

## Understanding primary care co-commissioning: uptake, scope of activity and process of change.

### Interim report summary (January 2016)

**Research team:** Dr Imelda McDermott, Professor Kath Checkland (PI), Dr Lynsey Warwick-Giles, and Dr Anna Coleman. **Contact:** Katherine.checkland@manchester.ac.uk.

This is an interim report for the third phase (April 15 to December 17) of our ongoing project following the development of Clinical Commissioning Groups (CCGs) in England since their initial establishment as 'Pathfinders'. The overarching aim is to explore the significant changes to the work of CCGs as they took over varying levels of new responsibility for commissioning primary care services from April 2015.

### Background

Under the Health and Social Care Act 2012, responsibility for commissioning primary care services was given to NHS England (NHSE). Part of the rationale for this was to move towards a more standardised model of primary care commissioning. However, it has become clear since 2010 that local flexibility and understanding is also required in order to properly match primary care provision to the needs of an aging population. Primary care co-commissioning was first mooted in the *Call to Action* in 2014, where "joint commissioning" was identified as one of national level supports to improve general practice. In May 2014, it was officially announced that CCGs would get 'new powers' under a new commissioning initiative. There are 3 levels of responsibility; (1) 'greater involvement' (where CCGs would have 'influence' but not take the lead in shaping primary care locally), (2) joint commissioning (where CCGs would set up a joint committee with NHSE AT), and (3) delegated authority (where CCGs would take over budgets from NHSE Area Teams and take the lead in primary care commissioning). Initially there was no clear expectation that CCGs would move from Level 1 and 2 to taking on full responsibility (Level 3) over time. However, one year on, CCGs operating at Level 1 and 2 were encouraged to consider applying for full delegation.

This report aims to explore the uptake of primary care co-commissioning nationally, develop an understanding of the rationale underlying the policy and the expected outcomes, and understand the scope of co-commissioning activity and the process of change. For this part of the study, our research questions are:

1. What are the CCG's objectives for their involvement in co-commissioning, and how do they intend to achieve these?
2. Which areas of activity and service are the CCGs focusing upon? What plans do they have to make changes to services?

### Methods

We started by exploring the uptake of primary care co-commissioning nationally. Using CCGs' application submissions (as provided by NHSE with CCGs' agreement), we created a database of CCGs ( $n=150$ ) listing their levels of co-commissioning arrangements, a named person responsible within each CCG, and detailed information on what was stated in their application. The amount of details written in each application varied widely with some CCGs simply replicating what was in the official documents. From the database we generated a representative sample of CCGs from Level 2 and 3 ( $n=37$ ) to target for the telephone survey. We also surveyed CCGs opting for Level 1 ( $n=12$ ). The telephone survey addressed the research questions above and the results were tabulated into a database for analysis. We also carried out a small number of interviews ( $n=6$ ) with senior Department of Health and NHSE staff who have played a role in the development of primary care co-commissioning policy, and undertook an in-depth analysis of the main policy documents related to co-commissioning in order to understand the official aspirations and 'programme theories' (Weiss, 2007) underlying the policy.

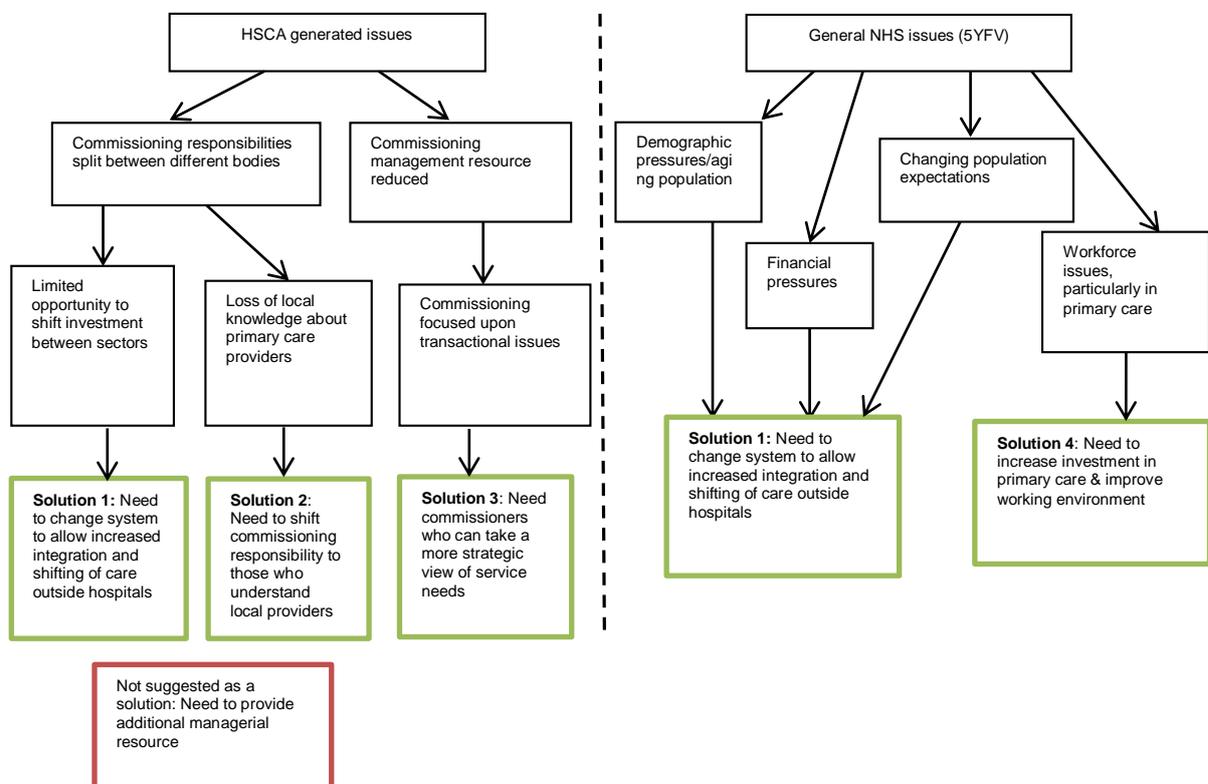
## Findings

### Programme theories

Our in-depth analysis of policy documents and interviews with senior policy makers suggest that co-commissioning was seen as (1) the “sticky plaster” or solutions to a number of problems which entered the system following the HSCA 2012 and (2) an opportunity to develop ‘placed-based’ commissioning. We identified two programme theories underpinning the need to move primary care commissioning from NHSE to CCGs:

1. Integration of budgets and commissioning responsibility with a single commissioner responsible for commissioning primary, community and secondary care for a geographical population will allow the shifting of resources between sectors, facilitate the development of a more integrated approach to service provision, and provide an environment which supports the development of integrated organisations delivering new models of care as envisaged in the Five Year Forward View (5YFV). This will deliver more care outside hospitals and care which is more integrated from the patient’s perspective, which will be more efficient, effective, and cheaper.
2. CCGs understand primary care and local needs. Allowing CCGs to commission primary care will support the development and implementation of local strategies for service improvement, support innovation in primary care, and allow investment in primary care (by allowing resource shifting as above). This will improve quality of care, make primary care a more attractive place to work, and facilitate recruitment and retention.

The following figure summarises the theories identified above:



### Telephone survey

The following table summarises the main findings from our telephone survey with CCGs undertaking **delegated responsibility (Level 3)** and **joint commissioning (Level 2)**. We found no systematic difference between the two levels as those undertaking joint did so to “test the water” before moving to delegated responsibility.

Topics	Telephone survey findings
Main objectives	<ul style="list-style-type: none"> <li>Majority claimed that their main objective was to “put commissioning back together” and having opportunity for local decision making and flexibility. Hence, giving CCGs the opportunity to look at the whole of general practice.</li> </ul>
Factors affecting CCGs involvement	<ul style="list-style-type: none"> <li>Uncertainty around conflicts of interest, governance, and risk and benefit around co-commissioning. Wanting better control over primary care and being “masters of own destiny”. A handful claimed that they had 'no choice as this is the direction of travel.</li> <li>For CCGs undertaking delegated commissioning, they see no point of doing joint as it was seen as a halfway position and not a lot of difference between joint and delegated.</li> <li>For CCGs undertaking joint commissioning, they were testing the water due to uncertainty around what would be involved in delegated authority.</li> </ul>
Plans to achieve the main objectives	<ul style="list-style-type: none"> <li>Developing and implementing primary care strategy, working collaboratively with other CCGs, or through contractual mechanisms.</li> <li>Some are exploring how primary care sat within the whole system (such as GP Federations, super-partnership, alliances, and Accountable Care Organisation).</li> </ul>
Benefits	<ul style="list-style-type: none"> <li>Generally, the main benefits were articulated as accruing to practices and CCGs, with patient and public benefits flowing from the subsequent improvements in care provided by practices</li> <li>For CCGs as a whole - masters of own destiny, being part of integration/joined up/transformational approach, having a coherent commissioning plans across the whole system, and capability of primary care transformation.</li> <li>For practices - having local flexibility and local decision making, masters of own destiny, and sustainability of the workforce.</li> <li>For patients - improving outcomes, quality of care, and a more joined up, proactive, and patient-centred care resulting from more sustainable and high quality general practices.</li> </ul>
Risks	<ul style="list-style-type: none"> <li>Resources in terms of workforce capacity and capability and running costs.</li> <li>Relational risk between the CCG and their members, with a tension between engaging and contractually managing them.</li> <li>Reputational risk with internal members due to fear of perceived conflicts of interest and with external partners.</li> <li>Financial risk for those taking on delegated responsibility.</li> </ul>
Success in 3 years' time	<ul style="list-style-type: none"> <li>Having seamless pathways for patients and increase access, more integrated services, sustainable workforce, and up scaling of primary care.</li> </ul>
Areas of activity and service	<ul style="list-style-type: none"> <li>Primary care quality, Directed Enhanced Services (DES), Personal Medical Services (PMS) and/or Alternative Provider Medical Services (APMS) review, and workforce.</li> </ul>
Structure & governance	<ul style="list-style-type: none"> <li>Majority had set up a (Joint) Primary Care Co-Commissioning Committee (PCCC).</li> <li>Some had set up various 'operational' groups that sit underneath the (Joint) PCCC.</li> <li>A handful had difficulty in agreeing the Terms of Reference for their governance arrangements due to the possibility of PCCC having an equal power to the CCG Governing Body.</li> <li>There was an issue with 'double delegation' for CCGs opting for delegated authority.</li> </ul>
Conflicts of interest	<ul style="list-style-type: none"> <li>Most defined it in terms of relational or financial involvement where CCG is commissioning services. It is about the <i>perception</i> rather than actual conflicts.</li> <li>The most commonly cited way to manage conflicts is by declaring it at the beginning of the meeting or being upfront in procurement about who is involved and what their involvement is.</li> </ul>
Experience of the process	<ul style="list-style-type: none"> <li>Chaotic and problematic due to the speed of the implementation, lack of information and clarity, and delay in Human Resource guidance. Although there was a clear national direction, this was not sensitive to local variations.</li> <li>Supports from NHSE which CCGs found to be most helpful; regular meetings with NHSE Area Teams, networks, national workshops, and staffing support.</li> <li>Additional supports wanted; staffing, capacity, flexibility in running cost allowance/management cost, clearer and timely information/guidance, and timely advice on learning coming out.</li> </ul>

For CCGs opting for '**greater involvement**' (Level 1):

- The main reason for opting this level was financial difficulty for e.g. CCGs in special measures or suffering a short term financial problem.
- Some CCGs are concerned that co-commissioning primary care would change the CCG's relationship with their members
- In some area, there was a strong Local Medical Council opposition.
- There were also concerns about financial risk, reputational risk, capacity issues and resource constraints.
- The majority of CCGs in this level intend to move to delegated arrangements in the near future, and that they feel some pressure from NHSE to do this

## **Discussion, actionable messages, and ongoing research**

The findings from our telephone survey indicate that *Theory 2* provides a better description of how CCGs currently see the process in which they are engaged. CCGs' main objectives for taking on co-commissioning responsibility were to enable them to commission primary care alongside the commissioning of other services, which was seen as an important gap in the HSCA 2012. This will give them an opportunity for local decision-making and local flexibility, and allow them to improve investment in primary care and so increase quality. There was little mention of place-based commissioning, new models of care, or an outcome-based approach, despite these being strong concepts in policy documents and interviews with senior policy makers. This suggests that CCGs immediate concerns revolve around the need to ensure sustainable high quality primary care services, but that some are aware of the longer-term potential to start to think creatively about how services are provided across a local geography. Although the picture is somewhat mixed, there is genuine enthusiasm for co-commissioning, with many CCGs eager to take the opportunity to improve both the quality and the sustainability of primary care services.

Our research has suggested a number of areas on which ongoing support and guidance could usefully focus:

- **Clear guidance as to what can and cannot be done**, and this needs to be regularly updated as CCGs start to take on their new responsibilities. Quick access to relevant legal and procedural advice would be useful.
- **CCGs need to be given time to develop new ways of working.** Assessment of CCGs' progress need to take into account that the process so far has been rapid, CCGs' new responsibilities are extensive, and management resource are limited.
- **The greatest risk was the lack of managerial resources.** This is a very important issue for CCGs and they will need considerable support from NHSE.
- **Additional supports needed include more financial resources and local managerial support from NHSE colleagues.** Those responsible for this agenda within the four NHSE regions could support the development of longer term relationships between NHSE managers with knowledge of local areas and their respective CCGs. Having a known manager to call upon for support was valued.
- **There may be a role for NHSE and for NHS Clinical Commissioners in developing a longer term support and development programme for CCGs** which focuses upon supporting them in thinking about the longer term strategic issues associated with primary, secondary and community services, with a view to supporting them in considering new ways of working.
- **CCGs will continue to require NHSE managerial support even after they have taken on delegated responsibility.** If it is intended that all CCGs be encouraged to take on co-commissioning responsibility, reassurance will be required about managerial and other resources.

In the next stage of the work (January 2016 to December 2017), we will choose 4 case study sites to explore in more detail the approach taken by CCGs to their new responsibilities and to understand the factors which are facilitating or inhibiting them from achieving their main objectives. The sites will be chosen to represent CCGs adopting different levels of co-commissioning responsibility and representing a range of characteristics determined from the initial telephone survey. We will also return to our 'panel' of interviewees for telephone surveys asking them about their experiences at 15 months (approximately July 2016) and 24 months (approximately April 2017) since taking on their new responsibility.