Next steps towards primary care co-commissioning

November 2014

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Publications Gateway Reference:	**02501**
Document Purpose	Implementation Support
Document Name	Next steps towards primary care co-commissioning
Author	NHS England and NHS Clinical Commissioners
Publication Date	10 November 2014
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, NHS England Regional Directors, NHS England Area Directors, GPs, NHS Commissioning Assembly
Additional Circulation List	National Association of Primary Care, Monitor, NHS Alliance, BMA (GP Committee), GMC, RCGP, DH, Healthwatch England, National Voices, All NHS England Employees
Description	This document aims to provide clarity and transparency around co-commissioning options, providing CCGs and area teams with the information and tools they need to choose and implement the right form of co-commissioning for their local health economy.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	Submit proposals, if required, in January 2015
Timing / Deadlines (if applicable)	**Implementation from 01 / 04 / 15**
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Document Status

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Next steps towards primary care co-commissioning

First published: November 2014

Prepared by: Ian Dodge, National Director: Commissioning Strategy

Classification: Official

Foreword by Amanda Doyle and Ian Dodge

"General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain … Steps we will take include … [giving] GP-led clinical commissioning GPs more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services".

The NHS Five Year Forward View, October 2014

The introduction of co-commissioning is an essential step towards expanding and strengthening primary medical care.

Co-commissioning is recognition that clinical commissioning groups (CCGs):

- are harnessing clinical insight and energy to drive changes in their local health systems that have not been achievable before now;

but

- are hindered from taking an holistic and integrated approach to improving healthcare for their local populations, due to their lack of say over the commissioning of both primary care and some specialised services; and

- are unable to unlock the full potential of their statutory duty to help improve the quality of general practice for patients.

That's why NHS England is giving CCGs the opportunity to assume greater power and influence over the commissioning of primary medical care from April 2015.

Although we are confident that co-commissioning - or delegation to CCGs - is in the best interests of patients, the *offer* from NHS England is just that: it is for each and every CCG to consider carefully, and make up its own mind as to how it will respond.

We know that the imposition of a single national solution just won't work, and will fail to take into account different local contexts.

CCGs are GP-led organisations. CCGs understand primary care, and are passionate about improving its quality, across all practices in their own geographical areas.

At the same time, individual GPs will also be conflicted in specific decisions about primary care commissioning. So, in order to harness the benefits of co-commissioning, yet guard fully against the risks, we have developed robust new and transparent arrangements for managing perceived and actual conflicts of interest. NHS England is formally consulting on these before issuing as statutory guidance for the first time.

In progressing this agenda, we have sought to provide NHS England and CCG leadership that is genuinely joint and open - and which has also involved lay members and councils.

In our discussions, we have promoted vigorous debate and challenge. We intend our approach to serve as a model for wider collaboration across NHS England and CCGs, right across the breadth of our shared agenda.

Right across the country, we are confident that CCGs and NHS England regions and areas will approach co-commissioning in a spirit of openness, partnership and practical problem solving.

We are optimistic that the agreements we have reached and proposals we set out in this document pave the way for better services for patients, and better value for the taxpayer. The proof is, of course, only in the doing - and the public evaluation of the doing.

This piece of paper signals the next stage in co-commissioning. By no means is it the end of the story. We will continue to work together closely to pick up and resolve teething troubles and to assess progress.

Ian Dodge
National Director:
Commissioning Strategy,
NHS England

Dr Amanda Doyle
Chief Clinical Officer,
NHS Blackpool CCG;
Co-chair, NHS Clinical Commissioners

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1 Executive summary

Next steps towards primary care co-commissioning gives clinical commissioning groups (CCGs) the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements. The document has been developed by the joint CCG and NHS England Primary Care Commissioning Programme Oversight Group in partnership with NHS Clinical Commissioners.

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 diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning **models** CCGs could take forward:

The **scope** of primary care co-commissioning in 2015/16 is general practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

Under joint and delegated arrangements, CCGs will have the opportunity to design a **local incentive scheme** as an alternative to the Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DES). This is without prejudice to the right of GMS practices to their entitlements, which are negotiated and set nationally. In order to ensure national consistency and delivery of the democratically-set goals for the NHS outlined in the Mandate set for us by the government, NHS England will continue to set national standing rules, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing **contracts for primary care provision** or award new ones, depending on local circumstances. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest. In delegated

arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

With regards to **governance** arrangements, we have developed draft governance frameworks and terms of reference for joint and delegated arrangements on behalf of CCGs, as appended in annex D, E and F. CCGs are encouraged to utilise these resources when establishing their governance arrangements.

A significant challenge of primary care co-commissioning is finding a way to ensure that CCGs can access the necessary **resources** as they take on new responsibilities. Pragmatic and flexible local arrangements for 2015/16 will need to be agreed by CCGs and area teams.

Conflicts of interest need to be carefully managed within co-commissioning. Whilst there is already conflicts of interest guidance in place for CCGs, this will be strengthened in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. A national framework for conflicts of interest in primary care co-commissioning will be published as statutory guidance in December 2014.

The **approvals process** for co-commissioning arrangements will be straightforward. The aim is to support as many CCGs as possible to implement co-commissioning arrangements by 1 April 2015. Unless a CCG has serious governance issues or is in a state akin to “special measures”, NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs who wish to implement joint or delegated arrangements will be required to complete a short proforma (annex A and B) and request a constitution amendment. The approvals process will be led by regional moderation panels with the new NHS England commissioning committee providing final sign off for delegated arrangements.

We also intend to make it as simple as possible for CCGs to **change their co-commissioning model**, should they so wish. Should this need arise, CCGs should discuss their plans with the relevant area team in the first instance as part of the CCG assurance process.

On-going assurance of co-commissioning arrangements will form part of the wider CCG assurance process. NHS England intends to work with CCGs to co-develop a revised approach to the current CCG assurance framework. NHS England will also ensure it continually **evaluates** the implementation of co-commissioning arrangements to share best practice and lessons learned with CCGs and area teams.

We hope this document is useful in helping to inform CCG decision making around primary care co-commissioning models and in providing clarity on the next steps towards the implementation of new arrangements. If you require any further information, please email: england.co-commissioning@nhs.net.

2 Background and context

In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. There has been a strong response from CCGs wishing to assume co-commissioning responsibilities. We want to harness this energy and address the frustrations CCGs have expressed in the current primary care commissioning arrangements, to more effectively shape high quality local services.

There are three possible models of primary care commissioning that CCGs could pursue:

The purpose of this document is to give CCGs an opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each model, including associated functions; governance arrangements; resources; and any potential risks, with advice on how to mitigate these. The document then sets out the steps towards implementing co-commissioning arrangements, including the timeline and approvals process.

This document is accompanied by a suite of practical resources and tools which are appended to support local implementation of co-commissioning arrangements. In addition, a national framework for the handling of conflicts of interest management for primary care co-commissioning is under development in partnership with NHS Clinical Commissioners. Whilst there is already conflicts of interest guidance in place for CCGs, we are strengthening this in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. The conflicts of interest framework will be published as statutory guidance in December 2014.

This document has been jointly developed with CCGs and NHS England through the Primary Care Co-commissioning Programme Oversight Group. The group is co-chaired by Dr Amanda Doyle (Chief Clinical Officer, NHS Blackpool CCG and Co-chair, NHS Clinical Commissioners) and Ian Dodge (National Director: Commissioning Strategy, NHS England) with membership set out in annex G. It has also been developed in partnership with NHS Clinical Commissioners.

3 Vision and aims of co-commissioning

This section sets out the long term vision for co-commissioning and the potential benefits it could bring for local populations.

Co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. The *Forward View* 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 a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will drive 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.

Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- Improved access to primary care and wider out-of-hospitals 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.

Co-commissioning could also lead to greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services. Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

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.

From 1 April 2015 we will be extending personal commissioning through The Integrated Personal Commissioning (IPC) programme. The IPC programme aims to bring health and social care together, identifying the totality of expenditure at the level of the individual, giving people more control over how this is used and enabling money to be spent in a more tailored way.

Furthermore, from 2015/16 CCGs will have the opportunity to co-commission some specialised services through a joint committee. We have also been encouraging CCGs and local authorities to strengthen their partnership approach so they can jointly and effectively work to align commissioning intentions for NHS, social care and public health services.

4 Scope of co-commissioning models

This section aims to support CCGs to make an informed decision on which co-commissioning model they would like to take forward. For each co-commissioning model, it set outs :

- the primary care commissioning functions it includes;
- governance arrangements; and
- opportunities, potential benefits and risks.

4.1 Overview of co-commissioning functions

The first step on the co-commissioning journey is for CCGs to decide which form of co-commissioning they would like to assume. There are three forms of co-commissioning CCGs could adopt:

In this section we aim to provide clarity and transparency around what each co-commissioning model would entail to support CCGs in their decision making.

4.1.1 Scope of primary care co-commissioning

Primary care commissioning covers a wide spectrum of activity. We have engaged with a large number of CCGs to agree the functions each co-commissioning model will encompass. We have agreed that in 2015/16, primary care co-commissioning arrangements will only include general practice services. CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no formal decision making role.

However, we recognise the ambition in some CCGs to take on a greater level of responsibility in the commissioning of dental, eye health and community pharmacy services and we will be looking into this for 2016/17, with full and proper engagement of the relevant professional groups.

4.1.2 **Local flexibilities for incentive schemes and contracts**

The purpose of primary care co-commissioning is to enable clinically led, optimal local solutions in response to local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies. This will be done by delegating functions and decision making to the local level.

Under delegated arrangements, CCGs would have the ability to offer GP practices the opportunity to participate in a locally designed contract, sensitive to the diverse needs of their particular communities, above or different from the national requirements e.g., as an alternative to QOF or directed enhanced services (DES). Similarly under joint arrangements, NHS England and CCGs could explore the option of implementing a locally designed incentive scheme. This is without prejudice to the rights of practices to their GMS entitlements which are negotiated and agreed nationally. Any migration from a national standard contract could only be affected through voluntary action.

In designing their own approach, it would be useful for CCGs that wish to design a new local incentive scheme to review the evaluation of the Somerset Practice Quality Scheme, as we learn more about this pilot initiative.

There will be no formal approvals process for a CCG which wishes to develop a local QOF scheme or DES. However, any proposed new incentive scheme should be subject to consultation with the Local Medical Committee (LMC), and be able to demonstrate improved outcomes, reduced inequalities and value for money. On-going assurance of new schemes would form part of the CCG assurance process.

With the freedoms of co-commissioning arises the need for mitigation of the potential risks of inconsistency of approach in areas where national consistency is clearly desirable. There is already an ability to set out core national requirements in GMS, PMS and APMS contracts through regulations. In line with this, NHS England reserves the right to set national standing rules, as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets and IT intra-operability. The standing rules would become part of a binding agreement underpinning the delegation of functions and budgets from NHS England to CCGs.

4.1.3 **Commissioning and awarding contracts for primary care provision**

In joint arrangements, commissioning decisions would be taken by the CCG and NHS England area team. In delegated arrangements, CCGs would be responsible for taking these decisions.

In joint and delegated arrangements - as is the case for any services that they commission - CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances.

In delegated arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act. In delegated and joint arrangements, where a CCG or a CCG and NHS England are found to have breached public procurement regulations and/or statutory guidance on conflicts of interest, Monitor may direct a CCG or a CCG and NHS England to act. NHS England may, ultimately, revoke a CCG's delegation.

Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities. This applies to joint and delegated arrangements.

4.1.4 **Parameters of primary care co-commissioning**

For all forms of primary care co-commissioning, there has been clear feedback from CCGs that it would not be appropriate for CCGs to take on certain specific pseudo-employer responsibilities around co-commissioning of primary medical care. We have therefore agreed that functions relating to individual GP performance management (medical performers' list for GPs, appraisal and revalidation) will be reserved to NHS England. NHS England will also be responsible for the administration of payments and list management. CCGs must assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.

Furthermore, the terms of GMS contracts – and any nationally determined elements of PMS and APMS contracts – will continue to be set out in the respective regulations and directions and cannot be varied by CCGs or joint committees.

For the avoidance of doubt, CCGs will be required to adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

4.1.5 **Summary of co-commissioning functions**

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	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 incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, revalidation	No	No	No

Further information on each co-commissioning model and the functions it encompasses is set out in section 4.2 to 4.4.

4.2 Greater involvement in primary care co-commissioning: scope and functions

Greater involvement in primary care co-commissioning is simply an invitation to CCGs to collaborate more closely with their area teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy. This form of co-commissioning will assist CCGs to fulfil their duty to improve the quality of primary medical care[1].

4.2.1 Scope of greater involvement in primary care commissioning

CCGs who wish to have greater involvement in primary care decision making could participate in discussions about all areas of primary care including primary medical care, eye health, dental and community pharmacy services, provided that NHS England retains its statutory decision-making responsibilities and there is appropriate involvement of local professional networks.

4.2.2 Governance arrangements for greater involvement in primary care decision making

No new governance arrangements would be required for a CCG to have greater involvement in the commissioning of primary care services and this involvement could be agreed between the CCG and its area team at any time. The effectiveness of these arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. It is in the CCG and area team's own interest to also engage local authorities, local Health and Wellbeing Boards and local communities in primary care decision making.

A CCG which adopts this model of co-commissioning is unlikely to encounter an increased number of conflicts of interest, as CCGs would not have formal accountability for decision making. However, they would need to remain mindful of conflicts of interests and follow prescribed guidance as set out in section 6.

In this model, CCGs have the opportunity - already available to them - to invest in primary care services. Annex H contains a series of frequently asked questions (FAQs) on investing in primary care for CCGs and area teams. Further details on the next steps to take forward this form of co-commissioning can be found in section 7.2.

[1] Section 14S NHS Act 2006 (as amended by the Health and Social Care Act 2012).

4.3 Joint commissioning arrangements: scope and functions

A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". Joint commissioning arrangements give CCGs and area teams an opportunity to more effectively plan and improve the provision of out-of hospital services for the benefit of patients and local populations. Within this model CCGs also have the option to pool funding for investment in primary care services as set out in section 4.3.3.

4.3.1 Joint commissioning functions

In 2015/16, joint commissioning arrangements will be limited to general practice services. The functions joint committees could cover are:

- 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; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

Joint commissioning arrangements will 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.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.3.2 **Joint commissioning governance arrangements**

CCGs could either form a joint committee or "committees in common" with their area team in order to jointly commission primary medical services.[2] With regards to joint committees, due to the passing of a Legislative Reform Order (LRO) by parliament, CCGs can now form a joint committee with one or more CCGs and NHS England. Further information on the LRO can be found here. NHS England's scheme of delegation is being reviewed and will be revised as appropriate to enable the formation of joint committees between NHS England and CCGs i.e., where NHS England invites one or more CCGs to form a joint committee.

A model terms of reference for joint commissioning arrangements, including scheme of delegation, are appended at annex D. This model applies to the establishment of a joint committee between the CCG (or CCGs) and NHS England. If CCGs and area teams intend to form a joint committee, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures. The joint committee structure allows a more efficient and effective way of working together than a committees-in-common approach and so this is the recommended governance structure for joint commissioning arrangements.

In joint commissioning arrangements, individual CCGs and NHS England always remain accountable for meeting their own statutory duties, for instance in relation to quality, financial resources, equality, health inequalities and public participation[3]. This means that in this arrangement, NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. CCGs and NHS England must ensure that any governance arrangement they put in place does not compromise their respective ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making. Arrangements should also comply with the conflicts of interest guidance – please refer to section 6 for further information.

The effectiveness of joint arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. NHS England and CCGs need to ensure that any governance arrangements put in place enable them to collaborate effectively.

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[2] A joint committee is a single committee to which multiple bodies (e.g. NHS England and one or more CCGs) delegate decision-making on particular matters. The joint committee then considers the issues in question and makes a single decision. In contrast, under a committees-in-common approach, each committee must still make its own decision on the issues in question.

[3] In the CCG's case these duties are set out in sections 14R, 14R, 14Z1, 14Z11, 14Z15, 223H, 223I, 223J and 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012; the Equality Act 2010.

Membership of joint committees

It is for area teams and CCGs to agree the full membership of their joint committees. In the interests of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the joint committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. It will be important to retain clinical leadership of commissioning in a joint committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.3.3 Pooled funds for joint commissioning

CCGs and area teams may wish to consider implementing a pooled fund arrangement under joint commissioning arrangements as per section 13V of Chapter A1 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Establishing a pooled fund will require close working between CCG and area team finance colleagues to ensure that the arrangement establishes clear financial controls and risk management systems and has clear accountability arrangements in place.

The funding of core primary medical services is an NHS England statutory function. Although NHS England can create a pooled fund which a CCG can contribute to, the CCG's contribution must relate to its own functions and so could not relate to core primary medical services. However, CCGs are able to invest in a way that is calculated to facilitate or is conducive or incidental to the provision of primary medical care and provided that no other body has a statutory duty to provide that funding. For example,

Where an area team currently commissions services using an APMS contract they could consider pooling funds with a CCG to secure a wider range of services, for example, enhanced care for vulnerable older people.

Further details on the next steps to take forward joint commissioning can be found in section 7.3.

4.4 Delegated commissioning arrangements: scope and functions

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. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. Naturally, CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation[4].

4.4.1 Delegated commissioning functions

There was considerable variation in the range of primary care commissioning functions that CCGs proposed to assume in their initial expressions of interest. Following discussions with CCGs, we have agreed that a standardised model of delegation would make most sense for practical reasons. CCGs have expressed a strong interest in assuming the following primary care functions which will be included in delegated arrangements:

- 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; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

[4] Section 14Z2 of the NHS Act (2006), as amended by the Health and Social Care Act (2012).

Delegated commissioning arrangements will 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.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.4.2 **Delegated commissioning governance arrangements**

NHS England has developed a model governance framework for delegated commissioning arrangements in order to avoid the need for CCGs to develop their own model. The recommendation is that CCGs establish a primary care commissioning committee to oversee the exercise of the delegated functions. A model terms of reference for delegated commissioning arrangements including scheme of delegation are appended at annex F. If CCGs intend to assume delegated responsibilities, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures.

A draft delegation is also appended at annex E. This is the formal document which records the delegation of authority by NHS England to CCGs. NHS England will issue a formal delegation agreement once the approvals process is completed.

In delegated commissioning arrangements, CCGs will remain accountable for meeting their own pre-existing statutory functions, for instance in relation to quality, financial resources and public participation[5]. CCGs must ensure that any governance arrangement they put in place does not compromise their ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making.

Membership of CCG primary care commissioning committees

It is for CCGs to agree the full membership of their primary care commissioning committee. CCGs will be required to ensure that it is chaired by a lay member and have a lay and executive majority. Furthermore, in the interest of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the delegated committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

[5] Sections 14R, 223H, 223I, 223J and 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012.

CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. Furthermore, it will be important to retain clinical involvement in a delegated committee arrangement to ensure the unique benefits of clinical commissioning are retained.

In this model new steps will be needed to manage potential conflicts of interest and these are set out in section 6.

Further details on the next steps to take forward delegated commissioning can be found in section 7.4.

5 Support and resources for co-commissioning

This section sets out how CCGs can access support and resources to deliver primary care co-commissioning.

A significant challenge involved in implementing primary care co-commissioning is finding a way to ensure that all CCGs can access the necessary resources as they take on new co-commissioning responsibilities. Both CCGs and NHS England recognise the difficulties of managing this fairly and in a way that both supports those CCGs which want to take on co-commissioning responsibilities and allows area teams to continue to safely and effectively deliver their remaining responsibilities.

Primary care commissioning is currently delivered by teams covering a large geography normally spanning several CCGs, and also covering all parts of primary care not just limited to general practice. There is no possibility of additional administrative resources being deployed on these services at this time due to running cost constraints.

Pragmatic and flexible local solutions will need to be agreed by CCGs and area teams to put in place arrangements that will work locally for 2015/16. These local agreements will need to ensure that:

- CCGs that take on delegated commissioning responsibilities have access to a fair share of the area team's primary care commissioning staff resources to deliver their responsibilities; and
- Area teams retain a fair share of existing resources to deliver all their ongoing primary care commissioning responsibilities.

There will be no nationally prescribed model: this will be a matter for local dialogue and determination. However, NHS England is committed to supporting local discussions in any way deemed helpful, and the current Primary Care Co-Commissioning Programme Oversight Group will continue to operate during the implementation period to help address practical issues.

5.1 Potential approaches for staffing

Where CCGs intend to take on joint or delegated responsibility for primary care commissioning, they should have a conversation with the area team regarding accessing support through the existing primary care team.

Given the limited size of existing primary care teams, potentially only part-time capacity would be available for individual CCGs taking on delegated commissioning responsibility, so it may be that collaborative arrangements between CCGs would be desirable to achieve greater critical mass. Staffing models for these arrangements will vary across the country and will require careful discussion to ensure that the practical, legal and staff engagement issues are clearly understood.

However, it is for CCGs to agree whether and how they would wish to work together. Where like-minded CCGs in an area team patch wish to collaborate, they need not necessarily be contiguous. In instances where they are not contiguous, the area team and CCGs would need to consider geographical practicalities for the staff concerned. These arrangements will need to take into account the size of the CCG, the number of primary care contracts held and the need for the area team to continue to deliver primary care commissioning functions not being delegated to CCGs and for areas where CCGs do not opt to take on delegated responsibilities.

Alternatively, some CCGs may wish to integrate primary care commissioning support with wider commissioning support from their Commissioning Support Unit (CSU). Again, in this scenario, arrangements should be agreed and implemented locally with particular attention to the practicalities.

It will be critical that local conversations are handled with maturity and due regard for members of staff involved to ensure transparent and mutually workable solutions.

5.2 Financial arrangements for co-commissioning

5.2.1 Financial information sharing

NHS England will ensure transparency in sharing financial information on primary care with CCGs. All CCGs will have the opportunity to discuss the current financial position for all local primary care services with their area team. CCGs will be provided with an analysis of their baseline expenditure for 2014/15 broken down between GP services and other primary care services by the end of November 2014. Final decisions regarding allocations for 2015/16 will be made by the NHS England Board in December 2014. An example of the level of detail area teams will be able to share can be found in the financial plan template – direct commissioning section of the NHS England website.

5.2.2 Financial allocations and running costs

We recognise that it will be challenging for some CCGs to implement co-commissioning arrangements, especially delegated arrangements, without an increase in running costs. Whilst it is not within our gift to increase running costs in 2015/16, NHS England will keep this situation under review. CCGs should discuss

with area teams options for sharing administrative resource to support the commissioning of primary care services.

In delegated arrangements, CCGs will receive funding for known future cost pressures within current allocations e.g. net growth in list sizes. In such circumstances, there may be a linked efficiency requirement which will need to be delivered in order for budgets to balance. Furthermore, if supported by clear strategies, CCGs would also have greater flexibility to "top up" their primary care allocation with funds from their main CCG allocation. For example:

A CCG currently commissions district nursing services from its community provider. The CCG could consider pooling the funding for this service with its primary care funding and arrange for district nursing services to be commissioned as part of primary care linked to GP practice nursing.

Full details on how area team allocations for primary care for 2014/15 and 2015/16 were calculated are published in the Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams. Annex F of this technical guide also sets out the detailed pace of change for each area team primary care allocation for 2014/15 and 2015/16.

Work is also currently underway to develop a target formula and place based allocations. Further information on the target formula will be available in early 2015 and the 'place-based' target in late 2015. It is anticipated that in 2015/16 the actual allocations for primary care will be made at CCG level rather than area team level.

5.2.3 **Variations in primary care funding**

It is recognised that there are historic variations in primary care funding across England and localities and we are taking steps to move towards a fair distribution of resources for primary care, based on the needs of diverse populations. The GMS Minimum Practice Income Guarantee (MPIG) will be phased out by April 2020, and a review of local PMS agreements is underway as set out in the Framework for Personal Medical Services (PMS) Contracts Review. Area teams should ensure that any decisions relating to future use of PMS funding are agreed with CCGs.

We envisage that CCG and primary care allocations will continue to move towards a fair distribution of resources and reflect inequalities, as in the current CCG formula. As part of any delegation of primary care commissioning responsibilities, area teams will provide details of any differential funding levels across localities.

6 Conflicts of interest

This section provides advice on conflicts of interest management for CCGs that implement co-commissioning arrangements.

Conflicts of interest, actual and perceived, need to be carefully managed within co-commissioning. Conflicts of interest are a matter of public interest, and it is also in the interest of the profession that this issue is robustly and transparently handled. 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 in commissioning roles.

However, without a strengthened approach, co-commissioning could significantly increase the frequency and range of potential conflicts of interest, especially for delegated arrangements. Therefore, NHS England, in partnership with NHS Clinical Commissioners, has developed a significantly enhanced framework for conflicts of interest management with clear minimum expectations for CCGs which assume co-commissioning responsibilities.

6.1 Current conflicts of interest guidance

There is a legal requirement for CCGs to have arrangements in place for managing conflicts of interest. Section 14O of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) sets out minimum requirements including:

NHS England must:

- Publish guidance to CCGs on the discharge of their duties.

CCGs must:

- Maintain appropriate registers of interests;
- Publish or make arrangements for the public to access those registers;
- Make arrangements requiring the prompt declaration of interests by the persons specified (members and employees) and ensure that these interests are entered into the relevant register;
- Make arrangements for managing conflicts of interest and potential conflicts of interest (e.g. developing appropriate policies and procedures); and

- Have regard to guidance published by NHS England in relation to conflicts of interest.

NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013

- A relevant body (including a CCG) must not award a contract for NHS health care services where conflicts, or potential conflicts of interest affect, or appear to affect, the integrity of the award.

6.2 Forthcoming guidance on managing conflicts of interest in primary care co-commissioning arrangements

A national framework for conflicts of interest management in primary care co-commissioning is being developed in partnership with NHS Clinical Commissioners and with formal engagement of Monitor and HealthWatch England. The guidance will:

- build on existing guidance;
- have regard to any statutory guidance issued by Monitor; and
- continue to facilitate clinically-led decision-making as far as possible within the important constraint of the effective management of conflicts of interests.

The guidance will include a strengthened approach to:

- **the make-up of the decision-making committee**: the committee must have a lay and executive majority and have a lay chair;
- **national training for CCG lay members** to support and strengthen their role;
- **external involvement of local stakeholders**: the local HealthWatch and a local authority member of the local Health and Wellbeing Board will have the right to serve as observers on the decision-making committee;

- **register of interest**: the public register of conflicts of interest will include information on the nature of the conflict and details of the conflicted parties. The register would form an obligatory part of the annual accounts and be signed off by external auditors; and

- **register of decisions**: CCGs will be required to maintain and publish, on a regular basis, a register of procurement decisions.

The guidance will be published in December 2014 as statutory guidance in accordance with section 14Z8 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The guidance will be specifically aimed at CCGs exercising delegated authority but all CCGs will be required to have regard to the principles set out in the guidance.

The CCG's audit committee chair and CCG Accountable Officer will be required to provide direct formal attestation that the CCG has complied with conflict of interest guidance.

7 Approvals and implementation process 2014/15

This section sets out the approvals and implementation process for co-commissioning arrangements including the:

- process for reviewing your preferred co-commissioning approach;
- approvals process for co-commissioning arrangements; and
- implementation timeline for 2014/15.

7.1.1 Principles of the approvals process

Based on feedback from CCGs and area teams, and in recognition that CCGs undertook a robust authorisation process in their establishment as statutory bodies, the approvals process for co-commissioning arrangements will be as straightforward as possible. The process will be governed by the following principles:

- It will be conducted openly and transparently and contain no surprises;
- It will minimise the administrative demands placed on CCGs and area teams; and
- On-going assurance of co-commissioning arrangements will form part of the CCG assurance process.

Unless a CCG has serious governance issues or is in a state akin to "special measures," NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs must also be able to demonstrate appropriate levels of sound financial control and meet all statutory and business planning requirements to progress delegated arrangements.

7.1.2 Opportunity to review your preferred co-commissioning arrangement

CCGs have requested a fresh opportunity to decide upon their preferred approach to primary care commissioning. We are therefore inviting CCGs to review their intentions and indicate their preferred co-commissioning arrangement in **January 2015**. As membership organisations, CCGs should fully engage with their members when considering co-commissioning options. It would also benefit CCGs and local stakeholders such as patients, local authorities, Health and Wellbeing Boards and HealthWatch to have an open and inclusive conversation about options and possible arrangements.

CCGs and area teams are asked to complete a short proforma should they wish to assume joint or delegated arrangements, as set out in the table below.

Co-commissioning model	Proforma	Submission date
Greater involvement in primary care commissioning decision making	There is no proforma to complete. Please liaise with your area team to take forward these arrangements, as set out in section 7.2.	Not applicable.
Joint commissioning	CCGs and area teams are asked to complete a proforma for joint arrangements (annex A). This proforma focuses upon the proposed governance arrangements for joint committees.	**30 January 2015**
Delegated commissioning	CCGs and area teams are asked to complete a proforma for delegated arrangements (annex B). This proforma focuses upon the CCG's approach to conflicts of interest management.	**12 noon on 9 January 2015**

Proformas for joint and delegated arrangements should be emailed to england.co-commissioning@nhs.net along with the requested supporting documentation which includes constitution amendment requests.

All delegated proformas must be submitted by **12 noon** on **9 January 2015** for arrangements to be implemented on **1 April 2015**. This is to allow sufficient time for financial transfers to be made. It would be preferential if arrangements were put in place on 1 April 2015 in the interests of agreeing staffing arrangements with area teams, although it may be possible to enable CCGs to implement delegated arrangements in-year in 2015/16.

Whilst these are formal deadlines, we know that in many areas CCGs and area teams are already engaging about co-commissioning, including financial arrangements and resources. We consider this to be good practice and would encourage all CCGs and area teams to adopt this approach.

7.1.3 **Procedure to agree a change to a CCG constitution**

Proposals for joint and delegated commissioning arrangements will require an amendment to a CCG's constitution. A suggested form of words for joint commissioning constitutional amendments, which can be tailored to individual circumstances, is included in annex C. Other minor amendments may also be

required in relation to delegated commissioning arrangements and these will be considered on an individual CCG basis.

The procedure for making an amendment is set out in the following guidance: Procedures for clinical commissioning group constitution change, merger and dissolution. As membership organisations, CCGs should consult with their members on any constitutional changes. CCGs also have a duty to consult with relevant stakeholders, such as local authorities, on constitutional changes.

The deadline for constitution amendment requests has been extended from 1 November 2014 to **12 noon** on **9 January 2015**. There is a further extension till 30 January 2015 for constitution amendments that relate solely to joint commissioning arrangements.

Co-commissioning form	Submission date for CCG constitutional changes
Joint commissioning	30 January 2015
Delegated commissioning	9 January 2015
All other constitution amendment requests	9 January 2015

All requests for constitution amendments should be emailed to england.co-commissioning@nhs.net **and the relevant regional team**. NHS England will acknowledge all applications for constitutional variations within two weeks of receipt and will notify the CCG in writing of the outcome of its decision within 8 weeks.

7.1.4 Governance arrangements for joint and delegated commissioning models

This document is accompanied by a suite of practical tools to support CCGs to implement co-commissioning arrangements locally including:

- Joint commissioning model governance structure, including model terms of reference for joint commissioning arrangements and scheme of delegation (Annex D)
- Draft delegation by NHS England (Annex E)
- Delegated commissioning model-draft terms of reference (Annex F)

NHS England has developed the governance frameworks on behalf of CCGs. CCGs are encouraged to use the template documents when developing co-commissioning arrangements. They can be amended to reflect local arrangements and to ensure consistency with the CCG's particular governance structure. They contain a number of points where the detail will need to be discussed and agreed as co-commissioning proposals are developed.

7.1.5 **Overview of the approvals process**

The approvals process for primary care co-commissioning is intended to be straightforward:

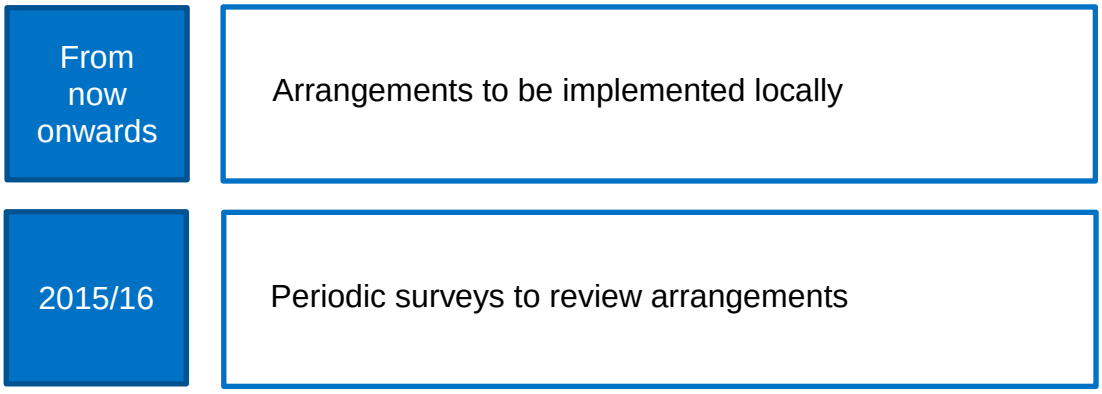
Co-commissioning model	Approvals process
Greater involvement in primary care commissioning decision making	No formal approvals process. Arrangements should be taken forward locally.
Joint commissioning	Proposals should be submitted to england.co-commissioning@nhs.net by 30 January 2015. Proposals will be agreed by regional teams, if they are assured that arrangements comply with the governance framework, for instance through the creation of a joint committee or "committee in common".
Delegated commissioning	Proposals should be submitted to england.co-commissioning@nhs.net by **12 noon** on **9 January 2015** for initial review by regional moderation panels. Final sign off will be undertaken by the proposed new Commissioning Committee of NHS England's Board.

Further information on the approvals process is set out in sections 7.2 to 7.4. On-going assurance of arrangements will form part of the CCG assurance process.

7.2 Greater involvement in primary care co-commissioning: approvals process and timeline

There is no formal approvals process for any CCG which wishes to have greater involvement in primary care decision making. Many CCGs are already working closely with their area teams to influence and shape primary care decision making and NHS England will continue to work with CCGs to establish effective arrangements. Periodic surveys will be conducted to provide an opportunity for CCGs and area teams to feedback on local arrangements. More information on the surveys will be provided in due course.

7.2.1 Summary of the approvals process and timeline



7.3 Joint commissioning proposals: approvals process and timeline

7.3.1 Joint commissioning proforma

CCGs that wish to assume joint commissioning responsibilities should work with their area teams to complete a short proforma (annex A) to confirm the agreed governance arrangements. Proformas should be submitted to england.co-commissioning@nhs.net by **30 January 2015** along with requested supporting information, including the proposed governance structure and constitution amendment request. A draft governance structure for joint commissioning arrangements is appended at annex D and can be amended to reflect local arrangements.

7.3.2 Approvals process

Regional moderation panels will convene in early February 2015 to review all submitted proposals, focusing upon the proposed governance arrangements and ensuring consistency of area team approach. Where a joint commissioning arrangement involves a pooled fund, the arrangement would need to comply with financial instructions (please refer to section 4.3.3). This is also an opportunity to take stock of the practical arrangements put in place locally by CCGs and area teams and to highlight and share best practice in this area.

Once regional teams are satisfied that the proposed arrangements comply with the legal framework and constitution amendments have been approved, arrangements can be implemented by **1 April 2015**. Area teams will inform CCGs once proposals have been approved and CCGs and NHS England will be required to sign a legally binding agreement to confirm how NHS England and CCGs will operate under the joint arrangement. Where proposals are not recommended for approval, regional teams will work with CCGs and area teams to support the development of joint arrangements.

All new arrangements for information handling as a result of joint commissioning arrangements must meet relevant information governance standards. CCGs are encouraged to review their Information Governance Toolkit assessment to ensure compliance with Department of Health Information Governance policies and standards.

7.3.3 **Summary of the approvals process and timeline**

November 2014 to January 2015	• CCGs and area teams should work together to further develop joint commissioning proposals.
30 January 2015	• Submission of proposal for joint arrangements (annex A). • Submission of constitutional amendment (annex C).
February to March 2015	• Regional moderation panel reviews proposals and makes recommendations for approval. • CCGs informed of the outcome of their constiutional amendment request. • If required, regional teams support the further development of proposals.
From 1 April 2015 onwards	• Arrangements implemented in full locally.

7.4 Delegated commissioning arrangements: approvals process and timeline

7.4.1 Delegated commissioning proforma

CCGs that wish to assume delegated commissioning responsibilities are asked to submit a short proforma (annex B) which focuses on the CCGs approach to conflicts of interest management. Proformas should be submitted to the national support centre team (england.co-commissioning@nhs.net) by **12 noon** on **9 January 2015** along with the requested supporting information, including the proposed delegated governance structure and constitution amendment request.

7.4.2 Approvals process

Regional moderation panels will convene in **mid-January 2015** to review all delegated proposals, specifically the CCG's proposed approach to conflicts of interest management. This is also an opportunity to take stock of the practical arrangements put in place locally by CCGs and area teams and to highlight and share best practice in this area.

A national moderation panel, in place to ensure consistency of approach across the country, will make final recommendations to the relevant new NHS England committee (likely to be the proposed new Commissioning Committee) on which proposals are ready to be taken forward from 1 April 2015. The committee will provide final sign off for delegated proposals in **February 2015**. Once proposals are approved, CCGs will need to set out their plans as per the 2015/16 NHS planning guidance which will be published in December 2014. Proposals will then be implemented on **1 April 2015**.

Where proposals are not recommended for approval, an appropriate plan will be developed between the CCG and area team, supported by regional teams, to either further develop proposals or to establish joint arrangements for 2015/16, if this is agreed to be the preferred approach. It would be preferential if arrangements were put in place on 1 April 2015 in the interests of agreeing staffing arrangements with area teams. However, there may be some flexibility to enable CCGs, who submit delegated arrangement proposals for 2016/17 to implement delegated arrangements in year in 2015/16.

Once delegated arrangements have been established, their effectiveness will be monitored as part of the CCG assurance process.

7.4.3 **Implementation arrangements**

Once delegated commissioning proposals have been signed off by the proposed new Commissioning Committee, CCGs will be required to sign a legally binding agreement to confirm the detail of how NHS England will delegate its general practice functions to CCGs.

NHS England's finance directorate will arrange for funds to be transferred on **1 April 2015** to enable CCGs to take forward arrangements thereafter**.** Funds will be transferred via an inter authority transfer in 2015/16. When discharging their duties, CCGs must comply with the Statement of Financial Entitlement (SFE) directions which set out the payments to be made under general medical services contracts. Business rules, which CCGs currently adhere to, will also apply to primary care commissioning. The 2014/15 business rules can be found in annex B of the financial plan template – direct commissioning section of the NHS England website.

All new arrangements for information handling as a result of delegated commissioning arrangements must meet relevant information governance standards. CCGs are encouraged to review their Information Governance Toolkit assessment in compliance with Department of Health Information Governance policies and standards. Information sharing will form part of the formal delegation agreement once arrangements have been approved.

7.4.4 **Summary of the approvals process and timeline**

November 2014 to January 2015	• CCGs and NHS England work together to further develop delegated commissioning proposals.
9 January 2015 (12 noon)	• Submission of proposal for delegated arrangements (annex B). • Submission of constitutional amendment (annex C).
February 2015	• Regional moderation panel review proposals and make recommendations for approval. • NHS England Commissioning Committee approves proposals
March 2015	• Subject to approval, NHS England's finance directorate arrange the transfer of delegated budgets. • CCGs informed of the outcome of their consitutional amendment request.
From 1 April 2015 onwards	• Arrangements implemented in full locally.

8 Changing a co-commissioning arrangement from 2015/16 onwards

This section sets out the process for changing a co-commissioning arrangement from 2015/16. This includes the approvals process and timeline.

CCGs are at different stages of their developmental journey and are facing a variety of local challenges. Therefore it is likely that the appetite to take on further responsibilities for primary care co-commissioning will vary across the country. We want CCGs to be able to move at their own pace, whilst also indicating that we see co-commissioning as a needful development towards mitigating current health inequalities and securing better integrated, more easily accessed, high quality care for patients. We expect that many CCGs may wish to enter into joint commissioning arrangements for 2015/16 to see how the agenda develops, before deciding to take on delegated responsibilities for 2016/17.

We intend to make it as straightforward as possible for CCGs to assume greater commissioning responsibilities from 2015/16 onwards, should they wish to. For example:

- CCGs which have no co-commissioning arrangements in place or opted for greater involvement, could apply for joint or delegated arrangements; or
- CCGs in joint arrangements could apply for delegated arrangements.

CCGs should discuss any plans to change their co-commissioning model with their area team in the first instance and new proposals should be discussed and planned as part of the CCG assurance process.

Future co-commissioning model	Approvals process *from 1 April 2015/16 onwards* to assume a new co-commissioning arrangement
Joint commissioning	CCGs should discuss their proposals with their area team and regional team. Any requests should be reviewed and agreed within the quarterly CCG assurance review meetings. The approvals process will follow the process set out in section 7.3 and the timeline will be confirmed by the area team.
Delegated commissioning	CCGs should discuss their proposals with their area team and regional team. NHS England and NHS Clinical Commissioners will in due course be developing the timetable for applications for 2016/17.

In the circumstance that a CCG wishes to terminate their co-commissioning arrangement, this would need to be by mutual agreement with NHS England. In these circumstances, it is expected that the CCG would move either from delegated arrangements to joint arrangements or joint arrangements to greater involvement.

9 Ongoing assurance

This section sets out on-going assurance arrangements for co-commissioning.

9.1 Overarching approach

NHS England is committed to working with CCGs to co-develop a revised approach to the current CCG assurance framework for 2015/16. The new assurance framework will be published in 2015. The on-going assurance of primary care co-commissioning arrangements will be managed as part of this wider CCG assurance process.

9.2 Principles

NHS England requires on-going assurance that its duties are being discharged effectively. The assurance process will be adapted according to the commissioning function that the CCG is undertaking. NHS England will look at ways of reducing the burden of assurance on the service whilst implementing a robust process that is mindful of the legislative framework.

There are three key principles governing the assurance process:

- It will be simplified to reduce unnecessary bureaucratic processes for both CCGs and NHS England;
- It will be based on a supportive conversation and the process will reflect the flexibility of NHS England to intervene differently in different circumstances; and
- There will be clear interventions for failing CCGs.

In particular, for co-commissioning the new assurance process will:

- test that core governance arrangements are working successfully, with specific attention to the effective local management of conflicts of interest;
- be specific about the achievement of local outcomes, with a particular focus on service delivery across the local health economy; and it will
- be co-designed and developed in strong partnership with CCGs and other key stakeholders prior to publication.

10 Development support and evaluation

This section sets out the support available to CCGs to implement co-commissioning and the on-going evaluation of co-commissioning arrangements.

10.1 Implementation roadshows and legal support

A series of roadshows will take place across the country to support CCGs and area teams to move towards implementing primary care co-commissioning arrangements. The purpose of these events is to:

- Set out the vision for the future as we move towards place-based commissioning, taking into account the vision described in the Five Year Forward View;
- Provide an opportunity for CCGs and area teams to raise any questions they may have about primary care co-commissioning and the impact of the changes;
- Provide technical advice to support the implementation of co-commissioning, specifically on the timeline and approvals process, the legalities of joint and delegated arrangements and conflicts of interest management; financial arrangements and HR and resources, and
- Offer a further opportunity for area teams and CCGs to work together on their joint proposals if they so wish.

The workshops will take place between 19 November and 2 December 2014. Further information and registration details can be found here. Due to high demand, CCGs are asked to only send one representative to the events. The events are not open to private businesses.

Further legal advice will also be available for CCGs that intend to implement joint and delegated arrangements. Your regional team will provide further information on how this can be accessed.

10.2 Learning and continuous development

It will be important that we review and share learning from the implementation of co-commissioning arrangements in real time in order to support CCGs' continuous development and improvement. We will evaluate the following:

- what is and is not working;
- any unforeseen perverse incentives and system blockages; and
- examples of good practice.

This will help us to improve the policy for future years. In addition, we are exploring options on how best to do the following:

- provide technical support where required;
- enable the dissemination of 'lessons learned' and supporting a network of practitioners to problem solve and share learning and experiences; and
- provide a web-based interactive platform for exchange and ideas.

Further information will be shared in due course.

11 Next steps

We hope this document is useful in helping to inform CCG decision making around primary care co-commissioning models and in providing clarity on the next steps towards the implementation of co-commissioning arrangements. If you require any further information, please email: england.co-commissioning@nhs.net.

We will be keeping the arrangements set out in this document under review in the light of the experience of their operation during 2015/16.

Furthermore, as primary care co-commissioning is the start of a longer journey towards place based commissioning, we recognise there is much work to be done to achieve this goal. NHS England is therefore committing to the following in 2015/16:

- We will look at options for the co-commissioning of dental, eye health, community pharmacy and public health services (such as immunisation and vaccinations), as we know some CCGs are keen to assume commissioning responsibilities in these areas. This will be done with full and proper engagement of the relevant professional groups.
- We will continue to work on arrangements for involving CCGs in the commissioning of specialised services.
- We will continue to monitor running cost allowances and resources to ensure that co-commissioning arrangements are sustainable.
- We will look into GP premises development, as part of the implementation of the NHS Five Year Forward View.

12 Glossary

APMS	Alternative Provider Medical Services
CCGs	Clinical Commissioning Groups
CSU	Commissioning Support Unit
DES	Directed Enhanced Services
FAQs	Frequently Asked Questions
GMS	General Medical Services
GPs	General Practitioners
IPC	Integrated Personal Commissioning Programme
JSNAs	Joint Strategic Needs Assessments
LES	Local Enhanced Services
LMC	Local Medical Committee
LRO	Legislative Reform Order
MPIG	Minimum Practice Income Guarantee
PMS	Personal Medical Services
QIPP	Quality Innovation Productivity and Prevention
QOF	Quality Outcomes Framework
SFE	Statement of Financial Entitlement

13 References

Department of Health, Information Governance Toolkit

Department of Health, 16 July 2008, End of Life Care Strategy

Department of Health, 29 September 2014, Statement of Financial Entitlement

HM Government, 2012, Health and Social Care Act 2012

NHS, 23 October 2014, NHS Five Year Forward View

NHS England, October 2012, Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services

NHS England, 28 March 2013, Managing conflicts of interests: Guidance for clinical commissioning groups

NHS England, 7 May 2013, CCG Assurance Framework 2013/14

NHS England, 24 May 2013, Procedures for clinical commissioning group constitution change, merger and dissolution

NHS England, September 2013, Transforming Participation in Health and Care guidance

NHS England, 25 March 2014, Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams

NHS England, September 2014, Framework for Personal Medical Services (PMS) Contracts Review

NHS England, 4 September 2014, Integrated Personal Commissioning (IPC) programme

NHS England, 29 September 2014, Update on the Legislative Reform Order (letter)

NHS England, Financial plan template – direct commissioning 2014/15 to 2018/19

14 Annexes

This document is accompanied by a suite of practical tools to support CCGs to implement co-commissioning arrangements locally including:

Annex A: Submission proforma for joint commissioning arrangements

Annex B: Submission proforma for delegated commissioning arrangements

Annex C: Model wording for amendments to CCGs' constitutions

Annex D: Model terms of reference for joint commissioning arrangements, including scheme of delegation

Annex E: Draft delegation by NHS England

Annex F: Delegated commissioning model - draft terms of reference

Annex G: Members of the Primary Care Co-commissioning Programme Oversight Group

Annex H: CCG investment in primary care frequently asked questions (FAQs)