the CCG

At the end of October NHS England (NHSE) published its “Five Year Forward View” which describes how the NHS plans to develop over the next few years. A key theme here is the development of primary care provision.

Following on from the Forward View, NHSE published “Next Steps Towards Primary Care Co-Commissioning” on the 10th November. The document is clearly an enabler for the vision described in the Forward View, but it has some significant implications for CCGs that require some urgent action.

This paper attempts to summarise some of the key points from these publications and proposes a response from the CCG. If the Governing Body agrees the recommendations this could lead to a change to the CCG constitution.

The two documents can be found by following these links:


Both publications are about 40 pages long (excluding Annexes), but they both have useful Executive Summaries that are only a couple of pages long. **Members are recommended to read these.**

**The Five Year Forward View – Profound Changes to Service Delivery**

The document begins by making the case for change in the NHS, sighting well recognised issues around widening health inequality, the need to improve quality and a widening financial and efficiency gap. In order to address these challenges, the Forward View suggests that a “new relationship” is needed with patients and communities that include a renewed focus on prevention and patient empowerment. Again, these concepts are not completely new and are broadly accepted.

Chapter 3 signals a number of significant changes to future models of care. The big themes here are *integration* and *local determination*.

The document describes new models of care for smaller hospitals, specialised care and maternity services, and states that new models of emergency care will require 7 day access to GP services. However, the most significant changes for the CCG relate to new models of primary and community care. In summary, two new models are described:
**Multispecialty Community Providers (MCPs).** In this model, groups of GP practices develop and manage a full range of community services for their local population with greatly enhanced access to specialist services and diagnostics in the community. The model could also include some elements of social care and even the management of community hospitals. Most interestingly, it is suggested that the new MCPs could take on the delegated responsibility for managing the health service budget for their registered population. In this model the CCG is not only a commissioner but also a provider of primary and community services. This service model actively promotes the redistribution of expenditure from acute to community and primary settings.

**Primary and Acute Care Systems (PACS).** In this model the theme is vertical integration downwards, with acute hospitals having the ability to establish and run their own GP and community services. An alternative model of PACS described in the paper suggests that MCPs could take over management of their local hospital (vertical integration upward). In these models, the PACS would have a delegated capitated budget for the whole health needs of their population as in some other parts of the world. This arrangement allows resources to be deployed where they have the greatest impact on patient outcomes. Locally, the central Nottinghamshire CCGs are already pursuing a similar model.

Both the MCP and PACS offer profound opportunities to reshape the way GP services are contracted and rewarded. Constraints around the national contracts (such as QOF and the behaviours that requires of GPs) could be removed through capitated budgets that share the benefits of improving health and reduced dependency on secondary care.

It is clear that the authors of the document believe that one of these two models will be in place in the future. Chapter 4 describes how the NHS will work with localities to make the necessary changes happen, stressing that the form of these new services will be up to local determination – but the direction of travel is unequivocal.

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**Next Steps Towards Primary Care Co-Commissioning: The CCG as a Commissioner of GP Services**

It is totally unsurprising that the NHSE has chosen to revisit the co-commissioning agenda in a more positive and structured way. Originally many observers thought that co-commissioning was simply a result of NHSE’s requirement to cut costs in the Area Teams, but it is clear that this is not the real driver.

The vision outlined in the Forward View require GP services to change (both MCPs and PACS see GP provision becoming part of an integrated health system) and if local determination is at the heart of the reforms then CCGs will need to commission these changes from their own Membership. If the CCG accepts the direction of travel for health services is MCPs or PACS then co-commissioning in some form is inevitable.

On the 10th November NHSE published new guidance around primary care co-commissioning. The guidance contains the basic options for co-commissioning that have been presented previously:

1) Greater involvement in decision making  
2) Joint commissioning arrangements with Area Teams  
3) Delegated commissioning arrangements
However, there are significant differences:

- The approvals process for options 2 and 3 is massively simplified.
- ATs have very limited control over models adopted for Option 3.
- There is lots more detail on next steps with practical solutions to issues such as governance.
- The fourth option (i.e. having no part in this at all) has disappeared!

The scope of commissioning for Options 2 and 3 are similar and include:

- 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
- Making decisions on ‘discretionary’ payments (e.g. returner/retainer schemes).

The only significant difference is that all decisions under Option 2 will require joint agreement with the NHSE Area Team.

Both options exclude individual GP performance management (medical performers’ list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management.

See Appendix A for a summary of the scope of each option for co-commissioning.

For the CCG to adopt either Option 2 or 3 a change to the CCG’s constitution will be required. The change would allow for the creation of a Joint Committee of the Governing Body which is made up of either the CCG and NHSE (Option 2) or CCG and other stakeholders (Option 3). These committees would be required to manage the Primary Care Budget whilst avoiding any potential conflicts of interest within the Governing Body. In both cases the committees will require Local Authority, Health Watch and Lay representatives to be involved.

In Option 2 the management of Primary Care contracting would stay with the Area Team, but the CCG would be required to contribute towards and support the Joint Committee. It is difficult to see that the AT would be able to service several local committees, so some form of joint arrangement with other CCGs would be extremely likely. In Option 3, the Area Team would transfer resources for commissioning GP services to the CCG. It is inconceivable that Nottingham West could undertake primary care contracting in isolation within the organisation’s management cost allowance – so cooperation with other CCGs would be necessary in this option too.

Option 1 does not require the CCG to do anything at this stage, but it has risks. It seems very likely that most CCGs will opt for Options 2 and 3, so a CCG opting for Option 1 may find that the resources of the Area Team could be significantly reduced. Should other CCGs establish new committee, governance and management arrangements it seems likely that no significant infrastructure would remain in the Area
Team for the CCG to work with. In any case it seems likely that the resources put into primary care commissioning could be significantly reduced.

The guidance suggests that CCGs can increase the level of co-commissioning they adopt as they develop, but this has risks too. If some CCGs establish good local arrangements earlier than others, it is difficult to imagine what benefit they would gain from allowing new CCGs to join and potentially destabilise arrangements that are working well. CCGs that “wait and see” might find that their future options are severely limited simply by the success of early adopters.

A Way Forward for Primary Care Commissioning

Since the Governing Body last discussed the issue of co-commissioning the policy agenda has clearly moved on with the publication of the Forward View, very strong signals from NHSE and a simplified approvals process. There is likely to be much more interest in Options 2 and 3 by other CCGs and this significantly affects the pros and cons of our own choices:

Option 1 seems like the path of least resistance, but the reality is that after resources have been allocated to CCGs wishing to adopt option 2 or 3 the residual GP contracting function would be very depleted. It is unclear what structures the CCG membership could work with after the changes have happened. Decision making would become overly bureaucratic and the CCG would have no power to affect improvements. Also, if the CCG wanted to actively take part in the development of MCPs or PACS some movement towards Options 2 and 3 seems inevitable.

Option 2 has many of the governance requirements of Option 3 and requires the CCG to establish and service a joint Committee. However, the make up of this would be at the discretion of the Area Team who would be unlikely to service individual CCG committees, and the committee might lack the necessary local focus to function effectively. If several CCGs have opted for Option 3 this option could suffer from the same operational issues as Option 1, with few resources remaining to service the new arrangements. On the plus side the CCG would not have the risks associated with staffing a primary care contracting team, but the limited range of resource might mean that the CCG ends up resourcing all change management itself but without total control of the outcome.

Option 3 requires significant new governance arrangements to be established quickly, and all the risk associated with the management of the GP contracting function would fall to CCGs. Nottingham West could not tolerate this risk alone, and so joint arrangements would have to be agreed and developed with a number of other CCGs (probably the three south Nottinghamshire CCGs as a minimum). Failure to agree these arrangements would disqualify this option simply on the basis of management cost. If effective and affordable arrangements could be developed, this option would provide the best basis to explore MCPs or PACS. However, if affordability forced a joint governance committee solution for smaller CCGs there is a risk that the benefits of local determination could be lost amongst “one size fits all” policy and that this might significantly disengage the CCG Membership. Whatever governance arrangements were put in place would need to specifically address and mitigate this point.

There is an Urgent Timescale Imperative:
If the CCG agrees Option 3, all the necessary documentation (including proposed amendments to the constitution) will have to be agreed and submitted by the 9th January. This will allow NHSE the necessary time to set budgets and plan staff transfers. Option 2 requires changes to the constitution and the negotiations with the Area Team about the new committees to be complete by the end of January. In both cases the changes have to be signed off by the Governing Body and the CCG Membership. If Option 1 was adopted, there would be no further opportunity to move to options 2 and 3 before April 2016.

Agreeing a Way Forward:

Given the need to agree the features of joint committee structures, it is impossible agree a definitive way forward without being clear what our partner CCGs plan to do. Early indications suggest that the leadership of the Nottinghamshire and Nottingham City CCGs will propose Option 3, but at the time of writing this paper, these discussions have not yet been undertaken at their Governing Bodies.

On balance it seems that Option 3 is the best way forward for the following reasons:

- It has the potential to give the CCG and its membership direct control over the future of primary care commissioning and its future development and funding.
- It avoids the uncertainty about what the Area Team might offer CCGs under options 1 and 2, and the opportunity for Area Team vetoes under Option 2.
- It allows the CCG to consider the possibilities and opportunities of MCPs and PACS without Area Team constraints.

However, in order to adopt Option 3 the CCG will have to be able to agree sensible and affordable arrangements with other local CCGs over the next couple of weeks and develop a new governance framework. This framework would have to carefully (and precisely) balance the need to share management and governance costs with the ability of CCGs to actively pursue their own service and delivery models without unreasonable challenge (i.e. avoid “one size fits all”).

These new arrangements would need to be considered in detail by the Membership, agreed by the Governing Body in December and formally by the Membership in January (probably through an extraordinary meeting of the PMG). This is a huge piece of work requiring very careful consideration.

The View of Our Membership is that We Should Support Option 3

The issue was discussed at length by the Membership at the Practice Members Group (PMG) meeting held on the 19th November. The Membership agreed that Option 3 was the most sensible way forward. Members were realistic about the risks associated with this course of action, but recognised that there was an urgent need to transform primary care services and that CCG control of this agenda was imperative. The PMG supported the recommendation that the CCG Executive Team open discussions with other CCGs to ascertain if a viable co-commissioning support structure was deliverable within the constraints of running costs. They agreed that a detailed proposal should be shared with the membership early in the New Year.
**Recommendation: Option 3 with Caveats and a Further Discussion**

The Governing Body is recommended to support the *development of a proposal* to adopt Option 3. Support of this recommendation would be in line with the views of the CCG Membership as expressed at the PMG meeting of the 19th November. If this recommendation is secured, the CCG will open discussions with other local CCGs to discuss the feasibility of adopting delegated commissioning arrangements from NHSE through a joint governance structure which supports local flexibility and innovation. Only if a sensible, affordable and locally focussed arrangement can be agreed, than a formal and detailed proposal would be put to the Governing Body in December (at an extraordinary meeting) and a meeting of the PMG in January.

In summary therefore, the Governing Body is recommended to:

- Approve development of a proposal to adopt Option 3 in conjunction with local CCGs.
- Await a further update.
- Approve the scheduling of an extraordinary meeting of the Governing Body at the discretion of the Chief Operating Officer to consider a detailed proposal on primary care co-commissioning and changes to the CCG constitution (should such a proposal prove feasible).

**Oliver Newbould**

Chief Operating Officer 20th November 2014
<table>
<thead>
<tr>
<th>Primary Care Function</th>
<th>Greater involvement</th>
<th>Joint Commissioning</th>
<th>Delegated Commissioning</th>
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<tr>
<td><strong>General Practice commissioning</strong></td>
<td>Potential for involvement in discussion but no decision making role</td>
<td>Jointly with Area Team</td>
<td>Yes</td>
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<td><strong>Pharmacy, eye health and dental commissioning</strong></td>
<td>Potential for involvement in discussion but no decision making role</td>
<td>Potential for involvement in discussion but no decision making role</td>
<td>Potential for involvement in discussion but no decision making role</td>
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<td><strong>Design and implementation of local incentives schemes</strong></td>
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<td>Subject to joint agreement with the area team</td>
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<td><strong>General practice budget management</strong></td>
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<td><strong>Complaints Management</strong></td>
<td>No</td>
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<td><strong>Contractual GP practice performance management</strong></td>
<td>Opportunity for involvement in performance management discussions</td>
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<td><strong>Medical performance list, appraisal, revalidation</strong></td>
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