General Practice co-commissioning – frequently asked questions

1. What is ‘co-commissioning’ in terms of general practice/primary care?
Co-commissioning is when two or more commissioners come together to commission healthcare services. In this context, it means NHS England (NHSE) working with clinical commissioning groups (CCGs) to commission primary care services, initially those provided by General Practice.

CCGs can choose to:

a) Have greater involvement in primary care decision-making by seeking to influence NHSE (current position for South Devon and Torbay CCG)

b) Enter into joint commissioning arrangements, moving from ‘influence NHSE’ to ‘formally work with/agree with NHSE’ (our intended position from October 2015). This allows CCGs, where it is considered appropriate, to pool resources with NHSE, or top up NHSE-held primary care budgets.

c) Take on delegated commissioning arrangements where most of the budgets and some associated commissioning responsibilities transfer to the CCG – the intended position from April 2016, subject to satisfactory transition from a) to b) as above

2. Why are we considering co-commissioning?
Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the needs of local populations. It will support the development of new and locally relevant models of care.

3. What are the intended benefits of co-commissioning?
Co-commissioning will give us the option of having more control of the wider NHS budget. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more efficient and effective services.

For example, it might enable a CCG to vary the terms of nationally defined specifications (such as extended hours or QOF) to better align to locally identified needs and priorities. We want to commission on the basis of achieving locally defined outcomes rather than nationally prescribed processes.
Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and Information Management and Technology (IM&T) challenges.

4. Which areas of primary care do co-commissioning cover?
Currently, primary care co-commissioning arrangements will only include the majority of general practice services. However, we might decide to take on a greater level of responsibility in the commissioning of dental, optical and in particular community pharmacy services, and this could start to become available during 2016/17.

5. Does co-commissioning raise issues for CCGs about managing conflicts of interest?
Conflicts of interest – actual and perceived – need to be carefully managed within co-commissioning. However, CCGs are already managing conflicts of interests as part of their day-to-day work, and there is formal guidance on managing conflicts of interests and a code of conduct in place for CCGs and General Practitioners who have commissioning roles.

6. To whom would a joint committee be accountable? Is it NHSE or the CCG’s governing body?
Each member of a joint committee is an equal member of the committee. CCG members are accountable to their governing body and to their membership.

7. Could the CCG start joint commissioning in shadow form?
Yes. We are exploring with NHSE whether we can do this from August this year, to give us added confidence ahead of intended start point of October 15.

8. What is the proposed membership of the local joint committee?
South Devon and Torbay CCG
- Non-Executive Member of the Governing Body (Chair)
- Lay Member (Vice-Chair)
- Chief Finance Officer or nominated deputy
- CCG Director with portfolio responsibility for primary care or nominated deputy
- Governing Body GP representative – non-voting
- Primary Care Redesign Board GP Chair – non-voting
- Two patient representatives (as identified in partnership with both local HealthWatch organisations and having active PPG roles)
- Non-Executive Member of the Governing Body with responsibility for non-medical provided care

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NHS England
- Director of Commissioning or nominated representative
- Head of Primary Care or nominated representative – non-voting

Torbay Council
- Director of Public Health or nominated representative

Devon County Council
- Director of Public Health or nominated representative

9. Who will retain the legal liability under joint or delegated arrangements?
NHSE retains legal liability for any functions it delegates to CCGs through these new arrangements.

10. Will CCGs, rather than NHSE, be responsible for making decisions about practice mergers, closures, list closures, once delegated commissioning commences?
Yes. Decisions relating to all delegated functions will fall to the CCG. However, the delegation agreement requires CCGs exercising delegated authority to consult with NHSE before making a decision about practice closures.

11. Will contracting, as well as commissioning responsibilities, be delegated to CCGs?
Appraisal and revalidation, responsibility for managing GMS, PMS and APMS contracts will be delegated to CCGs. Functions relating to medical performers’ lists for GPs are exempt.

12. Who owns the responsibility for GP contracts?
The CCG will contract on behalf of NHSE through the delegated authority. However, NHSE retains liability for how the functions are carried out.

13. As the terminology used is ‘delegated’, will contracts not remain with NHSE?
NHSE will remain the contract holder, and the functions of commissioning and contract management will be delegated to the CCG.

14. Are local CCGs intending to work together to exercise delegated functions?
When individual CCGs receive delegated functions from NHSE, they are able to collaborate with other CCGs. However, NHSE can only delegate its functions once, and therefore this delegation will be to a single CCG. Therefore, any committees functioning on behalf of more than one CCG could not be a decision-making body.
CCGs are more likely to collaborate through agreement where reason to do so is identified. This is most likely to occur where areas requiring particular expertise are identified.

15. Is it true that the CCG will be expected to deliver these changes within existing running cost allocations?
That is the stated national position. We will, however, continue to press for distribution of a portion of NHSE staff budget or comparable personnel transfer. We will not propose moving to delegated commissioning until we are satisfied that we can adequately resource this area of work and that the benefits of so doing outweigh the disadvantages.

16. Will CCGs be expected to make a prescribed surplus on delegated budgets?
The value of any required surplus the CCG will be expected to make is based on the entire CCG budget, and is not required to be specifically taken against delegated commissioning budgets.

17. Will local CCGs in ‘success regime’ arrangements be excluded from co-commissioning arrangements, and might this impact on us?
NHSE is clear that it doesn’t want to exclude any CCGs from being able to take on these responsibilities and all will be considered on a case-by-case basis.

18. Is the primary care/general practice allocation ring-fenced?
No, but the CCG will be held to account for delivering its primary care outcomes and, accordingly, for adequately resourcing General Practice. The CCG will be able to allocate additional funds to the primary care/general practice budget.

19. What about local incentive schemes – what can the CCG do?
There will be increased flexibility as long as we can demonstrate our plans are targeted to the needs of our local population(s).

20. Will premises’ reimbursements be included under delegated arrangements?
Only running costs for premises are currently included in delegated budgets (for 2015/16). This is a complex area and there is work going on centrally to understand the co-dependencies and legalities surrounding this issue.

21. Who will the CCG engage with?
We will engage with our membership about the preferred co-commissioning model. Any wider engagement is for local discretion.

22. Will the CCG constitution be changed?
Yes, and any constitution amendments will need to be signed off by our members.
23. If the CCG fails to secure a high-level quality of primary medical care services, what will NHSE do?
There is no specific answer to this, but if specific identified issues are not adequately addressed, the NHSE area team might want to discuss this with the CCG.

24. Has consideration been given to what happens if there is a clear disagreement (between CCG and NHSE) under joint arrangements?
Yes. Either party can choose to terminate the agreement and take the functions back. However, every effort would be made to resolve any dispute before resorting to termination.

25. What major risks has the CCG identified in moving to delegated commissioning?
The principle risks are: finance and capacity within the CCG. For each we would not propose moving forward until we are satisfied that the risk is better managed by revising current arrangements.

26. Can the CCG transfer budget from other areas of spend into primary care if it sees a benefit in doing so?
Yes.

27. Would all CCG schemes, such as enhanced services, be defined at CCG level, or might some be made at locality level?
It would be possible to define or vary such schemes at locality level where there is demonstrable added value in doing so. Generally speaking, it is probable that the start point for designing such services would be at CCG level.