South West London Collaborative Commissioning

Primary Care Co-commissioning Signing off our Governance for Joint Commissioning in SWL

Board Paper

V0.1

Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups and NHS England

'Working together to improve the quality of care in South West London'

Background

- In June 2014 Simon Stevens announced that CCGs would be offered an opportunity to consider a greater role and influence in the commissioning of core primary medical services – general practice, and were invited to express an interest to do so. In SWL, CCGs decided to submit a joint expression of interest, which outlined each CCG's local priorities for improvement of primary care services, and this proposal was accepted by NHS England.

- In November 2014, NHS England London LAT launched their strategic framework for primary care co-commissioning, which set out key ambitions and specifications for London for the improvement of primary care services over the next five years, in three areas: accessible care, co-ordinated care and proactive care. Commissioners from SWL were heavily involved in the stakeholder group to develop these specifications and make recommendations. In addition SWL commissioners were able to orientate NHS England on the local challenges and constraints to improvements.

- In SWL CCG commissioners believe that co-commissioning primary care will offer the opportunity to ensure that services in general practice are responsive and meet the rising demand of care. SWL CCG commissioners welcome the opportunity to have greater influence over how general practice is shaped, and how this aligns with local plans for out-of-hospital care and implementation of the Better Care Fund.

What can we expect to gain from joint primary care co-commissioning?

- Primary care co-commissioning will provide us with an opportunity for greater influence on local primary care service delivery and enable the commissioning of services in line with local priorities. The role of CCGs is essential to achieve this.
- Working to common goals across SWL can enable the delivery of high quality services for more patients as the SWL-NHSE Joint Committee can make decisions which apply across the health economy
- Additional benefits we should be seeking to exploit from primary care co-commissioning are:
    - **Scale:** Working at scale, in collaboration in a way that is not currently possible, we can agree priorities for general practice and decide what can be shifted into the community and hosted by primary care, where appropriate

      We will be in a better position to respond to the draft London Strategic Commissioning Framework general practice specifications, identifying emerging themes from a baseline audit and joint initiatives for maximum impact. We will be stronger together and have greater influence on the out of hospital agenda and the review and development of primary care estates
    - **Innovation:** Allowing for innovative working in a way which is limited by the current process e.g. improving analytics and triangulation of datasets, clinical systems, and existing CCG analytical software on pathways. This will allow for more accurate assessment of need and service redesign based on a clearer picture of local needs

      We have greater influence in the design and implementation of new provider models, networks and federations. Together we can take forward our ambitions for better use of technology in primary care, shared care records and more considered skill mix
    - **Localism:** Allowing clinicians to make decisions based on local insight and knowledge of patient needs bringing forward more than discrete quantitative and qualitative data sets. Locally we will be able to improve the interface between general practice teams and out-of-hospital teams and specialists, supporting our ambitions around integrated care

      Local insights and knowledge will enable the redesign of more effective local incentive schemes and a deeper appreciation of issues pertinent to primary care access and how these should be addressed. Stronger local relationships will support the adoption of new models of care and facilitate the implementation of the new general practice specifications

Agreeing the content of Part I of our proposal – the objectives and benefits of Joint Commissioning

Part I of our proposal must set out in 400 words SWL's objectives in pursuing joint commissioning and what we expect the benefits to be, particularly for patients.

The following has been drafted and is intended to be submitted on 30th January 2015

SWL's objectives in pursuing joint commissioning

- To have greater influence over the future design and development of primary care services, both locally and across SWL.
- To support the implementation of the SWL five-year strategic plan through the development of primary care services, and out-of-hospital services more broadly.
- To provide a basis for taking collective decisions about primary care issues that affect all of SWL's CCGs.
- To be able to influence and in time set incentives that reflect local and SWL needs, and will allow local commissioners to address the pressures facing general practice.
- To achieve greater consistency of outcomes across SWL.

The expected benefits of joint commissioning

- Services that are more responsive to local needs, and designed in accordance with patients' expectations.
- Improved quality of primary care provision, both within CCGs and across SWL.
- Greater consistency in the provision of primary care services across SWL, including greater consistency of outcomes for SWL's population.
- Greater stability in the provision of primary care.
- A primary care sector that, as part of broader out-of-hospital provision, has greater capacity and capability to address the local population's healthcare needs

The SWL proposal

- SWL CCG Chairs and Chief Officers have reviewed the benefits, challenges and options for co-commissioning with each other and NHS England and make recommendations that for 2015/16, SWL CCGs should opt for **Joint Commissioning** together and with NHS England, with a view to each CCG taking on delegated commissioning arrangements in 2016/17 if this is appropriate

- Joint Commissioning offers the opportunity for CCGs to commission general practice in partnership with NHS England and each other. It allows CCGs to build the capability and capacity to commission general practice alongside NHS England and with resource and support from NHS England

- It is recommended that joint commissioning is taken forward through a **Joint Committee model**, as outlined in the NHSE guidance *Next steps towards primary care co-commissioning.* Chairs and Chief officers in SWL have considered this recommendation in association with their legal support, and have decided that this is indeed the most appropriate form

- Whilst primary care co-commissioning is an opportunity for CCGs to join together to commission general practice, SWL commissioners recognise that improvement of general practice services must occur with local need and plans at it's heart. Chairs and Chief Officers in SWL intend to set up a Joint Committee which respects this position and enhances it

- In addition, Chairs and Chief Officers in SWL recognise that local stakeholders including patients and the public need to have a greater voice in the commissioning of primary care services, and therefore have addressed this in the proposals for the Joint Committee. Chairs and Chief Officers recognise the challenges presented with managing conflicts of interest robustly, and propose governance for the Joint Committee which adheres to the latest NHSE guidance (released on 18th December) and have taken extra measures to strengthen the governance for this

- The Terms of Reference for the Joint Committee accompany this document. The following information should be read in conjunction and explains the rationale for the major governance areas

Appendix 1
Explanatory notes and guidance to support Terms Of Reference

Explanatory notes & guidance

Guidance/Legal Framework	How should this work in practice for us in SWL?	Governance arrangement	Rationale/Explanation to support arrangement
What decision-making role will the Joint Committee take forward and specifically in which areas?			
The Joint Committee, will make decisions on all primary care commissioning and functions as set out in the guidance, in full. This includes: • 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); • 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, retirements, closures and terminations; and • Making decisions on 'discretionary' payment (e.g., returner/retainer schemes)	• *How will we design our arrangements in practice?* • *Would it be sensible to have sub-groups and processes which allow these functions to be taken on by different groups, seeking approval from the Joint Committee to take forward?* • *Who might these groups be?* • *Individual CCGs? NHSE representatives? A mixture? Non-voting membership? CSU? SWLCC? Other stakeholders invited to be involved?* • *How can we develop the TOR and Standing Order to reflect these governance arrangements and how we will conduct our commissioning responsibilities in practice?*	• The joint committee will be the decision-making body in governance terms. It can receive reports and recommendations but will make the 'decision' for matters reported in • The Joint Committee will jointly make decisions over these functions. In practice sub-groups, CCG representatives and NHSE team may take on these functions on behalf of the Joint Committee reporting into the Joint Committee for approval and decision-making • The TOR for the Joint Committee and working arrangements can be streamlined to reduce bottlenecks in working practices	• The stated functions of primary care co-commissioning will be delivered more locally, shifting from being commissioned at a central level, to locally at an SPG level, with a strong CCG-led focus • Bringing in difficult decisions into a Joint Committee governance model is considered protective around the risks associated with conflicts of interest • In practice, sub-groups across CCGs will carry out / enact jointly with NHSE many of the important functions for commissioning primary medical services. The Joint Committee will serve to approve this local commissioning, with opportunities to share local progress, best practice and create strategic alignment in improving general practice and wider primary care services • Discretionary payments relate to those payments by the NHS under the agreements of primary medical services
The commissioning responsibilities for primary care estates will remain with NHSE. NHSE will be providing further information on their approach to primary care estate.			

Explanatory notes & guidance

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What is the voting membership of the Joint Committee?			
The full NHSE guidance on conflict of interest was issued on 18th Dec. A summary version is accompanies this document. A lay Chair and lay Vice Chair are required for the Joint Committee. A lay and executive majority is required. Lay membership will need to undertake a national training programme which will be provided by NHSE An executive member of the committee can include a non-GP clinician or a GP out-of-area who does not hold any pecuniary interests. The principle is that the committee must have local GPs in a minority.	• *Who else should make up the voting membership of the Joint Committee?* • *How can we ensure the correct balance of clinical commissioning within the guidance framework and the risks posed by conflicts of interest?* • *How should we design a selection process for our lay Chair and Vice Chair?* • *What representation from NHSE in the Joint Committee is best and how will this voting membership work?*	• The voting membership from each CCG of the Joint Committee will include three members, which must include one lay member. This may include: ➢ CCG Chair ➢ CCG Chief Officer ➢ CCG Lay Member An executive member can be put forward, who is a non-GP clinician • One Lay member from this group will be selected as the Chair, and will be selected at the first meeting • 2 Vice Chairs will be selected from the committee, one will be a Lay Member and the second a Clinician, to be elected at the first meeting • Three representatives from NHSE will represent NHSE. This membership must include the Medical Director, Area Director and Head of Primary Care (or a named deputy of appropriate seniority for any of these representatives)	• Each voting member will be able to represent the views of their local area and CCG views for discussion where appropriate • SWL Chairs and Chief Officers strongly support the guidance for lay member input. Therefore each CCG will have representation. This will provide lay member input and strengthen governance arrangements around managing conflicts of interest, with each lay member having the knowledge of their local position where this is important • Clinical commissioning is fundamental to this Joint Committee

Explanatory notes & guidance

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What is the non-voting membership of the Joint Committee?			
The non- voting membership of the Joint Committee should include one HWB local authority representative and one Healthwatch representative. Non-voting member roles are to provide assurance and transparency around the management and declaration of conflicts of interest, as well as enabling the Joint Committee to take decisions which align with local needs and knowledge. Non-voting members shall be able to advise, but will not have a decision-making vote Local authority elected members are excluded from being a member of a CCG's governing body under the NHS (CCG) Regulations 2012. Local authority employees are **not** excluded (extracted from the statutory conflict of interest guidance)	• *How many HWB and Healthwatch representatives does it make sense to have in the Joint Committee? The guidance is not explicit, so does this mean one representative from each area?* • *How can we involve further stakeholder representation in sub-committees who can make recommendations to the Joint Committee? E.g. LMC/patient and public rep/ LA* • *Are there other non-voting members we need to consider e.g. finance representation?*	• As per the guidance, CCGs intend to extend a standing invitation to one elected Health and Wellbeing Board and Healthwatch representative from each CCG area • The Joint Committee reserves the right to invite non-voting attendees where appropriate and agreed. This may include for example finance representation or other representation • The Joint Committee will extend an invitation to one representative from each relevant Local Medical Committee as a non-voting attendee; one from London-wide LMC and one from Surrey and Sussex LMC	• Chairs and Chief Officers are committed to HWB and HealthWatch representation in the Joint Committee, recognising the valuable role of these organisations

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What voting majority will best suit the Joint Committee moving forward?			
There is limited NHSE guidance on this point. However the model TOR states… '*Each member of the Joint Committee shall have one vote. The Joint Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote*'	• *Should we decide on majority voting, how would this work best? What weight of voting should NHSE have, and should this be equal to other members?*	• Simple voting majority is agreed, where each organisation has a single vote. This allows any voting member to represent their organisation once • The voting majority which must be achieved to pass a decision by the Joint Committee must be 5 of 7 votes • This does not give NHSE the right of veto for decisions • Any decision which undermines the statutory duty of an individual organisation cannot be breached in passing the decision. The committee will be conducted to identify any such implications in advance of voting	• A simple voting majority is considered conducive to the effective functions of the Joint Committee. • It is recognised through CCG Board experience, that formal voting routinely rarely happens and is saved for exceptional decisions where it is important to demonstrate strong and public agreement or where discussion cannot reach an end decision with unanimous agreement • Chairs and Chief Officers are confident in their preference for a voting majority (as opposed to unanimity) based on their experience of collaborative working • It was recognised that it was inappropriate for the Lay Chair to have the casting vote as this places undue burden of responsibilities with respect to conflict of interest

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What is the role of CCG GBs with regard to decisions being made in the Joint Committee?			
CCG GB role will be advisory on issues related to primary care co-commissioning. Each Chief Officer and Chair, whilst a participant in the Joint Committee, shall be required to ensure that no decision taken by that Joint Committee would, on implementation, place his or her CCG in breach of its statutory duties. There will be discussion in each participating CCG. The representatives of each CCG can feed in the views of their Members for consideration to the fullest extent possible by the Joint Committee. Representation of individual GB member views and advice will be implemented in compliance with conflict of interest requirements and guidance and will be fully adhered to	• *How can we ensure through our TOR, governance arrangements and working practices that GB views are considered to the depth and detail that would allow appropriate decision-making and the best possible outcomes?* • *What scenarios can we plan for in advance that would help to strengthen our approach and the benefits of commissioning jointly?*	• The Joint Committee will act as the decision-making body • Each CCG will represent the views of its GB and CCG members and stakeholders • GB members should have confidence that their views and local direction will be adequately represented at the Joint Committee by their voting and non-voting representation • The governance arrangements will allow for working groups/sub-groups either at CCG level, NHSE level or across CCGs and NHSE to undertake primary care commissioning functions which have been delegated down from NHSE to the Joint Committee, which the subgroups undertake on behalf of the Joint Committee, and require approval/agreement by the Joint Committee	• SWL commissioners are taking up co-commissioning primary care to ensure that improvements in general practice services and wider primary care align with local need. Therefore the role of the CCG and local commissioning is intended to strengthen this • In many cases, the activity will be taken up locally, such as designing and managing local enhanced services, and progress will be reported into the Joint Committee • In some cases NHSE representatives may carry out the bulk of the activity, reporting in progress to the Joint Committee

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How will conflicts of interest be managed by the Joint Committee and how will voting rights be affected where one or more members are considered to have a conflict of interest?			
The Joint Committee shall adhere to the conflict of interest guidance where relevant to joint commissioning arrangements . The principles which CCGs already adhere to will contribute to the arrangements in the Joint Committee. The Joint Committee meetings will be held in public . Where a member declares a conflict of interest, that member may participate in discussion where appropriate, and depending on the nature of the conflict of interest. However, that member shall be excluded from voting and shall not attend voting. There will be a new contractual requirement for GP practices to publish on their practice website by 31 March 2016, the mean net earnings of GPs in their practice (to include contractor and salaried GPs) relating to 2014/15 financial year. Alongside the mean figure, practices must publish the number of full and part time GPs associated with the published figure. The figure will include earnings from NHS England, CCGs and local authorities for the provision of GP services that relate to the contract and which would have previously been commissioned by PCTs. Costs relating to premises will not be included. Fuller details will be included in the implementation guidance for the 2015/16 GP contract, due to be published in February 2015. This is an interim solution until arrangements are finalised for publishing individual GP net earnings in 2016/17 (extract from statutory guidance on managing conflict of interest)	• *How will our arrangements for managing conflicts of interest change for co-commissioning, in comparison to what we do in our CCGs?* • *What other measures may we wish to take in developing our approach to managing conflicts of interest?* • *What features of the guidance and other measures we take will help to give our stakeholders the confidence that we will be able to manage conflicts of interest robustly?* • *What resource will we need to manage this moving forward?*	The following additional measures are expected in the formal guidance: • The Joint Committee will have a lay and executive majority • Participating lay members will undergo the national training • Local HWB and Healthwatch membership will be invited to serve as non-voting members on the Joint Committee • A register of conflicts of interest will be held and will include information on the nature of the conflict and details of conflicted parties and would form an obligatory part of the annual accounts to be signed off by external auditors • A register of decisions will be held and will be required to be maintained and published on a regular basis • GPs are required to make public their earnings Each CCG is required to review their conflict of interest policy in line with the new guidance. Conflicts of interest arising will be dealt with using Wandsworth CCG's conflict of interest policy; to be updated.	• The Joint Committee shall adhere to the statutory guidance as released on 18th Dec, and each CCG is required to update their conflict of interest policy in accordance with the guidance. The Joint Committee shall adhere to the conflict of interest policy of Wandsworth CCG • SWL commissioners are aware of the national, local patient and public, member, GB and other stakeholder concerns around managing conflict of interest. Therefore the following 'extra measures' in SWL have been expressed: 1. A lay member will be present from each CCG in the Joint Committee 2. Each organisation will have a vote, rather than each member, representing the CCG 3.Any member with a conflict of interest shall be excluded from decision-making related to contracting or finances of GP services

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What processes and resource will be required to uphold and manage the governance of the Joint Committee?			
The Joint Committee will need to develop a Standing Orders (SO). This may be an existing CCG SO to support the governance and TOR	• *What processes would support the governance arrangements and working practices of the Joint Committee?* • *What is the timeline to develop our thinking for this?* • *How will we involve NHSE in this process and what resource will be available?* • *How will this fit into our future plans around the governance for the full programme in SWL?*	• Wandsworth CCG will act as the host organisation. The Business Manager of Wandsworth CCG shall act as Secretary to the Joint Committee. The Business Manager of Wandsworth CCG will produce an executive summary report which will be presented to the London Area Team of NHS England and the governing body of each of the CCGs	• This may include a Joint Committee Secretary who shall be in charge of upholding the Joint Committee governance in compliance with the TOR and the constitutional commitments. The Secretary may be responsible for maintaining the register on conflicts of interest and register of decisions, reporting in to the Chair and Vice Chair. The Secretary shall also be responsible for identifying and reporting justifications to the Chair, where matters discussed and decisions taken by the Joint Committee are not held in public. The Secretary would be responsible for responding on behalf of the Joint Committee on matters of Freedom of Information and other matters upholding the governance and compliant with the SO

In January 2015 NHSE will release further guidance on the risk-sharing and resourcing implications of co-commissioning in Joint Commissioning arrangements. It is for CCGs and the Local Area Team to discuss how these arrangements, including resourcing arrangements, will be taken forward in SWL.

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What role will CCGs take in the finances for co-commissioning primary care?			
Financial accountability of co-commissioning primary care will rest with NHSE. NHSE shall remain that statutory body who will hold the budget for Primary Care Medical Services. All decisions (for the above named functions) including those with financial implications, shall be taken through the Joint Committee. It is possible for CCGs to pool the primary care budget if this is desired It is possible for CCGs to invest their own funds in a way calculated to facilitate the provision of primary medical care, and conduct the associated governance through the Joint Committee, where it would already be committed to improving primary care	• *Whilst NHSE will hold the budget in the Joint Commissioning relationship, how will each CCG influence how the budget is being spent locally?* • *What statutory protections are in place over this issue?* • *What are the benefits and drawbacks of pooling funds? Can we pool partial funds and for what purpose?* • *Would each CCG wish to consider how their current investment into primary care will align with the allocated budget? How will this support the vision you have locally and the Transforming Primary Care vision in SWL?*	• The Joint Committee will be responsible for financial decision relating to the stated functions • CCGs will not pool their budgets for primary care co-commissioning. • In view of the possible move to delegated commissioning in 2016/17, it is suggested that CCGs 'shadow' the activities for managing the budget for core GP services	• This will need to be taken forward by CFOs with NHSE following consideration by COs and Chairs • CCGs will be using 2015/16 to jointly understand the budgets and how they align with spend being used to improve primary care (from CCG's current investment) • NHS England intend to release further guidance on risk sharing arrangements in Jan/Feb 2015

Next Steps

- This document should be read in conjunction with the draft Terms of Reference for the Joint Committee
- Each Governing Body and CCG Membership are invited to seek clarification before signing off the Terms of Reference which will be submitted to NHS England on 30th January
- Alongside this, each CCG's proposed constitutional amendments should be submitted to NHS England on 30th January with proposed sign-off dates indicated
- Each CCG is required to update and amend their conflicts of interest policy in line with the new national guidance