Understanding Primary Care Co-Commissioning: Uptake, Development, and Impacts
(Final Report)

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<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>AO</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>APMS</td>
<td>Alternative Provider Medical Services</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CoI</td>
<td>Conflicts of Interest</td>
</tr>
<tr>
<td>CoM</td>
<td>Council of Members</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>COO</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>CSU</td>
<td>Commissioning Support Unit</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>FYFV</td>
<td>Five Year Forward View</td>
</tr>
<tr>
<td>GB</td>
<td>Governing Body</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Services</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HSCA</td>
<td>Health and Social Care Act</td>
</tr>
<tr>
<td>HWB</td>
<td>Health and Wellbeing Board</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>MCP</td>
<td>Multispecialty Community Provider</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NMC</td>
<td>New Models of Care</td>
</tr>
<tr>
<td>PBC</td>
<td>Practice Based Commissioning</td>
</tr>
<tr>
<td>PbR</td>
<td>Payment by Results</td>
</tr>
<tr>
<td>PCCC</td>
<td>Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PEC</td>
<td>Professional Executive Committee</td>
</tr>
<tr>
<td>PH</td>
<td>Public Health</td>
</tr>
<tr>
<td>PMS</td>
<td>Personal Medical Services</td>
</tr>
<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
</tr>
<tr>
<td>SMT</td>
<td>Senior Management Team</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Plan</td>
</tr>
</tbody>
</table>
1 Introduction

1.1 Background

The White Paper “Equity and Excellence” (Department of Health, 2010) and the Health and Social Care Act 2012 gave the power and responsibility for commissioning health services and budgets to groups of GP practices called Clinical Commissioning Groups (CCGs), previously named GP commissioning consortia. The impetus for the Government’s reforms was to shift decision making as close as possible to individual patients. CCGs will commission the great majority of NHS services for their patients. However, they will not be directly responsible for commissioning services that GPs themselves provide. The responsibility for commissioning primary care services (medical, dental, eye health, and pharmacy) was given to a new statutory organisation called NHS England (NHSE), known as the NHS Commissioning Board in statute. This was to ensure a more standardised model and consistency in the management of the four groups. The White Paper states that:

The principle of rewarding quality will also apply in primary care. In general practice the Department will seek over time to establish a single contractual and funding model to promote quality improvement, deliver fairness for all practices, support free patient choice, and remove unnecessary barriers to new provision. (Equity and Excellence: Liberating the NHS, 2010 para 3.21)

However, it has become clear since 2010 that to properly match primary care provision to the needs of an aging population, local flexibility and understanding is required. There is considerable overlap between the ‘core’ General Medical Services (GMS) and Personal Medical Services (PMS) contracts (commissioned by NHSE) and services provided as ‘enhanced services’ (commissioned by CCGs), and it seems logical to bring those commissioning enhanced services into the process of commissioning the rest of primary care. Furthermore, the separation of funding streams between primary and community care means that CCGs lack the flexibility to shift funding to support patients most effectively at home.

In May 2014, following Simon Stevens appointment as the Chief Executive of NHS England, he announced that CCGs would get ‘new powers’ under a new commissioning initiative. CCGs were invited to take on greater role in commissioning primary care services. This would enable better integrated care outside hospitals, ensure that primary, community and mental health are properly resourced, and CCGs having more influence over how funding is invested for local population, which would ensure sustainability of their local NHS:

If we want to better integrate care outside hospitals, and properly resource primary, community and mental health services – at a time when overall funding is inevitably constrained – we need to make it easier for patients, local communities and local clinicians to exercise more clout over how services are developed. That means giving local CCGs greater influence over the way NHS funding is being invested for their local populations......So today I am inviting those CCGs that are interested in an expanded role in primary care to come forward and show how new powers would enable them to drive up the quality of care, cut health inequalities in primary care, and help put their local NHS on a sustainable path for the next five years and beyond. (Simon Stevens, Annual Conference of NHS Clinical Commissioners, 1st May 2014)

PRUComm have been commissioned by the Department of Health to evaluate the development of Clinical Commissioning Groups. This is the third phase of the project, which aims to understand the ways in which CCGs are responding to their new primary care co-commissioning responsibilities from April
of the project explored the development of ‘pathfinder’ CCGs, providing evidence to inform the process by which CCGs moved towards authorisation (Checkland et al., 2012). The second phase of the project explored the ‘added value’ that GPs bring to the commissioning process, using a realist evaluation framework to provide some practical lessons for CCGs as they seek to maximise the value of the roles played by clinicians in their work (McDermott et al., 2015).

1.2 Policy context

Following Simon Stevens’ announcement at the Annual Conference of NHS Clinical Commissioners, CCGs were asked to submit expressions of interest, by June 2014, setting out how they would like to exercise expanded commissioning function, specifically the commissioning of primary medical care. NHSE’s Primary Care Co-Commissioning Programme Oversight Group was tasked with supporting CCGs going through the approval process.

The Next Steps Toward Primary Care Co-commissioning (NHS England, 2014d) document, published in November 2014 and developed jointly by CCGs and NHSE’s Programme Oversight Group in partnership with NHS Clinical Commissioners, aims to provide clarity and transparency around co-commissioning options (Doyle, Dodge, Ellul, & Simon, 2014). The document highlighted the frustrations that CCGs have expressed with the current primary care commissioning arrangements hence the need to empower and enable CCGs to improve primary care services locally. It further emphasised that co-commissioning would enable the development of integrated out-of-hospital services and new models of care such as multispecialty community providers (MCPs) and primary and acute care systems (PACSs), as set out in the NHS Five Year Forward View (NHS England, 2014a). CCGs were asked to submit their applications by January 2015 in order for the co-commissioning arrangement to ‘go live’ from April 2015.

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

- **Greater involvement** (level 1) – CCGs would have ‘influence’ but not take the lead in shaping primary care locally. This was considered good practice but has no formal process.
- **Joint commissioning** (level 2) – CCGs would set up joint committees with one of the four NHSE regional teams (London, Midlands and East, North, and South) to share primary care commissioning responsibility. NHSE and CCG(s) were to set up a joint committee and funding would remain with NHSE finance so they remain party to all decision making.
- **Delegated authority** (level 3) – CCGs would take on delegated responsibility of some aspect of primary care commissioning. They would take over budgets from NHSE Regional Teams and take the lead on primary care commissioning.

The scope of co-commissioning activities include (NHS England, 2014d; Roughton & Hakin, 2014):

- Core general medical services contracts, including GMS, PMS, and Alternative Provider of Medical Services contracts - designing, monitoring, negotiating, and removing contracts,
- Newly designed enhanced services - Local Enhanced Services (LES) and Directed Enhanced Services (DES),
- Designing local incentive scheme as an alternative to the Quality and Outcomes Framework (QOF),
- Making decisions on whether to establish new GP practices in an area,
- Approving practice mergers,
- Making decisions on ‘discretionary’ payments, e.g. for premises reimbursement, returner/retainer schemes
However the plan to give CCGs ‘new powers’ to co-commission primary care raised concerns around conflicts of interest. Overcoming real and perceived conflicts associated with GPs commissioning or contracting themselves and performance managing the core GP contract of their members, with powers to issue breach notices and terminate contracts, were the key concerns highlighted by the British Medical Association (BMA) and Local Medical Committee (LMC). Guidance and supporting documents were published identifying risks and opportunities that CCGs need to consider when making their decision to take on the delegated responsibility (British Medical Association, 2016).

To mitigate the concerns over an increased risk of conflicts of interest, NHSE put in place a “strengthened” approach and published conflicts of interest framework as a statutory guidance (NHS England, 2014f). The framework includes establishing a decision-making committee that has a lay and executive majority (i.e. non-clinical) and a lay chair, and having a register of interests and register of decisions. NHSE also held various webinars and training events on how to manage conflicts of interest.

In addition to a concern over conflicts of interest, the Royal College of General Practice and NHS Clinical Commissioners (2014) emphasised the voluntary nature of the arrangement. In other words, CCGs are not obliged to apply for any of the models and can continue to operate under existing arrangements, which is to ‘do nothing’ and not take up the options proposed.

Initially there was no clear expectation that CCGs would move from ‘greater involvement’ or ‘joint commissioning’ in primary care commissioning to taking on full responsibility over time, although some of the expressions of interest explicitly proposed such a movement highlighting ‘phases’ by which the CCG would take on more responsibility over time. However, in October 2015, one year following the policy implementation NHSE issued a letter to CCGs encouraging those operating under ‘joint commissioning’ or ‘greater involvement’ to consider applying for full delegation by November 2015 (Dodge & Doyle, 2015). The letter set out perceived early benefits and opportunities of delegated commissioning and concluded by highlighting a shift towards a ‘place-based’ commissioning and the possibility of CCGs taking more responsibility of co-commissioning other primary care areas.

The following table presents a timeline of relevant events described above and published guidance, providing links to the relevant documents.

**Table 1: Timeline showing key events, documents, and guidance relating to primary care co-commissioning**

<table>
<thead>
<tr>
<th>Time</th>
<th>Summary of information</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 Apr 2014</td>
<td>Simon Stevens’ first appearance before the House of Commons Health Committee mentioning primary care co-commissioning.</td>
<td><a href="http://m.hsj.co.uk/5070378.article">http://m.hsj.co.uk/5070378.article</a></td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>URL</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>9 May 2014</td>
<td>Letter from Barbara Hakin to CCGs setting out how CCGs can submit expressions of interest.</td>
<td><a href="http://www.hsj.co.uk/Journals/2014/05/12/o/u/q/2014-05-09-CCG-co-commissioning-letter.pdf">http://www.hsj.co.uk/Journals/2014/05/12/o/u/q/2014-05-09-CCG-co-commissioning-letter.pdf</a></td>
</tr>
<tr>
<td>20 June 2014</td>
<td>CCGs deadline for submitting expressions of interest to primary care co-commissioning.</td>
<td></td>
</tr>
<tr>
<td>3 July 2014</td>
<td>NHS England’s Board meeting and paper revealed the three categories of co-commissioning and number of expressions of interest submitted for each category.</td>
<td><a href="http://www.england.nhs.uk/2014/06/27/board-meeting-3-july-2014/">http://www.england.nhs.uk/2014/06/27/board-meeting-3-july-2014/</a></td>
</tr>
<tr>
<td>Autumn 2014</td>
<td>CCG Assurance &amp; Development Committee ‘approvals in principle’</td>
<td></td>
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<tr>
<td>18 Dec 2014</td>
<td>The conflicts of interest framework published as statutory guidance</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Source</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>30 June 2016</td>
<td>Original deadline for final STP submission. By mid-June this was relaxed to a ‘work in progress’ deadline, with final submissions pushed back to October.</td>
<td><a href="https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-submission-guidance-june.pdf">www.england.nhs.uk/wp-content/uploads/2016/05/stp-submission-guidance-june.pdf</a></td>
</tr>
</tbody>
</table>

### 1.3 Research questions

There are three stages in this research:

- **Stage 1a**: Exploring the uptake of primary care co-commissioning nationally.
- **Stage 1b**: Developing an understanding of the rationale underlying the policy and the expected outcomes.
- **Stage 2a**: Understanding the scope of co-commissioning activity and the process of change.
- **Stage 2b**: Exploring CCGs experiences at 15 and 24 months’ following its implementation.
- **Stage 3**: Exploring the practice of co-commissioning, its impact, and factors facilitating or inhibiting CCGs from achieving their aims.

Findings from Stages 1a, 1b, and 2a have been published as an interim report (McDermott et al., 2016). This final report summarises the findings from the interim report and focuses on findings from Stages 2b and 3.
The specific research questions addressed in this report are:

1. **Understanding the scope of co-commissioning activity and the process of change:**
   a. What are NHS England’s main objectives for the delegation of responsibility for commissioning primary care?
   b. What are the CCG’s objectives for their involvement in co-commissioning, and how do they intend to achieve these?
   c. Which areas of activity and service are the CCGs focusing upon?
   d. What internal governance and other arrangements have been put in place to manage their new responsibilities?
   e. How did the CCG decide which arrangements to adopt? Who was involved in the decision making? What factors affected their decision?
   f. What plans do they have to make changes to services?
   g. How has NHSE managed the process, and what has been the impact on the work of NHSE ATs?

2. **Understanding the practice of co-commissioning:**
   a. How is the CCG setting about its co-commissioning tasks including assessing needs and deciding strategic priorities, designing & negotiating local contracts, approving ‘discretionary’ payments etc?
   b. What are the roles of GP Board members and other clinical members in co-commissioning?
   c. What are the roles of localities in co-commissioning?
   d. How are CCGs managing conflict of interest?
   e. How is the CCG interacting with non-GP providers of primary care services, and are they putting any contracts out to tender? If so, what is their objective for this?
   f. What are the arrangements for contract monitoring and performance management of practices?
   g. What are the resources available for this work, and who is performing it?
   h. What is the CCG’s experience of the assurance processes put in place by NHSE?

3. How does co-commissioning affect the **internal structure and functioning of the CCG**, including: roles; governance structures; relationships with member practices; perceptions of identity; and wider commissioning responsibilities?

4. How does co-commissioning affect the **external relationships** of the CCG including: relationships with other providers; relationships with the LMC; relationships with the HWB & LA; and the relationship with NHSE AT?

5. What (if any) new or altered services have been established as a result of co-commissioning, or, if no obvious changes have occurred, what impacts do they claim to have had on local primary care services? Focus will be upon progress against initial objectives, and any evidence of the realisation of the benefits claimed by NHSE (eg improved out of hospital care, improved integration, improved patient experience)

6. **What factors facilitated or inhibited the development of new services** or the improvement in existing services?

### 1.4 Structure of the report

The report is structured to answer the research questions listed in Section 1.3, specifically questions 2-6. Research question 1 has been addressed and published in the interim report (see McDermott et al., 2016). This Introduction is followed by a description of our methods. The findings are structured into five sections. The first two sections summarise the findings from the interim report, which is the
rationale underlying the policy on primary care co-commissioning and the uptake of primary care co-commissioning nationally. The next section compares the findings from the first telephone survey with the second telephone survey to trace the development of CCGs’ primary care co-commissioning arrangements and experiences. This is followed by an in-depth exploration of the implementation and conduct of primary care co-commissioning in four case study sites, specifically looking at the CCGs’ structures and governance, their approaches to commissioning and contracting, the management of conflicts of interests, internal and external relationships, and lastly the impacts, outcomes, and claims of success. The final section of the results explores factors which were found to affect the development and progress of CCGs assuming primary care commissioning responsibilities. A discussion section summarises these findings and compares with previous policy, with a final section presenting our conclusions and suggestions of lessons for the future.
2 Methods

We undertook an exploratory approach, combining evidence from interviews with policy makers, analysis of policy documents, telephone surveys with selected samples of CCGs, and detailed case studies.

2.1 Interviews with senior policy makers

In order to understand the official aspirations and ‘programme theories' (Weiss, 2007) underlying the policy, we carried out a small number of face-to-face interviews (n=6) with senior Department of Health and NHSE staff (June to July 2015) who had played a role in the development of primary care co-commissioning policy. We also undertook an in-depth analysis of the main policy documents related to co-commissioning.

2.2 Review of CCGs application documents

We explored the uptake of primary care co-commissioning nationally (April to May 2015) by reviewing CCGs’ application documents as provided by NHSE with CCGs’ agreement. We reviewed 147 applications from 150 CCGs (some CCGs had submitted a joint application with their neighbouring CCGs and one CCG declined to take part). We created a database of CCGs listing their levels of co-commissioning arrangements, contact details of a named person responsible within each CCG, and detailed information on what was stated or included in their application. Although CCGs were required to submit their application using a standardised form, we found that the amount of details written in each application varied widely with some CCGs simply replicating what was in the official documents.

2.3 Telephone surveys

From the database, described above, we selected a sample of CCGs to target for two telephone surveys. The first telephone survey was conducted at one year following the policy announcement (June to August 2015). Our sampling criteria included; level of co-commissioning responsibility, regional team the CCG belonged to, size of CCG, urban vs rural CCG, those undertaking collaborative commissioning with neighbouring CCG or having submitted a joint application, and those adopting new models of care (NHS England, 2014a). Questions focus on CCGs’ experiences, problem encountered, and factors facilitating or inhibiting their development as they were going through the process. Job title and roles of the participants varied between CCGs but in general, we interviewed the following people: Director/Associate Director/Senior Manager for Primary Care Commissioning, Director for Strategic Commissioning, Chair of Joint Co-Commissioning Committee, Head of Primary Care, CCG Chair/Chief Officer/Accountable Officer/Medical Director/Managing Director, Director for Strategy and Collaboration, Chief Development Officer, and Director of Governance.

We repeated the survey at two years following the policy announcement (August to October 2016). We contacted the same sample of CCGs. The second telephone survey was an opportunity to ask the initial sample of CCGs about the development of co-commissioning locally, to see whether their initial objectives for involvement were the same, whether the CCG had realised any benefits from the new responsibility and if they had made plans to move to a different level of co-commissioning. Between the first and second surveys, we found that a number of people had left the organisation or changed job roles which meant that recruitment was more problematic. Moreover, some of the CCGs we spoke with
have changed their levels of responsibilities either from greater involvement to joint or delegated or from joint to delegated. Results from both phases of the survey were tabulated into a database for analysis.

Table 2: No of responses from Level 3 (delegated responsibility) and Level 2 (joint commissioning) telephone surveys*

<table>
<thead>
<tr>
<th>Levels</th>
<th>Regions</th>
<th>Number of CCGs taking over responsibility on Apr 15</th>
<th>Sample CCGs</th>
<th>Total response from the first survey (June-Aug 15)</th>
<th>Number of sample CCGs that changed levels</th>
<th>Total response from the second survey (Aug-Oct 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegated (Level 3)</td>
<td>North</td>
<td>24</td>
<td>7</td>
<td>7</td>
<td>3 moved from L2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Midlands &amp; East</td>
<td>26</td>
<td>8</td>
<td>8</td>
<td>1 moved from L1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>London</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>No changes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>6 moved from L2 + 3 moved from L1</td>
<td>5</td>
</tr>
<tr>
<td>Total (L3)</td>
<td></td>
<td>64</td>
<td>20</td>
<td>20</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Joint (Level 2)</td>
<td>North</td>
<td>31</td>
<td>10</td>
<td>6</td>
<td>3 moved to L2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Midlands &amp; East</td>
<td>16</td>
<td>6</td>
<td>3</td>
<td>4 moved from L1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>London</td>
<td>20</td>
<td>3</td>
<td>1</td>
<td>No changes</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>20</td>
<td>7</td>
<td>7</td>
<td>6 moved to L3</td>
<td>1</td>
</tr>
<tr>
<td>Total (L2)</td>
<td></td>
<td>87</td>
<td>26</td>
<td>17</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>TOTL (L2+L3)</td>
<td></td>
<td>151</td>
<td>46</td>
<td>37</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

*L1 – greater involvement / L2 – Joint / L3 - delegated

We also surveyed a sample of CCGs who opted for greater involvement (Level 1). Questions for this sample of CCGs focus on the objectives and factors affecting their decision not to opt for delegated responsibility and their future intention.

Table 3: No of responses from Level 1 (greater involvement) telephone surveys

<table>
<thead>
<tr>
<th>Levels</th>
<th>Regions</th>
<th>Number of CCGs taking over responsibility on Apr 15</th>
<th>Sample CCGs</th>
<th>Total response from the first survey</th>
<th>Number of sample CCGs that changed levels</th>
<th>Total response from the second survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater involvement (Level 1)</td>
<td>North</td>
<td>12</td>
<td>12</td>
<td>3</td>
<td>No changes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Midlands &amp; East</td>
<td>16</td>
<td>16</td>
<td>5</td>
<td>4 moved to L2 + 1 moved to L3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>London</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>24</td>
<td>24</td>
<td>4</td>
<td>3 moved to L3</td>
<td>0</td>
</tr>
<tr>
<td>Total (L1)</td>
<td></td>
<td>58</td>
<td>58</td>
<td>12</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
2.4 Case studies

We conducted case studies in four CCGs nationally (January 2016 – April 2017). Initially, we planned to continue with two of our existing sites who have been involved in our CCG projects since 2010 (Checkland et al., 2012; McDermott et al., 2015) and identify two new sites based on findings from the first telephone survey. However, we found that even those sites with whom we were most familiar and who had been involved with our research before were quite reluctant to be involved. Once access to sites had been agreed, we also had some difficulty in accessing a full range of meetings, with some sites reluctant to allow us to attend non-public meetings. Concerns included issues of confidentiality and concerns about sharing of commercially sensitive information. Issues associated with this and the question of whether meetings were ‘public’ or ‘private’ are discussed in Section 3.5.3.1.

Table 4: Site characteristics

<table>
<thead>
<tr>
<th></th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
<td>North</td>
<td>Midlands &amp; East</td>
<td>South</td>
<td>North</td>
</tr>
<tr>
<td>Level</td>
<td>Delegated</td>
<td>Delegated</td>
<td>Delegated</td>
<td>Initially joint but have moved to Delegated</td>
</tr>
<tr>
<td>Population</td>
<td>Over 40 practices with population approx. 350K</td>
<td>Over 100 practices with population approx. 550K</td>
<td>Over 20 practices with population approx. 150K</td>
<td>Over 40 practices with population approx. 250K</td>
</tr>
<tr>
<td>Contract</td>
<td>Majority PMS practices, some GMS and APMS</td>
<td>All practices switched from PMS to GMS, no APMS</td>
<td>Majority GMS practices, some PMS and no APMS</td>
<td>Almost equal number of PMS and GMS practices, some APMS</td>
</tr>
<tr>
<td>Vanguard</td>
<td>Yes</td>
<td>Yes</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Federation</td>
<td>Yes</td>
<td>Yes</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Sustainability &amp; Transformation Plan (STP)</td>
<td>STP1</td>
<td>STP2</td>
<td>STP3</td>
<td>STP1</td>
</tr>
</tbody>
</table>

Our observations focused mainly on meetings associated with primary care co-commissioning. These include the Primary Care Commissioning Committee (PCCC) and its sub-committees or sub-groups with such names as strategy committee, operational committee, and quality committee. **We attended a total of 74 meetings (approximately 111 hours of observations). We conducted a total of 42 face-to-face interviews** with members of the PCCC such as the Lay Chair, Primary Care Manager, Head of Contract, Head of Quality, Head of Estates, Head of Engagement, Local Medical Council representative, and Director of Healthwatch. We also interviewed the CCGs’ Governing Body Chair, Accountable Officer, and Chief Finance Officer (see Section 3.4.1 for governance structure and PCCC members). The following table summarises the number of meetings attended and interviews conducted in our four case study CCGs.
Table 5: Number of meetings attended and interviews conducted.

<table>
<thead>
<tr>
<th>Data collected January 2016 – April 2017</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of meetings attended</td>
<td>13</td>
<td>24</td>
<td>6</td>
<td>31</td>
<td>74 (approx. 111 hours of observations)</td>
</tr>
<tr>
<td>Number of interviews conducted</td>
<td>7</td>
<td>13</td>
<td>11</td>
<td>11</td>
<td>42</td>
</tr>
</tbody>
</table>
3 Results

3.1 Rationale underlying the policy and expected outcomes

Our interviews with senior policy makers and analysis of the main policy documents on primary care co-commissioning identified two programme theories underpinning the policy. Detailed analysis can be found in our interim report (McDermott et al., 2016):

1. Integration of budgets and commissioning responsibility with a single commissioner for commissioning primary, community and secondary care for a geographical population. This 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* (FYFV) (NHS England, 2014a). This will then deliver more care outside hospitals and care, which from the patient’s perspective is more integrated and will be more efficient, effective, and cheaper.

2. CCGs understand primary care and local needs. Allowing CCGs to commission primary care, alongside other services the CCG was already commissioning, 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.

3.2 Uptake of primary care co-commissioning nationally

When co-commissioning was first announced in July 2014, most CCGs opted for joint commissioning due to uncertainty of what delegated responsibility involves coupled with no additional resources given.
<table>
<thead>
<tr>
<th>Levels</th>
<th>Regions</th>
<th>Number of CCGs taking over responsibility from April 15</th>
<th>Number of CCGs taking over responsibility from April 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegated (L3)</td>
<td>North</td>
<td>24</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Midlands &amp; East</td>
<td>26</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>London</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>8</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total (L3)</strong></td>
<td></td>
<td><strong>64</strong></td>
<td><strong>115</strong></td>
</tr>
<tr>
<td>Joint (L2)</td>
<td>North</td>
<td>31</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Midlands &amp; East</td>
<td>16</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>London</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total (L2)</strong></td>
<td></td>
<td><strong>87</strong></td>
<td><strong>68</strong></td>
</tr>
<tr>
<td><strong>TOTAL (L3+L2)</strong></td>
<td></td>
<td><strong>151 (147 applications)</strong></td>
<td><strong>183</strong></td>
</tr>
<tr>
<td>Greater involvement (L1)</td>
<td>North</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Midlands &amp; East</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>London</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total (L1)</strong></td>
<td></td>
<td><strong>58</strong></td>
<td><strong>26</strong></td>
</tr>
<tr>
<td><strong>Total number of CCGs</strong></td>
<td></td>
<td><strong>209</strong></td>
<td><strong>209</strong></td>
</tr>
</tbody>
</table>

By 2016/17, with 114 CCGs (out of 209) having moved towards delegated arrangements, all remaining CCGs are encouraged to take on delegated commissioning to support the development of place-based commissioning.

The next section explores the reasons behind CCGs’ decisions to opt for the level of co-commissioning they chose.

### 3.3 The scope of co co-commissioning activity and the process of change

This section summarises the main findings from two telephone surveys that we conducted in June 2015 and August 2016 (for detailed findings see McDermott et al., 2016). We spoke with representatives from 49 CCGs across all three levels of involvement for primary care co-commissioning in April 2015 and 21 representatives in August 2016 (a more detailed breakdown of the numbers is included in Table 6 above).

Job title and roles varied between CCGs but in general, we interviewed the following people: Director/Associate Director/Senior Manager for Primary Care Commissioning, Director for Strategic Commissioning, Chair of Joint Co-Commissioning Committee, Head of Primary Care, CCG Chair/Chief Officer/Accountable Officer/Medical Director/Managing Director, Director for Strategy and Collaboration, Chief Development Officer, and Director of Governance.

We explore: (1) CCGs’ objectives for their involvement in co-commissioning, how they intend to achieve these, and whether these objectives had been realised; (2) Main areas of activity and service that CCGs
are focusing upon; (3) Governance arrangements to manage the new responsibility; and (4) How the process of change had been managed.

**CCGs’ objectives for involvement and how they intend to achieve these**

When speaking with representatives from CCGs who had opted for either joint or delegated commissioning, their objectives for involvement were quite similar (for more detail see McDermott et al., 2016). There was a local aim of trying to ‘piece commissioning back together’, which in turn would encourage integration and widen transformation work. The ability to commission a whole pathway, from primary care to secondary care was perceived as a mechanism to improve the quality of services. **Overall, as membership organisations, co-commissioning responsibility was seen by CCGs as an opportunity to support primary care, re-design services and improve the relationship with the CCG membership.**

Two years following the policy implementation, when we carried out the second telephone survey, we found the initial objectives for CCGs’ involvement in the commissioning of primary care have remained the same for both joint and delegated commissioning. Local flexibility and influence were still perceived to be the main benefits of the new commissioning arrangements; some CCGs believed that the new responsibility would provide a step towards more place-based commissioning and in some cases the formation of Accountable Care Organisations. The level of primary care commissioning responsibility was found to impact on the achievements and outcomes that were discussed by CCG staff.

Delegated CCGs suggested that the responsibility had enabled them to deliver programmes of work that would help them reach their objectives. Examples of work included the development of local strategies based around general practice with a specific focus on sustainability and working together in larger groupings. It was suggested that co-commissioning had provided some CCGs with the necessary levers to encourage practices to become involved with new models of care. CCGs who opted for delegated responsibility referred to the time it had taken to realise the benefits of co-commissioning. For example, they implied that they were starting to see some of the benefits such as developed commissioning plans and the formation of local alliances in the second year of commissioning primary care. One CCG believed that they were stripping away the bureaucracy of primary care commissioning by interpreting NHSE policy in a meaningful way for practices. In contrast, CCGs who opted for joint commissioning implied that they were only slightly realising benefits of primary care commissioning, alluding to the process of joint commissioning being a waste of time because of the lack of clarity of what they were able to do and the involvement of NHSE in the decision-making process.

Interestingly, all of the joint commissioning CCGs we spoke with were opting to move to delegated commissioning in April 2016 or 2017 as they believed that was the direction of travel that NHSE were encouraging. One CCG claimed that their influence on the commissioning process had been minor and highlighted the need to move to delegated if they were going to make an impact. One joint commissioning CCG claimed that the Primary Care Commissioning Committee (PCCC) added clarity to the decision-making process, however they were unsure whether it had improved the relationship the CCG held with their member practices other than practices knowing who to contact should they be having any issues.

As part of the follow up survey we wanted to explore what CCGs perceived to be their main successes with regards to primary care commissioning. The responses from the CCGs were varied. For example, some CCGs thought the implementation of their governance arrangements constituted ‘success’, whereas others focused on the successes of trialling new ways of working. The responses differed dependent on whether the CCG opted for joint or delegated commissioning. This was an interesting
finding as the initial telephone survey did not find any differences between joint and delegated commissioners when they spoke of their objectives and what they would deem as success in three years’ time (see interim report McDermott et al., 2016). The table below identifies what successes CCGs believe they have achieved through co-commissioning.

Table 7: CCGs’ claims of success

<table>
<thead>
<tr>
<th>Delegated CCGs</th>
<th>Joint CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of the Primary Care Strategy</td>
<td>Built governance arrangements with NHSE</td>
</tr>
<tr>
<td>Trialling new ways of working with urgent access and different appointment systems</td>
<td>Engaging practices on new models of care</td>
</tr>
<tr>
<td>Implementation of a new quality contract (from PMS money)</td>
<td>Better relationship with NHSE</td>
</tr>
<tr>
<td>Relocated a walk in centre and re-procured registered list element</td>
<td>Growing involvement of patient participation groups in primary care</td>
</tr>
<tr>
<td>Implemented the Prime Minister’s challenge fund to support the development of a GP Federation</td>
<td>Estates and Technology Fund application</td>
</tr>
<tr>
<td>Integrating primary care into everything else that relates to commissioning</td>
<td>Practices changed patient access model</td>
</tr>
<tr>
<td>Better handle on quality</td>
<td></td>
</tr>
</tbody>
</table>

Main areas of activity and service

The initial telephone survey identified areas of activity and service that CCGs wanted to focus upon under primary care commissioning. The majority of CCGs wanted to focus on the quality of primary care, Directed Enhanced Services’ (DES), Primary Medical Services (PMS)/ Alternative Provider Medical Services (APMS) reviews and workforce (for more detail see McDermott et al., 2016). In the follow up survey, we found that these priorities remained the same. Some of the examples of work schemes mentioned by delegated commissioners included:

- improving enhanced services and moving planned care out of hospital
- practice mergers
- expanding quality improvement schemes
- reducing unplanned admissions
- improving prescribing.

For joint CCGs, responses were more mixed. A number of CCGs were still focusing on workforce, IT, and financial recovery as they discussed in the initial survey. However, most CCGs in joint commissioning have started to focus on new initiatives which were associated with an NHS England initiative, the General Practice Forward View (NHS England, 2016c). One CCG claimed that they have started looking at estates and moving onto conversations with member practices about new models of care. Another CCG claimed that their focus is on integrated working across various organisations and moving into a single contract to deliver all services in the community. One CCG claimed they have left the extended access DES and moved to a local scheme and are now working on the local vision for primary care and an associated ‘transformation plan’.

There was little appetite from CCGs to make any changes to the Quality and Outcome Framework (QOF), Personal Medical Services (PMS) contracts and/or Alternative Provider Medical Services (APMS) contracts. Most CCGs said that they had no plans to make changes to local quality frameworks and contracts. However, some CCGs had plans for Directed Enhanced Services (DES) with regards to
unplanned admissions and learning disabilities. The follow up interviews found that there was little difference between joint and delegated CCGs. The majority of CCGs had decided to continue with national QOF, regardless of level of responsibility. CCGs told us that they were concerned that any such changes would make member practices anxious and that there was little appetite from GPs for such any alterations to be made. There were a small number of CCGs that we spoke to who were making changes to QOF, in those specific areas GP practices were able to opt into the local scheme or still continue with the national indicators. Overall, ‘local QOF’ schemes were described as being more patient centred and moving away from a tick box exercise. There were also different approaches to managing DES; however the responsibility of co-commissioning was not found to be influential. There was some discussion from CCG staff about reviewing existing DES. One CCG planned to unify DES in line with CCG initiatives.

Historically many practices on a PMS contract received more funding per head of population than those on GMS contracts. NHS England had initiated a review of this, and this was continued by the CCGs in our survey. Most were developing initiatives to reinvest the so-called ‘PMS premium’ back into primary care in a more equitable fashion, trying to equalise levels of funding. Some examples of this include the development of a strategic framework by which all practices could be paid for providing additional services, and the reinvestment of the monies based on practice need.

Responses in the follow up survey regarding the APMS contracts were all focussed on local Walk-in Centres (WIC) and the re-procurement, or de-commissioning of those services. One delegated CCG had created a ‘bespoke’ APMS contract. Following the launch of the Five Year Forward View (NHS England, 2014a) in 2014, it was also announced that there would be an opportunity for GP practices to move onto a new, more flexible contract. However, considerable uncertainty remains about this, and there was a consensus among both delegated and joint commissioners that there were no plans to introduce such a contract until there was further detail and clarity about what the contract would offer. There was a perception that if CCGs started to initiate conversations with general practices about contracts that it would potentially scare the membership. We were told that the fact that such a contract would be likely to be time-limited rather than open-ended like the current GMS and PMS contracts limited its appeal.

In terms of wider initiatives of work that CCGs were involved in, most respondents (20 joint and delegated CCGs) in the second survey were part of one of the new models of care ‘Vanguards’ which were set up following the Five Year Forward View (NHS England, 2014a) to trial new ways of working. Only three delegated CCGs and five joint CCGs which were not part of such initiatives. They suggested that the reason for not being involved with Vanguards was because they were part of other initiatives such as the Prime Minister’s Challenge Fund (NHS England, 2013d), which was a national initiative to improve access to GP services. There were 57 pilot schemes nationally that have been approved by NHSE in general practice with an aim of improving access and leading on transformational change at a local level. One CCG suggested that Vanguard money had been taken away from them because of local political issues. In addition, their local GP Provider organisation was not perceived to be strong enough to be part of the Vanguard.

We asked each CCG about their involvement with the new Sustainability and Transformation Partnerships/Plans (STPs) (NHS England, 2016g), and the impact of such work on primary care. Primary care was seen as a beneficiary of work from the STPs with many aiming to move care out of hospitals. One CCG claimed that STPs were about the remodelling of care and therefore commissioning needs to be looked at differently. One CCG believed that primary care needed to be involved in STP discussions when considering what was in the remit of out of hospital care to ensure that general practice voice was heard. However, the process of developing STPs was said to be driven from the top down, which could potentially stop general practice engaging. In some areas, there was said to be a lack of discussion with primary care in the early establishment of the STP, which were said to be driven by acute hospitals. One
CCG described the STP as having ‘ice age thinking’ which meant that the STP had the potential of taking primary care backwards. It is because of this concern that the PCCC in this area felt it was important to try and inform the STP leadership about primary care. In general, STPs were found to be concentrating on perceived ‘big ticket’ areas such as cancer and leading an overarching programme of work. Primary care was seen as still under the control of localities (CCGs).

**Governance**

During the initial telephone survey, we asked what governance arrangements CCGs were establishing to deliver their new responsibility of primary care commissioning. The guidance recommended that CCGs set up Primary Care Commissioning Committees (PCCC) in order to manage their new responsibility. Initial confusion surrounded the guidance and the extent to which working in partnership with other CCGs was permitted was discussed in the interim report (McDermott et al., 2016). Most CCGs during the second phase of the telephone survey claimed that their governance structure (joint and delegated) was fit for purpose. One CCG had originally tried to do the primary care commissioning work using existing CCG structures. However, at the time of the second telephone interview they reported that this approach had not been adequate to deal with the new primary care commissioning role and they had therefore introduced a PCCC.

**Decision making process**

In our interim report, we identified the main risks identified by CCGs as being associated with taking on responsibility for primary care co-commissioning.

A majority of our participants undertaking joint and delegated commissioning identified resources as one of the main risks, in terms of workforce capacity and capability and running costs. They told us that the reduction in running costs, the loss of expertise previously present in Primary Care Trusts (PCTs) and their inability to employ their own staff may risk CCGs being unable to deliver NHSE expectations. The second main risk was a relational risk between the CCG and their members, with a tension between engaging and contractually managing them and the risk that the current close relationship might change if CCGs were to adopt a transactional rather than transformational approach. Lastly, reputational risk was a concern. This included a risk that the CCG would be seen by external partners as favouring primary care over other providers, and a risk that the CCG would be seen by its members and by other bodies as failing to prioritise patient’s needs because of perceived conflicts of interest.

However, one CCG claimed that they did not see conflicts of interest as a risk because there was an official guidance for this. For delegated, there was an additional financial and managerial risk i.e. whether or not there would be enough money and staff to deliver the services required.

In the follow up survey we wanted to ascertain whether any of these initial risks had been realised. Generally, both delegated and joint CCGs had all experienced the expected lack of resources, including a lack of managerial resource to deliver the primary care agenda. To try and manage the new programme of work CCGs were establishing primary care teams, without any additional resource. In some areas this was being delivered through the re-alignment staff portfolios of work. One joint CCG believed that they had mitigated the resource risk by bringing together primary, secondary, mental health and acute care to work in a more integrated way. Another CCG initially utilised the staff from the local Commissioning Support Unit (CSU). However, when the local unit was not accredited the CCG decided to directly increase their employed staff and put additional resource into primary care.
Other challenges had arisen because PCCC meetings are required to be held in public. It was felt that this had had an impact on their ability to deal with potentially contentious or confidential issues (see Section 3.5.3.1 on private vs public meetings). Only one CCG from the second telephone survey had found the transition had occurred without any significant issues arising.

We also wanted to explore whether any new risks had been identified once co-commissioning had started in earnest. The new risks identified by delegated commissioners were focused on managing the primary care agenda, trying to understand the technicalities of finances and also ensuring that providers were all being treated the same no matter the type of service provision. The new risks for joint commissioners seemed to focus more on managing the implications of taking on the responsibility, rather than the ‘doing’ of the work. For example, how would the CCG manage the additional workload and how would the responsibility impact on the CCG relationship with member practices.

*Table 8: Main risks for CCGs taking on primary care co-commissioning*

<table>
<thead>
<tr>
<th>Initial risks (from the first survey)</th>
<th>New risks (from the second survey)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Delegated CCGs</td>
</tr>
<tr>
<td>Resources in terms of workforce capacity and capability and running costs</td>
<td>Resource to support practices with poor CQC ratings</td>
</tr>
<tr>
<td>Relational risk between the CCG and their members, in terms of a tension between engaging and contractually managing them and change in close relationship if CCGs were to adopt transactional rather than transformational approach</td>
<td>Practice sustainability</td>
</tr>
<tr>
<td>Financial risk for those taking on delegated commissioning</td>
<td>Understanding technical financial issues</td>
</tr>
<tr>
<td>Reputational risk with internal members (fear of perceived conflicts of interest) and external partners</td>
<td>Testing the relationship with member practices-ensure that practices are being treat like any other providers</td>
</tr>
<tr>
<td>Management risk for those taking on delegated responsibility</td>
<td></td>
</tr>
</tbody>
</table>

*Relationship with NHSE*

When we spoke with CCGs about the relationship they held with their local NHSE team there was a clear distinction between joint and delegated commissioners. Delegated CCGs had found that the relationship between the CCG and NHSE was clearly defined, with NHSE having an assurance role.

CCGs are held to account on primary care in their quarterly assurance meetings and are expected to include primary care in their annual report. In contrast, joint CCGs did not feel that they were being held to account by NHSE, but they expected the relationship to change when/if they became
delegated commissioners. When describing their relationship with NHSE, joint CCGs had a mixed response. In some instances, the joint commissioning arrangement had not influenced the relationship between the CCG and NHSE. However, a number of CCGs had found the new working arrangements to have improved their relationship.

The majority of the CCGs who took part in the telephone survey were happy with the support they received from NHSE. Examples of support included: a hub of primary care staff in NHSE for CCGs to contact; a link primary care manager in NHSE; and NHSE’s attendance at primary care commissioning meetings. One joint CCG claimed that the support they had received from NHSE (contractual transactional support) was vital in deciding whether they should apply to become delegated commissioners.

Concerns raised by CCGs include: lack of or no information transfer from NHSE to CCGs; lack of meaningful and useful data that had been handed to CCGs; and wider confusion about the access to national funding for primary care. Initially, there was duplication of work and confusion concerning where and by whom decisions should be made by (NHSE or the CCG).

When we asked what extra support CCGs would have found useful when taking on the responsibility, CCGs articulated a need for workshops and the sharing of NHSE expertise. Overall, NHSE’s capacity and the lack of resource to support the agenda were commonly mentioned. Further details about the impact of NHSE Property Services on the co-commissioning agenda and the attendance of an NHSE finance person at CCG level meetings were advocated as being of use to CCGs. Most joint CCGs highlighted their concern for the lack of resource there is for the co-commissioning agenda and the implications of that if they became delegated commissioners.

Relationships with member practices

The impact of co-commissioning on the relationships CCGs had with their member practices was found to be varied and not necessarily related to the level of primary care commissioning responsibility. Some CCGs claimed that the change in responsibility had not impacted upon their relationship and some said that they were unsure whether practices actually understood the role of the CCG in the commissioning of primary care. Other CCGs suggested that they had seen a slight reduction in practice engagement with the CCG but they could not clearly account for this as a consequence of co-commissioning. Instead, the wider pressures that CCGs are facing were seen as a factor influencing the CCG/membership relationship. When talking about the relationship with member practices, a number of CCGs said that general practices now knew who to contact if there was an issue, supporting earlier engagement and support. This local control and ability to support practices was perceived to be a positive outcome of the policy changes.

Performance Management

The second phase of the telephone survey specifically asked whether CCGs (joint and delegated) were performance managing their practices and if so what mechanisms they had in place to monitor practices. Two CCGs said that they were not performance managing their practices at the time of the telephone survey. However, most CCGs said they were using monitoring tools that were already in existence, for example a 'quality dashboard', the Primary Care Web Tool and CQC reports. There appeared to be a lack of appetite amongst CCGs to be inventing new models/tools to capture data. One CCG mentioned that the lack of performance management of primary care from NHSE has led them to develop their own data sources to monitor the quality of general practice and assessing local
demands. The CCG wanted to measure unmet demand, focusing on access to GP appointments. It was generally acknowledged by the CCGs that the work they were doing with general practice was often reactive and they were trying to manage situations as they arose rather than proactively performance managing contracts.

Conflicts of interest

Data from the initial telephone survey helped us understand how CCGs were thinking about and defining conflicts of interest. Generally, conflicts of interest were seen as something that had always existed in the health service and would continue to do so. From the second telephone survey, we wanted to establish whether conflicts of interest had arisen and if so how the CCG had managed them. All CCGs we spoke with in the second telephone survey claimed that they have robust policies and procedures in place to deal with conflicts of interest. When a conflict arose, people who were deemed as conflicted would be asked to leave the room. Thus, they would not be involved in the discussion or decision making on that specific item on the agenda. A small number of CCGs emphasised that they were ‘tougher’ on primary care with regards to conflicts than they were with any other provider. This was seen as potentially detrimental to primary care work as the overcompensation of the conflict of interest policy often led to no clinical perspectives being discussed in meetings. A number of CCGs have employed an independent GP (from outside the CCG area) to offer clinical insight into primary care, however it was recognised that this did not allow for clinical knowledge specific to the local population to be incorporated into the discussion.

Findings from Level 1

The majority of CCGs in Level 1 we spoke with in 2015 had decided to move to joint or delegated level and therefore we only had one response in the second telephone survey. When asked why they had not opted to do joint or delegated commissioning initially they said that it was not the right time for them as a CCG. However, at the time of the second survey, they had applied to become delegated commissioners as they thought it would help them in their intentions to develop an accountable care system.

Overall, our findings show clearer differences between joint and delegated CCGs in the second telephone survey, in that delegated CCGs claimed that they were able to achieve or were moving to achieve their objectives whereas joint CCGs not so much. One of the reasons was that the role of CCGs and NHSE had become clearer, with NHSE having an assurance role hence allowing CCGs to make their own decision. Joint CCGs and those who were at Level 1 were intending or were in the process of moving to delegated level. We found limited evidence of appetite for new forms of contract, even amongst those with Vanguard(s) in their area. One of the main concerns was the time-limited nature of alternative contracts, which were thus seen as unattractive. At the time of our survey (August 2016), primary care did not seem to be meaningfully engaging with the early development of the Sustainability and Transformation Plan/Partnership (STP). Respondents told us that they found the process to be top down and driven by acute hospitals hence potentially discouraging general practice from engaging. For detailed analysis of CCGs’ experiences of ‘greater involvement’ and ‘actionable messages’ to support their development, see our interim report (McDermott et al. 2016)
3.4 The practice of co-commissioning

This section presents the main findings from our project. It starts by describing the structure and governance of Primary Care Commissioning Committee. This is followed by descriptions of the approaches taken by CCGs in our case studies to commissioning and contracting and illustrations of how the relationships, between the CCGs and their membership and between CCGs and external stakeholders, were developing following the delegation of co-commissioning responsibility. It discusses the concerns over conflicts of interests and how our case study CCGs were managing them before discussing the impacts and outcomes the CCGs would expect to achieve from taking on this new responsibility with concrete examples of any early successes.

3.4.1 Structures and governance

*Primary Care Commissioning Committee (PCCC)*

In exercising the primary care co-commissioning delegated functions, CCGs are required to establish a Primary Care Commissioning Committee (PCCC), which is a corporate decision-making committee. NHSE has published a model Terms of Reference (ToR) for both delegated and joint commissioning arrangements (NHS England, 2014c, 2015c). The model ToR did not dictate the particulars of each of the sections hence CCGs were given the flexibility to articulate each PCCC’s responsibilities, its membership, quorum, schedules, meetings frequency, accountability, procurement, and decision making. While this leaves room for local specificity in the process of shaping the final ToR document adopted by each CCG, this also lead to varying degrees of ambiguity in relation to what is expected from CCGs, or how best to define responsibilities, domains of operation, and lines of accountability. As we found in the early part of this study with CCG Governing Bodies (Checkland et al., 2016), this flexibility also leads to considerable variation in the make-up of committees.

CCGs in our case studies, by and large, adhered to the stipulated governance arrangements for joint and delegated commissioning. This was particularly evident in terms of PCCC’s membership requirements, the distribution of voting powers, and the Committee’s relation to each CCG’s Governing Body. All four CCGs nominated a lay member as Chair of the PCCC, and taking into consideration issues of conflict of interest had ensured a non-clinician voting majority. The following table lists the governance arrangements put in place by our case study CCGs.
### Table 9: CCGs Governance Arrangements for Primary Care Commissioning Committee

<table>
<thead>
<tr>
<th>Voting Members</th>
<th>CCG Site 1</th>
<th>CCG Site 2</th>
<th>CCG Site 3</th>
<th>CCG Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Site 1</td>
<td>Three CCG Lay Members</td>
<td>Two CCG Lay Members and one Lay Advisor</td>
<td>Two CCG Lay Members</td>
<td>Two CCG Lay Members and one Lay Advisor</td>
</tr>
<tr>
<td>CCG Site 2</td>
<td>CCG GB Nurse</td>
<td>CCG GB Nurse</td>
<td>CCG GB Nurse</td>
<td>CCG GB Nurse</td>
</tr>
<tr>
<td>CCG Site 3</td>
<td>CCG GB Secondary Care Consultant</td>
<td>CCG GB Secondary Care Consultant</td>
<td>CCG GB Secondary Care Consultant</td>
<td>CCG GB Secondary Care Consultant</td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>Independent Clinician</td>
<td>Clinical Lead for Primary Care Development</td>
<td>CCG GB GP Members</td>
<td>CCG GB Practice representatives</td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>CCG Chief Operating Officer</td>
<td>CCG Chief Operating Officer</td>
<td>CCG Chief Operating Officer</td>
<td>CCG Chief Operating Officer</td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>CCG Chief Finance Officer</td>
<td>CCG Chief Finance Officer</td>
<td>CCG Chief Finance Officer</td>
<td>CCG Chief Finance Officer</td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>CCG Head of Contracting</td>
<td>CCG Head of Contracting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>CCG Chief Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Voting Members</td>
<td>Health and Wellbeing Board representative</td>
<td>Health and Wellbeing Board representative</td>
<td>Health and Wellbeing Board representative</td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>Healthwatch representative</td>
<td>Healthwatch representative</td>
<td>Healthwatch representative</td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>NHS England representative</td>
<td>NHS England representative</td>
<td>NHS England representative</td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>CCG Deputy Chief Officers</td>
<td>Local Medical Council (LMC) representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>CCG Governance Lead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>CCG Director of Public Health</td>
<td>CCG Public Health Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>Associate Directors and Heads of Service, as appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invited/Observer</td>
<td>Local Medical Council (LMC) representative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Site 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quorum Requirements</td>
<td>Three members must be present and this must include; a Lay Member and</td>
<td>At least three Non-Executive members, 1 GP, 2 CCG Chief Officers,</td>
<td>One Lay Member, one GP, and one Executive member.</td>
<td>Four members present and this must include; Chief Officer or Chief</td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>either Chief Officer or Chief Finance Officer or Chief of Service</td>
<td>Chief Finance Officer, Head of Contracting, and any 2 non-voting</td>
<td></td>
<td>Finance Officer and two of the following: Lay Member (Audit or Patient</td>
</tr>
<tr>
<td>CCG Site 4</td>
<td>Delivery and Quality</td>
<td>members.</td>
<td></td>
<td>and Public Involvement), Nurse, or Secondary Care Consultant.</td>
</tr>
<tr>
<td>CCG Site 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule</td>
<td>Quarterly</td>
<td>Monthly; minimum of 10 meetings a year</td>
<td>No less than 5 times a year</td>
<td>Every month</td>
</tr>
</tbody>
</table>

The above governance arrangements were true at the time of data collection. Some CCGs have amended these arrangements. For example, Site 3 initially included an independent clinician for quorum.
requirements but had since excluded that clinician from quorum due to inability to commit the time to attend the meetings.

The initial guidance (NHS England, 2014d) stipulates that the committee must have a lay and executive majority and have a lay chair, and the PCCC Chair cannot be the Chair of the Audit Committee. The table above shows that PCCCs meet this requirement by including representatives of CCG organisational functions such as Finance, Contracts, and Engagement as voting members, although it is worth noting that this varies across CCGs. All CCGs also included representatives of NHSE as non-voting members and, when asked about accountability in interviews, many respondents saw this as an important, almost integral part of accountability relations. Similarities were found in the inclusion of CCG Chief Officers, CCG Governing Body (GB) nurse and secondary care clinician, and GP members (either CCG GB members or an independent clinician). Non-voting members included representatives from the local Healthwatch organisations, local Health and Wellbeing Boards, and Local Medical Councils (LMCs). For CCGs crossing two Local Authority boundaries, there were representations from both organisations.

The PCCC in Site 1, unlike the other three CCGs, was making use of an existing committee that the CCG had put in place to facilitate decision making about items which present conflicts of interest for GP members of the CCG Governing Body. Following delegated responsibility, although the committee carries out functions specifically relating to the commissioning of primary medical services, its functions were extended to other areas which present a conflict of interest.

In terms of decision making, the committees made decisions by consensus or a majority vote if necessary. The lay chair has a second and deciding vote if the Committee is unable to reach a unanimous decision. However, not all voting members were needed for quorum as requirements differ, and attendance was also quite irregular in terms of the persons attending meetings. The number of members required for quorum vary considerably ranging from three to ten. In Site 3, a GP member was included in the quorum but decision was outweighed by lay and executive members. In Site 4, four members (or their deputies) were required for quorum.

There were also varying approaches to the frequency of PCCC meetings, with one site mandating a monthly meeting and another working on a quarterly schedule. However, there is a requirement for the PCCC to hold their meetings in public and publish the minutes on their websites. However, the committee can exclude the public from meetings if it is believed that their presence would prejudice the public interest due to the confidential nature of the committees’ business or for other special reasons.

The PCCCs in all our study sites acted as a decision-making body. There was a line of reporting to the CCG Governing Body, but the PCCC was set up as independent of the Governing Body. Respondents identified the PCCC as a ‘sort of governing body for primary care’ or as ‘sitting beside the governing body’. While Governing Bodies have a majority of clinicians, PCCCs have a lay and executive majority.

In our case study CCGs, there was variance in the way internal arrangements to support the work of the PCCC had been setup. It was also apparent that CCGs found a need to separate between the PCCC, which assumed a more strategic, systematic role for the development of primary care, and the management of operations required to achieve the PCCC’s ambitions. Under names such as Primary Care Operational Group, Primary Care Working Group, or Primary Care Strategy Working Group, each site had set up a working group under the PCCC, with each CCG dividing the workload differently according to each organisation’s internal dynamics.

The development of these operational groups varied in each of our case study CCGs. Some established an operational group at the very beginning of their co-commissioning role, but others, such as Site 3, started initially with only a PCCC, deciding later that it was necessary to separate the strategic and operational role of the committee:
The [PCCC] has been running on a monthly basis for just over a year now. We have decided a few months ago that we would introduce a Primary Care Operational Group as a lot of the PCCC meetings had been taken up with more operational elements, that it was felt [the PCCC] was becoming a bit bogged down with that side of things. [Manager ID37]

Indeed, the internal relationship between the nominated PCCC and additional CCG committees was an ongoing concern and a matter of continual development as part of a learning process:

The PCCC will be making decisions. But some of them are not easy to predict in advance. [...] I think we’re still working some of that out and checking in terms of... the contracts for example, looking at the values of contracts, mapping out how that fits with our stand over financial instructions, the power that the committee has. So I wouldn’t say we’ve got it firmly fixed. I think we did do quite a lot of research with other CCGs before we started when we were going through taking on full delegation and thinking about how we were going to do that. What we found really was that other people weren’t...even that had been doing it for a few months, were not entirely...a lot have not really had anything coming through. [Manager ID43]

The role of and relationships between the various committees continued to evolve. The changes in structure and the crossovers between primary care and additional domains of commissioning are likely to increase in the future, as CCGs are becoming more involved in the wider national initiatives (see Section 3.5.4).

**Role of lay members and clinicians**

In accordance with NHSE requirements, the PCCC is a hybrid forum, bringing together clinicians, lay members, and CCG managers. Decision making by this forum will therefore require a complex interaction between divergent world-views, expertise, and interests.

In relation to the involvement of lay members, our study site recognised that having a majority of non-executives in PCCC meetings has its benefits. In Site 2, the Chair of the PCCC characterised their presence as especially beneficial because of their ability to understand the local context. Drawing on his past experience with a PCT in which lay members were also brought in for advice:

In this area it was very quickly recognised that non-executives added real value to a majority of clinical board. They had very close connections with their communities. They could be conduits, strong representatives of local interests, non-clinical interests. They had an understanding of housing, education, social services, of the voluntary sector, and that kind of senses were as important determinants of the quality of people’s lives as health taken on its own. [Lay member ID14]

In meetings in this site, lay members were frequently observed to question and challenge clinicians for further explanations and elaborations of clinical opinion. This played a role in both informing committee discussions as well as in making sure that publicly available minutes were accessible and understandable to the public.

However, despite being in the minority on the PCCC, the role of clinicians remains important. The following respondent talked about the ‘soft power’ that clinicians presence has on voting members and how the PCCC calls for a “redefinition of the notion of leadership”:

We may be non-executives taking decisions but we’re here in the presence of two other constituencies. One is patient representatives and so on. The other is the clinical input from GPs and GPs’ organisations, like the LMC [Local Medical Council]. They have an influence on us. They
may not have executive power, but they have an influence, and I feel that the best form of decision making is not necessarily through imposing one's authority through an executive function, but influencing people, because when you influence people you make them understand what it is you are trying to implement [...] you need to convince them. [...] What we are talking about here is about leadership of a very different kind. It is redefining the notion of leadership. [Lay member ID14]

This was acknowledged by another interviewee who pointed to how the presence of clinicians and those with experience of primary care ensured unintended consequences could be avoided, especially in the context of financial ramification:

I think one of the big advantages is of having GPs practice managers involved early on, even if they are not allowed to make a decision. It allows those making the decision to be informed of what the reality is. Otherwise, you get unintended consequences. You know lock five people in a room to make a decision about something, and unless they actually know what's going to happen at the front line, there will be unintended consequences. [Manager ID31]

In our case study CCGs, clinicians' involvement was not only confined in governance roles but also in operational and transactional work. GPs joined various working groups which functioned to implement PCCC decisions and to devise operational plans. Another respondent also highlighted GPs' contribution at an early stage of the CCG taking on co-commissioning responsibility and the value of having GP-to-GP conversations:

[when we assumed responsibility] the CCG stepped in with local knowledge and actually had some really good conversations, GP to GP if you like. [...] Because we are clinically led, you know, I could recognise what the challenges were; we were better than the NHSE area team because they are not GPs. [CCG Chair GP ID27]

While recognised as highly beneficial, GPs involvement with the work of primary care commissioning raised a potential for conflicts of interests. To mitigate this, GPs were asked to either leave the room or not allowed to participate in the discussions. One CCG Chair described how this left GP leaders feeling frustrated as they were not able to see the full picture of what was happening in their CCG:

It leaves GP leaders like me frustrated because some of the conflicts of interest and governance means that I don't get to see a full picture that I like, because as a strategist, and responsible for the vision of where we're going, I need to understand a broad brush of everything. [CCG Chair GP ID8]

Moreover, asking GPs to leave the room could lead to a situation in which a group of people (lay members and executive managers) making clinically-related decision without any clinical input, as described by our respondent:

It was a major contract which had to be approved by Governing Body, however, all of the GPs there, or themselves, provide minor surgery for our patients, and therefore, we were all directly conflicted. What happened was, that in fact at that stage, almost to be seen to be cleaner than clean, all the GPs left the room. But then of course, we said well firstly that seemed very silly, because it was a public meeting anyway, so if it was a public meeting then they could've still stood at the back. The problem was, it was then taken over that there were no clinicians left in the room, so we were therefore discussing...are you a clinician yourself? No, ok, so therefore, the remaining group are discussing the pros and cons of a minor surgery contract without any clinician being in the room. So we said what should have actually have happened was that we should've all stayed in the room and said that we can take no part in active discussion, however,
we are here for advice if you need that advice, but we can only respond to questions if asked by the independent members. [GP ID17]

The situation described above was common, as the CCGs work hard to show themselves to be taking conflicts of interest seriously (see Section 3.4.3.). This highlights a contradiction which sits at the heart of the CCG model - CCGs being clinically-led organisations having to reduce or remove clinical involvement from primary care commissioning decisions due to concerns over conflicts of interest.

Another group involved in primary care commissioning through participation in PCCC decision making were the executive managers. All our case study CCGs appointed Primary Care Managers, whose role was to assist and guide practices towards achieving each CCG’s commissioning objectives. This remit of this role included; maintaining quality assurance and the compliance of practices with the local incentive schemes, developing and monitoring locally commissioned services and thus work closely with the contract teams and the quality monitoring teams, and seeking to identify local practices who needed further support. The manager in Site 1, unlike in other sites, also had a strategic role to oversee the commissioning of primary care and was responsible for the development of the CCG’s primary care strategy. This role was described as ‘therapeutic’, alluding to practice managers’ need to be able to voice their concerns and for their difficulties heard and addressed.

Assurance

NHSE conducts an annual performance assessment of CCGs. The criteria of assessment are set out in the CCG assurance framework. The first assurance framework (NHS England, 2013b) was based on the CCG authorisation process and structured around six domains, covering capability assessment and potential to deliver. Following the delegation of responsibility from NHSE to CCGs to commission primary care services (NHS England, 2014d) from April 2015 and publication of Five Year Forward View (NHS England, 2014a) in October 2014, the assurance framework (NHS England, 2015a) was refreshed to consists of five components (well-led organisation, performance, financial management, planning, and delegated functions).

For primary care commissioning responsibility, CCGs are required to prepare a quarterly self-certification of compliance which need to be signed off by the CCG Governing Body (if delegated) or the joint committee of CCG and NHSE (if joint commissioning). The measurement for competence in primary care commissioning is against five areas; (1) governance and management of potential conflicts of interest, (2) procurement, (3) expiry of contracts, (4) availability of services, and (5) outcomes.

The refreshed framework is taking a more ‘risk-based approach’, which differentiates ‘high performing’ CCGs and those whose performance give cause for concern. CCGs are assessed according to four categories (which are consistent to those used by CQC):

- Outstanding – CCGs are fully assured across the five areas;
- Good – CCGs overall are well-led and have good organisational capability. CCGs will be required to produce their own improvement plan and report to NHSE on the process;
- Limited assurance/required improvement – CCGs have serious performance or financial challenges and a high level of risk. CCGs will be required to develop an improvement plan which will be approved and monitored by NHSE;
- Not assured – CCGs are failing or at risk of failing to discharge their functions. NHSE will conduct an assessment to identify the underlying causes and specify remedial actions in the improvement plan.
Interventions by NHSE could take various forms depending on individual CCGs’ circumstances but could include; having to have all plans signed off by NHSE, removal of functions to another CCGs, or (in an extreme case) dissolution of the CCG. CCGs could also go into ‘special measures’, if they have persistent and chronic performance challenges such as financial challenges and/or governance difficulties over a period of two quarters. For delegated functions, this means that CCGs will not be able to self-certify compliance, will be subject to continuous assurance and NHSE will consider reversing the delegated functions. However, the assurance framework emphasises that not all CCGs with the same issues will be put in special measures; it is triggered by the extent to which the CCG is regarded as having a credible recovery plan.

Starting in 2016/17, NHSE replaced the CCG Assurance Framework and the CCG Performance Dashboard with a unified CCG Improvement and Assessment Framework (CCG IAF) (NHS England, 2016a). The new CCG IAF has been designed to sit alongside and be consistent with the Five Year Forward View (NHS England, 2014a) and NHS Planning Guidance (NHS England and NHS Improvement, 2016) and is based on performance indicators that lend themselves to the new Sustainability and Transformation Plans (STPs) (NHS England, 2016g). The focus of the new framework is on ‘practical support rather than assurance and monitoring’. Under this framework, CCG will be assessed for improvement under four domains (Better Health, Better Care, Sustainability, and Leadership) and six clinical priorities (mental health, dementia, learning disabilities, cancer, diabetes, and maternity) comprising 60 indicators across 29 areas. Assessment consists of an annual review taking into account that CCGs do not have full control over the performance of all indicators. Using a four-point ‘Ofsted-style’ ranking system (outstanding, good, requires improvement, inadequate), NHSE then ranks CCGs and publishes the results on MyNHS. For delegated responsibility, CCGs will need to provide annual and quarterly self-certification focusing on conflicts of interest. This could include indicating that the CCG has a clear policy for management of conflicts of interests, completed mandatory training for staff, and published any breaches on the CCG’s website. The self-certifications are to be signed off by the CCG’s Accountable Officer and submitted to NHSE local team, who will collate the information onto a spreadsheet and submit to NHSE national team from all CCGs in the region. CCGs will be rated as; compliant (100% criteria met), partially compliant, or not compliant (if 0% criteria are met).

Assurance through the new framework was not discussed much in our case study sites. However, we observed a meeting which discussed how the new CCG IAF was directly linked to operational matters. The following exchanges shows how the manager was aware about the need to align the CCG’s commissioning intention with the assessment framework:

[Commissioning team] have been working on the Improvement Assessment Framework to make sure that all commissioning intentions address the nine must do’s. I have a document itemizing how we will do that. I will include it in the minutes so people are assured that our commissioning is mapped to the nine must do’s and CCG Implementation Assessment Framework. What we do have is a suite of documents about all the detail for the next year. It's to assure the committee we are on ball. Needs to be signed by December before Christmas.

[Commissioning meeting October 2016, M30]

Although the CCG IAF had not been discussed much during our observations, there were discussions about accountability more broadly with various respondents expressing different views on accountability relations. It was acknowledged that the presence of an NHSE Representative in PCCC meetings was an important element for accountability relations as a form of assurance and a way of being held to account.
3.4.2 Approaches to commissioning and contracting

In this section of the report we discuss the approaches being taken to commissioning and contracting by our case study CCGs. It starts by describing the CCGs’ strategic plan and ‘new’ initiatives developed to support the plan. It then discusses the CCGs’ plan for Quality Outcomes Framework (QOF), Directed Enhanced Services (DEss), Personal Medical Services (PMS) and Alternative Provider of Medical Services (APMS) contracts. Lastly, it illustrates how our case study CCGs navigates through the Estates and Technology Fund, which was one of the main areas of work for the Primary Care Commissioning Committee during our fieldwork.

3.4.2.1 Strategic plans

Our case study CCGs had developed strategic plans which outlined how they were planning to support, enable, strengthen, sustain, and/or transform general practice to address the challenges or pressures that the local healthcare systems are facing. The plans were developed to deliver the aspirations in the Five Year Forward View (FYFV) (NHS England, 2014a) and General Practice Forward View (GPFV) (NHS England, 2016d). They were also used as a basis to develop the place-based strategies for the Sustainability and Transformation Plans (STPs) (NHS England, 2016g).

This section describes the CCGs’ strategies in terms of how the plans were developed, where the CCGs want to be, and how they planned to achieve it.

Summary - structures and governance

- CCGs who took on delegated responsibility early in the process found it has taken them some time to arrive at a working governance structure.
- All CCGs must have a Primary Care Commissioning Committee (PCCC). However, over and above this requirement there is some complexity, with CCGs adopting different structures and governance procedures. In particular, CCGs vary in:
  - membership and governance of the PCCC
  - the extent to which the PCCC undertakes an operational role
  - sub-committee structures and functions
  - frequency of meetings
- Clinicians are becoming more involved in primary care commissioning, but conflicts of interest place some limitations on this
- The role of NHS England remains important, even in those CCGs adopting full delegation
- There is some evidence of a disconnect between the Governing Body and the work of the relatively autonomous PCCC, with some GB leaders suggesting that the need to separate the two areas of work prevents the development of a more joined-up approach
- The new CCG Improvement and Assessment Framework imposes a number of commissioning requirements on CCGs
Development of the plans

The content of the plan generally focused on general practice, hence called General Practice Strategy in most of our sites, apart from Site 4 who emphasised that their plan should be called Primary Care Strategy. They believed that the plan should support and reflect the working with the wider primary care development. This had implications in terms of ownership of the plan in Site 4, where the plan was developed by the CCG Governing Body rather than the Primary Care Commissioning Committee (PCCC). In all the other sites the development of the plans were overseen by the PCCC. Site 1 had put in place additional mechanisms to ensure that work is carried out effectively. They had formed a delivery team (members including the CCG quality, finance, and contracting), an evaluation team (to assess whether the plan is effective and value for money), and reference groups (to oversee the implementation and evaluation of the plan and providing assurance on patient and public engagement).

The plans were developed with engagement with a wide range of stakeholders. CCGs in our case study did extensive engagements, either through events and/or surveys with patients and the public. The CCGs also consulted with practice members, GP Federations, the Local Medical Council and Healthwatch. Site 4 consulted their plan with wider stakeholders such as the Foundation Trusts and the third sector.

Where do the CCGs want to be?

The plans were developed to address various pressures and challenges in the local health systems. All CCGs in our cases study recognised an increasing demand due to aging population and patients with multiple and complex needs. Additionally, Sites 2 had population living in the most deprived areas with higher unemployment and Site 4 had population that cover parts of the most affluent and parts of the most deprived areas. Workload had also increased as a consequence of increasing demand. These challenges added with national workforce crisis (lack of GPs), financial pressures (rising costs and changes to core contracts), and primary care estates in need of modernisation put the local health systems under immense pressure hence patients not always receiving the quality and standard of care they need.

In their plans, CCGs claimed that these challenges can be addressed by having a more integrated approach to delivering health and social care services for the local community. The vision was to achieve a people-centred, locally driven, and/or integrated primary care with general practice at its heart. It was envisaged that an integrated approach to delivering health services would improve outcomes, reduce avoidable illness, reduce hospital admissions, and reduce care expenditure.

A priority in all our case study sites was to support practices working more closely together. This did not necessarily mean practice mergers, although there were instances of practice mergers in Sites 1 and 3 and Federations merger in Site 4. Mergers were partly linked to estates improvement, where three or four small practices in the same area were moving into one new building together. In Site 4, there were discussions about small, often single-handed practices working collaboratively in order to share resources to fund joint roles that would be unaffordable for a single practice and to share the same policy and procedures. There were plans to use funding from the GP Resilience Fund to appoint a new staff member to support collaborative working between practices, with a particular focus on smaller practices. The CCG was also considering how to encourage practices to join the Federation and work more closely together.

Other priority areas were development of general practice ‘at scale’ to enable greater delivery of out-of-hospital care, integrated community and social care, and the delivery of health improvement and
prevention initiatives in Site 1. Sites 3 and 4, on the other hand, planned to increase the delivery of care closer to home by focus on access to general practice in Site 3 and on access to care in a primary and community setting in Site 4. Site 2 identified several priority areas such as; reducing variation, shifting resources from secondary care, supporting urgent care, and patient engagement.

**How do the CCGs plan to achieve it?**

The following were identified as enablers to achieve the CCGs’ vision for a people-centred, locally driven, and/or integrated primary care; investment, workforce, workload, care redesign, estates, technology, and strong relationship.

**Investment and opportunities contained in the national and local initiatives** were seen as a major contributor to enabling CCGs achieving their vision. The investment identified by the CCGs included; the CCGs’ own budget, the delegated budget for primary care commissioning, local commissioning services, GP Access Fund (NHS England, 2013d), Vanguard funding (NHS England, 2014a), and General Practice Forward View funding stream (NHS England, 2016d).

All CCGs also recognised the need to identify the workforce gap in terms of skills/competency gap and planned retirements. They aimed to do this by developing a training academy or hub either locally, regionally, and/or working together with national organisations such as NHS England and Health Education England to commission the workforce required.

To manage workload and redesign care, CCGs identified the need to develop training and development for a wide range of roles within primary care. Some of the roles identified include medical generalist, advanced nurse practitioner, allied health professional, physician assistant, healthcare assistant, care navigator, and/or physiotherapist/counsellor/occupational therapist/consultant in primary care. However, the most common role piloted was pharmacist in primary care. For example, Site 1 piloted clinical pharmacists in primary care to measure the impact on GP workload. Patients could access clinical pharmacists instead of GPs and nurses for advice and monitoring of long-term conditions. The aim was to relieved GPs’ time of much of the workload related to hospital discharge medication, ad hoc medication queries, medicines optimisation, and medicines monitoring. Site 4, on the other hand, did a case study in which one GP practice recruited a pharmacy team, comprised of a pharmacy technician, a non-prescribing pharmacist, and a prescribing pharmacist, to take on the equivalent workload of a full-time GP. The team was to provide support for prescribing queries, clinical audits, dealing directly with patients to promote compliance, achieving Quality and Outcome Framework (QOF) target, and clinical governance.

In addition to developing wider roles within primary care, two of our case study CCGs (Sites 1 and 3) had identified how they planned to help GP practices to release capacity using the 10 High Impact Actions identified in the GPFV (NHS England, 2016d). These actions include; active signposting, new consultation types, develop wider primary care team, partnership working, social prescribing, and self-care.

In their plan, all our case study CCGs had also identified how they planned to improve access in general practice. Site 1 planned to provide a four-hour standard for clinical triage and a 48-hour standard for routine GP appointments. They also planned to provide additional patient contacts and extended access 7 days a week in their GP Federations. Practices in Site 3 took a more shared approach to providing extended urgent on the day access and working with existing walk-in services. They also planned to improve access for routine non-urgent care via direct access rather than GP referral. Site 4 planned to locally agree to an interpretation of areas of services not defined in the General Medical Services (GMS) contract for e.g. all practices to provide consistency of access, online access for appointments and prescriptions, and telephone consultations. The CCG also planned for an equitable access to additional
services, such as enhanced care home provision and minor injury services, and access to services closer to home delivered in primary care rather than secondary care setting.

Improvement in the **GP estates and technology** was funded through the national initiative via the Estates and Technology Transformation Fund (see Section 3.4.2.5). The CCGs’ estates strategies were developed with the Local Estates Forum, which brings together key stakeholders from health care (primary, secondary, and community providers), Local Authority, NHS Property Services, and NHS England. The CCGs generally have similar IT strategies, which was to provide a range of online services such as; e-consultation, electronic repeat prescriptions, patient online access to their medical records and appointments booking, and share care record for general practice.

Lastly, Site 4 identified **strong relationships** as fundamental to the success of their strategy. The relationships they referred to were not only the usual links with secondary and community care but also with voluntary sector, third sector, social care, school, and businesses.

The following table summarises the CCGs’ primary care strategies.
Table 10: CCGs’ Primary Care Strategies

<table>
<thead>
<tr>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
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<tbody>
<tr>
<td>Pressure/challenges – why this strategy?</td>
<td>• Aging population with long-term conditions. • Increased workload due to aging population with complex health conditions • Difficulty in recruiting GPs • Investment on core GP services fallen but the CCG has invested proportionately more in general practice than other areas.</td>
<td>• Increasing demand from patients with multiple and complex needs • In some of the most deprived areas with higher unemployment • GP retirement and national workforce crisis • Financial pressure • Buildings need modernisation • Variation of the quality of GP services • Uncertainties with national contracts having a significant impact in a range of ways.</td>
<td>• Services become more reactive to crisis management • Increase in variation • Decrease patient safety and quality • Increase in cost (utilisation of locum) • Increased pressure to the rest of the healthcare system • Increase in loss of GPs and practice staff • Practice closure.</td>
</tr>
<tr>
<td>Where do the CCGs want to be?</td>
<td>• People-centred primary care.</td>
<td>• General practice at the heart of integrated services • Integrated approach to delivering healthcare services for the local community.</td>
<td>• General practice with patients at its heart.</td>
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<tr>
<td>Focus of CCGs’ work</td>
<td>• General practice ‘at scale’ • Workforce • Workload • Estates • Technology • Care redesign.</td>
<td>• Investment in primary care • Managing shift from secondary to primary care • Supporting urgent care strategy • Reduction in variation in access • Workforce • Workload • Estates • Technology.</td>
<td>• Standardisation of access • Workforce • Estates • Technology.</td>
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<tr>
<td>Enablers</td>
<td>Workforce/ workload/ care redesign</td>
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<tr>
<td>• Investment and opportunities in national and local initiatives such as GPFV funding stream and Vanguard funding</td>
<td>• 10 High Impact Actions</td>
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<tr>
<td>• Estates and technology</td>
<td>• Clinical pharmacists in primary care</td>
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<td>• Redesigning care and improving access.</td>
<td>• Physiotherapists in primary care</td>
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<td></td>
<td>• Integrated primary care &amp; community nursing</td>
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<td></td>
<td>• Consultant attachment to a GP Federation</td>
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<td></td>
<td>• Primary healthcare assistant apprenticeships</td>
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<td></td>
<td>• Care navigator for all GP practices</td>
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<td>• Physician associates and advanced care practitioners.</td>
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<td></td>
<td>• Working with regional and national training centres to create apprenticeship and tailored training packages for primary care and the wider workforce with the local authority and voluntary organisations.</td>
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<td></td>
<td>• Clinical pharmacists in primary care</td>
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<td>• Mental health therapists</td>
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<td>• Practice nurses</td>
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<td>• Physician assistants</td>
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<td>• Practice managers</td>
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<td></td>
<td>• Receptionists.</td>
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<td>• Vanguard funding</td>
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<td></td>
<td>• Greater use of technology</td>
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<td>• Workforce</td>
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<td>• New quality and performance monitoring process</td>
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<td></td>
<td>• Primary care development and education</td>
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<td></td>
<td>• Fit for purpose estates</td>
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<td></td>
<td>• Supporting member practices to deliver Care Quality Commission (CQC) and operating requirements.</td>
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<td></td>
<td>• 10 High Impact Actions/Time for Care/Resilience Programme/GP Improvement programme</td>
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<td></td>
<td>• Practice integrated pharmacy team initiative</td>
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<td></td>
<td>• Direct access to Physiotherapists in general practice</td>
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<td>• Counsellors in primary care</td>
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<td></td>
<td>• Participation in national practice manager Development Programme</td>
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<td>• Return to practice scheme and hosting of student nurses.</td>
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<td></td>
<td>• Strong relationships with a wide range of stakeholders</td>
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<td></td>
<td>• Workforce – addressing challenges of being a clinician and a business owner</td>
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<td></td>
<td>• Estates.</td>
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<td></td>
<td>• Pharmacists and occupational therapists in general practice for those aged 65 and above</td>
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<td></td>
<td>• A pharmacy team with a range of skills (pharmacy technician, non-prescribing pharmacists, and prescribing pharmacists)</td>
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<td></td>
<td>• Patients to be seen by a nurse, allied health professional, pharmacist, or healthcare assistant</td>
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<td>• Patient education on self-management.</td>
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3.4.2.2 ‘New’ primary care initiatives

All of our case study sites have introduced various forms of local incentive schemes (also called ‘contracts’ or ‘frameworks’). An impetus for these schemes was the need to redistribute the money released from the Personal Medical Services (PMS) review, to improve access and promote a consistent level of service delivery across the CCG, and to encourage practices to develop new ways of working. This section starts by providing an overview of the schemes (including outcomes expected), source and amount of funding, and challenges in developing and/or implementing the schemes.

Background of the schemes

Most of the schemes introduced by CCGs in our case study sites (apart from Site 4 as at the time of data collection this site only recently moved to take on delegated responsibility hence the focus of their work was to ensure smooth transition) were generally used to support GP practices working together or working ‘at scale’ and/or to streamline various local incentive schemes into one scheme with a unified contract to reduce the need to monitor the delivery of multiple contracts.

Site 1 introduced various schemes with different objectives. The CCG’s intention was to explore the possibility of streamlining these schemes (covering non-core GP funding) into a unified contract. The unified contract is to be introduced from April 2018 and aligned to the vanguard agreement. Outcomes expected from the schemes include: having a more permanent extended access to GP practices; driving behavioural change in practices to manage more activity in the community; and practices working together initially around informal networks (focusing on different clinical areas such as lung cancer, cardiology etc) and building a relationship between primary and secondary care staff to create a cohesive group of practices to support the development of GP Federations and vanguard.

Unlike Site 1 which introduced a variety of schemes, Sites 2 and 3 decided to focus on one scheme. Site 2 introduced an all-in-one scheme which will replace all local individual incentive schemes from April 2016. The CCG organised a series of workshops to elicit views from member practices on how the money could be invested using a local contract. The workshops helped the CCG to circumvent the predicament of needing GPs clinical input to develop the contract without actually letting GPs write their own contract due to conflict of interest and to ensure transparency around the spending of public funds. Engagement with GP members was also deemed necessary to the success of the scheme. It ensured members’ ownership of the scheme rather than feeling it as something that had been mandated or dictated by the CCG. Clinical input was also provided by the public health consultant within the CCG. The public health consultant provided knowledge of the different needs in the local population as well as information on similarly commissioned contracts in other CCGs.

Practices were expected to meet weighted standards around four overarching themes (access and experience, outcomes and variation, quality/workforce, and wellbeing) associated with the CCG’s aspirations. The scheme would streamline the reporting and monitoring mechanisms. Outcomes expected from the scheme include; increased access, improved outcomes, reduction in health inequalities, and reduction in variation in service delivery across practices, and overall value for money. The scheme aligned primary care commissioning with the delivery of the Five Year Forward View (NHS England, 2014a) and more integrated services. It was envisioned that the scheme would enable practices to work together to deliver a more consistent level of services and hence facilitate primary care to engage more effectively with secondary care. The scheme was seen as the main vehicle for improving primary care.

Practices were asked to make an opt-in or opt-out decision on an annual basis with no option to change the decision part way through that year. They were free to collaborate with other practices
‘at scale’ to deliver the standards. Practices were also given options to either dispense with the national QOF and invest that money in the new scheme or to retain QOF and develop a new set of standards for a reduced amount of money. They decided to retain QOF in its standard national format.

Similar to Site 2, the scheme in Site 3 was introduced to encourage practices to work together to ensure successful implementation of new ways of working and ‘at scale’ working. However, the outcomes expected from Site 3 were specifically on transforming the care of patients aged 75 or older and reduce avoidable admissions. The CCG invited practices to apply for funding. In their application, practices were asked to outline issues such as how they intend to use the funding, what benefits they want to see, how will they know that the schemes worked, how will they report to the CCG, and how their plans fit in with the CCG’s commissioning intentions.

In addition to the scheme described above, Site 1 and 3 had introduced an additional scheme which addressed medicines management in primary care. Site 1 implemented an incentive scheme for prescribing using indicators based on quality and/or cost that are important for the CCG to deliver the Quality, Innovation, Productivity and Prevention (QIPP), a national programme to drive quality improvements and efficiency savings. The indicator targets were related to national and local prescribing levels. Each practice will be required to achieve majority of the indicators in order to receive payment and the scheme incentivised collaboration between practices in networks by offering an additional payment for collective achievement of indicators. Underachieving practices received additional support and peer review. The scheme was self-funding as the cost is top-sliced from the prescribing budget prior to its distribution to practices. Site 3 implemented a pilot scheme involving placing an integrated pharmacy team comprising one senior and one junior pharmacist and one pharmacy technician in two practices. The team’s role was to optimise medicines use and management in order to improve service delivery and patient outcomes. The benefits of the pilot were captured by Key Performance Indicators (KPIs) that measured risk/harm reduction, medicines cost reduction and reduction in GP workload. Data from the first three months of the pilot showed monetary savings due to an optimised use of medicines and avoided hospital admissions. There were plans to expand the pilot to cover all practices in and also develop the workforce. A longer-term strategy would need to be developed before the scheme could be rolled out across all practices in the CCG.

Source and amount of funding

The various schemes in Site 1 were funded using a combination of funding. The Everyone Counts: Planning for Patients 2014/15 – 2018/19 (NHS England, 2013c) planning guidance suggested CCGs to put aside a non-recurrent funding at £5 per head of population (broadly equated to £50 per targeted patient) into developing primary care services for vulnerable patients. The CCG developed Scheme A to do this where £3 was targeted to provide additional patient care and £2 for achievement of Key Performance Indicators (KPIs) relating to several domains including; integrated care, patient and public engagement, improving outcomes and population health, primary care quality, engagement of membership, and sustainability. For the first two years (2014-16), these non-recurrent funds would be set aside to encourage practices to work together initially as informal networks and eventually into GP Federations. All member practices signed up to the scheme and had to submit an annual capacity plan outlining the additional patient care provided over and above their core contract, the types of staff delivering the care and the cost. Practices who did not adequately achieve KPIs did not receive payment.

Due to funding constraints, the level of non-recurrent funding for Scheme A was no longer feasible. Nevertheless, there was a desire to continue funding practices for things that were delivered successfully as a result of this scheme such as A&E attendance not rising as quickly as elsewhere. The CCG decided to migrate some of the content of Scheme A into various ‘new’ schemes; extended
patient access was migrated into Scheme B and network development into Scheme C, and care planning into Scheme D.

**Scheme B (additional patient access)** was funded from the delegated primary care budget to provide a recurrent fund for practices to make additional access (including same day access and extended access) more permanent. The funding for this scheme was tied to the delegated budget i.e. if the budget were to be reduced; the recurrent funding for the scheme would also be reduced. This scheme was funded at £3 per head of geographical population (rather than registered population). The main incentives for practices to increase activity under this scheme was peer pressure and the Care Quality Commission (CQC) rating, with the monetary incentive viewed as less important. The scheme was also tied to another scheme i.e. to be eligible for Scheme B, practices must also signed up to Scheme D.

The remaining £2 per head per registered patient from Scheme A was repackaged as **Scheme C (network development)** to support practices to work together on clinical commissioning. The CCG decided to fund the £2 per head with its contingency fund as they recognised the need to invest in general practice and primary care. However, networks and Federations would need to generate savings such as reduced unnecessary tests and referrals to continue receiving the funding. All member practices signed up to this scheme and work together as networks to support the development of GP Federations and build relationships between GPs and secondary care clinicians. Scheme C differs from Scheme A in two important aspects: (1) Scheme C is self-funding i.e. the networks will need to make cash-releasing savings to get funded for the scheme and (2) Payments are contingent on network level performance. This will motivate the individual practices to perform well due to peer pressure. The CCG committed funds from the primary care element of its non-recurrent budget for 2016/17, conditional on network plans to materialise the necessary savings. This scheme was aligned with the CCG’s strategic ambition for primary care and the wider health system as well as the Vanguard agreement.

**Scheme D (care planning)** was funded from review of PMS premium and additional funding from a Local Enhanced Services (LES). The majority of practices in Site 1 held PMS contracts and there was a significant amount of PMS premium funding to be redistributed in order to equalise funding with the GMS practices. Funding was available at approximately £8 per head of population and dependent on the practice’s weighted list size and the amount of the delegated budget. Therefore, if the registered patient population increases and/or there are changes to the delegated budget, the payment would be adjusted. Penalties may be levied in the case of underachievement. The scheme was built on the Primary Care Strategy and incentivised practices to implement the strategy. It consisted of a number of indicators covering four domains; quality of care, access, continuity and holistic care. The scheme provided payment for additional work over and above the core contract hence Commissioning for Quality and Innovations (CQUINs), i.e. payment framework to support improvements in quality of services and the creation of new and innovative care, were not applicable to the contract and it is exclusive of Quality and Outcomes Framework (QOF) and Directed Enhanced Services (DES). This scheme incentivised practices to; standardise access to general practice, ensure a consistent level of service provision across the CCG, the CCG’s 24/7 strategy, and quality improvement.

For all the three ‘new’ schemes (Schemes B, C, and D), a contractual mechanism was tied to these schemes where practices were required to sign either a one-year or a two-year ‘contract’. For Scheme D, the LMC was involved in negotiating the contract with the CCG on behalf of practices.

Similar to Scheme A in Site 1, **Site 3** used the funding suggested in *Everyone Counts: Planning for Patients 2014/15 – 2018/19* (NHS England, 2013c) to support GP practices transforming the care of patients aged 75 or older and reduce avoidable admissions (non-recurrent at £5 per head of population). CCGs were expected to provide additional funding to commission additional services which practices, either individually or collectively, have identified will further support improving the quality of care for older people. The plan should complement the initiatives funded through the
Better Care Fund (NHS England, 2013a). To sustain the delivery of the scheme, Site 3 decided to make this funding recurrent at £2.50 per head of population. The reason for reduction in funding was that the CCG viewed that participating practices had already implemented and embedded the schemes eliminating the need to fund implementation cost on an on-going basis. The funding was viewed as primary care’s money i.e. keeping the amount within primary care and the scheme was rebadged as a primary care development fund. Initiatives funded under this scheme include; home visits to the frail elderly, regular GP visits to nursing homes, and enabling mobile working by better use of IT.

In the third quarter of 2016, the £2.50 per head funding was tied to the achievement of dementia diagnosis rates. This was prompted by the CCG failing to achieve the National Dementia Diagnosis Target and the consequent risk of being placed under legal directions. The outcomes based framework means that practices can only access the £2.50 per head funds upon achievement of the diagnosis rate target. The diagnosis rate would be measured monthly and practices paid on a quarterly basis. Practices were not obliged to use the funds to support the delivery of improved diagnosis, but may do so. There remains an obligation on practices to use the funding for the benefit of the elderly and/or frail population if not used to improve dementia diagnosis. The framework did not affect the total funding available for primary care, but rather when individual practices are able to access the funding. Funds not accessed during the 2016/17 financial year could be carried forward to the following financial year and may be tied to an increased performance on dementia diagnosis rates. The remaining balance of £2.50 per head of population was retained in the primary care budget and used to support building community-based health and social care teams. This money was allocated to ‘sub-localities’ (based on geographical location) using the weighted capitation formula used to generate primary care budgets. The money was seen as an incentive to encourage groups of GP practices within the sub-localities to develop ‘cluster’ working and generate their own ideas for innovative and collaborative use of the funds such as clinical outcomes, sharing back office function, and providing 8 to 8 services.

The all-in-one scheme in Site 2 was funded by a combination of the delegated primary care budget, the released PMS premium, and additional investment by the CCG from surpluses in previous years generated as a result of improvement in the quality of the contracts with secondary and voluntary sector providers with activity level data rather than block contracts. The CCG has consolidated these funding into a single funding used to support primary care. The contract for the scheme was mutually dependent upon the ‘core’ contract i.e. only a provider under either the GMS, PMS or APMS contracts would be eligible to provide services required under the scheme. The scheme was used to cover services that were beyond the ‘core’ contract. Practices who meet the standards can potentially receive an additional £10 per head. During the first two years of the contract delivery, majority of the additional payment was for delivery of the contract including signing up to the contract, implementation of all the delivery requirements of the standards, enabling the CCG to access data to monitor the contract, and longer GP practice opening hours. The remaining payment was for delivery of outcomes or outputs. Payments were made in instalments during the year with the last payment being a reconciliation based on delivery of the standards. However the financial balancing payment was subject to delivery of ALL standards and the CCG reserves the right to claw back to all areas not delivered. After the first two years, it was planned that payment would increase to £16 per head as a result of an expansion of the access standard to cover 8-to-8 working. Although at the time of fieldwork there was still an ongoing debate of whether the £6 increase was actually additional money for practices as funding through Directed Enhanced Services (DES) and 7-day access would be changing.

Challenges in developing and implementing the scheme

The development and implementation of the scheme was not without challenges. In all sites, it took some time for practices to familiarise themselves with the content and implementation of the
contract. For example, in Site 2, the initial version of the scheme was seen by GPs as very ambitious and concerns were raised about the feasibility of the contract, given current challenges in primary care. There were also anxieties that some of the suggested indicators were not always amenable to actions on the part of GPs, as one of our respondents describes it:

Some of the concerns were about...say for example it asked you to reduce A&E attendances for example...but where I think the difficulty was is that it wasn’t always in a GP’s control to do all of these things and would it be fair to suffer financially as a result of that? [GP ID16]

Following an intervention and a review by various stakeholders including the Primary Care Co-Commissioning Committee, the CCG Governing Body, the Local Medical Council, GP Directors and groups of practices, the scheme was simplified and the number of standards was reduced to include only those that was under GPs’ control. Another change was to the wording, from Key Performance Indicators (KPIs) to ‘outcomes’ and ‘outputs’ to make it more palatable to GP members.

In addition to content, there was a concern around the accuracy of the funding attached to the indicators/outcomes/outputs. Early feedback on the scheme introduced in Site 2 indicated that the funding attached to the indicators was not accurate. This resulted in a reallocation, but not a decrease in the funding even though the standards had been reduced. It was also agreed that there would be funding for an additional cost neutral standard, but it has proved difficult to find a standard that would deliver efficiency savings.

Early in the implementation of the scheme, there was a feeling among member practices that the CCG was imposing the scheme on them and despite engagement exercises the new initiative was met with a mixed response. For example, in Site 2, smaller practices criticised the framework for being easier for larger practices to implement due to their larger workforce and resources and that these practices would be receiving money for doing many of the things they already do. CCG staff felt that although practices had signed up to the scheme, some were not working sufficiently to deliver it. This posed a problem for the CCG who had a responsibility to ensure that practices are doing what they signed up.

There were also problems with developing appropriate IT systems to extract the relevant data from practices to monitor them. In Site 2, a company was contracted to install a bespoke software system in practices to monitor outcomes. The installation of the system was rushed and consequently failed to work properly and capture the relevant information, instead slowing down IT systems in practices. This caused difficulties for practices who could not demonstrate they were delivering the outcomes to receive payment. As an alternative, the CCG commissioned the Commissioning Support Unit (CSU) to develop templates that practices could fill in and enter into the CCG’s clinical systems. However, this created additional work for practices that they explicitly said they wanted to avoid.

Lastly, on the levelling of PMS funding to GMS, especially in Site 1 where many practices were PMS practices, the handful of GMS practices had to get used to providing an enhanced level of service that was familiar to PMS practices. The domains were measured in different ways and while some of the domains and indicators lend themselves to clinical system searches, others such as the quality and access measures are more difficult to quantify and measure and require more detailed monitoring. However, the CCG wanted to avoid a large system that would be burdensome for both the CCG and member practices. The CCG also needed to ensure that practices were not funded for something that was paid elsewhere and to ensure that it provided value for money from the redistributed PMS funding while also helping the CCG to achieve its strategic aims and objectives. In Site 2, some PMS practices which had reverted to GMS felt they were entitled to the money without demonstrating what they had done to achieve it.
Outcomes claimed

Outcomes claimed from the scheme was minimal. For example, Site 3 claimed that their scheme led to reduction in hospital admissions, particularly in the over-75 age group, however this was based on a report from one practice:

So, one of the schemes was to enable protected GP time to go into nursing homes. So, one GP has, you know, very pleased to send me an end of year report including a really good testimony from the nursing homes that they went into to say what a difference it had made. The staff felt more confident in dealing with the patients rather than phoning nine, nine, nine, or, you know. And, you know, the practice also had worked out that they had less, far less, ambulance call outs to those nursing homes as well. [Manager ID35]

The CCG felt that more evidence was necessary to inform the decision to continue funding the schemes albeit at a reduced level. Evidence and monitoring of the schemes would also serve to quell doubts raised by a GP member of the PCCC that the positive impacts in terms of reduced admissions and referrals could be sustained with the reduced funding. The evidence shortage was seen as a problem affecting primary care more widely, compared to other parts of the health care system and not necessarily unique to this CCG.

In Site 1, the CCG claimed that Scheme A led to A&E attendances not rising as quickly as elsewhere, although they did not find reduction in A&E attendances. This was viewed as a successful outcome for this scheme. The scheme also facilitated additional capacity in primary care by employing extra staff on fixed-term contracts. This contributed to a slower increase in admissions to secondary care, particularly to A&E. The CCG also claimed that Scheme B enabled the continuation of this increased capacity in primary care, with more of a focus on the skill-mix of staff.

Table 11 (below) summarises the initiatives from the three of our sites which had set these up. Site 4 were in the process of developing a similar initiative, but it is not yet fully developed.
Table 11: ‘New’ primary care initiatives

<table>
<thead>
<tr>
<th>Purpose of funding</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>To explore the possibility of streamlining these schemes (covering non-core GP funding) into a unified contract.</td>
<td>To replace all local individual incentive schemes with an all-in-one scheme.</td>
<td>To support GP practices transforming the care of patients aged 75 or older and reduce avoidable admissions.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount of funding</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The first two years non-recurrent at £5 per head of population then recurrent at £3 per head of geographical population to provide additional access and the remaining £2 per head of registered population to support network development.</td>
<td>The first two years at £10 per head of population with a plan to increase to £16 per head as a result of an expansion of the access standard to cover 8-to-8 working.</td>
<td>The first two years non-recurrent at £5 per head of population then recurrent at £2.50 per head to continue the scheme but payment tied to dementia diagnosis rate and the remaining £2.50 per head to support ‘cluster’ working.</td>
<td></td>
</tr>
<tr>
<td>• Approx £8 per head of population and dependent on the practice’s weighted list size and the amount of the delegated budget.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source of funding</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegated primary care budget, released PMS premium, Local Enhanced Services (LES), and the CCG contingency fund.</td>
<td>Delegated primary care budget, released PMS premium, and additional investment by the CCG drawing on other budgets and the reserve.</td>
<td>CCG funding.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Areas incentivised</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Additional patient access (including same day access and extended access)</td>
<td>• Primary care provision</td>
<td>• Home visits to the frail elderly</td>
<td></td>
</tr>
<tr>
<td>• Network development (patient care, effective clinical commissioning, cost effectiveness)</td>
<td>• Access to multidisciplinary team</td>
<td>• Regular GP visits to nursing homes</td>
<td></td>
</tr>
<tr>
<td>• Care planning (quality of care, access, continuity of care, and holistic care).</td>
<td>• Demand management for planned and unplanned care</td>
<td>• Mobile working by better use of IT</td>
<td></td>
</tr>
<tr>
<td>• Medicines management (using indicators based on quality and/or cost to deliver the Quality, Innovation, Productivity and Prevention (QIPP)).</td>
<td>• Prescribing</td>
<td>• Medicines management (risk/harm reduction, medicines cost reduction and reduction in GP workload).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Exception writing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Workforce development</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Self-care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes claimed</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E attendances not rising as quickly as elsewhere</td>
<td>The scheme was in development at the time of data collection.</td>
<td>Reduction in hospital admissions for patients aged 75 or older.</td>
<td></td>
</tr>
<tr>
<td>Increased capacity in primary care with more skill-mix.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.4.2.3 Local Quality and Outcomes Framework (QOF) and Directed Enhanced Services (DES)

All of our case study CCGs continued with the national Quality and Outcomes Framework (QOF) and have not made changes to it, partly because the membership had no desire for this. In Site 1, the CCG was awaiting the publication of the contract for the new models of care before contemplating any changes to QOF. One interviewee highlighted that an advantage of the national QOF is that it produces a rich national data source in terms of registers and it would be detrimental to lose that:

   The other advantage of QOF too is there’s a good information infrastructure behind it and so if you want to know how many diabetics there are in the country you can add up all the QOF registers at the practices, which is all available; so it gives you quite a rich data source as well, so I wouldn’t want to lose that. [Independent GP ID9]

It was recognised that developing a local QOF would not be an easy process, a view that was informed by the experience of developing a local incentive contract. There was an acknowledgement that a local QOF works better than the national QOF for practices with distinctive populations such as a University practice or a practice serving vulnerable populations. In one site, a local QOF was implemented for a practice serving a University population before the CCG took on co-commissioning. Subsequently, the CCG worked with the practice to redesign the local QOF to make the indicators and targets more meaningful. The local QOF differs from the national QOF in that it is not possible to exception code patients. The practice agreed the payment linked to the indicators with the PCT or NHSE prior to the CCG taking on commissioning of primary care. The monetary value of the indicators has remained static for a number of years, although the list size has increased and this is under consideration by the CCG. Going forward, the PCCC will decide whether or not to continue this local QOF scheme and if so, what the content and indicators will be. There was complementarity between local incentive schemes developed under co-commissioning and QOF and DES.

Since taking on co-commissioning, our case study sites have reviewed enhanced services or were planning to do so. In Site 1, Directed Enhanced Services (DES) and Local Enhanced Services (LES) were examined in conjunction with the PMS Review with a view to encompassing non-core services into core services to circumvent additional payments. This site also planned to make changes to the extended hours DES as part of a wider strategy on access but planned to do this in conjunction with NHSE. Site 2 requested the NHSE Regional Team to manage DESs for 2016/17.

3.4.2.4 Personal Medical Services (PMS) and Alternative Providers of Medical Services (APMS)

The PMS Review was an area of work undertaken in all of our case study sites. The number of affected practices varied by site from over 30 practices in Site 1 to only two practices in Site 3. Practices were given a choice of reverting to a GMS contract or providing additional enhanced services under a new PMS contract.

In Site 1, majority were PMS practices and retained this contract following the PMS review. On the other hand, in Site 2, majority of PMS practices reverted to GMS following the review. In Site 3, one practice transferred to GMS, while the other signed a new PMS contract and retained funding for the provision of additional services. Site 4 has an almost equal number of GMS and PMS practices.

CCGs were obliged to retain any monies released from the PMS Premium Review in their primary care budgets. It was recognised that PMS practices would lose income for e.g. in one of our case study CCGs, the PMS review led to one practice faced losing almost half its income and brought a
legal challenge against NHSE. However, it was thought that this risk would be balanced out with the reinvestment of funds into other primary care initiatives, such as the ‘new’ incentive schemes described in Section 3.4.2.2. However how the monies were redistributed was a source of contention in Site 4. Due to the late start and reduced take-up by practices of the scheme introduced in Site 4 following the PMS review, there was an underspend of the budget. A discussion during a Governing Body meeting about how to use this underspend revealed some resentment on the part of GP members that the money would be used to reduce an overspend in acute care in order to balance the overall CCG budget. The issue of underspend has prompted discussions about the content and design of the schemes in order to ensure that the requirements for practices were attainable.

In Sites 1 and 4, transitional funding had been arranged for former PMS practices at risk of becoming financially unviable due to the withdrawal of funds. In Site 4, the PMS Premium disadvantaged three practices with young and deprived patient populations that the Carr-Hill allocation formula did not adequately account for. The PCCC agreed that some of the funds released from the PMS Premium Review would be ring-fenced to provide additional funding for these three practices. The practices do not have to offer additional services in order to receive this money; rather it is about maintaining their viability, as other practices are unable to take on additional services in the case of practice failure. There are plans to reduce the PMS funding of these practices over a longer period in order to ensure equitable funding across practices. This has affected the funding available for the other practices to receive through the access schemes. At the time of writing, the CCG was reviewing practices to see if more than the three aforementioned could potentially become unstable because of income reduction due to the PMS Review. The PCCC was also considering whether to make funding for the vulnerable practices recurrent. This may entail service transformation and new models of working in order to increase resilience.

In Site 1, a transition funding was established by ring-fencing money that was top-sliced from the redistributed PMS Premium in order to offer practices targeted support for the implementation of a new incentive scheme. Practices who signed up to this scheme will receive an additional funding to enable them to devote their time to implement the scheme. Some fund was also set aside to provide additional support for struggling practices. Practices were monitored during the year for progress towards achieving the milestones.

APMS contracts did not feature prominently in our case study sites. In Site 4, an APMS contract was going out to tender while in Site 1, an APMS contract expired but was not renewed due to quality concerns. In Site 2, members of the PCCC expressed some concern when only two APMS practices were approached to deliver an enhanced service to provide urgent primary medical services cover.

### 3.4.2.5 Estates and Technology

In December 2014, NHSE announced a £1 billion four-year investment programme to support primary care infrastructure. The aim of the programme was to improve access and the range of services in primary care (including premises, technology, workforce, and working ‘at scale’) through what was called the *Primary Care Infrastructure Fund* (NHS England, 2015b). This is part of the additional funding to support the FYFV. In January 2015, GPs were invited to submit bids for the investment. Bids for investment need to demonstrate that (1) it improves access to general practice (including increased appointment and patient contact time) and/or (2) it reduces emergency attendances or admissions to hospitals by those over 75. Most of the bids submitted have focused on extending GP premises.

To send a clear signal that the bids are designed to improve services for patients, NHSE set out a new arrangement for this fund for 2016/17 onwards and called it the *Primary Care Transformation Fund* (NHS England, 2015e). Rather than individual GPs submitting the bid directly to NHSE, it was subjected to an initial bidding process by the CCG. CCG recommendations should reflect the local
estates strategies and demonstrate engagement across the local health economy. This will include not only premises development but also digital and technological developments. It needs meet one or more of the following criteria; (1) increased capacity for primary care services out of hospital, (2) commitment to a wider range of services to reduce unplanned admissions to hospital, (3) improving seven-day access to effective care, and/or (4) increased training capacity. Guidance for submission of the recommendations for funding was planned to be published in December 2015 and proposal to be submitted in February 2016. However, the guidance was not published until May 2016 and was renamed Estates and Technology Fund (NHS England, 2016b) following the publication of General Practice Forward View in April 2016 (NHS England, 2016c). The guidance emphasised that CCGs’ prioritisation need to take into account the STP developments (NHS England, 2016g), Local Estates Strategies (Department of Health, 2015a), and Local Digital Road Maps (NHS England, 2016h).

There were four stages of the process. CCGs were required to prioritise recommendations (June 2016) by assigning a ranking, to assist NHSE identifying those projects that were identified as most important. NHSE carried out an initial review (August 2016) against a set of criteria for programme funding. For recommendations that move to the due diligence stage, CCGs were to work with GP practices to provide detailed information in preparation for business cases to be considered. However the degree of detail varied according to the type and scale of scheme recommended.

Decisions around funding of the scheme will be based on the development of formal documentation covering all aspects of the scheme, which will be used to draft a grant agreement.

All proposals were assessed against four core criteria (NHS England, 2016b):

1. enabling extended access to effective care (for e.g. premises that facilitates access to out-of-hour services or IT projects that facilitate remote consultations),
2. increased capacity of clinical services out of hospital,
3. increased training capacity (investment in infrastructure that support expansion of training for doctors, community nurses and other primary care staff), and
4. enabling access to wider services as set out in commissioning intentions to reduce unplanned admissions to hospital (for e.g. premises developments which allow co-location of a wider range of services or IT projects which allow general practice to deliver service via electronic systems).

In addition to core criteria, there were separate additional criteria for an estates scheme (such as patient involvement and engagement, deliverability of the project and consistency with Local Estates Strategy) and a technology scheme (such as alignment with the Local Digital Roadmap and consideration of Information Governance).

The development of primary care estates is closely linked to the wider health economy. The Department of Health has produced a framework for commissioners to produce their local estates strategy through the Local Estates Forum (LEF) (Department of Health, 2015a), although the name might differ in some areas as there may be already such structure in place such as Estates Strategy Groups or Estates work streams. Advice is also available from NHS Property Services and Community Health Partnerships to guide and co-ordinate development of the strategies. The framework identified a ‘holistic’ approach to estates planning, where it includes primary and community care estate, non-clinical estate such as office/administrative bases, engagement with secondary and tertiary care estate, and engagement with wider public sector estate. The LEF ensures that all estates strategies are aligned. The strategy needs to include the current context (existing estates), vision (estates needed), gap analysis (comparing existing with future estates), options identification, clear delivery plans, and a timetable.

Funding available was initially for 60% but revisions are currently being negotiated to set the criteria upon which 100% grant can be made. The funding is divided into three cohorts; (1) to be delivered by 31st March 2017, (2) to be delivered by 31st March 2019, (3) unlikely to be delivered within the life
of the scheme. Initial review was done by the NHSE regional team. The national team provided ‘oversight’ of the process.

As our observations were carried out at an early stage of the delegation, the majority of what we observed on ETTF process was around the prioritisation process.

**Prioritisation process**

For this stage of the process, NHSE has provided CCGs with assessment/prioritisation tools which can be tailored locally where weightings can be applied to local CCG priorities. In all but one of our case study sites (Site 1), the prioritisation was done by the PCCC. Site 1 decided to delegate the responsibility to prioritise the bid to a sub-group. This was due to short timescale, which made it difficult to get every member of the PCCC to be involved in the process.

**One of the main considerations that CCGs in our case study sites focused on in their prioritisation process is ‘strategy’.** However, the question is whose strategy should they prioritise? There were references to the CCG’s wider strategy, the local estates strategy, the strategy of the wider health economy, the individual GP practice’s strategy, or what the population want. The following describes how CCGs in our case study sites attempted to deliberate over these various and often conflicting ‘strategies’.

All CCGs conducted a Six-Facet Survey done by NHS Property Services. The estate was appraised in terms of its physical condition, functional suitability, space utilisation, quality, statutory compliance such as health and safety, and environmental management. The survey rated the premises in terms of those who needs most assistance the most i.e. in terms of the condition of the building (for e.g. having a steep hill and no good access):

> Well, we’re quite lucky in a way that we don’t have many practices that are in terrible condition, but we do have some that we know are on a finite timeline to when they wouldn’t be adequate. Within [name of a local area], for instance, we’ve got a practice just round the corner here that is on a steep hill, no good access. [Manager ID32]

One practice was struggling with practice management, administration, and GPs whilst another was barely coping with demand. The CCG was encouraging them to look at ways to share resources and get together to explore various opportunities. Our case study CCGs described the need to create a balance between identifying those who are struggling with compliance and articulating a wider strategy. This wider strategy included, for example, building ‘hubs’ (with adult social care, public health, and other health and social care services) for struggling practices to share premises and functions.

For Site 3, the deliberation was around the need to help struggling practices and taking a wider view in terms of what they need as a CCG. The CCG was considering whether they should have a strategic vision or be reactive to practices’ needs. Having a strategic vision would allow the CCG to divert funds elsewhere rather than prop up a struggling practice when patients may be better off accessing services elsewhere.

The need to take a *strategic view*, in the sense of looking at the CCG’s strategy, the wider health economy and limited financial resources, was the argument that CCGs in our case study sites often mention:

> One of the things we did debate quite long and hard, I’m not sure if that was a PCCC but it was about taking a *strategic view*, of what premises we do need. Because, the thing that brought it home to me was, you’ve got [name of a GP practice], in our area. It’s a smallish practice, quite a defined little small locality, but there’s no obvious premises there. Now, strategically, how much is going to cost the NHS, to continue to have a surgery there, develop one, or whatever. Would it be better to actually grasp the nettle, and say actually,
we’re not going to have one there, and actually, those patients will have to gravitate that one, you know, North, South, East and West. Now, yes, I would be up in arms if it was my community and I’m going to have to travel ten miles to the GP. I accept all that, [...] but we have to make some strategic decisions. Money is limited, and the longer you stick with sticking plasters, actually you’re just pouring money down the drain. It needs to take strategic views, same as they do with hospitals. [Manager ID31]

However, the CCG’s strategic view, which is generally about bringing GP practices together, did not always align with the strategy of an individual GP practice, which is about making their practices fit for purpose:

CCG Chair: I’d like to have been more prescriptive in the strategy, but it is not my strategy or the CCGs, it is the member practices strategy. I think we only need about 10 practices and that all branch practices should be removed. If we said that it wouldn’t go down well. [There was laughter in the room.]
CCG Accountable Officer: I think we are downplaying ourselves here. We are thinking about bringing practices together and that will take time.
Practice Development Manager: This issue and the risk is that we might not get the transformation fund. [Primary Care Strategy Group meeting August 2016, M49, emphasis added]

Because at the moment, if...as I referred to under the GMS contract obligation, our strategic role is trying to steer the development into the right places. But as much as we try and steer that, we are reliant to a large extent, on GMS contractors stating to us that they want to do something, that they want to build something. And that often reflects the desires and the financial benefits to an individual practice, rather than the benefit to the whole service. [Manager ID21]

A lot of my practices as well are single-handers in quite tired old premises. A lot of them are converted houses, so there’s a lot of work that we’ve been trying to do with them around estates. [...] You know, there’s four of you that are all single handers within the same area and it makes sense for you to become in one building with the council support around you, and you’ll have a nice shiny build, but it has to be led through them, through the GMS contract. So it’s trying to lead them towards...I mean, you know, we can’t force anything on them, we would never want to, but it’s trying to get them into the mind-set. [Manager ID24]

Practical issues such as availability of land in the local area for new build could also affect GPs’ decision to put forward for the fund:

I think that the ownership of surgeries that need to be getting bigger and bigger isn’t necessarily something that GPs want to be involved with. There’s desperate need for investment and I know that there’s estates and transformation...estates and technology transformation fund. I don’t think that is going to go anywhere near addressing the problems that we’ve got. And it’s a very ongoing situation, we’ve got two practices that really need new premises that aren’t in a position to be able to be put forward for that transformation fund because they haven’t got land, they haven’t got anywhere they can build, but they are the two that really need something. [Manager ID37].

Patient choice was another major drive in CCGs’ prioritisation. There was a need to balance between the need of patients in a few practices against the entire population of the CCG. However, what the local population want i.e. access to their GP in their local area, supported by impact assessment, may not align with both the CCG’s strategy and the strategy of an individual GP practice:

We’ve had one public-facing meeting where we had a full house, so we had 70-plus patients. [...] And what was astonishing last week, and not to be underestimated - and I have come across this before from a community development background - is that there is really a
sense of community in [name of a local area]. You know, to the point where they will put up with leaky roofs and substantive facilities. As long as they can have access to their GP in that location, at a time hopefully that’s suitable to them, they don’t mind, you know, a smelly floor, as they put it. In fact, one guy said, [...] this new facility, it’s going to have so much more [...] Wi-Fi and a prayer room. And one guy said, do you know what, we don’t want Wi-Fi and a prayer room, you know, we’re quite happy to sit in the waiting room waiting to see you, doctor; we know it’s not the best of places but actually it’s ours. Yeah, so as shabby as it is, what they were saying was, hands off, it’s ours. [...] And they were even offering to come in and help the GP turn it around and, [...] fix the leaky roof and get onto [name of a local council]. [...] And I think the GP was a little bit overwhelmed with that. [...] All he wanted to do was provide them with a new shiny building. And they were saying, half a mile’s too far. [...] And actually, the impact assessment on that [...] there’s no community bus that runs through the estate, they would have to go out and back in, effectively. So if you have got [...] a long term condition or you’re elderly, or [...] you have mobility difficulties, people would find it a real struggle to get there. [Manager ID22]

In addition to ‘strategy’, the ‘transformational’ aspect of the project was often highlighted. However, there were no clearly identifiable criteria by which this was defined. In one of the meetings we observed (Site 3), the CCG was describing a ‘transformational’ bid in terms of building a ‘hub’ for a dilapidated practice:

[Primary care contract manager] had an item on the Estates and Technology Transformation Fund (ETTF).

[...] Locality representative1: are IM&T [Information Management and Technology] in the order that we agreed? We could select one property to go as number one.

LMC representative: we should weigh the impacts by population.

Locality representative1: I suggest [Practice A] as number one as the site has been identified and put IM&T after that. We need to fundamentally change estate. We can’t put IT in dilapidated properties that we’ll move out of in future.

[...] Chief Finance Officer: we’re prioritising IT against a multi-million pound development. That’s not right. The CCG can look after IT but can’t help [Practice A] anyway for revenue.

Locality representative2: it’s the first time there is decent money for estates; we don’t want to invest in IT.

Quality Manager: we need to get [Practice A] sorted. There’s no point putting IT into dilapidated buildings.

[...] Locality representative1: of course they’re going to play games and make an investment in a fancy building with ribbon cutting. With [Practice A], the land has been identified [...] this would be transformational for [Practice A].

Chief Finance Officer: imagine the conversation with [Practice A] – you’ve got a messaging service! [Primary Care Commissioning Committee meeting June 2016, M40]

The above example also shows that there was a question of transformational for whom? In the case of Site 3 in the above example, the transformation was seen as beneficial for the practice or the local area rather than the CCG or the wider health economy.

In another meeting in Site 4, we observed a comment about what is not ‘transformational’:

CCG Chair: So we have passed the first check point. Are we aware of any that didn’t go through? There is the one in [neighbouring CCG] but that isn’t transformational (there was a
joke about painting lines in the car park). [Primary Care Strategy Group meeting October 2016, M52]

**Financial implications** were another area of consideration. In other words, can the CCG afford financially to support the project? This is because GP practices are entitled to support to pay for ongoing rent costs associated with their buildings. The following excerpt illustrates the financial risk associated with supporting the ETTF bid:

Deputy Chief Finance Officer: Collectively, as an organisation, this is about prioritisation around trying to find, as an organisation we got to be able to manage the financial increase - obviously if they are coming one by one and you approve them [...] It's not an issue, but if we have 10 we will have a problem.

Lay Member: What is in the pipeline? Do we know?
Head of Estates: We do. There is [an estate group] review that tracks the projects, uplifters, so there's a rough idea. It indicates the numbers and is fed to finance.

Lay Member: What are we ok to cover?
Deputy Chief Finance Officer: Overall for the organisation, if we agree it will have significant impact on the financial position as these are for 5-10 years...

[Unidentified]: We are going through a process of looking at all the CCG - what development we think is necessary, how well utilised and suitable the premises are and developing a strategy. We are half way through this process and we will report to committee, but we have to evaluate using criteria - like here - and we can't stop the world. [Primary Care Commissioning Committee meeting October 2016, M28]

**Deliverability** of the project also determined the prioritisation. In Site 3, the CCG had identified three projects that fit their strategic priorities. However, to ensure that they did not lose the funding, they decided to propose another three alternative projects that are more likely to get funded i.e. those can be completed by the end of March 2017.

**Estates expertise**

CCGs in our case studies claimed that estates were an area that was very challenging for them. The benefit of having an expert in this area is something that was highlighted by CCGs in our case studies, although lack of resources limited their ability to do this. The lack of estates expertise within CCGs means that they have to assign different people to work together and are learning as they go along:

So they might be able to get the big capital pay out from the ETTF, but equally we would be responsible for any recurrent revenue consequence that comes as a result of a new build. So have we got that in the delegated budget, is there scope there? So it is all of those things now that we’re thinking about in terms of estates. And not having an expert on the ground to do it. [...] so we’re just really trying to work together to make sure we’ve covered all the essentials. But none of us are experts in it, so you’re trying to learn it as you go along.

[Manager ID10]

The lack of estates expertise has caused Site 1 to have an ongoing dispute with NHS Property Services about who is responsible for empty and unused property. The CCG has been receiving bills for an unused property but the Chief Finance Officer has been refusing to pay the bills and has sent the invoice back to NHS Property Services. The following extract from a primary care strategy group meeting describes this issue:

Primary Care Programme Manager said that they need to do a Quality Impact Assessment for this practice. As the Walk-in Centre (WIC) is co-located with registered list, patients will get confused about which practice is closing down. [...] The lease for the premise is until 2022 and they are only halfway through.
Someone asked whether this is the CCG’s risk?
Primary care contract manager said that following her conversation with Chief Finance Officer (CFO), CFO said that the risk is property services. The Manager added that every time they received an invoice, the CFO void the invoice and send it back to the property services and refused to pay it.
Primary Care Programme Manager added that they are still arguing about whose risk this is.  
[Primary Care Strategy Group meeting June 2016, M9]

The benefit of having an estates expertise is echoed in another CCG. Site 3 was considering having a joint team with a neighbouring CCG, which would extend their influence not only on estates but also legal and workforce issues. The CCG viewed these as areas in which specific skills are required. These skills were said to be scarce and it would be more strategic and cost effective to have shared service functions for those specialist skills.

Only one of our case study sites (Site 2) had the resources to employ a head of estates. This specialist argued that having someone like him/her would help the CCG make efficiency gains, for example, by exploring the possibilities of moving the CCG headquarter to somewhere cheaper or by defending the CCG from paying for shortfalls as a consequence of a contract signed by the previous commissioning organisation (the Primary Care Trust):

I talk about the CCG not holding any estate. All CCGs have the responsibility for their own HQ [headquarter] estate, okay. They do hold that. They do hold the lease, and it’s a bit of the job. And the reason I don’t refer to it, is it’s a bit of the job that does need some professional...and that’s not coming from Property Services, where I think the original structure was. Property Services would be the guidance to do that. And that’s not occurring, because again, this financial incentive to do anything. We as a CCG here, have a lease expiry on this building in 2019. Property Services’ view would be, because it’s beneficial to them, to renew the lease and stay here. Actually, when I come at it, I say, no, actually, we’re going to look, we’re going to do a true options appraisal of what our options are. And those options must include going away from Property Services. In fact, some of those options include working with [Local Authority], because they’ve got vacant, void estate that is suitable and much cheaper than this probably. […] But there’s no incentive in the structure of the system for Property Services to drive us out of the building where they have an interest. […] So they don’t do it. So CCGs who don’t have some expertise, some independent expertise, and you certainly wouldn’t need a full time person to run your HQ estate. But somebody shared amongst a group of CCGs, doing that would be beneficial, just in their HQ element.[…] I worry when they start bringing in consultants to do estates strategies, because they just don’t, they have no ownership of it, they don’t understand. They’re just ticking the box on a document that nobody ever opens. They’ve no ownership of it, rather than it being a live document. So it does concern me when they do that sort of approach, yes. […] They [NHS Property Services] just knock on the door of the CCG. We’ve got a shortfall of money. […] I’m in a position now to start to defend the CCG on those. But other parts of the country, where they haven’t got any estates expertise, they’re just going to be paying the bills. [Manager ID21]

Experience of the process

CCGs in our study welcomed the desperately needed investment in premises. Moreover, the fact that CCGs have a greater input into the process is seen as a positive development compared to the previous iteration of the scheme. However, having separate prioritisation processes for estates and technology have caused some confusion around which bids CCGs should prioritise. The following excerpt from Site 3 illustrates the difficulty that members of the PCCC encountered when deciding whether they should prioritise funding a dilapidated property or investing in technology:
Primary care contract manager had an item on the Estates and Technology Transformation Fund (ETTF).

Primary care contract manager: the Committee agreed the shortlist in April for premises and IT.

Locality representative: must combine now?

Primary care contract manager: shortlist must include both estate and IT as one list. We recommend the IT bids 1, 2, & 3 as they will have an impact across all practices.

Locality lead: so practices looking for premises are pushed down the list?

Locality representative: are IM&T [Information Management and Technology] in the order that we agreed? We could select one property to go as number one.

LMC representative: we should weigh the impacts by population.

Locality representative: I suggest [name of a local practice] as number one as the site has been identified and put IM&T after that. We need to fundamentally change estate. We can’t put IT in dilapidated properties that we’ll move out of in future.

Chair of Primary Care Commissioning Committee asked for clarity about fund.

LMC representative: we need to prioritise. We can submit all bids. Then there’s mysterious decisions taken by NHSE as to what is funded and prioritised.

Chief Finance Officer: we’re prioritising IT against a multi-million pound development. That’s not right. The CCG can look after IT but can’t help [name of a local practice].

Primary care contract manager: we have to help [Practice A] anyway for revenue.

Locality lead: it’s the first time there is decent money for estates; we don’t want to invest it in IT.

Quality Manager: we need to get [Practice A] sorted. There’s no point putting IT into dilapidated buildings.

[...] Locality representative: of course they’re going to play games and make an investment in a fancy building with ribbon cutting. With [Practice A], the land has been identified, then 2 should be [Practice B] and 3, IT.

Chair of Primary Care Commissioning Committee: seems like an odd way of doing things.

Chief Finance Officer: the Fund will be oversubscribed.

Head of Contract: worth going for a bigger scheme.

Locality representative: this would be transformational for [Practice A].

Chief Finance Officer: imagine the conversation with [Practice A] – you’ve got a messaging service!

Chair of Primary Care Commissioning Committee: who decides what?

Chief Finance Officer: We do.

Locality representative: [Practice A], IM&T, three red ones and first three IM&T.

Chair of Primary Care Commissioning Committee: Happy?

[Everyone agreed] [Primary Care Commissioning Committee meeting June 2016, M40]

Delay in the publication of the guidance has led some to feel that the fund has been overpromised:

Felt that this has been overpromised. Initially about estates then transformation and now panic in general practice. [Independent GP ID9 comment at Primary Care Strategy Group meeting February 2016, M2]

And it has caused frustration with the process for others:

I think another significant disappointment on ETTF, was that some of our priority projects are major infrastructure rebuilds or new builds, where we still weren’t clear whether we get 100per cent funding, 66per cent funding. So some of our higher priority bids are projects that are on the...that are in process, in the approval process. [...] It’s not clear from NHS England still, as to what percentage those could be supported. Now it’s suggested that something up to 40per cent, but the Premises Directions need a rewrite and alteration for us.
to be able to do that. And we’re now told that the Premises Directions are not going to be republished until January. And on past experience, I can see January becoming February or even March. So I can see that rolling into next year and cohort two, planning those projects, if the Premises Directions are not defined at Christmas, it impacts large projects and the progress of large projects through next year, next financial year. Because it just seems a no sense approach. Nobody’s realises the lead-in times to developing projects. [Manager ID21]

Similarly, the lack of clarity in what is expected of CCGs in NHSE’s initial review process has caused anxiety:

Primary care contract manager: OK, this is just a quick verbal update. The submissions went in on 30th June. There were seven Estates projects and three IT. These were all prioritised at the PCCC [Primary Care Commissioning Committee meeting]. [Summary of the bids] We have a meeting with NHSE to discuss the bids. However, we’re lacking information to inform the panel’s decision. [...] only estates bids will be discussed as the IT bids don’t count. The LMC will be in attendance and NHS Property Services.

[...]
LMC representative: There should be a clear terms of reference for CCGs. It’s unclear what to say in the presentation.
Chief Finance Officer: what are the outputs of the meeting?
LMC representative: it’s not clear and it’s causing anxiety.
NHSE interim Contract Manager: the purpose is for NHSE to listen to the bid and ask questions.
LMC representative: it would be helpful to know the purpose of the first round. [Primary Care Operational Group meeting July 2016, M41]

The change in funding allocation, where projects are more likely to get funded if they can be completed within the current financial year (by March 2017), means that CCGs would need to set their preferred projects aside as these tended to be long-term projects:

ETTF is an extremely frustrating process. One of the major problems that we have, is major infrastructure bids, be them technology or construction, have a significant difficulty in being able to compartmentalise projects into financial years. Just by the nature of projects, they need to run over a number of years. One of the changes that we thought from Primary Care Infrastructure Fund [PCIF] to ETTF, was that it will be a remaining three year fund. And in recent days, only last week, we then heard that again, it’s been allocated into years. There’s now a question of how many projects can be done between now and the end of March next year. And projects that are higher priority, tend to be the higher value, greater project, more significant projects, that just do not fit into that, can we just now suddenly do them between now and next March? So we seem to be back to exactly where we were with PCIF and the reason PCIF didn’t spend and underspent, was because a lot of projects were ruled out, because they couldn’t complete within the financial year. So we’re just absolutely back to square one, where we were. [...] So I think that is a frustration that we’re back to this categorisation of year by year. So that doesn’t work great. [Manager ID21]

Overall, our case study CCGs welcomed the much needed investment in primary care estates. However, delay in the publication of guidance and changes in the processes, along with short timescale, has created challenges for CCGs. The fact that CCGs have a greater input into the process is seen as a positive development compared to the previous iteration of the scheme. However, having separate prioritisation processes for estates and technology, although they are part of the same fund, have caused CCGs to prioritise schemes more likely to be funded which have generally been short term rather than long term investments. In prioritising the bids, CCGs take into account the various ‘strategies’ (CCG’s, individual GP practice’s, population, and the wider health economy),
financial implication (CCGs would be responsible for any recurrent revenue consequences of the fund), and deliverability of the projects.

**Summary: the practice of co-commissioning**

- The CCGs in our survey and case study sites have focused upon three main areas:
  - The introduction of new practice incentive schemes
  - Rationalisation of PMS/APMS contracts
  - Investment of additional funding in estates and technology
- Strategic plans for investment have been developed through stakeholder engagement, particularly practices, but also, in some cases, patients/the public
- Many plans focus upon incentivising and supporting practices to work together and provide a broader range of services. There is a clear focus on ensuring the sustainability of general practice. This includes a focus on the development of a broader range of skill mix and improving access, as well as improving the quality and consistency of services. There has been little appetite for local QOF schemes
- Investment to support these plans comes from a number of sources, including:
  - The existing primary care budget, with the reinvestment of funds previously used to support PMS contracts
  - Consolidation of existing Directed and Local Enhanced Services
  - The wider CCG budget – although this has been limited by budgetary pressures, with some CCGs forced to use primary care funds to support secondary care budgets
  - Other funding streams, such as the Estates and Technology Transformation Fund (ETTF)
- Issues arising include:
  - The complexity of the schemes
  - The sustainability of the various funding streams, particularly in the current resource-constrained environment
  - The monitoring of the various investment schemes, with difficulty in defining and monitoring clear expected outcomes
- The ETTF has been particularly problematic to administer:
  - CCGs were expected to prioritise ‘bids’ in a very short timescale
  - ‘Transformation’ proved difficult to operationalise
  - Strategic need was difficult to define, with potential conflicts between practices’ strategic needs (as property owners) and the broader strategy of the CCG. This is complicated by the fact that investment in premises generates ongoing longer term costs for the CCG
  - Prioritisation of bids was a compromise between those regarded as aligned with the CCG’s strategy, and those deliverable in the short time available
  - Many CCGs identify a specific lack of capacity and expertise in estates management, with some reporting ongoing disagreements with NHS Property Services over roles and responsibilities

3.4.3 Conflicts of interest

Conflicts of interest took on increased importance when the delegation of commissioning of primary care services to CCGs put GPs in the position of both commissioners and providers of primary care, as articulated by the following GP respondent:
Ultimately the CCG is a commissioner and the member practices are providers. There’s an inherent conflict of interest. [GP ID16]

This section first outlines the published guidance on managing conflicts of interest for CCGs and the wider NHS. It then explores interviewee’s views on conflicts of interest including the statutory guidance for CCGs and describes the different types of conflicts of interest. We then discuss how CCGs in our study were managing such conflicts of interest in practice.

**Conflicts of interest statutory guidance**

In December 2014, prior to CCGs taking on responsibility for primary care commissioning, NHSE published statutory guidance for CCGs on conflicts of interest (NHS England, 2014b). The 2014 Guidance recognised that by taking on responsibility for commissioning primary care, CCGs would expose themselves to a greater risk of both real and perceived conflicts of interest. This necessitated a strengthening of the existing guidance. CCGs had to verify that they complied with the guidance when they applied to take on delegated or joint commissioning responsibilities, as well as during the annual certification process.

NHSE updated the 2014 guidance in June 2016 (NHS England, 2016e), following NHSE’s 2015/16 co-commissioning conflicts of interest audit (National Audit Office, 2015), a report by the National Audit Office, and feedback from a public consultation exercise. The revised guidance recognised that conflicts of interest are inevitable and appropriate management of conflicts of interest is necessary to assure the public, health care providers and Parliament that CCG decisions are fair, transparent, robust, and offer value for money. **The purposes of the revised guidance are to support the understanding and management of conflicts of interest among commissioners, enable commissioners to act fairly and transparently in the best interests of their patients and the local population, and to maintain public confidence in the NHS.** More specifically, the document guides CCGs on:

- how to identify and manage conflicts of interest
- declarations of interests
- the maintenance of registers of interests
- appointments and roles and responsibilities within the CCG
- the management of conflicts of interest at meetings and throughout the commissioning cycle
- the role of the internal audit
- procedure in the case of breaches of the guidance
- the impact of non-compliance
- conflicts of interest training.

The key changes in the revised guidance were:

- the appointment of a minimum of three lay members to the CCG Governing Body
- the appointment a conflicts of interest guardian
- the inclusion of a robust process for managing breaches of the conflicts of interest policy and publication of anonymised details of the breach on the CCG’s website
- strengthened provisions around decision making when a committee member has a conflict
- strengthened provisions around the management of gifts and hospitality
- CCGs should undertake an annual audit of conflicts of interest management as part of internal audit and include the audit findings in the annual end-of-year governance statement
- CCG employees, committee members and practice staff involved in CCG business must undertake mandatory online conflicts of interest training provided by NHSE.
During 2016, NHSE established a task and finish group comprising senior leaders in statutory, representative and professional bodies, charged with expanding guidance on conflicts of interest to all NHSE organisations to complement the statutory guidance for CCGs. The group sought to bring clarity and standardisation to the rules without imposing additional burdens on organisations and staff in terms of adherence. In June 2017, NHSE published a revised guidance for CCGs (NHS England, 2017) with a number of minor amendments to ensure that it is fully align with NHSE-wide guidance (NHS England, 2017a) which introduces consistent approaches to managing conflicts of interest across NHS organisations. The purpose of the NHS-wide guidance is to provide advice to organisations and staff about how to act in common situations where conflicts can arise, and supports the management of conflicts of interest. It provides definitions of actual and potential conflicts of interest and covers what NHS staff and organisations should do to manage conflicts of interest including declarations, maintenance and publication of registers and how to address breaches of the policy.

**CCGs’ views on conflicts of interest and NHSE guidance**

For some GPs and CCG employees, it was not immediately evident why conflicts of interest should be an issue for undue concern. One interviewee pointed out that conflicts of interest had existed prior to primary care co-commissioning so it was not a new issue faced by CCGs. For example, when commissioning of primary care services was the responsibility of NHSE, CCGs could commission Local Enhanced Services (LESs) that were outside the scope of the GMS contract to respond to local needs and priorities:

I mean, you know, even before we took on co-commissioning we did commission some services from primary care which are called locally commissioned services. And we have, you know, in developing those services; we have clinical leads who are also providers. So, it is something that you are always aware of. But, you put, kind of, controls into place. So, when we were developing some of those locally commissioned services our clinical leads take, you know, help to develop the clinical side of it, but, we don’t discuss finance until it goes to the procurement committee or something like that. So, it’s, you know, I suppose you just have to deal with it as well as you can…..but I don’t see it as a huge problem, conflict of interest. [Manager, ID35]

This resonated with a view that:

GPs are ultimately trustworthy people and, therefore can rise above conflicts and make decisions. [CCG Chair GP ID38]

During conflicts of interest training in Site 4, one GP attendee pointed out that with his practice partners, he had to make decisions that would affect practice income. It was not clear to him how making decisions with the CCG that affected income differed from practice decision making (Site 4, Conflicts of Interest training session, November 2016). However, the fundamental difference between CCGs (as statutory organisations) and individual GP practices (as independent contractors) is that GPs are not publicly accountable in the same way as CCGs, as elucidated by an interviewee in Site 2:

You see, as independent providers there is no obligation on them [GPs] to be publicly accountable in the same way as we are as a CCG. However, if they’re using public money there is an obligation on them to explain how are we best going to use it. So there is this dichotomy here in the NHS between a public service being run by independent contractors, which has always been, I think, in a sense, a difficulty for the NHS ever since it was formed in 1948. [Lay Member ID14]

Therefore, a central issue was the public interest and ensuring value for money for public funds. It was necessary for the custodians of these funds to persuade the public that the CCG had no vested
interests. The *perception* of a conflict of interest was viewed as being just as serious as an *actual* conflict of interest:

I think it’s something that we are very conscious of, not just that it doesn’t happen but that it is perceived not to happen either because I think if we ever step away from that, it could make the whole thing fail, you know what I mean? If people perceive that there is unacceptable goings on, then we failed even if there is or there isn’t. So I think it’s really important that we are very, very robust in our discussions, recognising that that conflict of interest is there and managing. [LMC representative GP ID30]

Part of the rationale for transferring responsibility for commissioning primary care to CCGs was to utilise knowledge of local population needs. This meant that GP’s conflicts were an inevitable consequence of being knowledgeable about their subject and possessing the local knowledge cited as a benefit of having GPs commission primary care:

So…and the whole point is that you should be conflicted because if you’re conflicted it means you know about your subject. [CCG Chair GP ID8]

I mean, I think it’s impossible to avoid the conflict as I said before because I think the fact is that if you’re going to have engagement of the people that really understands the local population and its needs on a daily basis and you involve them in decision making for the healthcare or make them responsible for the decision making and the healthcare for those patients you’re inevitably going to create conflict. Actually to an extent the conflicts are inevitable and a good thing and it’s about managing them. [LMC representative GP ID30]

Therefore, *conflicts of interest are seen as something to be managed rather than eliminated* and CCGs have to perform a balancing act between utilising the important input of GPs in terms of knowledge of local health issues and the conflicts that stem from GPs as members of the organisation holding their contracts.

It’s a balancing act as well, between what enables the CCG to function as a member led organisation, a clinical led organisation and how we make sure that we are managing it so that central providers are not given an advantage in a competitive world really. It’s a balancing act and as I say there’s not one size fits all, I think it’s always going to be difficult for us and primary care commissioning has made it more difficult. [Manager ID43]

Almost all discussions had a financial and workload impact on practices and yet it was felt that GPs had to be involved in those discussions. A clear example of this was how to obtain clinical input to a new outcome-based incentive scheme:

I know that the [new primary care initiative], there was a huge conflict of interest around that obviously, because we couldn’t necessarily let GPs write their own contract, but we also needed their input into it. So, we did some workshops and we developed something, and then it went to directors, and they looked at it, and then it went to Co-commissioning Committee to be signed off. [Manager ID25]

CCGs also had to avoid giving their GP members a competitive advantage. A particular challenge was faced by the case study sites with GP federations. In Site 2, some federations required help and support in the early stages of their establishment and the CCG had to be careful about drawing a clear line in terms of their input as the Federation and also as a potential provider:

So the plan is to try and meet with the federation to say, okay, well, what support would you like to then be able to look at that against potential conflict of interest to see where the middle ground is that can actually support them with that. Because I think without that support, again, it’s going to be very difficult for them to deliver all the requirements that are needed for them. Yeah, but then would you do something like write a bid or a tender for an organisation when you are a commissioning…for a provider when you are a commissioning
organisation? That’s where it...because that’s what they want, that’s what they need, because they haven’t got that experience. [Manager ID24]

Respondents also voiced opinions on the revised NHSE statutory guidance published in 2016 (NHS England, 2016e). It appears that a revision of the guidance was necessary as there was still some confusion regarding procedures around conflicts of interest:

But it’s still sometimes not everybody gets where there’s a conflict of interest and what you should be doing in terms of declaring that conflict, managing that conflict, even down to business support to that committee, knowing when they have to make it absolutely clear in the minutes. [Lay Member ID15]

There were differing views regarding the updated guidance, in particular about the Register(s) of Interest, which now must include:

- All CCG employees including full- and part-time staff, including those on short-term contracts;
- All members of the CCG’s committees and sub-committees/subgroups;
- All members of the CCG including GP Partners and any person directly involved in decision making of the CCG.

One of our respondents thought it was an improvement on the original guidance, which could be interpreted differently by CCGs:

Well, before what we did was we only looked at people involved in commissioning from member practices, so we went to networks. We didn’t have a register of all GP partners. The new guidance is every single member of staff, whether they’re a GP or whether they’re a cleaner, they will be declaring their address and they’ll be published, so we’re waiting for that. [Manager ID13]

However, another interviewee viewed the new guidance as a “kneejerk reaction” [Lay Member ID15] which was too encompassing and even unreasonable and implied there would be a push back by CCGs, particularly as it was becoming too onerous to update the Register of Interests and Register of Gifts and Hospitality.

Nevertheless, in Site 2 we did observe that the PCCC was following up on practices that did not declare all interests:

Chair of Primary Care Commissioning Committee: A new form for conflict of Interest with four sets of definitions of potential conflict of interest have been sent out to practices. I understand four of you [referring to committee members] haven’t returned it yet, and we have their names! Please fill and send them back to us because it is a very important part of good governance and accountability.

Lay Member: And we will be audited, it is mandatory and part of it is the declaration of interest

Chair of Primary Care Commissioning Committee: So not optional or nice to have, but mandatory that we fill this. [Primary Care Commissioning Committee meeting, December 2016, M37]

There was also a concern that such an all-embracing policy would create suspicion when people did not declare an interest, particularly due to the “incestuous” nature of the medical profession:

But when somebody comes back on no declarations of interests you think you must have some outside declarations of interests somewhere, you must have something to do with somebody. [Lay Member ID15]

While the new guidance clarified some issues, there remained some confusion over terminology as evidenced by this exchange at a training session:
Head of Quality: I have an issue with the phrase close relative and close friends. What does that mean?
Governance Manager: That is very difficult to define.
Head of Quality: I joke, but I drink cocktails with a senior manager at [local hospital], does that need to be declared?
Governance Manager: The consultation did try to define the categories but I am not sure whether that has helped. I think we have to go back to perceptions.
Chief Finance Officer: I think it is reasonable as an observer to know that we will be friends with people in the local area but we need to declare that.
CCG Chair: In terms of workload, what category does that fall into? We make decisions that impact on our workload regularly.
Governance Manager: I suspect that would come under non-financial.
GP practice representative: Practices are a business and if we decide to increase workload it will increase profit and if we reduce workload it will reduce our profits.
Governance Manager: To manage Conflict of interest it is based on risk and it is likely that people may not be able to take part in certain conversations. Financial conflicts of interest are more risky.
GP practice representative: This is about transparency, you need to declare them but can still be involved.
Governance Manager: I just want to reflect, how do you feel about this?
Head of Quality: I have a whole issue with the close relative which has caused me some anxiety. I have a personal problem whereby I married someone and I had to declare my sister in laws job role and that has been publicly declared which has caused a family problem because of my job role.
CCG Chief Officer: We cannot be drawing people’s details into the public arena.
Governance Manager: There is no definition on a relative; a definition could cause more problems due to how families work. [Conflicts of interest training session November 2016, M58]

The revised statutory guidance recommends a minimum of three lay members on the Governing Body. This requirement was seen as a challenge to CCGs as the guidance stipulates that the PCCC and the Audit Committee must also have a lay Chair but the same individual cannot take on both roles. Nevertheless, one of our case study sites (Site 3) had already implemented this before the publication of the new guidance and recruited a new lay member following the publication of the guidance.

Another concern related to secondary employment. The revised guidance stipulates that individuals obtain permission before engaging in secondary employment, and CCGs have a right to refuse this permission if an unmanageable conflict could potentially ensue (NHS England, 2016e). However, it was not clear why secondary employment would be an issue if appropriate arrangements were in place to deal with conflicts of interest:

And a lot of pharmacists, medicines management people do things like conferences and advice to external organisations, and they’re saying, well, you can’t do that anymore, you’ve got to have one job or the other. Now, that’s a big issue for the pharmaceutical people within CCGs. So loads of them have secondary sources of income from advice, and now they’re being told you can’t do that, and they’re all saying well, hang on a bit, why can’t we do this if we have that Chinese wall and it’s separate? [Lay Member ID15]

**Types of conflicts of interest**

There are two types of conflicts of interest we identified from our case study sites. One arising from GP’s influence over discussions and decision making as well as GPs potential bias towards
primary care. The other arising from committee members other than GPs and practice managers, including lay members.

Although GPs are in the minority on the PCCC, they may unduly influence decisions and this more ambiguous conflict of interest is more difficult to deal with than more overt conflict of interest:

And then any decisions that go through for increased funding or for changes to funding streams would go through to primary care co-commissioning, so there was this central fund that was hypothecated, ring-fenced funds that came through last year, through GP £5 a head that was allocated. We decided to continue with that GP £5 a head. And those decisions and agreements went through primary care, and obviously you have to be aware that there’s a conflict there, because the Primary Care Committee, albeit that the clinical representation is outweighed by the main membership, but you know, that if the conversation is being influenced by GPs, they’ve got a conflict of interest there, because they’ve got two hats on. [Manager ID34]

I don’t think that overt conflicts of interest are a problem I think that they’re well recognised and managed in meetings. I think it’s much more difficult the relationships between practices and how that can influence and the relationships between clinicians and practice managers. I think it’s a challenge to then to be able to park all of that and I would recognise how difficult that could be. And I don’t know how if I’m honest, I’m not sure how easy that would be, that is going to be going forward. I think there’s a potential there for some influence on decisions that isn’t overt but that does happen and I think we have to be very careful about that. [Manager ID37]

This soft influence was less apparent in Site 1, which employed an independent GP, implying that GPs pre-existing relationships with other committee members may be important.

There was also concern about conflict of interest arising from GPs natural predisposition towards primary care:

From a negative perspective, I think the conflicts of interest are quite an issue and I’ve seen that already in the five weeks I’m here and even if they’re not from a...if not from a blatant, haha, now I’m in charge of this, I can line my own pocket and make devious decisions, it’s not particularly from that, they can put things in place to stop people being involved in a decision, but, you know,...inevitably, GPs are passionate and worried about primary care. So if they had a choice about do I spend this money on primary care or secondary care or give it to public health or something? They’re going to say primary care. So even if it’s not an obvious conflict of interest, it’s a not obvious conflict, you know, it’s just...so how do we get around that? What do our hospital colleagues think around our conflict of interests, you know, if we go now in our contract and say we’re taking £5,000,000 out of the hospital, because we’re going to spend it on more GPs and we’re going to have less secondary care commissions....I think they would then worry about the conflict of interests......if push came to shove, to make it quick and make a decision about do we [do] this in primary care or do we do this in secondary care? And I think hospitals then would [cry foul] about the conflict of interests on that. [Manager ID42]

We observed evidence of this desire for GPs to prioritise investment in primary care during the observation of a Governing Body meeting in Site 4. The context of the discussion was the financial position of the CCG and the risk of a deficit in the overall budget, despite the requirement for the CCG to break-even. A GP member expressed concern that an underspend of the PMS Premium meant that less had been spent on primary care overall. Spending on primary care had increased but practices did not avail themselves of all the funding available to them from the released PMS funds. However, the GP representative understood that the unspent money would be ring fenced for
primary care. This led to the voicing of resistance to using the underspend of the PMS premium to achieve overall financial balance.

GP practice representative: Obviously we have not seen this before because it was with NHSE. We should use this opportunity to reinvest it into primary care.

CCG Chief Officer: We will do that next year like [Secondary Care Advisor] said.

GP practice representative: Why not now?

CCG Chief Officer: Because we have [...] overspend that we need to reduce. We are not throwing money at primary care that is not on the books and which will not help deliver the reduction of spend.

CCG Chair: We are massively conflicted in this conversation.

Secondary Care Advisor: The comforting news with the PMS premium is that if we underspend we can carry it forward and therefore we have more to spend in our gift next year. What is not comforting is the mathematics, if we underspend on something and just re-invest it, you will drive yourself into deficit because you are not dealing with the overspend. We are responsible for the whole budget and we need to make it balance.

GP practice representative: Year on year we prop up secondary care with additional funding but not primary care.

Lay Member: You are getting into debates here that raise conflict of interest issues. The long term plan is to switch the spend from acute into the community and primary care.

CCG Chair: I can assure you we did not plan to underspend on primary care. Next year we have plenty of plans to invest in primary care. The plan has always been the shift towards primary care. [Governing Body meeting November 2016, M54]

The use of robust evidence-based information in decision making can help to avoid bias on the part of clinical and non-clinical committee members as described by our respondents:

When we sit round the table we’ve got to put our prejudices and biases, hang them up with our coats outside the door and look at the evidence and decide and make our decisions on the evidence and not necessarily bring our bias into... The patient reps will bring in the patient voice, as it were. The clinicians will bring in their own, and then you have to kind of balance all these things out. Sure, our un-evidenced biases and prejudice can play no part in the decision making. [Lay Member ID14]

There have been instances where for example there was the LMC representative has contributed in ways which I would have ruled inappropriate...... I think we have to be very careful about that. And actually the instances I’m thinking of that are of concern not simply to the public but to the decision making process I would say in terms of equality and parity across the GP membership in this CCG. So I think it’s about getting robust evidence-based information to the committee and making decisions on that basis, rather than off-the-hoof comments or suggestions about particular practices and whether they may or may not be viable in five years, for example. [Healthwatch representative ID29]

During our meeting observations in Sites 1 and 2, there were instances where the lay Chair of the PCCC was conflicted and had to hand over the Chair to another lay member. In Site 1, the conflict arose as the Chair (who was substituting for the usual Chair who was on leave) was a patient at a practice under discussion for the relevant item. Although the new Chair suggested the former Chair could have participated in the discussion but not recorded a vote, the latter declined following a discussion with the Patient Representative Group of the relevant practice. This indicates that the emphasis on lay (and non-executive) membership of the committee does not fully resolve the issues around conflicts of interest.
Management of conflicts of interest

In order to address conflicts of interest, CCGs are required to establish a primary care commissioning committee. However, to balance conflicts of interest with the need for local knowledge and clinical input, our case study sites adopted different approaches. Site 1 recruited GPs from an outside area whilst Sites 3 and 4 included their GP members who hold different contracts. Additionally, one year following the delegation, Site 4 decided to recruit an external GP to sit on the PCCC and the operational group. The purpose was to ensure the clinical voice was not lost when the GP members have to leave the room during discussions which present conflicts of interest. Site 2, on the other hand, included their GP members as non-voting members.

All CCGs in our case studies include a secondary care clinician on the PCCC, although they are not always present at the meeting:

So where there’s any challenge about conflict of interests they can be completely open to scrutiny because there are no local GPs there. So the clinical advice, as you know, comes from a GP who works externally, and for me I think that works really well in terms of the governance and the scrutiny. [Lay member ID7]

What we try to do is make sure that we’re getting clinical input in other ways. So there is the secondary care advisor sits on the committee as well to try and make sure there’s some clinical input. [Manager ID43]

In line with the statutory guidance, all of our case study CCGs have maintained and/or published a Register of Interests on their websites. Three of our case study sites (Sites 1, 2 and 3) also published a Register of Gifts and Hospitality.

All our case study sites had processes in place for members to declare any conflicts of interest at the outset of the meeting. Following a declaration, our case study sites pursued different approaches. In some instances, the conflicted individuals left the room for the entirety of the discussion and vote for the relevant item. In others, the individuals either remained in the room to contribute to the discussion but not vote, or remained but did not partake in the discussion or vote for the relevant item. Some sites deemed it acceptable for the conflicted individual(s) to stay in the room despite exclusion from the discussion and/or vote when the meeting was in public. The appropriate action taken following a declaration did not appear to be consistent but rather depended on the particular item under discussion. This meant that GPs were sometimes involved in discussions about funding or contracts as illustrated by the following respondents:

But if you look at some of the business we’ve done in the last few weeks with the [name of a practice] which was the APMS practices I’d said that was being re-procured, you know; that was a classic example of one where we could stay in the room, make the decisions and everything because none of us were conflicted because it’s not our practice, it’s not our contract, it’s nothing. Then, when you move on to the PMS schemes, where we’re talking about, you know, giving money to the [number of practices on PMS contracts], essentially we go out. [CCG Chair GP ID38]

With the conflict of interest policy, they would be out of the room if they were directly conflicted, if they were discussing, I don't know, for example, an estates issue or funding that affected their practice or their locality directly. But if it came to a vote around overall funding pot for primary care or new initiatives for primary care, the GPs are in the minority there. And I think that's fine and that's good. [Manager ID33]

Some flexibility in approach may be necessary in order to avoid an impasse in the business of the committee as evidenced by the following example where all GPs left the room prior to a discussion about a contract with no committee member remaining to provide clinical input:
We were discussing minor surgery and the minor surgery contract to provide minor surgery for our patients. And that was quite a big contract, probably worth several hundred thousands of pounds, if not more. So it was a major contract which had to be approved by governing body, however, all of the GPs there, or themselves, provide minor surgery for our patients, and therefore, we were all directly conflicted. What happened was, that in fact at that stage, almost to be seen to be cleaner than clean, all the GPs left the room. But then of course, we said well firstly that seemed very silly, because it was a public meeting anyway, so if it was a public meeting then they could’ve still stood at the back. The problem was, it was then taken over that there were no clinicians left in the room, so we were therefore discussing...are you a clinician yourself? No, ok, so therefore, the remaining group are discussing the pros and cons of a minor surgery contract without any clinician being in the room. So we said well that is actually stupid, how can they make the right decision when there is no one to ask for advice? So we said what should have actually have happened was that we should’ve all stayed in the room and said that we can take no part in active discussion, however, we are here for advice if you need that advice, but we can only respond to questions if asked by the independent members. [GP ID17]

Respondents recognised the important role of the lay membership of the PCCC in terms of their independence and ability to challenge other members:

We recruited a new lay member particularly to take responsibility for primary care commissioning so that we could separate it out from other business within the CCG because of the conflict of interest for our GPs. [CCG Accountable Officer ID28]

But the committee, our primary care commissioning committee, is heavily represented by independent and lay governing body members, so as a CCG we have more than is required anyway because we’ve always seen the value of having that additional independent and lay challenge. [Manager ID19]

The attendance and active participation of non-clinical members, such as executive and lay members, was also viewed an important safeguard against potential conflicts for clinical members when their input was required:

we were talking about winter access and schemes and he was, you know, I’m so conflicted in this conversation and it was a development conversation and it was just, like, well, you’re not the only person that’s sat in this room, there are other people in it, we need a clinical view about how would this work in practice, but you’re not the one that will make the decision on it and there are other people in this room that will help you manage your conflict. [Manager ID46]

A similar view was also echoed during a discussion in one of the PCCC meeting we attended [M40] where for the meetings to be quorate they needed a lay majority.

There was also an understanding that declarations of interest were not only the responsibility of the affected committee member, but there was also an onus of other committee members to bring the conflict to the attention of the committee and for committee members to challenge each other about any conflict:

People have got that opportunity to challenge, but I don’t...so if I’m sat in quality safety committee and I’m aware that somebody hasn’t declared and I think there’s a conflict, then I will call that out in the meeting and we’ll have a conversation about how do we handle it? And it’ll be documented and that’s what people do, yeah. [Manager ID46]

We’ve very openly discussed conflict of interest and where we think that there are conflicts of interest, we’ll say so. So I’ll say to somebody but you have to realise when they have a
discussion, that’s something I will say because I’m beginning to realise you have a conflict of interest. So we very openly have those discussions. [CCG Accountable Officer ID28]

While our case study CCGs recognised that conflict of interest was an issue, they felt confident that the governance structures and policies put in place to address and manage conflicts of interest were adequate.

It’s inevitable that there will be conflicts of interest on the committee and we’re really...we manage conflicts of interest really robustly and we do that in everything that we do and the committee is no exception [Manager ID43]

So they’re there, without a shadow of a doubt, I think we’re strong in terms of the management of conflicts of interest in this organisation, I think [Governance Manager] is very much keeping everybody abreast of change around, you know, the policy around it, we’re pretty tight in our committees about how we manage the conflicts and always have been prior to the fully delegated. [Manager ID46]

We were, you know, we were going into a different world of actually having a transactional relationship with the GPs, which could sometimes be tricky when they are members. But, by setting up the PCCC, we took that conflict of interest out. [CCG Chair GP ID27]

GP members have had to adjust to the new governance arrangements and additional scrutiny that had arisen as a result of co-commissioning and this was seen as a big change for them. There was some cognisance that the GP membership were not always happy with the new policies.

sometimes the GP membership may feel they want more involvement or more say in what happens and I think that’s where there can be some disharmony or disunity or sometimes frustration or unhappiness that why was this commissioned? Why hasn’t my practice had that offer of being able to do this service or that service? Because sometimes possibly they feel if we are a GP member organisation why can’t we as a member just decide everything? I think there has to be a middle ground. [GP ID16]

GPs on the Governing Body felt divorced from the primary care committee and this caused frustration as primary care was their area of expertise and the separation could inhibit a strategic overview of the CCGs responsibilities:

It doesn’t feel great as a chair of an organisation to be constantly excluded, thrown out, removed from meetings, but that’s just... you have to deal with it. That’s the complications of the world that we live in, and so...yeah. [...] Yes. Yes. It’s always there. And you can’t manage that by...if I’m running a public board meeting, do I want to be thrown out of my own meeting, when I’m chairing it? No. It doesn’t feel good. It feels a bit odd. It doesn’t feel comfortable, so that’s speaking personally, but I suppose we manage that by doing actually those discussions in Primary Care Commissioning Committee, and then you just report the minutes of PCCC into the...you just accept them. So you...but then it means that you don’t...you’ve got to be careful of what...and think about how you make sure you have these strategic discussions about general practice with the board. [CCG Chair GP ID8]

There was also resentment that GPs did not create the issue of conflicts of interest yet they were seemingly to blame for it.

The cynic in me will say well the government created...we didn’t create this ourselves, the government created this system, they brought it up and then said that you need to manage the conflicts of interest. But they created the conflicts of interest in the first place. I mean, they created a body because they specifically wanted to do so, which has a majority of GPs voting on it. They said that they wanted to hand down Primary Care Commissioning, and then said well now you’ve got all these conflicts of interest, and look at all the rotten things that you are doing. So well, they created the body in the first place. [GP ID17]
However, it was felt that the procedures were necessary, even if they were not always popular:

But we have the conflicts of interest stuff and we need to look independently of these things and we've made the right decisions and some of them might be tough decisions and you can't always give people what they always want. [Manager ID42]

Overall, conflicts of interest have been recognised as an important issue since the inception of CCGs and gained renewed attention with the delegation of responsibility for commissioning of primary care. NHSE has published (at various times) statutory guidance for CCGs to manage conflicts of interest. However, despite our case study CCGs adhering to this guidance, respondents voiced concern about the potential for less overt conflicts that are potentially more difficult to identify and address. In particular, GPs and practice managers are able to exert influence on other committee members, despite governance arrangements limiting their participation. Despite the weight given to lay membership of primary care commissioning committees, lay members are not always immune to conflicts of interest.

**Summary - conflicts of interest**

- Conflicts of Interest (CoI) are an inevitable consequence of the delegation of primary care co-commissioning responsibility
- All our case study CCGs have put in place structures and procedures to minimise the impact of CoI, although not all CCG leaders regard CoI as particularly significant or important
- The fundamental concern underlying CoI guidance is trust and the proper stewardship of public funds. We identified two forms of CoI:
  - Direct CoI, in which a CCG member or their family have the potential to benefit directly from CCG decisions
  - Indirect CoI, in which GPs, whilst having no direct involvement in decisions, are able to wield ‘soft’ influence on those making the decisions, in part because of their knowledge and stature as clinicians
- Lay members of CCG GBs and managers may also have CoI
- Following various iterations of the CoI guidance (2014, 2016 and 2017 publications), management of CoI includes:
  - A comprehensive register of interests
  - Withdrawal of committee members from discussions
  - Appointment of lay members and/or of clinicians from outside the local area to committees
  - Willingness to challenge each other
- These measures have some unintended consequences:
  - Loss of clinical expertise when all GPs are required to leave the room or not take part in discussions
  - A degree of disconnect between the wider work of the CCG and the work of the PCCC
  - Complexities for those CCGs that wish to support the development of co-operative networks/Federations of GP practices, as they feel constrained from offering material support
- New guidance was issued by NHS England in June 2017 to support the management of CoI. Some found previous iterations (2014 and 2016 versions) of the guidance to be both overly prescriptive and onerous (requiring, for example, the registering of interests of all family members), whilst at the same time still leaving considerable room for interpretation. This resulted in considerable differences between CCGs in how CoI are dealt with, which the most recent guidance is designed to address.
3.4.4 Relationships

In this section, we provide an overview of how CCGs’ relationship with member practices and with external stakeholders develops following CCGs being delegated primary care commissioning responsibility.

3.4.4.1 Being membership organisation

3.4.4.1.1 Internal relationship with member practices

CCGs were established as membership organisations, with local GP practices being members of a CCG and having GP representatives from local practices on the Governing Body. The role of the CCG was to commission healthcare services including mental health care, urgent and elective hospital care and community services. CCGs were expected to work closely with Public Health, situated in the Local Authority post the HSCA12 but initially had no responsibility for commissioning primary care (their membership). As a membership organisation, CCGs had a responsibility to support general practice.

When CCGs were offered the opportunity to commission primary care medical services, the decision to take on the responsibility had to be decided by the Governing Body and the membership. Our case study CCGs described the overall experience of becoming a primary care commissioner to be quite positive:

We had 99.7% of our GPs voted in favour of us taking primary care commissioning. So, we have taken the membership on the journey with us. They are very much behind us and already I think we have seen changes on the ground. So, massive improvements in engagement and the GPs seem to have faith that we can actually make things better for them [CCG Chair GP ID27].

It was suggested by some CCG staff that there was no ‘right’ option, staying with the status quo or taking on the primary care agenda had different advantages and disadvantages for the CCG and its membership:

So, we did a Survey Monkey to all our members, we asked them to vote, which level of delegation they wanted. We had a full members event, presented the options, had a discussion, gave them a forum to have discussion between themselves. We did another straw poll using the keypads, so we had that event before we did the Survey Monkey, so we just took a short poll there and then we went out for a Survey Monkey, got the answer back that said, you know, you’re damned if you do, you’re damned if you don’t, go for it. So we took the full delegation [Manager ID19].

One of our case study sites (Site 4) originally opted for joint commissioning working alongside NHSE to gain experience of primary care commissioning. After one year of working with NHSE under a joint arrangement, the CCG decided to take on delegated responsibility. Engagement and conversations with the membership practices had to be held for the two different phases of co-commissioning. This engagement was to ensure that practices were in support of the CCG taking on further responsibility from NHSE:

So we asked the membership about taking on...so they were involved in that decision. From memory I think they voted...I mean it wasn’t a vote as to whether we would go for it or not but we did ask the membership to vote, so we did a lot of work with the membership, talking to them before through our business meetings, through practice protected time and then ultimately every practice was asked their view. We also do regular practice visits so we can have those open conversations about it. The membership was supportive of us going for
full delegation, initially for joint commissioning and then for full delegation, so it was done with their support [Manager ID43].

CCGs in our case studies claimed that the membership were informed about the potential changes and the implications of the new responsibility and this informed their practice vote to help make the decision on which level of co-commissioning to opt for. There was an acceptance that you would not expect all GP practices to agree 100% with the decision; however, the majority of members enabled the change to occur.

Our case study CCGs spoke of their relationship with member practices and suggested that the new responsibility had in some instances strengthened the relationship and bought benefits, whereas in others it had deteriorated. Site 3 commented that the existing good relationships they had with members prior to taking on co-commissioning was an important element both in deciding to take on the delegated role and in the smooth running of the new structure.

Where sites felt the new responsibilities had strengthened some of their member relationships, they were able to be more involved with developing specifications and continue the work they had already been doing with practices:

I think it’s probably strengthened the relationship because we are more involved in developing them as a service but I’m not sure that we wouldn’t have done it anyway, if that makes sense, which was why it made sense to take co-commissioning on. So we do pre CQC [Care Quality Commission] visits with them to help them assess how they would be scored against CQC and help them address, identify what they need to address with the CQC. We do performance visits with them, which are supportive. They are led by the locality GP with performance lead, so they go out with all their data and graphs and sit down with them and go through all that information and talk about what the challenges to improving their performance [CCG Accountable Officer ID28].

Site 1 suggested that being a local commissioner of primary care services rather than an arms-length body like NHS had fostered trust between the CCG and the membership:

So I think it gives us credibility with the practices, an influence with the practices to change things, as well as contractual levers and money to change things with as well. So it gives us far more scope to do something different with general practice than it was when it was sort of arm’s length in NHS England [Independent GP ID9].

Moreover, by taking on delegated responsibility, the membership would have more levers to hold the CCG to account:

Yeah. Well it goes back to earlier conversation, doesn’t it, around membership organisations? So I guess all the time that it was commissioned by NHS England and if you’re sat as a GP member on the governing body or you’re a GP practice who want to do what they want, if primary care wasn’t what you wanted it to be, you could all be on exactly the same side and say that terrible NHS England aren’t very good at this, are they? […] but the bit that could change is now it’s delegated, I think our governing body and members will feel accountable to all of their membership who are absolutely passionate about improving primary care and we now have the tools to do it, we have the budget to do it, it is our local decisions. So that feels a bit more like the membership are going to hold us to account, that’s something they’re really passionate about [Manager ID42].

However, there has been much debate on the capacity of CCGs to take on a new commissioning role. One site suggested that they were able to respond in a more efficient manner to practices as they did not work on the large footprint like NHSE. This operational difference was perceived by the CCG as being well received by the member practices:
So I think from an operational, let’s work everything out together, sort of thing, that’s been very positive, because they felt very remote from NHS England, and felt they didn’t get a service at all, from them, because NHS England was covering a massive area, rather than that localised, and knowing the practices and what their needs are [Manager ID20].

In Site 3, there were concerns about being able to manage the additional workload of primary care commissioning for e.g. the financial and contractual element of the work. This could have been influenced by the lack of additional resource and support that was provided to CCGs. However, member practices have fed back to the CCG that they have improved the service since taking on the responsibility from NHSE therefore the new responsibility has not been detrimental to the good relationship that existed between the CCG and the membership:

I think it’s been good for us as a CCG; it’s strengthened our relationship with our members. I think we haven’t...one of the things we were anxious about in taking it on was dropping the ball in terms of payments to our members or just not managing the system. And I think certainly the feedback we’ve had is, we haven’t done that and actually it’s an improved service than they did have from NHS England [Manager ID33].

Performance management vs peer support

With general practice being members of the CCG, taking on the delegated responsibility has also raised a number of challenges for CCGs. These include balancing the role of the CCG as a supportive membership organisation versus the more contractual performance management role experienced in a formal commissioner-provider relationship.

In Site 2, the difficulties surrounding performance management were discussed with regards to the changing dynamics between member practices and the CCG because of their change in status. As membership organisations CCGs have experience of helping and supporting their member practices regarding practice quality and peer support (often delivered through practice visits and business meetings). Having the responsibility for the commissioning of primary care potentially increased the need for the CCG to be more critical of practices and be more challenging with regards to the contract. This has the potential of causing tension between the CCG staff and the membership as the nature of their relationship has fundamentally changed:

it’s not been without its challenges, and being a membership organisation, where GPs felt that we were working together, then suddenly you’re performance managing them around their contracts, not always performance managing, but particularly challenging them against things, I think the relationships and the partnerships issue has been a challenge for the CCG personally [Manager ID20].

Site 4 attempted to overcome the confusion and tensions of being a supportive membership organisation and a performance managing organisation through the use of the workforce. The role of support and performance management was separated so that practices understand who will be monitoring them against their contract and who will be supporting them. This idea was still in its infancy and no firm plans to separate the work have been formalised:

I think we need to do a bit of when we’re looking at our structures and the people that are doing some things actually have some clear line between certain rules in the organisation, you can’t be their friend one day and then send them a contractual breach notice the next, it’s just not possible to do that, so we need to be a bit smarter around who is providing that support improvement function and who is being the contractor and commissioner here and I think that’s work that we’re just beginning to work through... [...] I think it will cause more damage in the long term, because we’ll lose the trust and the support and the ability to find things out and the ability to influence in practice in the way that they’ve been able to do that over the last few years if forever we’re being seen as the person with the big stick and we
need to protect that bit of resource that does some of the support and think about how that fits with the Federation and development of the strategy [Manager ID46].

On the other hand, some GP providers have expectations that they should be treated differently to other providers because of their membership status and existing relationship they have with the CCG:

Yeah, and I think, like I said, going forward for the five year forward view, it enables us to commission everybody, so acute, primary care, mental health, all the rest of it, for place based commissioning, going forward for the future. But I think that, because we are a membership organisation, our members don’t always feel that they, I suppose some of the GPs, because they think they’re members, they should get everything they want, well it doesn’t work like that, if that makes sense, don’t quote me on this exactly, these words [Manager ID20].

In addition to managing the tension between performance managing and supporting practices, we observed our case study CCGs encountered difficulty in differentiating between performance management of practices and individual GPs performance management, which is not within the scope of co-commissioning responsibility. Under the delegation agreements, it is CCGs’ responsibility to monitor and manage the performance of practices. However, the conduct of individual GPs is monitored by NHS England and the general medical Council (GMC), whilst the safety and performance of practices comes under the purview of the Care Quality Commission (CQC). In addition, NHS England retains responsibility for complaints made against GP practices. This complexity can cause issues for single handed practices where a single GP’s conduct equates to the conduct of a practice. For example, in Site 3 we observed tensions manifested with issues around which body was responsible for which element of the quality framework or what was the proper sequence of intervention where an issue had been identified:

Primary care contract manager: We have the Action Plan. There will be the revisit of the CQC and we will see the outcome.

NHSE representative: There’s a concern about safety and if the practice doesn’t improve then the question is why the CQC did not do something in a timely way? Is the algorithm in the public and patient interest?

Locality lead: We made the decision to wait for the CQC as it is not appropriate for us to go in first.

NHSE representative: The CQC do not hold the contract – so any action sits with the CCG. IT is up to the CCG to hold the practice to account and it is a contract for a public service. IT is not about being punitive ... if there is a filing in secondary care then you take action ... there’s requirements in the contract that are not being met. [Primary Care Commissioning Committee meeting August 2016, M42]

Similarly in another site (Site 1), we observed the split between the CCGs, who hold and manage practice contracts, and the CQC, who monitor the services provided by GPs, lead to concrete issues in which CCGs are finding it hard to respond to quality concerns. The CCG decided not to review an existing APMS contract due to quality concerns. The practice did not always have GPs present on site and a quality issue was reported by an existing staff member. However, as the CQC rated the practice as ‘good’, the CCG needed to do additional quality assessment of this practice.

Another example was around a prescribing issue:

Medicines Management Update-Oxycodone prescribing
Practice support pharmacist: I want to raise some concerns with the prescribing of oxycodone. The lead GP is dismissive of our concerns and is refusing to change to prescribing a cheaper brand. Another GP is prescribing oxycodone on blue prescriptions (normally
meant for methadone). These are all issues from the same practice but different GPs; there are concerns with cost and safety.

Medicine optimisation officer: This has been an on-going issue for over 2 years. The GP is almost protective of their patients.

Practice support pharmacist: I think that with regards to patient 1 that they want the more expensive brand as it has a higher street value. The GP says that this is not an issue with the patient but other members of the practice think they are undesirable.

Independent GP: Is this a trend within the practice?

Practice development manager: Patient 1 was admitted into hospital on one occasion and secondary care questioned the dose of oxycodone that the patient was receiving.

Independent GP: How do you want to approach this? Is it a practice issue or a single performer issue?

Quality manager: Is the blue prescription wrong?

Primary care programme manager: It is unorthodox.

Practice development manager: I contacted [name of NHSE representative] to see whether it was a contractual issue, she said it was difficult to prove.

Quality manager: From a GMC perspective, is it unsafe?

Independent GP: yes. There could be lots of speculation. Do we have a prescribing lead?

Medicines management representative: [Name of the CCG’s prescribing lead].

Independent GP: I will talk to [name of the CCG’s prescribing lead]; I’m concerned about the patient.

NHSE representative: It sounds like a peer to peer conversation is required. [Primary Care Operational Group meeting April 2017, M74]

In this example, the focus is upon the conduct of an individual GP (the responsibility of NHS England and the GMC), but there are additional concerns about the management of the issue within the practice. The pragmatic response is to talk ‘peer to peer’ with the GP concerned; should this not resolve the issue, then the CCG would need to consider which agencies to involve.

National policy vs local decision

Our case study CCGs suggested that, unrelated to primary care commissioning, changes to the organisations and demands placed on them from national level has caused the CCGs’ relationship with their members to deteriorate. The need to implement national policy often made membership feel that they were not part of the decision making process and there was concern that some would feel disenfranchised by this. Our case study CCGs tried to manage the demands that were placed upon them by NHSE (central policy) whilst fostering a sense of membership on a local footprint with their member practice. This was proving to be a challenge for the CCGs:

I think the relationship with member practices regardless has deteriorated. I think because when we first started as a CCG, it felt very much we were all in it together and I think as things have gone on, as things have developed, we’ve become a bigger organisation again. There are a number of things that we have to do that come from NHS England and I think it’s...we’ve not necessarily always engaged as well as we could, but, like, that’s a key example, we got an email yesterday and we’ve got to do a return today, there’s no way you can have....No and I do think that has impacted, the tighter deadlines have impacted [Manager ID45].

Evidence from other sites further attests to the difficulties CCGs face in balancing the requirements of central policy with being a membership organisation and the interests of local primary care needs. Whilst many members have embraced national policy in response to the CCG implementing the objectives of the Five Year Forward View (NHS England, 2014a), there were tensions from others who did not understand the CCGs role in co-commissioning and neither understand the need for or
want to move towards collaborative general practice. For example in Site 2, there was a split between members who were moving at pace and organised into Federations and those who felt that national policy was being imposed on them and that they were being forced to come together:

Yeah, and I think there's…it hasn’t helped the relationship that they have with the CCG because they don’t understand, you know, the Five Year Forward View and the STPs [Sustainability and Transformation Plans]. That’s not a CCG decision. What we’re trying to help you with is how, as a CCG and as members, we help you respond to that. Yeah, it’s difficult [Manager ID24].

Many discussed the benefits and opportunities of current national policy, which focuses upon a ‘place-based’ approach. They suggested that taking control of primary care commissioning from NHSE would allow them to be more responsive to problems, take control of decision making and join together different ‘pots’ of general practice resources for the benefit of local patient populations, and that this would, overall, benefit their relationship with their members. However, there were examples of incongruence between the CCG, national policy and the democratic processes of what it means to be a membership organisation. This was found to impact on both the CCG and their members in most sites who described similar issues in feeling frustration over their responsibilities to NHSE and contradictions of ‘having to’ enact policy rather than collectively discuss and act in the interest of local needs.

In addition to national policy, national targets on which CCGs are monitored were found in some instances to cause tension and disengagement with the GPs. In Site 3, the national ambition to achieve diagnosis rates for two-thirds of the estimated number of people with dementia (Department of Health, 2015b) has caused disengagement from some GP members. As the CCG were not performing well on their dementia diagnosis rate, they wanted to introduce a new scheme to encourage improved rates. GPs perceived it to be neither “ethical nor appropriate” to participate in a reward scheme that was not about providing the best care for their patients. However, the CCG argued that had to introduce the scheme as there were fears that they would be put under direction by NHSE for failing to achieve this national target:

Director of Strategy: We have the oldest population in the UK so this means higher attrition rates. Historically, there was nothing to offer patients after a diagnosis, however, there is an evolving evidence base on diagnosis….there’s been disconnect from clinicians as they couldn’t see the benefit of a diagnosis.

Locality representative: there’s been active disengagement from some GPs as they viewed it as wrong to participate in a reward scheme [referenced a £50 payment] that involved recording a code and was not about providing care for the patient – GPs viewed this as neither ethical nor appropriate….this helps to explain disengagement.

CCG Chief Officer: A huge amount of work has gone into this […] and I recognise that priorities have been elsewhere [reference to patient transport fiasco]. There are two issues: the CCG is looking to roll-out a world-class dementia service and it doesn’t match up to be one of the lowest nationally in terms of dementia reporting rates; 2: this is of importance to the Secretary of State…if the target is not met then it will be very challenging as a CCG going forward…I think the proposal is a reasonable solution and practices can spend the money on dementia or other care for the frail elderly.

Chair of Primary Care Commissioning Committee: are we happy to support the recommendation?

Chief Finance Officer: I’m ashamed to say it but I am [had previously mentioned restricting access to incentivise practices to improve performance]….lack of assurance from NHSE.

Chair of Primary Care Commissioning Committee: It’s approved then. [Primary Care Commissioning Committee Meeting October 2016]
Overall, the impacts of CCGs’ taking on primary care commissioning on their relationships with their GP members vary. The delegated responsibility had in some instances strengthened this relationship for example in getting GP members to be more involved with developing service specifications and in providing more levers for members to hold CCGs to account for improving primary care services. However this responsibility is not without its challenges. CCGs need to balance between the role of being a supportive membership organisation and the more formal contractual management role and between having to enact national policy and collectively discuss and act in the interest of local needs.

3.4.4.1.1.2 Relationship with GP Federations and networks

We found both formal and informal collaborations of GP practices in our case study CCGs. Three CCGs (apart from Site 3) had between one to three GP federations in their area. During Federations’ initial development, our case study CCGs were unclear in terms of what is the function of a Federation, what does it mean to be a “Federation”, and who should be leading its development locally. There was also an uncertainty about whether what was forming was a “true” Federation, i.e. having a formal arrangement for organisations to form into a single group, or Federation in name only.

In all four CCGs, there were a number of more informal networks of GP practices working collaboratively, supported by the CCGs with a view of moving towards formal collaborations. For example in Site 1, the CCG started by providing resources (in this case a network manager) to practices to form informal ‘networks’. The aim was to encourage joint working between practices and develop trust amongst the practices with the hope of it having a positive impact on the development of GP Federations in the area:

I do think it did. Because the CCG put a lot of resource in that, they gave each other a network manager, so they’ve got somebody coordinating them and bringing them together, and you do need that. I think what you see now is a lot more trust between practices and the fact that some have gone on to do some of these models at a higher practice level means that they trust each other. So you’ve got practices across the way now who book into the system as another practice to help manage the on the day demand. So I think what we’ve seen through the transition now the [name of an initiative] finished and there’s been a little bit of reconfiguration of some of the GP networks in response to how the GP federations have been set up. So hopefully they’ll not lose all that really positive working relationship that had formed between some of the networks. But I think what it also does is again it’s just a bit of a lull while they reform and re-establish some of those links. So you don’t want to lose that momentum. But the federations are there and that’s what we have to acknowledge [Manager ID10].

Whilst CCGs in our case studies acknowledged the support needed to develop the Federations, they were aware of the potential conflicts of interest in providing support to a primary care provider organisation whilst having the responsibility for commissioning local primary care services:

Some of them [referring to the Federations] have wanted more support than others; some of them have just got on with it. [...] But the conflict of interest is difficult. So we can only do so much, as we can do really, because it would put the CCG in a very difficult position, you know, if supporting a provider, organisations develop, and then obviously if they’ve gone one attender, the challenge to us would be quite significant, so we’ve been quite clear that we’ll only support them to so far, in the thinking stage, the doing stage is for them to move forward [Manager ID20].
Our case study CCGs were clear that the support they offered to GP Federations was in terms of the vision and opportunities afforded by forming a Federation but not in developing them as a provider organisation:

That’s been a challenge, I have to say. Because we started off by giving them some support about, what does it mean to federate, what’s your visions, your values? But actually to help them then set up a legal structure, and then work with them in that legal structure, is not our role as commissioners. If that makes sense? Because it’s their bid, they’re a provider organisation. So that’s why, as I say, it’s a bit of a challenge. So we’ve supported them to think about, how they can think about it, and what the opportunities might be, but once they’ve done, we’ve worked with them to look at what their visions and values might be, how they come to those using their group, and directed them to legal people. But then, at that point, we’ve then stepped back. Because we can’t get involved in developing them as a provider organisation [Manager ID20].

A clear distinction was made between supporting and establishing Federations. As a commissioning body, it is not within the CCGs’ scope to develop a provider organisation and it would raise conflicts of interest. However, as a membership organisation, the CCGs want to support new ways of working which would be potentially beneficial for their membership. One way to do this, as suggested by one of our respondents in Site 1, was to move to a more transactional and contractual relationship once the Federation was formed.

Overall, our case study sites were aware of the need to support the development of local GP Federations to ensure the sustainability of general practice. GP Federations were established in some of our case study CCGs before primary care commissioning was delegated to CCGs. The responsibility of co-commissioning raised issues and challenges regarding conflicts of interest for the CCGs. As a membership organisation, CCGs want to ensure the sustainability of general practice however the new commissioning role has led to CCGs having to find equilibrium between ensuring the development of general practice whilst managing them as any other provider of services that CCGs deal with on a regular basis.

3.4.4.1.1.3 The role of Localities

Two of our case study CCGs (Sites 2 and 3) have organised their practices into Locality groups (or Localities). In Site 2, the Locality groups (known as ‘Local Commissioning Groups’) were initially set up as standalone CCGs during ‘pathfinder’ process before deciding to merge to form a larger CCG for authorisation (Checkland et al., 2012). On the other hand, the CCG in Site 3 was formed by a merger of previous Practice-based Commissioning (PBC) groups (see Section 4.2 for comparison with PBC). To maintain the existing successful working, these previous PBC groups were configured as Locality groups.

Locality meetings in both sites were generally attended by local GPs, practice nurses, community services, and practice managers. The meetings were chaired by a GP and meet monthly. The groups functioned as a vehicle for communication between the CCGs and their membership and as a mechanism for piloting ongoing or new initiatives.

In Site 2, each Local Commissioning Groups (LCGs) were supported by a Manager. As the number of GP practices covered by each LCGs varied from a handful to over 20 practices, to manage the workload and to get practices to start working together and eventually to federate, these practices were divided into cohorts of practices based on geographical locations. Hence some practices would fall within two Localities but was seen by the CCG as a more ‘natural’ partners in terms of their geography to work together on thing such as longer opening hours. However, the idea of working as a cohort of practices was causing anxiety between practices and the CCG as the practices interpreted this as the CCG’s attempt to break up the LCGs and supporting the development of GP Federations.
On the other hand, in Site 3, Localities were divided into ‘sub-localities’, which were configured around their community hospitals. The sub-localities were configured to encourage joint working, which was based on ‘place-based’ approach focusing on 30-50,000 population. The focus was to encourage GP practices to work together on areas such as clinical outcomes, sharing back office function, and providing 8-to-8 services. Each sub-locality was supported by a Band 8 Cluster Lead. Within the sub-localities, there were ‘integrated locality’ groups, which were multi-disciplinary teams consisting of consisting of GPs, community services, mental health services, adult social care, and social services working together to avoid unnecessary referrals into acute services, with GPs being described as a ‘broker’. These integrated locality groups will be the basis for rolling out the new models of care as identified in the *Five Year Forward View* (NHS England, 2014a). The groups were given the autonomy to decide on their priorities of work and pace of development as they have different population demographics, hence different use of urgent and non-elective admissions and different ways of working with some practices within those groups working more closely together:

So it's that kind of localised approach in line with the five-year forward that recognises local need, rather than a one size fits all [Manager ID33].

An example of ‘successful’ piece of work completed by one of the groups was on integrated pharmacy, with a view of developing a community contract for medicines management function at the integrated locality level.

From our observations, we found that a Primary Care Manager assigned to a Locality group, whose role was to provide a two-way communication channel between the CCG and its membership was helpful. These managers were seen as a facilitator, a problem solver, a first point of contact for any queries that practices have, as described by our interviewee:

The main crux of the role is to be support to practices, so to be their first point of contact, to be their go-to person, to be the coordinator of the local commissioning groups, the boards, the meetings, but also to help them in delivering the *Five Year Forward View*, [name of a primary care initiative] [...]. So it’s around being that facilitator, enabler, point them in the right direction, role... so we’ll be their first point of contact for any queries. It can be...quite often it's queries relating to NHSE, because a lot of them, they don't understand it's not a CCG, but we'll try and find the contacts for them. Sometimes it can be questions about, you know, claims, processes, processes within the CCG, leases, IT issues. It can be anything really, so you're kind of like their problem solver [Manager ID24].

The CCGs’ ‘new’ initiatives described in Section 3.4.2.2 were used as a vehicle to support the development of collaborative working at the Locality level:

I believe one of the fundamentals of this was that, yes, you could sign up to [the CCG’s initiative] as an individual practice but I think the emphasis was also that several areas could be done by collaborating with other practices [Manager ID19].

It was about providing a purpose for practices to work ‘at scale’:

It’s federation and those, sort of, networks, et cetera, they work when there is an objective. They don't work for no reason. Why do you create a federation, if you don’t have an overall objective, or a reason? And, currently, in [sub-locality A], there is no overriding reason. I think [sub-locality B] does have a reason, because they're looking at combining practices, they're looking at a big premises development, so that makes sense. There will be practices who will want to work with other practices. I mean, we have a practice just around the corner, [...] and you can virtually see them theoretically through that wall, and we would work with them, but there’d be no thoughts of merging, or anything [Manager ID31].
We also found that Locality groups were being used for a range of other purposes such as for piloting/trialling initiatives such as quality/performance management, organising extended opening hours between practices and the roll out of integrated pharmacy, although these could also be viewed within the context of fostering collaborative working. In Site 3, the piloting of an integrated pharmacy scheme within general practice was considered a successful step towards providing cost benefits to the CCG by both reducing spend on medicines and by reducing GPs workload. Similarly, Site 2 claimed that they had reduced the variety in the provision of certain services and found that by collaborating within their Localities (prompted by new outcomes-based incentive framework), they found a way of working ‘at scale’ for the benefit of both the patient and general practice as this manager explained to us:

So, if you were a patient in one practice, another one down the road, totally different things going on. So, the standardising of that for example is one method whereby one practice could say we will do ECGs for our neighbouring five practices. Rather than every single practice having to provide that service but they’ve collaborated and found a way of working out a scale. [Manager ID19]

Overall, the role of Localities in our case study CCGs were to support GP practices working together and to encourage collaborative working between primary, community, secondary, voluntary, and social care to support the development of new models of care.

3.4.4.1.2 External relationships

3.4.4.1.2.1 Involvement of Health and Wellbeing Board and Local Authorities

The Next Steps towards Primary Care Co-Commissioning (NHS England, 2014d) document stated that

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 (p14).

To do so, CCGs were to invite representatives of local authority representative from the local Health and Wellbeing Board (HWB) to observe the Primary Care Commissioning Committee (PCCC) meetings as non-voting members. From our observations, we found that the relationship with the HWB and Local Authority (LA) with regards to primary care commissioning was variable across different CCGs. HWB representatives had been invited by all of our case study CCGs to attend PCCC meetings, however the attendance was not consistent across the sites. In Site 3 it was felt that the HWB did not make an effort to participate in the PCCC:

Our Local Authority has never bothered to engage in that group, although they have been invited [CCG Accountable Officer ID28].

In Site 4, the lack of attendance of HWB representatives at the PCCC was perceived by a CCG manager as understandable due to the nature of PCCC meetings. It was suggested that the HWB were interested in the local primary care strategy rather than observing the decision-making processes within the CCG:

Things like the Health and Wellbeing Board, we have invited them as members onto our committee, but they tend not to come. I’m not sure they see it as widely relevant, and to be honest we’ve not had huge amounts of business going through. So, they’re, I think they’re more...well the Health and Wellbeing Board are more interested in the strategy actually, rather than, you know, the decision-making mechanisms, and we’ve taken our strategy through Health and Wellbeing Board [CCG Accountable Officer ID39].

On the other hand, in Site 1, although the HWB representative regularly attended PCCC meetings, the councillor was not familiar with the workings of the CCG and primary care and needed to be supported by a Public Health officer.
The areas of work the CCGs in our case studies were involved in with the Local Authorities were around the integration agenda and estates in the area. For example, the CCG in Site 2 was working with the Local Authority to redevelop a building to house different services, including putting a new health centre:

I’ve found is that that relationship with [Local Authority] has over the years, created a lot of projects that wouldn’t have occurred if we hadn’t known. We have done joint developments. We did one for example, a library building that the Local Authority couldn’t afford to keep it going. It was a library building in the community centre. They wanted to close it down and actually, we said, well, we’ll redevelop it with you. We put a health centre into it. The library retained the small part and the community centre a smaller part. And it’s breathed new life into the building and the building’s been running like that now for about four years. And it regenerated something that would once have been closed down [Manager ID21].

However, there are broader portfolios of work between CCGs and Local Authorities which although not directly part of primary care commissioning, have an impact on general practice. For example, Site 1 was implementing a new model of care locally, with an emphasis on integration between health and social care. A priority for the CCG was to ensure that primary care was included in the integrated model of working by ensuring that primary care was discussed and understood by the stakeholders:

They’ve had to language, common language, you know, general...a GP to a counsellor is a...you know, and even social workers working in primary care are still not...still a little bit novel in some areas. So we’ve got to recognise that. So we’re doing a lot of work in [Site 1] about health and social care integration. We’re talking about co...shared commissioning, co-commissioning between ourselves and local authority, and there’s an interesting con...so where will...where does primary care best fit in that model moving forward? We are...from a health perspective we can help that conversation, we can broker it, but recognising that the third sector and Local Authority have got a lot that they can play [Manager ID12].

The relationship between CCGs and the LA was heavily influenced by austerity and the continual budget reductions that were being faced in the LA. In Site 2, they said that there have been numerous attempts in the past to link health and social care together, however there was a certain point where organisations became protective of their own budgets and therefore integrated ways of working were inhibited by financial crises:

How do you encourage people to self-govern while providing the framework in which the different aspects of their lives are connected together. A very bitter example of course is health and social care and how for so many years we’ve not been able to match the two things together, because one is in the hands of the local authority and the other is in the hands of the NHS, the health service. Why have we taken so long to even start talking about bringing these...? And we have tried in the past. Section 75 payments, whatever, groups of people like people with learning difficulties, we’ve worked with those, because they have a foot in both camps, local authority and health, and we’ve tried very hard to pool budgets together but then the local politics kicks in. There’s a gap in the local authority finances and the NHS is worried that if you give them any money it’ll disappear forever and it will never be used for those... It may well be true [Lay member ID14].

The financial pressures that were being experienced in public health were discussed at one PCCC meeting regarding GPs offering screening services. Site 2 have been receiving individual funding requests where GPs were asked to do work which might be argued not in their core contract. The example in this site was around Hepatitis B contract tracing. They had an ongoing discussion with Public Health and this issue had been raised at the PCCC because aspects of the public health
portfolio were perceived to be taken on by the CCG as a consequence of the financial pressures that the Local Authority was experiencing.

Overall, the relationships between the various CCGs and their HWBs and LAs was varied. Some HWB representatives attended the PCCC whereas in other sites it was felt that there was a lack of engagement. However, it was clear that although people were not necessarily attending meetings, broader pieces of work between the CCGs and LAs were on-going and the integration of services and new models of care would impact on primary care. Therefore, it was important for the CCG to ensure that primary care was included in the conversations.

3.4.4.1.2.2 Patient and public involvement

In our case study sites, the CCGs’ engagement and communications team generally attended the primary care strategy/operational group meetings. At the meetings we observed and interviews we conducted, there were references towards the engagement activities that the CCGs organised, especially in relation to changes to practices such as practice closure or relocation. The following are typical examples:

So we’ve had one provider meeting, we’ve had one public-facing meeting where we had a full house, so we had 70-plus patients. This week, Wednesday, we’ve got another provider meeting and we’ve got another patient-facing meeting that we expect, again, to be full and very vocal. And that’s good, I’d much rather people come and tell us what they think of the proposals. [Manager ID22]

Branch Closure Request
Communications and Engagement Manager updated on patient engagement. The engagement is starting this month. They now have a copy of patient letter, leaflet, stakeholder letter, and questionnaire in post to go to all patients.
Primary Care Co-Commissioning Manager added that a 6-week consultation period was agreed.
Communications and Engagement Manager said that there are concerns [about the consultation period] from politicians in the area. [...] Also need to make it clear in the stakeholders’ letter what is the CCG’s role in this. [Primary Care Strategy Group February 2016, M2]

However we did not observe much patient/public attendance at the primary care commissioning committee meetings we observed. In one of the meetings in Site 1, the committee made a special arrangement to the meeting room as they were expecting practice members or the public to attend the meeting due to a discussion on a practice closure on the agenda. However no member of practices, patients, or the public attended the meeting. In Site 4, we observed an anxiety around the possibility of public attendance at primary care commissioning committee meeting:

This was an interesting meeting regarding the public/private sections of the meeting and how the meeting was re-jigged to suit the CCG and Col issues because no members of the public were there. A rather amusing point of the meeting was when the NHSE member of staff walked into the room (unknown to the CCG) conversation just stopped mid-sentence in case it was a member of public. Even though they weren’t even talking about anything controversial the tension in the room rose quickly and highlighted the issues that the CCG face when holding meetings in public and private. [Meeting notes, Primary Care Commissioning Committee January 2017, M62]

Site 2 was discussing the possibility for the patient and public advisory group to attend the primary care development group meetings. However at the time of our data collection this was still being discussed and no decisions have been made. Whilst Site 3 worked with their neighbouring CCGs’ patients and participation groups where they trained volunteers to go into GP practices to talk to patients and observe the environment to understand patient experiences.
3.4.4.1.2.3 Working with neighbouring CCGs

We asked each case study site about their relationship with other CCGs and if they had formed any working relationships. When discussing this external relationship, it was clear that the delegated primary care responsibility is just one element of a CCG’s responsibility and therefore CCGs do work alongside each other where it is deemed of benefit to the organisations and the local population. For example, in Site 4, they were trying to formalise a joint committee arrangement whereby local CCGs can commission services over a much larger geographical footprint. This raised issues regarding the membership and the need for a formal vote because of the impact on the CCG constitution:

CCG Accountable Officer: This is for the GB [Governing Body] to consider and endorse the direction of travel but the final decision remains with the members as joint commissioning arrangements will impact on the constitution. We want to strengthen our existing collaborative commissioning with a joint committee across [region]. The joint committee is made up of members that represent the organisations; our legal advisors say that the decision lies with the membership. The overall responsibility and accountability remains with each CCG as that cannot be delegated. [...] This work predates STPs and we think that by establishing a joint committee that it could also help manage the STP. We will only put things into the joint committee where there is a benefit for something to happen on a [regional] level [Governing Body February 2017, M64]

In some of our case CCGs, informal networks were established to provide CCGs with a forum to discuss different issues that they were facing and provide support and examples of how they were managing certain contractual changes. For example, the PMS review and the implications for their member practices. These informal networks were recognised as being a useful mechanism to manage primary care commissioning, learning from one another; when NHSE were not able to provide the support that CCGs required because of their own capacity issues:

So certainly I know from the network that we’ve got of other delegated CCGs...so the three of us that went first in [name of an area] have had an informal network, so we’ll bounce things off each other and say how have you managed this, how have you managed that, and I think for some of the examples that we’ve talked about, even within the three of us. So we had to reissue PMS contracts, and two of us have done it and one of them hasn’t. They’ve got a smaller number of PMS practices. So NHS England has done that on their behalf. So even though that’s clearly part of the devolved functions there has still been some negotiation with some areas about which they’re doing. I think that’s due to capacity within the CCGs. I think it’s also due to the capacity at NHS England, and I think it’s been a balancing act really trying to find a happy medium of who’s best placed and who’s got that resource to do the work. [Manager ID10]

Other CCGs have not formalised their relationships into networks, although links have been made and relationships have been forged between individuals with primary care responsibility across neighbouring CCGs:

Other CCGs, I know [Primary care contract manager] works quite closely with her counterpart in the other [name of a neighbouring CCG] because they have taken on co-commissioning as well. So, I think there is a bit of, kind of mutual support there [Manager ID39].

However, it was felt that a committee-in-common across a number of CCGs was likely to happen once more CCGs opted for delegated commissioning:

Not at the moment but I think as more CCGs take co-commissioning that is going to...that probably will...well there may be but not that I know of [Manager ID39].
Certain factors were found to be useful in fostering good relationships with neighbouring CCGs. These included a number of CCGs being situated in the same building and joint appointments across multiple CCGs. In Site 4, the decision to move from joint to delegated commissioning was influenced by an employee of the CCG who had a joint appointment in a neighbouring CCG. This joint appointment offered insight and an opportunity for knowledge sharing into the working practices and challenges that the neighbouring CCG were facing as delegated commissioners. This highlighted there were few differences being experienced between joint and delegated commissioners:

But for the last year while she was essentially sitting on both committees...and she said that there wasn’t really very much difference. So we knew, and that’s why I say that it felt like we were delegated last year really apart from just with a few more hurdles and obstacles. So we knew what we were taking on, I think, from [neighbouring CCG] perspective. [CCG Chair GP ID38].

The CCG in Site 3 was located in the same building as a neighbouring CCG which helped form a good working relationship across the CCGs and enabled them to work closely together on specific pieces of work:

With other CCGs, because we shared a building with [name of a neighbouring CCG] there’s a very good relationship for us with them, we worked as an operational contracting team, we worked very closely with them. I have some involvement with [name of another neighbouring CCG] as well so the local CCGs yes. And I have spoken to others mainly through contacts, my ex-colleagues from NHS England who have moved to other CCGs. So no, there needs to be a network, there needs to be a network of primary care contracting across the CCGs otherwise things could get lost again. I think it’s important network that needs to be established to make sure that co commissioning...the co commissioning teams have a network, people to feed with and from. [Manager ID37]

Site 3 had also discussed the possibility of having a joint post across two CCGs focusing specifically on primary care. However, because of timing differences across the CCGs it was found that it would be beneficial for the CCG in our case study site (Site 3) not share the post owing to the amount of work that was required to do primary care co-commissioning. The original decision to share the post was made before the responsibility of co-commissioning had been experienced by the CCG which may help explain why the CCGs changed their plans once they started to commission primary care:

We were going to share the 8A with [a neighbouring CCG], although they didn’t go forward with co-commissioning at that time, they were going to go forward this year, so we were going to take the posts for a year and then they were to share them and we felt that was fine because we needed to establish co-commissioning and do a bit of catch up but [a neighbouring CCG] still haven’t picked up co-commissioning where it’s, kind of, being landed on everybody anyway and they are now quite keen to share the resource but we’re not really keen to share it because we found it so useful having the staff entirely to ourselves. [CCG Accountable Officer ID28]

Although the CCGs within this study suggested that networks or support from other CCGs was useful with regards to primary care commissioning. Wider local issues and decisions were found to be influential and in some cases could jeopardise the relationship with other CCGs. For example, Site 3 decided that they would step away from a local alliance that was being developed by a number of CCGs because it was not focusing on their local population or the providers that the CCG used. This decision caused tension between the other CCGs in the alliance and an unsettled period with regards to joint working.

Overall, our case study sites found the relationships that they had with their neighbouring CCGs to be useful in terms of knowledge sharing and support. The mechanisms underpinning these
relationships differed depending on geography and local circumstances. The relationships varied from formal ways of working (established networks and joint appointments across CCGs) to informal mechanisms (sharing a building with another CCG which provided regular dialogue). Generally, having extended relationships with other CCGs was found to be beneficial for the primary care agenda.

### 3.4.4.1.2.4 Engagement with others

The engagement with others including organisations such as Healthwatch and the Local Medical Council (LMC) was mixed across the CCGs within our study. In the interim report (McDermott et al., 2016), we discussed the findings from our initial telephone survey and found that following an initial announcement that NHSE would delegate primary care commissioning responsibilities to CCGs, some LMCs were quite vocal about how CCGs should not take on the extra work.

Some CCGs in our case studies had also experienced their LMC’s opposition. For example, in Site 3, the LMC suggested that the GP membership should vote against the CCG taking on the responsibility. However, the membership felt that the relationship between the practices and the CCG was strong enough for the CCG to take on the responsibility:

> We have a good relationship with the LMC. I think our local rep is really good. When we went to our members to say we should take on co-commissioning, the LMC wrote to everybody and said don’t do but our membership ignored them and I have to say that our local LMC rep said that whilst they didn’t think that other CCGs should do it, that they thought that we should because the relationship was good enough between the membership and the CCG for them to be able to trust what we were doing, whereas in other areas it wasn’t necessarily like that, so that was good. So, no, I found the LMC quite supportive [CCG Accountable Officer ID28]

Although the LMC in Site 3 was initially opposed to the CCG’s decision to take on primary care commissioning responsibilities, the CCG’s relationship with the local LMC was still described as a positive working relationship:

> We have a very good working relationship with our LMC, although they didn’t support us initially, by the end they did. And we meet with them regularly; they don’t have any issues with it. [CCG Chair GP ID27]

In Site 4, the CCG’s relationship with the LMC was still in early development. It was acknowledged that the LMC representatives were starting to understand the role of the CCG with the commissioning of primary care which had helped to improve their relationship:

> I don’t know, from an LMC point of view, maybe it’s, well, with the exception of the hospital reconfiguration programme were we’ve had a lot of LMC feedback, I think the fact that they understand now that the CCG can serve breach notice and can go through that process, I think that’s probably improved the relationship slightly. [Manager ID45]

However, there were some wider issues regarding the reconfiguration of local hospitals which had further impact upon the relationship with the LMC. This demonstrates how the relationship with the LMC is multifaceted and broader than primary care commissioning alone:

> Yeah, there have, absolutely, and they’ve taken a particular stance around what our proposals around the hospital are that have played out that are against the changes, but actually what the root cause of some of that is about, was the impact on primary care, rather than necessarily the changes, but it’s had a profound impact on the relationship between the organisation and the LMC and there’s a lot of work now going on to be able to move forward in a productive way in that relationship. [Manager ID46]
The LMC was described as having an important role in supporting general practice and the difference in opinions between the LMC and CCGs were an accepted consequence of the different roles the two organisations had with relation to general practice:

So they...basically they got like the elements from the contract into a template and then what I then did was mapped that against the CQC standards to make sure that we were picking up the quality elements of it. One of the issues we have around that is that...we had at the time, was when we were developing the template, which is purely from the contract, because...as you’ll be aware, we have LMC reps that, you know, are on our committees, they were of the view, if it’s not in the contract why are you asking practices. So for me, it was a slight struggle because for quality there are some real specific questions I would have liked to have asked, because it’s not I the contract, so we had to think about how can we ask those same questions. [Manager ID23]

Although the role of the LMC was perceived to have a place in the CCG, in contrast, Site 1 decided that the LMC could not be a representative on the Primary Care Commissioning Committee because it raised issues regarding conflicts of interest. This view was echoed by a Healthwatch representative in Site 3 where they thought some contributions from the LMC representative were not appropriate.

Although the LMC were not members of the PCCC in Site 1, the CCG and the LMC worked together to develop some local schemes. An equitable funding scheme was developed by the CCG and LMC to ensure that practices were not disadvantaged by changes to funding. This negotiation enabled a pot of money to be ring fenced to offer targeted support for a specific local contract. The CCG agreed with the LMC on which practices should be funded.

We found that our case study CCGs had wider relationships with other organisations that had influence upon the primary care agenda. In Site 3, the relationship with Healthwatch was seen to be very important and useful for both the CCG and the local population. Healthwatch have a good source of local knowledge which is useful to the CCG for the planning and commissioning of services. Their relationship provided a mechanism of communication between the CCG, volunteers within the community and the local population:

Well, I would say positively. I mean we have a lot of relationships at different levels doing different things, and that’s great, but obviously for us and for the CCG primary care is one of the biggies, and getting that right, particularly in the current context, and some of the issues we’ve been raising around the ability to get appointments, et cetera, get on lists, extremely important to the local population. And for me to be able to come on to these meetings, giving information to my team who in turn can give appropriate information to volunteers, [...] spreading the word about what is happening and, as I say, also gathering information to come back and feed into the leadership here, I think can only be very positive; and it’s still developing but it’s all heading in the right direction, I would say [Healthwatch representative ID29]

In addition to the LMC and Healthwatch, CCGs in our case studies also found the relationship with the Care Quality Commission (CQC) useful with regards to troubled practices and issues that the CCG were trying to tackle. For example, in Site 4, the quality team in the CCG held meetings with NHSE and the CQC when trying to understand and resolve issues that a troubled practice was experiencing. When practices were in breach of their contract or potential issues of safety, the CCG and CQC worked together to try and bring about a suitable solution.

The CCG work portfolio is varied and the addition of primary care has influenced the wider relationships that they have with other organisations. As expected, the relationships with the LMC and Healthwatch are variable dependent upon the local context and past working histories. This is demonstrated by the engagement of Healthwatch in some CCGs but not others within this research project. An interesting aspect of these relationships is that they are broader than just primary care.
and therefore the relationships that the CCG holds with the LMC for example may be seen as useful and ‘good’ with regards to primary care but more broader changes such as hospital reconfigurations are likely to influence the relationship and the working practices. Thus, it is difficult to understand the local relationships that CCGs hold with other organisations when focusing on primary care in isolation.

3.4.4.1.3 Relationship with NHSE

The relationships between NHSE and CCGs around the commissioning of primary care have changed as delegation has developed and commissioning work has become embedded into the day-to-day activities of CCGs. The period of assuming responsibility was characterised by a high degree of ambiguity in relation to the distribution of tasks (who does what?), the processes of handling practice issues (who goes in first?), and operational matters (how is this done?). NHSE’s past handling of primary care commissioning has left considerable legacy issues for CCGs to address making the initial period of assuming responsibility particularly challenging.

It is worth noting that CCGs’ relationship with NHSE are multidimensional and the experiences of working alongside NHSE on primary care commissioning has been described by our respondents as both ‘excellent’ as well as ‘dreadful’. The quality and effectiveness of the relationship dependent on many factors, such as the level of delegation uptake, organisational function (for example, whether it is a relationship between engagement teams, finance teams, or contract teams), purpose of engagement (for example, whether the relationship is on operational basis or a more strategic one), and mostly contingent on personal familiarity and past work-experience (for example, whether CCG employees are past NHSE employees or seconded personnel).

Out of the many challenges, an emphasis was given to problems of access to information and those involving communication issues. This was particularly evident in the case of financial information and the processing of contracts. Site 2, for instance, did not have access to electronic contract records even after 16 months, or Site 3 only having access to Calculating Quality Reporting Services (CQRS), a reporting and payment system for quality achievement in GP practices, since April 2016, without the possibility to examine historic data or trend changes. Having responsibility for contracts without access to the full system makes the work of the contracts team extremely difficult, as explained by the following interviewee:

We haven’t got control of that [quality reporting system]. [...] S you know, whilst we’re holding the contract, we can’t deal with probably 30 percent of the queries that we’re getting through because we haven’t go a[ccess to the systems. [Manager ID20]

The lack of access to electronic records means that CCGs are left in the dark when it comes to financial queries, making the CCG’s relation with GP members difficult.

The above exemplifies CCGs mixed position as an organisation responsible for commissioning primary care and engaging with GP practices while simultaneously being reliant on NHSE’s timetables, internal working schedules, systems and procedures. The lack of clear communication leads to many difficulties, as explained by our interviewee:

NHSE are the ones signing off GMS contracts [...]. The last communication with NHSE was that [x number of contract] have been signed off [...] there is no indication that any of this have been signed off by NHSE. [GP ID41]

This does not only impact on how GPs view and relate to the CCG, but also has a direct implication on the CCG’s financial position. For example, any changes in GP’s seniority band translate to additional expenses as practices attract higher sums of money. With no access to the details in the system, CCGs can only experience these changes to their financial position without proper explanation thus making planning and foresight difficult. In Site 2, this has been dealt by inquires to
the practice and additional clarification work as the contracts team found it hard to understand the changes to financial circumstances.

**Communication problems were not restricted to contracts alone, but also pervaded the work of the quality teams.** For example, in Site 2, reports on how the CCG did not receive any information on which practices have been visited by NHSE in the past made it difficult to ensure continuity of quality monitoring. This was addressed by developing a visiting pilot and the contracts team going out to visit practices, but not every breakdown of communication can be handled with such a workaround, and these sorts of gaps still exists now, extending to the CCG’s day-to-day activities. This hindrance puts CCGs at risk. At another site, NHSE appears under ‘gaps in control’ on many of the sections of the PCCC’s Risk Registry. As effective decision making dependent and, at times, jeopardised by the need to wait for NHSE to take action, this poses a major issue for CCGs.

A further example was where quality related requests were not adequately addressed. This was particularly challenging as even though evidence of poorly performing practices might be collected and sent to NHSE, there was a lack of feedback loop leaving the CCG in the dark as to the outcome of submissions and NHSE’s action plans with regards to such requests:

> I’ve only had to refer maybe I think two [practices] under the performance route. Once we do refer there’s no feedback loop so we don’t actually know what...I’m told it’s a conversation with sort of like a medical director at NHS England and the GP concerned, a professional, but we don’t ever get any feedback. [...] So it’s difficult when I then have to go back to say, it’s been managed, it’s gone to this stage, there is no feedback loop. Because of course all these people that have been affected are saying well what’s happened, you know, what’s happening, is he still...and you know, even as a CCG we don’t get told, so that’s a big of a gap actually. [Manager ID23]

This lack of feedback loop has led to delays in the CCG’s response to quality issues in this site as they can only take action if the GP has not been practicing for over a year:

> Although there’s no feedback loop per se, once it’s been referred, we still need to know...particularly for GPs that have gone off sick, because there’s an element where we’re paying the sick pay. So we’ve got a GP off sick at the moment, and you know, all I can do is say...is email NHS England or ring them, what’s the latest update on this, well we’ve asked him to come in for a meeting and he hasn’t come in. So I’ve said, well what’s sort of the trigger, when would you basically like you know, take further action? They said, well he has to be not practising for a year before they would do anything.

While with issues illustrated above the difficulty was around getting a timely response from NHSE, with others it seems that NHSE’s timetables were far too short for CCGs to be able to effectively respond. For example, the timescale during delegation process, from the publication of the guidance and getting support needed from member practices and engagements with stakeholder to approval was about four months. The process was described as hectic and very challenging:

> it was felt that it was the right time. However, we knew we needed to take our membership with us. The timescale was, even by NHS England's standards, bonkers. You'll have to find a more erudite term than that for your report, if it features. But was challenging, shall we say. [Manager ID33]

The shortness of timescales and the lack of fit between what was required in terms of CCGs own capacity and what NHSE expected has also transpired after delegation and during the operation of co-commissioning. For example, Site 1 reported an increased anxiety waiting for guidance on the Estates and Technology Fund submission, which was initially expected in March 2016 but was not published until May 2016. Following the publication of the guidance, the CCG was expected to consult with the Local Estates Forum (who only meet 6-weekly), do the prioritisation, and submit the
bid by June 2016. Similarly, in the case of a requirement to implement a new standard for practices opening hours, the following has been discussed in Site 2:

NHSE told us that we need to procure a new 8-to-8 standard and has given us four months to do a massive procurement. We are pushing back on this, but they might still say we have to do it. We will implement this starting April 1st and it will become part of New Models of Care 2018, but there is not enough procurement staff and it is also going to cost the CCG. [Primary Care Operational Group November 2016, M34]

The timetables attached to requests did not take into consideration each CCG’s ability to comply, and there was often lack of resources resulting in a rushed implementation process. This had direct impact on timescales with projects being pushed to the next financial year, making planning extremely difficult and adding to the risks facing CCGs:

There is a risk to the CCG that in the way funding are allocated from NHSE for the GP Forward View, the funding will not materialise during the financial year they are committed for. This is the same problem as with procurement as the problem is not only money but also process. NHSE continues to impose challenges in timescale on the CCG that can result in lost opportunity. [Primary Care Operational Group November 2016, M34]

Our case study CCGs also expressed dissatisfaction with how funding schemes and guidance are devised and then communicated to CCGs. One example was the Estates and Technology Fund (ETTF). While CCGs were asked to put forward bids, it was not clear initially if funding covered 100% or 66%, as it was dependent on the Department of Health’s publishing the revised Premises Directions. As the funding would cover large and expensive projects, this made it difficult for CCGs to make decisions on which projects to prioritise.

Even though there was much to be desired in how NHSE relates to particular segments of CCGs’ delegation work, CCGs in our case studies expressed some positive relationships and mutual support. One respondent commented on the benefit of having a nursing expertise from NHSE:

Well exactly it’s into existing roles and responsibilities. So the only extra capacity is what we’re able to draw down from NHS England in terms of advice, so the medical leadership and a bit of...there’s a bit of nursing support that we just get...if we’re going out to do a quality assurance visit in a practice, we’d ask NHS England if they want to be part of that and we might use some of their nursing expertise to be part of that. [Manager ID46]

Engagement with GP practices and patients is another part in which NHSE seems to be aligned with CCG work, particularly in Site 2. NHSE’s direct contribution was also apparent when a representative attended the PCCC’s and was able to comment, provide critique, and make an informed observation, as one of our respondents describe it to us:

And then [name of an NHSE representative], from NHS England, comes – I think there’s been one meeting, maybe two meetings where he hasn’t been able to attend. Our primary care commissioning, but comes from NHS England, and, you know, is always very helpful in his observations, and his critique as a member of that group. [CCG Accountable Officer ID28]

However, this was not always the case and while pivotal, NHSE representation was not always available.
Summary- CCG relationships

With member practices:
- Case study CCGs had all engaged their members in the decision making process around assuming responsibility for primary care commissioning
- We found that CCGs regarded their new responsibilities as having the potential to both improve and inhibit their relationships with their member practices:
  - Relationships may be improved by the potential for more direct impact on practices offered by the primary care commissioning role
  - Relationships may be threatened by the role of CCGs in performance management of practices, and by the requirement to implement national policies and priorities which may be at odds with local CCG/practice priorities
- Performance management of practices is complicated by the variety of actors involved:
  - CCGs are responsible for overall practice performance against contractual requirements
  - CQC are responsible for practice safety, procedures and care quality
  - NHS England is responsible for the management of poor performance by individual GPs and for responding to complaints
- In reality these elements may overlap, with resulting complexity and potential difficulty in understanding who is responsible for intervention. Case study CCGs are focusing upon providing support to improve rather than punitive approaches to performance management

With developing GP provider networks/federations
- Our case study CCGs are supporting the development of GP provider networks/federations, but they are cautious about potential conflicts of interest

With CCG locality groups
- Many CCGs have Locality sub-groups
- In some areas these are providing a nucleus for collaborative working between practices and across boundaries with community and social care. In some areas this is supporting the development of so-called ‘new care models’
- Specific managerial support at Locality level appears to facilitate this approach
- Locality groups are also used as testing grounds for potential innovations

With other CCGs
- CCGs are working together on wider commissioning initiatives, including pooling commissioning responsibilities for some types of secondary care services across a wider footprint
- Responsibility for commissioning primary care cannot be pooled, because statutory responsibility for primary care commissioning remains with NHS England
- CCGs have found sharing knowledge and expertise with their neighbours to be beneficial
- Good collaborative relationships are facilitated by:
  - Sharing buildings
  - Joint appointments
  - Joint projects

With Health and Wellbeing Boards and Local Authorities
- CCGs are encouraged to invite HWB members and LA representatives to be non-voting attendees at PCCC meetings
- In practice, attendance and engagement by these groups was variable
- Where these relationships work well, they can facilitate collaborative working and integration
- The pressure on Local Authority budgets was felt to be a significant issue by many
Relationships cont:

**Patient and Public Involvement:**
- Most engagement with the public took place around the issue of practice closures or mergers, with CCGs very aware of local sensitivities about these issues
- Public meetings called to discuss potential closures or mergers were generally very well attended
- However, there was significantly less engagement with the routine business of primary care commissioning, with minimal attendance at ‘public’ committee meetings and no mechanisms for broader public engagement around primary care provision in our care study sites
- We found little evidence that holding meetings in public increases transparency, as committee members were very guarded as to what they would discuss in the public part of meetings

**Other relationships:**
- CCGs are engaging with a variety of other organisations and groups with regard to their primary care co-commissioning responsibilities. These include:
  - The local LMC
  - Local Healthwatch
  - Care Quality Commission

**With NHS England:**
- Our case study CCGs identified considerable legacy issues as they took over responsibility for primary care commissioning from NHSE. These included:
  - Access to information about contracts and finance
  - Ambiguity as to where some responsibilities lies
- Relationships are multidimensional, with experiences varying from ‘excellent’ to ‘dreadful’. The quality of working relationships appears contingent upon:
  - The area of work involved (eg finance and contracts appeared more problematic than engagement)
  - Whether the focus was upon strategic or operational matters
  - Personal familiarity and relationships, with past experience of working together described as very helpful
- Communication was reported as a particular issue, including:
  - Delays in obtaining access to electronic contract records (eg CQRS)
  - Lack of information about past NHSE contract monitoring activities
  - Lack of feedback from NHSE if the CCG reported performance concerns
- Primary care co-commissioning by CCGs does not have a legislative basis, with NHSE retaining statutory responsibility. This generates issues, with CCGs reliant on NHSE timetables and systems
- Timescales for CCGs to respond to NHSE initiatives were described as too short, with insufficient information or time to consider responses. For e.g. the ETTF required very rapid responses, whilst associated guidance was unclear.
- Respondents reported positive experiences of NHSE representation at PCCC meetings, although such representation was not always available.
3.4.5 Impacts, outcomes, and claims of success

We asked our case study CCGs to talk about the outcomes and impacts they would expect from taking on the delegated responsibility or what they hope to achieve in three to five years and also to give us concrete examples of any early successes.

3.4.5.1 Impacts

In terms of the impact of primary care co-commissioning, our case study CCGs claimed that taking on co-commissioning responsibility has allowed them to have more control over commissioning decisions hence they can make strategic decisions and commission in a more joined up way:

It allows you to make the decisions around things like, for example, if you have practices that are unsustainable, for example. If we look at what we’re trying to achieve through our strategy we know that practices need to work together in different ways. Things like proposals for practice mergers, for example. That’s something that we can now decide on, where as previously they might have been...those decisions would have been made by NHS England without understanding if it fitted with the local strategy, and if it made any logical sense. Because sometimes practices merge, you know, from far ends of town just because, you know, they’ve got that relationship, but it doesn’t actually [...] make strategic sense. [...] So, by having full delegation we’re far better placed to be able to oversee, and guide primary care alongside the knowledge of what might be happening in the hospital programme [...].

It’s about being able to see the whole picture really, rather than relying on NHS England to be able to commission the primary care bit, in a way that’s going to be able to meet the needs of a re-configured hospital service, for example. [CCG Accountable Officer ID39]

I think it has allowed us to commission in a much more joined up way, because we are commissioning the whole of the out of hospital agenda now. [CCG Chair GP ID27]

Well, I don’t expect it to be earth shattering, but, as I say, it’s about [...] getting control of the things that we needed to control to do our job properly, which is...within NHS new terms is to keep a sustainable service while we transform it into a better service, and we couldn’t do that without co-commissioning, because there was a big bit that was missing. [CCG Chair GP ID8]

Others claimed that taking on co-commissioning has enabled local decision making:

Build on the commissioning within primary care and...which is exactly what co-commissioning is about, and localising as well so that we’re dealing with commissioning for the local [...] practices to address the challenges that they have in each of those areas. Which is very different, we’ve got different areas within the CCG so there isn’t a one size fits all commissioning really for that. I think it needs to be smaller and I think that’s where co-commissioning can help. [Manager ID37]

This manager described how co-commissioning would enable the CCG to be creative in how they can relieve the pressure in primary care and also start thinking about commissioning on a population basis at a local level:

I think we do need to see rapid change. If you think that...everybody tells me, I've not been into this, but 80 per cent of healthcare is provided within a primary care setting, it's your go to person for going to for your first point of contact for healthcare. When there was the junior doctors’ strike I think there was extra capacity in primary care and I’m not sure how busy A&E departments were. I think there is a case for are we looking too far downstream in terms of solutions to some of the emergency problems that we’ve got. And I think if co-commissioning allows us to look further upstream to find that solution in terms of increasing
capacity in primary care, and that might be from primary care alternatives, minor injuries units, other clinics that could be held within primary care, if we look further upstream then maybe we'll relieve the pressure further downstream. And that is hopefully what co-commissioning means to us, that we've taken on responsibility for that segment of the care pathway, [...] I think that only becomes sustainable if you start looking at a different scale of primary care. So primary care doesn't look like an individual practice with 5000/6000 registered lists, but maybe it looks slightly broader. We need to be looking at 30,000/35,000 registered lists as a planning unit. It doesn't mean that they're all in the same building, but that should be the planning unit that we should start thinking about. Because I'm aware that if you start thinking about 35,000 patients in a single building then everybody will see that they've lost access through it because they're having to travel potentially further for primary care. So it might need to look different, but there should be a planning unit of, say, 35,000 in terms of registered patients, and then it starts becoming more localised. And hopefully that is what co-commissioning is going to allow us to do, is start really commissioning on a population base at a local level. [Manager ID32]

3.4.5.2 Outcomes

In terms of outcomes, some of our respondents claimed that by taking on primary care commissioning responsibility, they have more control over commissioning budget which they can now use to support GPs working together hence relieving pressure in primary care:

Hopelessly, less pressure on our primary care, because [...] I do believe our primary care colleagues when they say that primary care is close to falling over. So that has all these things about improved urgent care, improved discharge from hospital, improved multiagency work, [...] it can't meet additional unmet need, it has to - well, ideally, it would - but also, it has, as a priority, to reduce the pressure on primary care. [...] I think we're in a far better position to develop - federations is too strong a word, I don't think we'll ever do that because I don't think this will quite work effectively in rural areas - but I think it will be far easier to get those kind of partnerships between GPs because we have the commissioning budget and we can do those inducements, and that relationship with them as well. It's more than just a contract, it's that relationship we have with our practices. [...] And we can support primary care far better by being the main commissioner of it. [Manager ID33]

Moreover, CCGs would also be in a better position (due to being clinically-led) to encourage integrated working between primary and community care hence making primary care stronger:

I think some of the outcomes in terms of the future of primary care I think would exist anyway whether or not we were co-commissioning or what extent to which co-commissioning helps that, so I guess in terms of leaving primary care in a stronger state as it can be, potentially primary and community care working more closely together, and primary care probably working more closely together than it has in the past and potentially localities, you know, and possibly making a level of decisions and, I think, clinical involvement of the CCGs that maybe we haven't had historically in PCGs, PCTs. [Manager ID36]

One of our respondents differentiated between tangible outcome, such as getting sign up for a new incentive schemes, and intangible outcome, such as relationship with member practices:

I think it means that hopefully we've got the approach right. But the more tangible ones for me are we've got all the contracts up to date, we've got the premium contract agreed, we've finished the equitable funding review. So some really big ticks and some sort of process outcomes I think we've finished. But it's the intangible ones that I'm quite pleased about. [...] I think for me the intangible outcome is already that practices... It could have been a really tricky thing to do. So up until taking on co-commissioning CCGs have had a very
supportive arm round the shoulder role with primary care. We’re here to commission together and that’s what we do. [Manager ID10]

### 3.4.5.3 Claims of success

We asked our respondents to give us concrete examples of what they have been able to achieve since taking on primary care commissioning responsibility.

Some of our respondents argued that it was too soon to claim any successes. However, most respondents claimed that co-commissioning has improved the CCGs’ relationship with their members. Being clinically-led meant that CCGs can have a GP to GP conversation with member practices which NHSE was unable to do:

> Because the first one that fell over was managed by the area team and it was a disaster, am I allowed to say that. It was only when the CCG stepped in with the local knowledge and actually had some really good conversations, GP to GP if you like, and actually did the practical. Because we closed the practices and in fact the GPs of that practice that took over most of the patients said to me, you know, nothing happened until the CCG came in on this and actually had those conversations, and had those difficult conversations, but had a pragmatic approach. Because we are clinically lead, you know, I could recognise what the challenges were; we were better than the area team because they are not GPs. So, yeah, the feedback has definitely been that the CCG have managed this very well. [CCG GP Chair ID27]

Moreover, having the capacity to do the work has contributed to the improved relationship between the CCGs and their members:

> I think it's been good for us as a CCG, it's strengthened our relationship with our members. I think we haven't...one of the things we were anxious about in taking it on was dropping the ball in terms of payments to our members or just not managing the system. And I think certainly the feedback we've had is, we haven't done that and actually it's an improved service than they did have from NHS England. [...] I would say that our members probably have experienced a more responsive service to payments, invoicing, problems, and so on. That's certainly the reports I've had from them. And again, that's not a criticism of NHS England, that's a capacity issue. They're a team of eight managing, I don't know how many, 200 practices or whatever. We've got two people managing 20. It's doable. [Manager ID33]

One of the Primary Care Manager we interviewed described how they need to adopt a supporting role:

> I think for me the CCG puts a lot of emphasis on GPs as our...they're our members, so when I’m going out to practices I always have in the back of my mind, they’re our members, we’ve got to support them. It’s not a case of like you know, beating them round the head, you haven’t done this, it’s...I always think...and actually the colleagues that I work with in contracting, we always think, well how can we help them first, or what’s behind that, before we jump to conclusions, or issue breaches or things like that. So I think it’s a positive thing because we can put that support in as well. I think it’s the support for me, that we can provide them. But I think it’s good, I welcome it as well. I think also I think the benefit of having that local knowledge and that control as well. [Manager ID23]

Another manager described how the CCG conducted various visits to practices when they took on delegated responsibility to build the relationship and introduced faces and names of the person they can contact in the CCG. **The CCG’s ability to appoint a Primary Care Manager to develop and maintain supportive relationships with GP members were seen as a contributing factor to improved relationship**, as described by one of the GPs:
Ultimately, I think the two benefits for me would be that we have got local people, so we know their names and you can ring them up, they will come out to our practice. I can’t recall anybody from NHS England ever coming out to our practice. I don’t know the names of anybody that was involved. We actually have a named, unfortunately ours is actually changing, but we have a named Primary Care Manager. I know what her name is. I have got email address. I can contact her. If we have got a problem, they will come out to our practice and we can go through the issues. [...] So we have got named people that we can contact. So that is the first big thing. [GP ID17]

This view was echoed by a Healthwatch representative:

For us collectively as Healthwatch – it feels a much more integrated way forward because you can imagine the public come to us if they’ve got concerns or questions, which may be around, oh, my GP list is closed; and we can check that out, we can do that really easily now, whereas before that was quite a tortuous process. So communication is much easier. Interaction is much easier, sharing of intelligence. We collect all the feedback we get from the population [...] we can feed in anything that relates to both primary care and GP practices in particular. [...] And for me to be able to come on to these meetings [primary care commissioning meetings], give information to my team who in turn can give appropriate information to volunteers, [...] spreading the word about what is happening and, [...] also gathering information to come back and feed into the leadership here [Healthwatch], I think can only be very positive; and it’s still developing but it’s all heading in the right direction, I would say. [...] It used to be extremely difficult to get responses from NHS England from the regional teams, very, very difficult. Very difficult. So that has improved. [...] We get enquiries about, oh, I’m told this practice list is closed; I can come directly to someone I know now at the CCG and say, what’s the situation here, and get those responses very quickly. I feel there’s an open door and any concerns I could, in the meetings or indeed outside of meetings I have someone I can engage with and talk to who will, if they can’t deal with the issue at hand will know who can and who I can be signposted on to [Healthwatch representative ID29].

We identified some of the things that the CCGs claimed they were able to do after taking on the co-commissioning responsibility. The first was to standardise and reduce variation in general practice. Site 2 had developed a ‘new’ incentive scheme (see Section 3.4.2.2) and ‘successfully’ getting sign up from majority of the practices to standardise their opening hours:

[...] with the access, you’ve got some of the larger practices that, they don’t close for a half day. They’re all open till seven o’clock, some of them, some of the very large practices, but then you’ve got single handers that could be half a mile down the road that close two afternoons a week, and they only open till five o’clock two days a week. It’s very much around, how do we address that? That’s a very big thing for practices to get their head around, their staffing models, the HR issues around that, to say that within 12 months we’ve got [majority] practices doing it, it’s quite an achievement. [Manager ID24]

The CCG Chair in Site 4 claimed that they had successfully supported one of their practices to write their own local QOF:

Yeah, I mean I think the local [practice name] QOF was an early success and actually a classic example of something that NHS England did really badly for, you know, the two or three years and then we did it really well – and mainly because we actually spoke to them, [...] and like communicated and [...] had a discussion; simple things like that. So that was a really good success story really [...] They have a local QOF because [essentially their population is different] they can’t earn any money through QOF. So they had this local QOF But NHS England just came up with like ridiculous things for them to chase.. And [...] they had to hand leaflets out and just bonkers stuff. And the [practice] said, well why are we doing this
– well, because you’ve got to have a local QOF. So they were just chasing ridiculous targets and in the end they just said, well fine, we’ll just chase them and get them on...but they weren’t meaningful at all. [...] And in some ways actually what we did this year was almost had an adult discussion with them and said, well why don’t you tell us what...why don’t you write the local QOF – that’s a bit radical. [...] we had a look at what they wanted to do and then got into a discussion about where the percentages should be [...]. So the QOF this year is relevant and actually there doing something that might actually help their population rather than just ticking boxes. [CCG Chair GP ID38]

A manager in Site 2 claimed that they were able to shift resources around with the cost being covered by the CCG:

We’ve had a situation where a GP went off on unexpected sick, practice manager couldn’t cope, didn’t know how to cover it and normally what you’d get is manager frantically trying to get locums, wouldn’t know what to do and we swooped in. One of the [primary care] managers [...] she went and sat on reception. We got some additional practice manager time from a very experienced manager, put that in but the CCG covered the cost. We got one of the local practices to caretake that and it was all sorted. We ended up finding that that GP wanted to take retirement so we actually found him a partner so he could step down so all of that happened that wouldn’t have happened before. [Manager ID26]

Another claimed that they were able to support practices, especially smaller practices, to develop new ways of working:

Some of the successes of it? Seeing some of my smaller practices that I’ve actually built those relationships with, they’ve implemented new ways of working, they’re working with other practices. I love that. I went into a practice the other day, they’re quite good anyway, but I went in and they had a huge folder, they said, oh we’ve done this, this and this, and we’ve got this problem here, how can you help us? [Manager ID25]

A Lay Member in Site 2 claimed that co-commissioning has enabled GPs to start thinking about the wider population rather than focusing only on their registered patients:

You know what co-commissioning has done? It has obliged the practitioners, usually independent practitioners, to accept responsibility for the health of patients beyond their list size. So it’s not just simply their captured audiences, it’s what do they think about a little bit further than that, and indeed not only further than that, for the whole CCG, and indeed not only for that but for the whole country. So it has obliged them to increase the generosity of spirit as practitioners, and say to their own patients we think about others because ultimately it’s good for you as well. It’s done that. The co-commissioning has engaged with people who may not otherwise have felt that way. And they have by and large responded to that challenge I think. So it’s a cautious optimism I have where professionals who may not have talked to each other in the past are now beginning to see a real purpose in it, not just simply as window dressing or because the CCG says so, but because there’s real value in it, and they’re now becoming in a sense, I suppose, from aloof from the community to be part of that community. That’s what it’s done. [...] There are still aspects of our professions who still maintain that sense of superiority and aloofness and so on, but it’s moving in the right direction. [Lay Member ID14]

Our respondents in Site 1 claimed success mostly in terms of supporting the development of their new model of care:

I think the success of it will be to be able to draw a line along that route from individual practices, remote contracts, to practices working together, to networks and federations, to general practice being a full participant in the wider primary care, and us having kept pace with that in a way that incentivise and draw people’s along, but also makes sure there’s a
solid contractual framework so that the public can see that we’re spending NHS cash in a way that’s delivering better care. I think that it’s being able to point to some of those things, like our care planning stuff and our additional activity, our constraining of A&E attendances, things like that that I think are the evidence that where we’re going is the right thing, and I want to build on that. [Independent GP ID9]

Some of the ‘metrics’ Site 1 were considering of using to measure ‘success’ include:

If I was to think about some metrics about [new models of care]. I would be looking at, 1) workforce, 2) staff retention, from both medical nursing and unqualified staff. I'd be looking at staff culture, so the family and friends test. I'd be looking at complaints and I’d also be using some of our quality indicators that are in our dashboard. So, for example, serious untoward incidents, meds management, errors, GP access surveys, because there's something about making sure that your core service is right because you can’t...in my view, unless you’ve got your core primary care services right you can’t then go and develop into being a new model of care. [Manager ID 11]

Although our respondents were generally positive in claiming some early successes, a Lay Member we interviewed claimed that co-commissioning has created more hassle than success:

Has that been a success? I don’t know what you would say... I think we’ve took it on well and I think as an organisation we’ve embraced it and we’ve done it, but as regards a tangible benefit to the organisation of it I’m not really 100 per cent certain what that’s done for us, other than I guess with a shed load of things like conflicts of interests that we have to manage, admin problems to manage, finances to manage on their behalf, and when you’re talking about contracts and LESs [Local Enhanced Services] and DESs [Directed Enhanced Services] loads of hassle between the GPs and the organisation, well, we don’t want to pay for this or we don’t want to pay for that, so the outcomes framework and things like that. So I’m not really sure. [Lay Member ID15]

**Summary- claims to impact**

Respondents reported:
- Improved ability to ‘join up’ the commissioning of primary and secondary/community care
- Better local decision-making
- Improved ability to plan primary care services for the population

Specific claims to success relating to delegated responsibility included:
- Improved relationships with member practices
- Clinicians better able to manage performance concerns amongst member practices than NHSE managers
- Provision of better support for practices, including named individuals who know their local practices
- Better relationship with local Healthwatch, with consequent improvement in response to patient feedback
- Successful introduction of local investment schemes which aim to standardise and improve practice performance

However, some respondents also reported ‘increased hassle’, with considerable additional workload without additional resources.
3.5 Factors affecting the development of primary care commissioning

3.5.1 Legislation

The delegation of NHSE’s statutory responsibility of commissioning primary care services to CCGs was seen as a ‘sticky plaster’ to start trying to build what was lost following the Health and Social Care Act 2012 i.e. as a policy workaround (McDermott et al 2016). This created problems during the delegation process and continues to do so.

During the initial set-up, many CCGs had planned to work collaboratively with their neighbouring CCGs by forming joint committees. However, later in the process it emerged that this was a ‘double delegation’, which was not legally permitted (see McDermott et al. 2016 for details around double delegation). This has led to some CCGs having to re-structure their governance arrangement.

Initial guidance (NHS England, 2014d) also suggested that CCGs would be responsible for complaints management i.e. the management and dealing with complaints about the services provided and commissioned by NHSE. One year following delegation, NHSE clarified that “under the current legal framework NHSE cannot delegate complaints management to CCGs, although a management arrangement could be implemented” (NHS England 2015d, p.10).

In addition to unclear guidance, the lack of delineated roles and responsibilities between CCGs and NHSE have created further difficulties in CCGs’ assuming their primary care commissioning responsibility. As part of the delegation process, CCGs and NHSE need to identify the roles and responsibilities that CCGs wish to undertake, to share with NHSE Regional Team, or to have the NHSE Regional Team transact or undertake on the CCG’s behalf. However, in practice, we observed a general ambiguity as to the distribution of these roles and responsibilities and the difficulties it caused.

Site 1 encounter an ongoing issue around the risks associated with property leases. On one of the contracts, it became unclear whether the risk associated with the lease for a premise was a CCG risk or not. Whilst the Chief Finance Officer believed this was a risk that belonged to NHS Property Services, the CCG was the one receiving the invoices. Site 1 refused to pay and the matter was still being resolved at the time of the study.

Such misalignments in perspectives due to lack of clarity were frequently discussed in other sites with incidents including, for example, past legal disputes between NHSE and practices which were now hanging in the air with no clear ‘owner’ of the problem. This has led to a feeling of ‘sole-commissioning’:

Co-commissioning is a misnomer because it’s not really co- with anybody. We’re doing it all ourselves, because NHSE go don’t ask us. [...] So we are virtually 100 percent responsible for commissioning general practice. [CCG Chair GP ID8]

Lack of clarity in terms of roles and responsibilities within delegated commissioning could led GPs to be burdened by additional work not in their contract, as the following exchanges illustrate:

LMC Representative: This extends beyond Hep B and should include the context for Flu when we get requests to investigate patients in nursing homes or contact tracing, so not just the conditions associated with Hep B, but other requests not covered by the contract. GPs asks me – ‘what should I do?’; they say they do not have the expertise. Who is supposed to do it?

PCCC Chair: Who is supposed to?
Locality representative: With Public Health there was a public nurse going around doing this, but when Public Health moved to NHSE there is no nurse.

PCCC Chair: I don’t know the answer, are GPs not trained? How do we resolve the issue of a service that was there and is not there? [Primary Care Commissioning Committee October 2016, M28]

NHSE is not clear about what are the practice’s responsibilities. [Name of a provider] will no longer offer this service. Only the practices will. However, there is no letter yet from NHSE to practices stating that [Name of a provider will no longer offer this. There is a risk for practices that decide to use midwifery services. [...]]

Independent GP: Who is going to track the pregnant patients? Practices or midwives?

Manager: There’s a standard maternity template on SystemOne which midwives can use. Even though they are not delivering that service, they will still need to inform the women. [Primary Care Strategy Group March 2016, M3]

Moreover, with NHSE still holding the statutory responsibility, CCGs are required to keep NHSE informed if any of their decisions could involve legal challenge and/or attract media attention. The following interviewee described how this relationship works in practice:

So we keep NHS England informed. Because we've got delegation, then it's up to us to do that. But in terms of any of the premises relocation work or anything we do around primary care development, where there's a little bit of - controversy's probably not the right word - but where we've got a difference of opinion between what the GP wishes to do and what the population wishes, then we make sure we keep NHS England in the loop. Particularly as we might get some local media coverage, so they need to be sighted on that. We might get letters in from parliamentary members and elected members locally. We might get petitions, as we have done in the past. [Manager ID22]

### Summary - legislation

Statutory responsibility for primary care commissioning remains with NHSE. This has a number of consequences:

- Initial lack of clarity early in the delegation process, such as CCGs not permitted to form joint committees with neighbouring CCGs, requiring CCGs to rethink their governance arrangements
- Ongoing lack of clarity about some roles and responsibilities, for example in relation to the performance management of different aspects of GP and practice work
- Need for continued close working between CCGs and NHSE as complexities are worked out in real time.

### 3.5.2 The role of individuals and the need for expertise

The ability of CCGs to draw on existing and past NHSE experience was crucial. The lack of managerial resources, loss of expertise, and ambiguity around requirements makes individuals particularly pivotal for the success of CCGs’ work. As roles and attached tasks were not clear enough and with the work of primary care commissioning being slowly understood as it progressed, **individuals’ experience with primary care commissioning and their connections with NHSE make a significant impact**.
As part of the delegation support process, there were three possible models of staffing that CCGs could draw on from NHSE: NHSE staff could be assigned to a CCG while they remain in their roles and locations (Model 1 – Assignment); they could be relocated and seconded to the CCG (Model 2 – Secondment); or they could be directly employed by the CCG (Model 3 – Employment).

Our respondents described the importance of knowing ‘who to ring’ at NHSE:

I do think it’s been advantageous, because I’ve got a good relationship, still employed by NHS England, where you do find an issue you can work through that with somebody that you know and somebody that you trust. I think we’re quite open at being able to pick up the phone to each other and saying oh, you might have missed this or you need to do that. [Manager ID10]

The CCG Accountable Officer from Site 2 claimed that the CCG’s ability to directly employed NHSE staff has made the transition period much smoother:

Because initially the idea was that NHS England would do it for a period and then there would a be a sort of big bang swap, but once we’d taken on [name of a Manager who previously worked at NHSE and now employed by the CCG] it was agreed a sort of gradual process. But if you’re taking on a member of staff doing it, she has all the contacts, so I think that probably made it smoother than, say, our neighbours’ downstairs where the managers came from within the CCG. [CCG Accountable Officer ID18]

In addition to experience of working at NHSE, staff with experience of primary care were another factor enabling CCGs to commission primary care ‘successfully’, at varying levels as they drew on their past expertise. This became apparent, for example, in the case of a finance staff who did not have primary care experience in Site 4:

So, in effect, I think then…you know, suddenly added value…so the example I gave around having some finance staff who really understand what a GP is as a finance business and how they, you know, how their finances work and how you do a primary care development, we haven’t got any of those staff anymore, so we’re a bit stuck. [Manager ID42]

Another example was exemplified in other sites where primary care experience was available and became transformative:

[Name of a Manager who previously worked at NHSE, seconded from NHSE, and now directly employed by the CCG] started working for the CCG in July and since then has really influenced the primary care commissioning agenda. Introduced topics and issues that the CCG have to focus on within the primary care agenda. She came up with a spreadsheet that focuses on aspects of primary care commissioning such as de-mergers, practices that are experiencing difficulties and the transition plan that was agreed with NHSE. [Manager ID10]

The nurse has got no clue at all so I’m talking her through what to click on EMIS [GP practice’s clinical system] and say, have a look, what does that percentage say? Okay, well, you’re reasoning for that would be… So I, sort of, talk them through something like that. The other primary care development managers probably wouldn’t be able to do that. They’d have to pass that on or phone me. [Manager ID26]

However, the lack of primary care experience could lead to a situation where people who do have experience working in primary care end up taking on additional work which was not part of their direct role, as described by the following experienced manager in Site 2:

I think part of my busyness comes from that additional facet of, you used to be a practice manager, will you sit on this panel because we need someone. We’re doing a new service spec for commissioning a new interpreted service for primary care. We need someone who would have a level of understanding in general practice. So they put me on the panel. Then it’s a case of, oh, we’re going to do some training, some role playing with this company
called Geese and they’re going to develop a theatre based training for frontline staff and all the challenges that they face. We need somebody who knows about general practice. So before I know it I’m on all these panels and I go, okay. Of course I will go into a practice and say, have you done your statement of purpose for CQC? Have you done your population groups? Shall we do your presentation ready for when they call you? So I suppose I use it as an extended role of my previous role to go in and say, let’s get this...what would have helped me, because a lot of these managers, they know what they’ve got to do they just haven’t got the time and the resources to do it so why try and pool that? So, yes, I think this role is busy but you can make it busier if you want to and I like to be busy. [Manager ID26]

This phenomenon extends further than primary care development and includes additional function of the CCG.

Following the HSCA 2012, people with expertise in primary care were mostly transferred from the Primary Care Trusts (PCTs) to Commissioning Support Units (CSUs). CSUs were developed to provide services to CCGs ranging from business support (for e.g. financial planning, human resources, and IT) to commissioning (for e.g. health needs assessment, healthcare procurement, and contract negotiation and management). However, with some CSUs failing the accreditation process, and CCGs’ reluctance to outsource vital commissioning support functions due to fear of losing local knowledge and trusted relationships (Petsoulas et al., 2014), much expertise and knowledge about primary care were lost. This was felt to be a particular problem in relation to the services related to payment to practices. Historically these had been administered by PCTs. Following the HSCA12, responsibility was outsourced to Capita:

And the loss of the support...primary care support service the regeneration of the primary care support service and from a local organisation where there was such organisational memory people have been working there for 20 years knew absolutely everything about all of the local practices that’s been disbanded. [...] So Primary Care Support Service [...] So we lost a lot of the knowledge people who had been working in the organisation for so many years that they had a great knowledge of...and hands-on a lot of information. And again that information has been lost, with each reorganisation, with each change there’s a loss of information although people try to keep it, it doesn’t link through, it doesn’t follow through. So Primary Care Support Service [...] has now gone to Capita and so that becomes more and more distant. We have no personal contact it’s far more distant, it’s a new process and again it all becomes far more of a challenge, there’s no...you lose that being able to find answers quickly. And a lot of information has been lost as well. [Manager ID37]

More generally, NHSE reduced its staff capacity considerably, and some respondents felt that primary care had been disproportionately affected by this:

They [NHSE] haven’t got much expert, you know, they’ve only got a small number of staff now, so they do the basics, but it’s difficult for them to go and do it, they haven’t got many people who are experts in this stuff either, but I think there’s been a loss of expertise and capacity around primary care, compared to PCT days, because we took the efficiency saving out, we went to area teams with a lot of staff left or got made redundant, or whatever, we went down to a smaller group of staff, because [we we’re going to do it once] across a bigger area, that lost us some expertise anyway and now we’ve disentangled and we’ve got back out again and we haven’t increased that staff back up, so they’re just going to get more run ragged now trying to report everything for CCGs when they’ve been designed to only do it once across [NHSE regional team]. [Manager ID42]

The loss of expertise in primary care following the HSCA 2012 meant that there were few human resources left within NHSE that could be delegated to CCGs. CCGs were therefore expected to invest some of their financial resources to compensate for the lack of investment into primary care during
NHSE’s handling and to remedy or manage ongoing issues brought about due to this loss of expertise.

CCGs in our case study sites had to re-establish their relationships with member practices and invest in employing additional staff to assume their delegated responsibility. This had financial implications as well as propagated inconsistencies between CCGs as each needed to adjust to local deficiencies in expertise and capacity due to its own previous employee composition. In Site 2, the CCG’s investment in additional staff had resulted in an increase in the CCG’s running cost:

I know that other teams have just sort of absorbed stuff, so it has had quite an impact across the organisation, but particularly within the quality team and obviously the whole new function of co-commissioning. [...] Where they found the money from this year I’m not sure. [Manager ID13]

However, there was much uncertainty as to future funding for these roles:

Well this was our primary care monies that weren’t spent, so we had a bit of flexibility. But this year we’re told unlikely we’re going to get that level of underspend, so they’ll probably have to put a business case in to get it funded. [Manager ID23]

We would have preferred to get additional money to do it, because at the end of the day it’s diverted money away from what we might have used elsewhere, but it was seen as such a priority it became a must do. [...] I think just through reorganisation. It didn’t come from the primary care; it was outside, so it was part of the CCG management. [Manager ID23]

We are actively managing it and making cuts elsewhere. We’ve had to let staff go in other areas, so we’ve had to change the focus, but that adds extra stress to the organisation [CCG Chair GP ID8]

The lack of dedicated funding for management personnel was highlighted to be counter-productive in terms of financial efficiencies. One of our interviewee acknowledged the importance of financial savings and stressed the advantages of having someone in an operational role who understood primary care and could support efficiencies:

Yeah, it is a draw and...but actually, whilst that is a draw for the primary care development and strategy, actually, what somebody like myself can bring to the operational element and the cost operation, you can more than fund the post in the efficiencies you’re making in those operational costs. [Manager ID22]

**Summary- the role of individuals and expertise**

The HSCA12 resulted in a significant upheaval amongst managerial staff, with considerable loss of expertise within the NHS due to redundancies and reductions in managerial budgets. Primary care commissioning was particularly affected, with the loss of local primary care commissioning teams. This loss of expertise has been experienced as difficult by CCGs as they take on responsibility for primary care commissioning. The presence/absence of individuals with primary care-related expertise was highlighted as significant in relation to:

- The need for known local contacts in NHSE who could be contacted easily for advice
- The costs associated with having to replace lost expertise
- The loss of specific expertise, for example the loss of finance staff who understand primary care finances
- Additional work for those who do have the relevant primary care expertise, sometimes requiring them to work beyond their formal role
- Complicated employment arrangements, including assignment, secondment or transfer of employment
3.5.3 Unintended consequences

3.5.3.1 Public vs private meetings

Prior to the HSCA12, primary care commissioning was undertaken by Primary Care Trusts (PCTs). Whilst PCT Board meetings were held in public, meetings of operational groups (including those relating to primary care commissioning) were held in private. When responsibility for primary care co-commissioning was delegated to CCGs, the decision was made to require CCGs to hold PCCC meetings in public. This was argued to be an important mechanism to reduce the risk of conflicts of interest.

The Terms of Reference for delegated commissioning Primary Care Commissioning Committee (PCCC) meetings do, however, make provision to exclude the public from meetings in circumstances such as:

whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. (NHS England, 2014e)

In response to these requirements, all of our case study CCGs divided their meetings into ‘public’ meetings (where members of the public were allowed to attend) and ‘private’ meetings (where members of the public were excluded). This separation has caused dilemma around the notions of what can and should be discussed in meetings held in public and what should be discussed in private.

A recurring theme across our case study sites was around risk registers. Although what was on the register can be briefly discussed in public meetings, the details of the risks may contain ‘sensitive’, ‘confidential’, and/or ‘controversial’ information which could be interpreted as politically sensitive for e.g. closure of a GP practice or the quality of provider services. Hence distributions of this type of information were carefully managed to avoid misinterpretation, as shown in the following discussion in one of the PCCC meetings we observed:

Chair of Primary Care Commissioning Committee: There are 2 new risks to discuss in the private section as either have a reputational or financial implication for the CCG.
CCG Chief Officer: private risks should not be circulated in public papers.
CCG Deputy Chief Officer: does the committee want to split the risk register?
Chair of Primary Care Commissioning Committee: yes we should else it is messy.
Lay member: all risks are in the public domain!
Chair of Primary Care Commissioning Committee: all information should be in the public domain. We need a discussion today on how risks should be presented to the public.
[Unidentified]: issue is not the risk but the discussion.
Public Health consultant: the issue is political and how interpreted by the public.
Chair of Primary Care Commissioning Committee: what is making people uncomfortable? Let’s discuss.
GP lead: should be discussed in private section of the Governing Body as well, not the public.
Chair of Primary Care Commissioning Committee: [CCG Chief Officer] to have a discussion with [CCG Chair] about it. [Primary Care Commissioning Committee August 2016, M26]

As the above exchanges also show, even a discussion on whether something should be discussed in public should take place in a private meeting. In general, when in doubt members of the committee would defer to the Chair of PCCC clarification, move the discussion to the private section of the meeting at the Chair’s discretion, or take the discussion ‘out of the room’.
We also observed discussions about how to manage information coming to PCCC public meetings from Operational Groups which held their meetings in private. Framing reports to overcome the incongruence of simultaneously being communicative and transparent but respectful of confidential and sensitive information, was a source of confusion, as the following extract illustrates:

Chair of Audit Committee: These [PCOG - Primary Care Operational Group] notes don’t say much!
Primary Care Contract Support: PCOG is not a public meeting. The PCCC is and the material is in the public domain.
Governance Support: Sensitive information can be discussed in PCOG. If we receive a Freedom of Information request then we need to provide it all.
Chair of Audit Committee: I don’t understand.
NHSE representative: Something just being sensitive or awkward doesn’t justify.
Chief Finance Officer: we’ll have a think about the mechanics. [Primary Care Commissioning Committee August 2016, M42]

Despite the anxiety surrounding public meetings, all our case study CCGs attempted to make the agenda and papers for PCCC meetings publicly available. However, there were occasions where these were not available in advance of the meetings. On the other hand, even when public meetings were advertised, members of the public did not always attend. We observed a meeting in Site 1 where the CCG made an effort to organise the meeting room as they were expecting a number of patients and public to attend due to a discussion about a closure of a GP practice, there were no patients and public attended the meeting to the CCG’s surprise. Similar view was echoed in other sites:

And they [Primary Care Co-Commissioning Committee meeting] are public meetings held in public as well. Not that I think the public have ever attended but they are meetings held in public. [Manager ID33]

The lack of public attendance had consequently led Site 4 to run some of their meetings in an informal way by mixing their public and private discussions in an informal order.

Overall, the requirement to hold meetings in public appeared to have a paradoxical effect to at least partially reduce transparency. Thus, for example, we observed a number of discussions in which it was agreed that the topic should be ‘taken out of the room’. This renders the locus of decision making unclear. Our observations suggest that a significant proportion of the work done in PCCC meetings involves issues which may be commercially or politically sensitive, and which can therefore legitimately be discussed in private. This, coupled with the paradoxical reduction in transparency associated with the concern about discussing difficult issues in public, suggests that the requirement to hold meetings in public may not be having the required effect.

**Public vs private meetings**

The requirement to hold PCCC meetings in public may paradoxically act to reduce transparency, as some discussions are consequently taken ‘out of the room’. Whilst governance and management structures vary, the work done by Primary Care Commissioning Committee is often quite operational in nature, generating a requirement for significant portions of the meetings to be held in private.
3.5.3.2 Property management

The ramification of the HSCA 2012, and particularly the abolition of PCTs, was felt in the domain of property management as legislation proved very unclear. Primary care estates is a complex area, with a complex patchwork of property ownership, including ownership by individuals, ownership by partnerships, standard leasing arrangements and private finance initiative leases. **A main and persistent issue was the problem of nominating a head lease for buildings and how current contractual designs are mounting challenges:**

[Providers] are on a five year contract or less ... so they cannot sign leases for greater than their contract term. The lenders determine, well, they won’t lend the money, because it’s not secured. Any you’ve got to look at, can the CCG in some way, underwrite it? Well, they way to underwrite it was to take a head lease, and that’s been the stopper since the end of the PCTs. That’s why there’s been very little development, because people are trying to find solutions and ways round that. That is a major element which still isn’t really resolved in how and who, within the NHS, takes the responsibility for those shorter term contracts to be able to tie that service provision into the building. Now, you might say that us as commissioners, we could do it [...] but nobody has really gone ahead and determined that at the moment. [CCG Accountable Officer ID18]

Such feeling of being stuck between legal frameworks and NHSE’s lack of determination with regards to property guidance was also felt in Site 1, where the CCG Chair voiced a strong dissatisfaction with the current situation:

NHSE are still doing estates but we have taken estates back because that’s another nightmare for them not be involved because they just say No. Can we spend ten thousand pounds more on rent for this practice that’s desperate for space? No! What’s NHSE’s view on branch surgeries? You don’t have a view. You do what you want. That’s not taking into account where the branch is, what the need of the population is – none of that. [CCG Chair GP ID8]

The misalignment between estate lease durations and providers’ contracts was making CCG’s work difficult across their areas of operation. For example, Site 1 decided to “not renew” the contract of an existing APMS practice due to poor quality and safety performance. At subsequent meetings there was considerable discussion over what could be done with the remainder of the lease on the building.

It is also worth noting that the problem with property and estate management went further than an issue of underdeveloped of NHSE strategy or a lack of addressing the changes brought about by the HSCA 2012. While CCGs are in-charge of managing primary care covering a population catchment, the decisions of whether or not to pursue estate development was still in the hands of individual GPs according to their GMS contracts.

Thus, **while CCGs were expected to devise local strategies which often include estate development, practice mergers, or expansion – especially in light of current policy climates that favour commissioning ‘at scale’ – they still lack the legal framework with which to mandate such changes and operationalise their estate programmes.**
Primary care estates

Primary care estates is a complex area, with a patchwork of property ownership, including ownership by individuals, ownership by partnerships, standard leasing arrangements and private finance initiative leases. Particular issues were observed in relation to:

- Development of estates, with CCGs lacking authority to mandate changes to premises
- Issues with finance, with estate development potentially generating further financial liabilities over many years due to rules governing rent reimbursement to practices
- Misalignment between APMS contract duration and leases on properties, potentially leaving empty properties which must be paid for
- Lack of clarity over where responsibility lies for holding leases, with CCGs reluctant to do so but NHSE declining to take responsibility. The role of NHS property services is unclear
- Our respondents suggested that this was an area in which guidance was poorly developed and unclear

3.5.4 Wider national initiatives

The Five Year Forward View (FYFV) (NHS England, 2014a), which was published in October 2014 and produced in collaboration by various stakeholders (NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission, and the NHS Trust Development Authority), argued that there was broad consensus on what the future of the NHS needs to be. There were three ‘gaps’ that the NHS need to address – health and wellbeing gap, care and quality gap, and funding and efficiency gap. It was argued that to do this, the traditional boundaries between primary, community, and secondary care need to be dissolved. The new direction to be taken included: having networks of care (not just organisations); more out-of-hospital care; more integrated services (between primary and specialist hospital care, physical and mental health services, and health and social care); and stimulating the creation of new models of care.

There was recognition that no ‘one size fits all’ hence a number of different approaches were suggested. Central to most of these is the need to move quickly to develop more integrated care providers or networks of care providers to meet the needs of local people, especially those with long-term conditions and multiple health problems. This was done by pilot sites called ‘Vanguards’. The first 29 Vanguards were chosen in March 2015 focusing on the following models: multispecialty community providers (MCP - blending primary and specialist services in one organisation and multidisciplinary teams providing services in the community); primary and acute care systems (PACS – integrating primary, hospital, and mental health services); and enhanced health in care homes (multi-agency support and the use of new technologies to help people stay at home). In July 2015, eight additional urgent and emergency care vanguards were announced, focusing on developing new approaches to reduce pressure on A&E departments. A further 13 acute care collaborations vanguards were announced in September 2015, aiming to link hospitals to improve clinical and financial viability and reducing variations in care.

To deliver the FYFV, NHS were required to produce a five-year Sustainability and Transformation Plan (STP), which is place-based plan aimed to drive the FYFV, and a one-year Operational Plan, which is organisation-based plan that needs to be consistent with the emerging STP. The local health and care systems were asked to consider their ‘transformation footprints’. They are the “geographic scope of their STP” and “should be locally defined, based on natural communities, existing working relationships, patient flows and take into account of the scale needed to deliver the services,
transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning” (NHS England, 2016a, p.6).

There were 44 STP footprint areas with each STP area asked to designate a leader. In March 2016, STP leads were confirmed, with majority of leaders coming from Foundation Trusts/NHS Trusts (provider organisations) or Clinical Commissioning Groups (commissioning organisations) and only six leaders coming from Local Government. These leaders, appointed by NHS England, are responsible for overseeing regional planning across the health and care system, including the reconciliation of different, often competing, interests of organisations to meet the needs of the local population. As described in NHSE guidance, STPs are “the route map for how the local NHS and its partners make a reality of [plans for the future]” (NHS England and NHS Improvement, 2016, p.4). STPs vary considerably with each having its own strategic plan and organisational composition. Thus, for example, some STPs include as many as 12 different CCGs while others include only one, and some have a footprint crossing local authority boundaries, whilst others are co-terminus with one.

Although STPs have no statutory basis, the refreshed 2016/17 NHS Mandate to NHS England (Department of Health 2016) and NHS Planning Guidance 2016/17-2020/21 (NHS England 2016a) were substantially changed to focus on the delivery of the FYFV and STP. Moreover, CCGs applying for merger and dissolution would now need to show that the merger “provide a more logical footprint for delivery of the local STP” (NHS England, 2016b, p.9). In April 2017, STPs became “the single application and approval point for local organisations to access NHS transformation funding” (NHS England, 2016f).

All but one of our case study CCGs were involved in at least one vanguard either at a local and/or regional level. Two of our case CCGs were in the same STP area.

**CCGs’ views on the New Models of Care and Sustainability and Transformation Plans**

All of our case CCGs was involved in supporting the development of New Models of Care (NMC) in their local area. The support that CCGs in our case studies provided to GP practices was through the various initiatives as identified in Section 3.4.2.2. The emphasis of these initiatives was to encourage several practices to provide services collaboratively, for example providing standardised access where one practice to do the 8-to-8 service for a number of neighbouring practices. The idea was to turn these initiatives into a ‘contract’ that can be delivered by groups of practices, federations, super-practices, or multi-speciality community providers. These initiatives were described as “toll to drive forward collaboration” [GP ID16] and “strategic step towards budget delegation and development of new models of care” (PCCC meeting site 1). However, CCGs’ in our case studies were clear that as commissioners, their involvement should only be limited to the developmental stage. Once practices have formalised arrangements such as federations, CCGs would not be involved in how federations develop.

Our findings highlight that there were mixed views of what NMCs will mean for the future of primary care and the impact they could have on CCGs and their members. Our case study CCGs could see the opportunities coming from implementing NMCs and talked of those who were enthusiastic about the direction of travel and those who took a more negative, unenthusiastic perspective, largely due to resistance to change or change apathy:

I think there's some hesitation by our GPs. So, we're a member organisation. I think there's some worry over what it means with our GP colleagues across the patch and I think we...I think there's a cohort of people who see it as an opportunity to shape the future and then there's a cohort of people who think, you know, it's concerning about the future of general practice. [Independent GP ID9]

Some expressed the potential difficulties of bringing people together through the NMCs who would not necessarily choose to do so or have no previous history of working together:
You can't just throw half a dozen professionals in a room and just expect them to work together, because integration is more than co-location in my view. [Independent GP ID9]

[...] you can't force primary care, individual practices to work with each other, if they haven't got a history of a relationship or some trust, so there's lots of work that needs to be done. [Manager ID19]

Hence collaborative working is something which is not to be taken as a given but something to be worked on and facilitated. Factors that could facilitate collaborative working included having a locality chair, who is a GP, who could who could convince their GP colleagues of the merits of federating and the savings to be made by coming together and working as one organisation in preparation for the inevitable introduction of NCMs and adopting a slow and iterative approach when introducing changes affecting practices.

Although there was a strong support for developing the NMCs and the direction envisaged in the FYFV, this was less so for STP as it was seen as a policy workaround:

[...] STPs are the latest patch to fix the Lansley mistakes, so I always...it amuses me really, because I think of it a bit like Microsoft Windows, you know, you issue a product, doesn't work, and then you spent the next three years issuing patches to repair it when it was your fault it was broken in the first bloody place. And that's what happened. So Lansley reformed the NHS, it was a disaster, and then they've immediately started issuing patches to repair it; including some that they issued whilst they were actually breaking it in the first place. [...] But I think the five year forward view is almost exactly the opposite, so what the five year forward view did was exactly the same in the sense that it took a broad diagnosis and a sound-check across the system that teased out all of the ideas and thoughts that people had, but unlike Lansley, it didn't then turn them into a plan that no one owned. It built them into a consensus that pretty much everybody owned. So, it's very rare for me to hear colleagues fundamentally disagree with five year forward view. Pretty much everybody sees it as in the right space, almost entirely. [...] And I think it's a plan that pretty much everybody signs up to. It was an exceptionally well done piece of planning work, actually, it's probably the best tactical level plan the NHS has produced. So, yes, it doesn't surprise me there's a strong level of support. [CCG Accountable Officer ID18]

STPs were compared to PCT clusters in a sense that it is seen as being about integrated commissioning on a place basis bringing together health and social care. However, one of the main challenges identified by our respondents was that STPs have no legal basis and hence there were concerns expressed about the accountability and governance of STPs:

And what we're doing for STPs is going back to PCT clusters; and also trying to recreate a, kind of, a strategic health authority level, capability in the NHS. The problem is there's no governance for it, there's no legal basis to it, so it's being done as a kind of moral imperative. So, I mean [STP lead] absolutely no authority over anybody [...]. STP is...I mean GP federations; those are commercial decisions. And GPs are doing that not for...they're doing it because they believe it will be financially advantageous to them to do so. So those are commercially driven decisions by business men, there not...STPs, there's no commercial advantage to STP. [...] The problem [with STP] is there's no governance for it, there's no legal basis to it, so it's being done as a kind of moral imperative. So, I mean [STP lead] absolutely no authority over anybody [...]. [CCG Accountable Officer ID18]

CCGs are asking themselves that question, well, we had this STP and we've been told we've got to have this STP and we've got to look at things across the board, but it's got no real accountability at the moment. Everywhere is sovereign board, but you think, well, where is the governance? It's very woolly, the governance around STPs is quite woolly at the moment
and I think that needs to be...well, I would think the next step is well, we’re having an STP and it will have some organisational form going forward. [Lay Member ID15]

Moreover, although there was recognition of the need to deliver some services ‘at scale’, PCT clusters were seen as having the ‘right scale’:

But PCT clusters were probably in the right scale, and it’s no great surprise to me that the three STPs that we’ve got are the same as the three PCT clusters that we broke up to create CCGs. [...] I think it’s because there is just a sensible way to organise the commissioning of health and social care really. You have to be able to work at a certain scale, you have to be able to commission a range of services across the spectrum of the care pathway, you have to be able to work in partnership with local government to make it a success. So, you know, however you chop it up, basically eventually, you end up coming back to those design principles; and when you apply those you end up with PCT clusters, or STP or, you know. So it’s a kind of unassailable logic really. [CCG Accountable Officer ID18]

**Locally-based primary care plan vs Sustainability and Transformation Plan**

One of the rationales behind the transfer of primary care commissioning responsibilities from NHSE to CCGs was to support the development and implementation of ‘local’ strategies supported by ‘local’ knowledge (McDermott et al. 2016). Whilst primary care is viewed by our case study CCGs as something to be commissioned and provided at a ‘local’ level, the development of the New Models of Care (NMCS) and Sustainability and Transformation Plans (STPs) are something that happens on a ‘wider footprint’ i.e. at a regional and/or national level:

Yeah, so on the high level stuff, taking the STP, I think that’s quite...so because primary care is commissioned on a very local footprint, when you talk about the [STP area], I don’t think you talk about primary care that much, because you don’t need to do that on a [STP area] basis, so why do we need, you know, because inevitably, I think people will talk about it on the basis of, I’m interested in it, I’m passionate about it, therefore, I like to talk about it, but if talking about it on a [STP area] basis means we’re all going to do it the same across [STP area] while there’s somebody else called head of [STP area] going to make the decision on my behalf, then I don’t’ think I want to talk about primary care anymore, because I’m deciding how we’re going to do it in [CCG area]. [...] So it inevitably gets mentioned in STPs and stuff, but I don’t think the STP is a construct that really lends itself to commission in primary care, definitely in [STP area]. [Manager ID42]

So, my interpretation of how we’ve landed, where we've landed, is that...it sounds trite but I mean it's kind of local services for local people. So, general practice is a local service, community services, district nursing, for example, is a local community based service. Whereas what's happening with our hospitals needs to happen at a bigger footprint, so re-provision of stroke services, for example. [...] So, we're having to do that on a wider footprint. [...] I think that's also the same for things like major trauma. [Manager ID11]

However, one of the above respondents added that although their CCG viewed general practice as something that should be provided at a local level, this may not be the case for other CCGs or STP areas. **History of working together seems to contribute to whether or not general practice can be delivered ‘at scale’**.

As primary care was seen something to be planned and commissioned locally and STPs on a wider footprint, there were concerns about how this is all going to fit together. Our respondents described the process of linking locally-based primary care plan with STPs as doing the ‘knitting’ and likened it to a ‘jigsaw’. One of the challenges for CCGs was to keep the connectivity between the two, as described by the following respondent:
So, my view, I suppose our view on that [primary care] is actually that we needed a local plan about what all of that looks like for us and we'll feed that to the STP, so it's a two-way process, the STPs have come up with their high level work plans and they will have leads working on those. [...] The challenge for us will be is keeping connectivity between the two so that, you know, they are aligned, otherwise we could end up with an STP plan that says we are going to do X,Y, Z and local plan that says we are going to do A,B,C. Neither the two will meet and nothing will get delivered and the challenge that we have got to do as a system, it means we can't afford to do that. So it will be challenging for staff, I think, because they are going to have to get their heads around about this is our local plan and then they will have to be clear about and I am having to link into these regional pieces of work, and understanding it's the same thing is not the same as everybody appreciating that it does actually increase the work pressure, because people feel like they are playing in two areas. [Manager ID19]

Moreover, as the above respondent also described, the additional work required to aligned locally-based primary care plans with STPs would increase the work pressure on an already stretched resources. Our case study CCGs described to us how they need to grapple with understanding which services can be planned and commissioned locally, on a 'place' basis, and which can be provided on a 'wider footprint'. The deliberation seems to couch around population size, geographical footprint, relationship with local hospitals and Local Authority, and the current system in place:

So that's [region]. So that's ambulance services, specialist commissioning. So that's at a, what is it, circa 3.5/4 million population. We've then, of course, got this bad old STP thing now and that, for us, is [STP area] [...] Then we've got [local hospital], its footprint is 500,000. Then we've got, in this context, [CCG A] place. So our operational plan takes in...so our place is around primary care, prevention, health and social care integration. Our [local hospital A] place then [...] is around system resilience, elective care, urgent care. So those are system wide issues. What we're trying to do here then, so primary care has got to play locally into local integration pathways but it also, as a major refererr [...] However, we've also got to be aware that [local hospital A] will be having conversations with [local hospital B], they already are with [local hospital C], with other acute trusts. So we have got to be aware that's being managed through the STP process as we move forward, and then, of course, ambulance. So I also carry that model with me but the building block, deliberately, is there. That's place. [...] Is there, but inevitably [...] what you've got is there at the moment [local hospital A] in [CCG A] manage community services. So a significant part of our [vanguard] [...] the new entity will require community services to come out of the hospital, and they're fine with that. Now [CCG B] have a different model. They've already got a social enterprise that manages community services for them but we still need to understand how that impacts on the system. So my overview...my sort of raison d'être, if you like, is [...] to make sure we've got alignment. Yeah, but also to understand what's happening there we're actively part of the [STP area]. We're a vanguard network at [STP area], and that will be about, at some stage, [...] allocating specialist [...] in primary care centres, etcetera. So that, again, you know, it's dynamic, isn't it? [...] Yeah, and that's our STP. That's...our local STP...because we talk...in [CCG A] we've got [number of local STPs] and they're all around Health and Wellbeing Board and in [CCG A] we've got a co-terminus in [CCG B]. [Manager ID12]

Another respondent described to us that one of the factors affecting the discussion about service provision on a 'wider footprint' was to do with the level of specialism and expertise required in delivering that service and quoted the Royal College guidelines on retaining clinical skills:

So, if you look nationally we've got a shortage of medics, we've got a shortage of nurses, so, therefore, we need to start to think about how best we can provide those services. [...] So,
it's like the other wider footprint, you get more of your workforce in there and then people will be able to get...they'll be...rather than looking at, like you were saying, because it's just places and it's too small really you're kind of looking at something that's bigger, covering a bigger coverage of the population, you've got your specialism and you've got expertise? [...] and you've also got, and we think it's really important, is the numbers of patients that you touch with certain conditions. So, there are Royal College guidelines on how many, and they vary but there are Royal College guidelines that say, you need to be seeing x amount of these patients in order for you to retain your clinical skills. So, that's one of the other drivers, is that you need a skilled workforce to deal with some of these patients. So, that's my interpretation of why the chiefs made some decisions around place based [CCG area] and [STP area] based. [Manager ID11]

Another factor identified was the national policy drivers:

[...] but there're also the other policy drivers as well, isn't there? You know, so there're the policy drivers around urgent emergency care and improving urgent emergency care, and, again, there's a conversation about what do you provide locally, what would you provide on a [regional level]? [Manager ID11]

The same respondent claimed that the concept around local vs STP footprints has become a mental model for them, although this is not something that can be easily conveyed to patients:

This concept of local versus the STP footprint is something that's very much a mental model now, but it is complicated and, you know, it's very often for our public and our patients who use our services, they want local service provision. [...] but then there's a question over sustainability of services and that whole discussion around, you need x amount of patients throughput in order to keep up clinical skills, [...] I think it's a difficult concept in terms of getting that over to patients. [Manager ID11]

In addition to a tension between locally-based primary care plan and STP, there was a concern that integration between health and social care would erode clinical leadership which is inherent in CCGs:

I think it [primary care] should be at place based. I think those professional leadership roles are really important, especially if you're going down the integration route. One of my concerns is that we may lose that if we integrate with the local authority and that professional leadership, clinical leadership, is critical to what we do. So, I've seen some services, not just in [name of an area] but regionally, where, since those services have gone to the local authority, the clinical engagement has not been as strong as it should be. [Manager ID11]

It was unclear to our case study CCGs how STPs, which have a wider footprint than CCGs, could drive and support primary care which is very much about locality:

I think there's an interesting ongoing dialogue about what, across a bigger footprint...what's the role of a bigger footprint STP in helping us drive and support primary care? I'd be surprised if there was much on primary care in there in the first instance. I think that's a thing that would make CCGs balk at it again actually. I think they get their head around why you would make decisions on things like cancer services, or stroke, or some of those, sort of, things. I wouldn't start with primary care with something like that. [CCG Accountable Officer ID39]

Disenfranchised GPs

The sense of disconnect between local needs and regional-level decision making added with tensions between clinically-led CCGs and national schemes has led to a growing
disenfranchisement amongst GP members in our case study CCGs. In the context of STPs, there seem to be a particular grievance as to how engagement was handled by NHSE. The process was described as a “very painful journey”:

Locality representative 1: what about NCM and doing a view on that?
Primary Care Development Manager: is that the transformational plan.
Locality representative 2: having been published oh 'the great world of STPs' since we weren’t consulted.. We’re only in one STP
[…]
Locality representative 3: why was there no consultation?
Head of engagement: It was a very painful journey, the fault is with NHSE and with how they handled it badly. Very badly to be honest. We would have published from day one, that’s how we do, but NHSE didn’t want for some spark someone looking and saying about a hole nobody looked at. [Primary Care Development Group October 2016, M31]

This was made more complicated with member practices do not always understand what national initiatives such as STPs are, as described by the following respondent:

And I don’t think yet that, not just the board GPs but the wider membership, I don’t think that they get STP at all yet really. [Lay member ID15]

Another example of disconnect between clinical perspective and national schemes was the dementia diagnosis rate. This is the Prime Minister’s challenge scheme launched in February 2015 and one of the 10 priorities areas identified by NHSE as part of the FYFV where GPs would receive £55 for each patient they diagnosed with dementia. This initiative was seen as something that was “dictated from on high”:

There’s been a big Prime Minister’s challenge, you know, to get the number of patients diagnosed with dementia recorded […]. Now, he is Prime Minister no longer, so we wonder whether, then a wow, let’s have a look at something else. Let’s count another, let’s count something different next year. That, I think, just comes down to the CCG, not through the co-commissioning group. It’s things like that, that would take our eye off the ball, that are dictated from on high. [CCG Accountable Officer ID28]

GPs in Site 3 felt it was wrong to participate in a reward scheme that was not about providing care for their patients. They did not see the benefit of diagnosis that does not lead to treatment and the targets were seen as not making sense from a clinical perspective:

Director of Strategy: […] Historically, there was nothing to offer patients after a diagnosis, however, there is an evolving evidence base on diagnosis….there’s been a disconnect from clinicians as they couldn’t see the benefit of a diagnosis.
Locality representative: there’s been active disengagement from some GPs as they viewed it as wrong to participate in a reward scheme that involved recording a code and was not about providing care for the patient – GPs viewed this as neither ethical nor appropriate. This helps to explain disengagement. [Primary Care Commissioning Committee October 2016]

LMC representative: this is an economic/political target and they’re asking clinicians to fill the numbers in. […] Dementia is an incurable disease and there’s no treatment. It wouldn’t satisfy the clinical criteria for screening. [Primary Care Operational Group September 2016, M43]

Overall, our case study CCGs were involved and supportive of the development of NMCs. However, there were some reservations towards how STPs were developing, partly due to the perception that STPs were put in place as a policy workaround hence lacking the legal basis to implement changes. Moreover, there were concerns over tensions between between locally-based primary care plan and
STPs which are based on a wider footprint and that integration between health and social care would erode clinical leadership which is inherent in CCGs.

**Summary: Wider national initiatives**

Our respondents expressed mixed views about wider national initiatives such as new models of care and STPs.

For NMC:
- Collaborative working requires trust, which takes time to develop
- The process of collaboration can be facilitated by trusted local leaders

For STPs:
- STPs were seen as a ‘policy workaround’, required to ‘fix’ the problems introduced by the HSCA12
- Several respondents highlighted the fact that many STPs cover similar geographical areas to the PCT Clusters which were formed prior to the HSCA12
- This was seen as an appropriate scale over which to plan for hospital-based services. However, there were a number of issues raised, including:
  - Concerns about unclear governance processes
  - Concerns about lack of accountability in the STP process
  - A strong belief that appropriate management of primary care requires a more local focus, and associated concerns that STPs were overlooking the needs of primary care and that GP voices were not being heard
  - Some evidence that the STP process is complicating their commissioning role, as providers are more focused on the STP process than on their engagement with local commissioners
  - Complexity associated with overlapping footprints and scales
  - Concern about a loss of clinical leadership in the system

Overall, our respondents highlighted their clear commitment to the local and a concern that recent developments were marginalising local voices. National initiatives, such as the drive to increase the diagnosis of dementia were seen as interfering with the process of local priority setting.

**3.5.5 Overall experience of delegation**

Our case study CCGs viewed co-commissioning as inevitably the direction of travel. This was because, as our respondents claimed, NHSE do not understand the realities of general practice and that CCGs would be able to sustain primary care longer than NHSE:

NHSE don’t understand the realities of general care practice [Comment made at the Primary Care Development Group meeting November 2016, M36]

I think it’s [general practice] not sustainable and by handing us the commissioning of it they’ve [NHSE] effectively handed us a poisoned chalice. But I think we’ll prop it up longer than if we’d left it, you know, as NHS England [CCG Chair GP ID38].

In terms of the overall process, the short timescale from announcement to policy implementation made the transfer of responsibility challenging. For example, one of our case study CCGs who
initially opted for joint commissioning did not know that NHSE retain the casting vote in the joint committee:

we’ve always worked with NHS England, but I think in terms of making the decisions, at times that was quite challenging in that the local view might have been different from NHS England’s view and having a committee...when the original guidance came out it didn’t say that NHS England would retain the casting vote in respect of any decisions that were made by the Joint Committee. They had two representatives on there and we’ve got seven, but actually they retained a casting vote for anything that was within their responsibilities. Actually, that was a very different...that was quite a big thing to suddenly put in and wasn’t there originally when we made the application to do joint commissioning. So I think that did bring with it some challenges. I think probably...I suppose they were supporting a number of CCGs all doing different things, so we were doing joint commissioning, our neighbours...one neighbour was doing full delegation, another neighbour was just doing great involvement. So I think that was probably quite challenging from their point of view, everyone doing something different. [Manager ID43]

Although CCGs were given the responsibility of commissioning primary care services, the lack of expertise delegated with the responsibility has caused CCGs struggling to grapple with what the scope of activities entails in practice:

It was difficult trying to prepare [the application] when you didn’t really know the scope of what was included.[...] I suppose vague because there wasn’t national guidance, but also because apart from one individual [...] no one at the CCG had worked in primary care commissioning, everyone had either left or gone to NHS England. [...] So we had quite a gap in organisational knowledge I think, so even when we got the delegation agreement we read about the functions, knowing really what that meant, the volume of work, the resources, we didn’t have the level of detail we have about other functions. [Manager ID11]

Moreover, as NHSE still hold the statutory responsibility, early in the process, there was some confusion around whether certain functions could be legally delegated to CCGs. For example, complaints management. In the guidance (NHS England, 2014d), it was stated that delegated CCGs will be responsible for complaints management. However, it later emerged that under the current legal framework NHSE cannot delegate complaints management to CCGs, although a management arrangement could be implemented (NHS England, 2015d). Another example was freedom of information requests, as they can cover both organisations:

I think sometimes it’s still a bit blurry. We’ve had examples this week, even with a delegation agreement, even with the tools and the models that we’ve got, that says some of the functions are quite clearly still reserved to NHS England and some of the functions are quite clearly ours. We still end up sometimes having a bit of a debate with them about oh well, we think that’s you and we think that’s us. So real examples of those have been around freedom of information requests where you might get a request that covers both organisations or covers the time period where both have been responsible. [...] So I think if it works well and it works as a partnership it’s okay, and I think once people have done a few freedom of information requests or they’ve followed some of these processes it becomes more embedded with whose responsibility it is. [Manager ID11]

The above extract also described how CCGs had to learn on the job, a common theme identified by our case study CCGs. However, the biggest struggle for our case study sites was around primary care contracting:

The bit that we struggle with is because when we became a CCG primary care commissioning or contracting went to NHS England, the knowledge and the experience went to NHS England and we don’t have that in the CCG and I think that’s the bit that we’re
finding most difficult that, for us, I’d never worked in primary care contracting, but, yet, I find myself now doing primary care contracting and the people who have got the knowledge and experience are based at NHS England. [Manager ID45]

I think the biggest problem has been having access to the right level of resource in terms of contracting finance, some of the support structures, because there isn’t enough of that at NHS England to help us really effectively. [...] but one or two people are really struggling to hold the whole thing together because the thing that happens when you take over something like this, you look under a rock and you think, oh my God, I can’t believe that, and then you find another contract that’s not been renewed, and then something else is wrong; and then you think, oh my goodness me I didn’t think we were going to take this over. And then you’ve got to fix it because you’re now responsible for it. And so I think there’s been a slight mismatch in the amount of work that needed to be done and the amount of resource that was deployed to it. I think that’s starting to catch up a little bit but then we’ve now got a bigger thing to think about for the future. [Independent GP ID9]

The lack of expertise on primary care contracting within CCGs, added to the transactional approach taken by NHSE, had caused our case study CCGs to deal with legacy issues in the first year of delegation, before they could even start being proactive. In Site 1, we observed the CCG having difficulty getting hold of the contracts or discovered that an APMS contract, a time-limited contract for non-traditional GP providers, had no contract end date. On the other hand, in Site 2, we observed the CCG having to deal with an on-going concern over additional contracts. There were three additional contracts for the area and following discussion with neighbouring CCGs, the responsibilities for these contracts were shared between the three CCGs. The reason these additional contracts were delegated to CCGs was because they were badged as primary care. This created significant issues for the CCG. Initially they were not able to get hold of the contracts. It was not clear who had originally commissioned the service or who had signed the contract. They also found out that the contract value was less than the service required making it difficult for the CCG to deliver the service.

In addition to the difficulty in getting hold of some of the primary care contracts from NHSE, access to historic data is another issue brought up by our case study CCGs:

Well for example the CQRS system which is a system that records the data for QOF and for the DESs that will subsequently trigger the payments for that and that’s something that practices are really interested in of course. As a CCG we have been unable to access that, with effect from the 1st of April this year 2016 we can now access CQRS, however we can’t access historic data so there’s no ability for us to have a look at trends, have a look to see how things have changed and we have to ask NHS England for all of that information. For the QOF signoff we had to ask for all of the background information to be able to authorise all of the payments. There’s a lot of information still held by NHS England that we don’t have direct access to and that’s not necessarily anybody’s fault it’s the way the greater system works and it’s data, it’s access to data that is very frustrating and having to ask people who are busy doing their own work to provide data for us to do our work is...can be uncomfortable when you know how busy they are. So there needs to be and we’ve tried to push for a change to the CQRS system so that we can access data from the 1st of April 2013 which would be really useful to us and unlock a lot of the other systems like that. It’s the systems it’s not the people, I know the people are working as well as they possibly can, the systems don’t allow it. [Manager ID37]

Our case study CCGs also claimed that having a membership model has made it difficult to undertake primary care development due to conflicts of interest:

The second most difficult thing then, I think, has been to drive forward primary care development in a member organisation configuration is...it’s a difficult balance
because...and it was always going to be a problem, this is kind of why membership model is difficult for primary care commissioning...but, you know, our stakeholders are also our...have a massive peculiar interest in the decision we make about the way we commission, so it’s difficult. You know, it’s given us a bunch of challenges in terms of the way we’ve brought the [name of a local initiative] in. I think we’ve managed them, but it’s been a challenge, yes. [CCG Accountable Officer ID18]

It’s quite difficult as a membership organisation, because the whole point of a membership organisation is you do what the membership want or it’s difficult not to do what the membership want and particularly around all the primary care stuff, you know. If you’re a membership organisation and the view is that you’re not doing very well in primary care, which is where your membership works, that’s a difficult place to be, isn’t it? [Manager ID42]

We asked CCGs to identify factors which were helpful during the transition process and were told that having NHSE staff seconded or assigned to the CCG was beneficial in terms of providing continuity of service provision. It was also helpful that although CCGs have been delegated the responsibility, there were a lot of hand-holding by NHSE early in the process:

we’d have been a trouble if there hadn’t have been a lot of hand-holding by NHS England in that first six to nine months. [Manager ID32]

which is hangover from...well which NHS England obviously...it was kicked off during NHS England. And what we’ve agreed with that is that they’re continuing to work with us on it. So they haven’t just dropped it like a hot potato. We’ve agreed we’ll carry on doing some of that together, which is fine, and it’s helpful, but where there’s other areas that have said actually we can just pick this up and get on with it, then we’ve done that where that’s felt best. It doesn’t feel like they’re holding us to account but they are, if you know what I mean. They’re not, sort of, standing over us with a big stick every two minutes, but it does get picked up in routine conversations, and we have ongoing dialogue about where we know there are issues. So it actually feels okay at the moment. [CCG Accountable Officer ID39]

Overall, CCGs in our case study found the delegation process challenging. However, as pointed out by one of our respondents:

I’ve never known a transfer yet where we got it absolutely right. [Manager ID32]
Summary: Experiences of delegation

Our case study CCGs told us that they had taken on responsibility for primary care co-commissioning because they were committed to the long term sustainability of general practice, and that they felt that CCGs, with their local knowledge and clinical leadership would be better placed to do this than NHSE. However, they highlighted a number of significant issues:

- The process of delegation had been described as rapid and difficult by those CCGs who went early in the process, and there was an early lack of clear information and guidance, requiring CCGs to learn as they went along.
- There remains confusion about some of the legal aspects surrounding delegation, in particular around who has responsibility for different functions.
- The fact that NHSE retains statutory responsibility for primary care commissioning means that even those CCGs with delegated responsibility will need to maintain an ongoing close relationship with NHSE.
- CCGs report a lack of managerial capacity both in general (i.e. the number of staff available to manage the workload) and in particular (i.e. lack of specific expertise such as estates or contract management).
- There is an ongoing need to deal with legacy issues arising from NHSE’s commissioning of primary care, complicated by lack of audit trails and information about decisions that were made.
- Conflicts of interest are an inevitable feature of primary care co-commissioning by CCGs which are ‘membership organisations’, and this complicates the relationship between CCGs and their member practices.

The secondment of staff from NHSE to CCGS was highlighted as the most helpful approach to managing some of these complexities.
4 Discussion

4.1 Summary: assessing programme theories

Our study suggests that CCGs have taken to primary care co-commissioning with varying degrees of enthusiasm, but with a clear sense that the commissioning of primary care services requires local knowledge and involvement of trusted managers with expertise in primary care. Our initial engagement with relevant documents and with senior policy makers and managers highlighted two programme theories as to why primary care co-commissioning by CCGs was desirable:

- It would bring clinicians with relevant local knowledge and expertise back into the commissioning process, supporting the development of locally-relevant plans
- It would allow a ‘place-based approach’, with the potential to move money between budgets and to facilitate integration between primary, secondary, and community care

Our case studies show that the first of these arguments has significant resonance for those involved. The importance of local knowledge and the involvement of known and trusted managers was cited in interviews and observed in meetings. However, we have identified some issues with the development of local-relevant plans, including:

- Potential conflicts or lack of alignment between plans made at CCG level and the strategic plans of individual GP practices as independent businesses
- Issues associated with conflicts of interest which can, at times, limit the ability of GPs with relevant local knowledge to contribute to decision-making
- Intrusion of national-level requirements and potential mismatches between national initiatives and local plans
- Concern about the lack of visibility of primary care services in local STPs, with the effect that local primary care plans may be over-ridden or impeded.

The concept of a ‘place-based’ approach to services is one which has gained currency in recent years. Whilst it is not often clearly defined, those involved in the early stages of our study shared a common understanding of ‘place-based’ as encompassing joined-up commissioning of services for patients in particular geographical areas, with associated shifts of resources between primary, community and hospital services. It was envisaged that CCGs would be able to use their new primary care commissioning powers to facilitate this type of integration and resource-shifting. We did not find significant evidence of this occurring in practice. In some of our case study sites, new models of care are being developed, and commissioners were keen to invest in community-based alternatives to secondary care services. However, in general we found the funds for these investments were coming from existing primary care sources – including money reallocated via the PMS review, as well as investment funds such as those associated with the Estates and Technology Transformation Fund – rather than from disinvestments in other sectors or from pooling of resources across sectors. Even in those sites with developing Vanguards, we found no evidence of an appetite amongst GPs for any change in their base contracts. Thus, investments were occurring via ‘add on’ contracts funded from existing sources. The pressures currently being felt by primary care providers across the country meant that the focus of all of our sites was on sustaining, developing and supporting primary care, rather than in developing new approaches. This meant mobilising whatever resources could be found to provide additional support for practices to extend and improve the services that they provide, with a significant focus upon ‘levelling up’ care provision to ensure a consistent approach across the area. The concomitant squeeze on secondary care budgets meant that in some places, resources intended to support primary care were in danger of being used to plug deficits in secondary care budgets. We found some evidence that the need to keep primary care co-commissioning structures and processes separate to the wider work of the CCG in order to minimise
conflicts of interest may act to limit opportunities for taking a truly place-based approach. Those GPs with lead roles in the wider CCG were frequently required to leave the room in PCCC meetings, with some telling us that this limited the extent to which they were able to take an overview of all care sectors, as would be required to support a 'place-based' approach to commissioning.

We found a number of common types of issues affecting how CCGs have taken on their new role:

- **Issues associated with the speed at which change occurred**, from announcement in May 2014 and when co-commissioning go-live in 2015. These issues were generally short-lived, but were significant at the time, requiring considerable work and taking up significant amounts of managerial and clinical time. Some CCGs had to reorganise their governance structures in response to belated guidance.

- **Ongoing practical issues.** CCGs have taken on responsibility for commissioning primary care services with no additional managerial resources.
  - This has meant that personnel are spread very thinly, and there are areas of work (e.g. estates, primary care finance) in which the relevant expertise has been lost in the significant down-sizing of the managerial workforce following the HSCA12.
  - Access to information is a problem in two areas. Firstly, we found a number of examples in which past decisions taken by NHSE could not be verified or clearly documented. Secondly, CCGs reported difficulties in obtaining the information about practice performance that they needed to manage payments.
  - Conflicts of interest (CoI) are a structural issue that cannot be managed away. Adequate management of CoI was a priority in our sites, but at best all that can be achieved is transparency. NHSE guidance on this issue was not always helpful, and we found that procedures to manage conflicts of interest may have the paradoxical effect of reducing the advantages of having GPs knowledge about their local area involved in commissioning. Some CCGs had adopted an approach involving involvement of independent GPs (ie from another area) or recently retired local GPs in order to provide clinical input without immediate financial conflicts.

- **Problems generated by the current legislative context.** NHSE retains statutory responsibility for primary care commissioning, with delegated commissioning described by many of our respondents (both policymakers and CCG staff) as a way to ‘workaround’ the problems that this generates. Ongoing issues associated with the current legislative context include:
  - Requirement for ongoing involvement of NHSE, even for those CCGs with fully delegated responsibility, with NHSE continuing to hold the Primary Care budget.
  - Lack of clarity over who is responsible for what. This is a particular issue in the area of primary care estates, with significant legacy issues arising from HSCA12.
  - Cumbersome governance arrangements.
  - Fragmentation of responsibilities with respect to performance management of GP practices, with CCGs, NHSE and the CQC having overlapping roles and responsibilities. This latter issue goes somewhat wider than simply primary care commissioning, as the HSCA12 divided commissioning responsibilities in new ways. This has generated lack of clarity around issues of responsibility for areas such as screening. Responsibility for property services, including leases, was an issue in our case study sites.

4.2 The practice of primary care co-commissioning

Our case study CCGs and those involved in our telephone survey were largely focusing their efforts in three areas:
- Reactive work required to manage ongoing issues, including legacy issues inherited from NHSE. These often involved estates or issues to do with APMS contracts
- Proactive development of primary care strategies and plans
- A national scheme to improve estates and information systems

**Primary care strategies** were largely focused upon: improving quality of care provided; encouraging practices to work together in larger groups to provide standardised access and/or a more integrated approach to delivering health and social care services; and developing general practice ‘at scale’ to enable greater delivery of out-of-hospital and delivery of care closer to home. The mechanism to bring about these changes focused upon financial incentivisation of areas of work such as: commitment to a range of care standards, including proactive care of vulnerable patients; improved access; development of co-operative working between practices to deliver a wider range of services, including the formation of formal federations; and medicines management and prescribing. These schemes were funded via:
- The existing primary care budget, with the reinvestment of funds previously used to support PMS contracts
- Consolidation of existing Directed and Local Enhanced Services
- The wider CCG budget – although this has been limited by budgetary pressures, with some CCGs forced to use primary care funds to support secondary care budgets

The focus on estates and technology was driven by a national scheme which brought its own funding.

These approaches and strategies bear a strong resemblance to incentive schemes developed under the Practice-based Commissioning initiative which preceded the HSCA12 (Checkland et al., 2008, 2009; Checkland et al., 2011; Coleman et al., 2010; Coleman et al., 2007; Coleman et al., 2009). Practice-based Commissioning (PBC) was an initiative which was intended to increase the involvement of clinicians in commissioning. Primary Care Trusts retained overall statutory responsibility for commissioning, but indicative budgets were delegated to groups of GPs, supported by managers. The scheme was relatively short lived, beginning in 2006-7 and effectively ending following the publication of the White Paper, *Equity and Excellence* in 2010 (Department of Health, 2010). Evaluation suggested that, whilst PBC groups had limited success in catalysing widespread service redesign, there was evidence of a commitment to and progress towards the performance management of participating practices, alongside a variety of incentive schemes designed to improve access to services and the range of services available in primary care. Examples of behaviours or services incentivised under PBC included (Coleman et al., 2009):
- changing prescribing behaviour, such as switching patients onto simvastatin (the cheapest statin drug) from other statins, switching to generic drugs
- working as a practice to scrutinise referrals and redirect or prevent if possible
- reducing the number of follow up appointments patients received in outpatients by scrutinising letters and cancelling those deemed unnecessary
- agreement to review and validate budgetary data monthly
- succeeding in saving money against allocated prescribing budget
- reducing admissions for long term conditions
- attendance at Consortium meetings and educational events
- compliance with new patient pathways/ services as they were developed and rolled out
- Piloting software to make checks on hospital data.

It can be seen from this list that, whilst some of these schemes may have differed quantitatively from those we saw associated with primary care co-commissioning (i.e. many PBC schemes were relatively small scale), they were qualitatively similar (see Table 11, p40), focusing upon:
• Incentivising desired practice behaviour and provision of services
• Incentivising practices to proactively manage patients in order to reduce the use of secondary care services

Table 12 (below) sets out the similarities and differences between PBC and primary care co-commissioning.
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<thead>
<tr>
<th>Purpose / scope</th>
<th>PBC</th>
<th>Co-commissioning</th>
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<tbody>
<tr>
<td>Provision of an indicative budget to groups of practices, intended to engage clinicians in commissioning. Policy focus upon shifting care from hospitals into the community, but in practice many groups focused upon improving primary care services. Statutory responsibility remained with PCT. Did not include core GP contracts, which were commissioned by the PCT. Coverage virtually 100% of practices in England</td>
<td>Focus upon primary care services. Intended to facilitate ‘place-based’ commissioning, and improve planning and provision of primary care services. Statutory responsibility remains with NHSE. Includes core GP contracts. More CCGs moving towards full delegation, but remains short of full coverage</td>
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| Fit with wider commissioning agenda | Variable, depending upon the attitude of the PCT. In some areas the PBC group had significant input into the overall commissioning process, in others focus was more limited. | Intended to facilitate integration between commissioning different types of services. However, conflict of interest concerns mean that primary care commissioning is somewhat separate from the wider commissioning work of the CCG |

| Budgets and savings | Budgets varied, but could cover secondary care services, prescribing, community services. Excluded primary care core budgets (GMS, PMS, APMS), but included Local and Directed Enhanced service payments. Potential to move funds between budgets (eg savings made on secondary care could be invested in primary care) | Budgets include GMS, PMS and APMS, along with Local and Directed Enhanced services. Potential to move funds between budgets |

| Incentives | Range of schemes, usually referred to as ‘incentive’ schemes, focusing upon:  
- Incentivising desired practice behaviour and provision of services  
- Incentivising practices to proactively manage patients in order to reduce the use of secondary care services  
Funded from primary care development monies plus DES/LES and reinvestment of savings | Range of additional schemes, often referred to as a ‘contract’. Focus upon:  
- Incentivising desired practice behaviour and service, with a focus on collaboration between practices (including the development of formal ‘federation’) and on standardising care  
- Incentivising proactive management of vulnerable patients and avoidance of secondary care usage  
Funding from recycling PMS funding, DES/LES. Potential for reinvestment of funds saved from other CCG budgets |

| Management and information support | Variable. Most PBC groups had designated managerial support from experienced PCT staff. Host PCT also had full range of expertise available | Limited – no additional management funding, despite increased workload. Some support provided by NHSE, including seconded staff in some areas. Significant gaps in available expertise. |

| Service developments | Focus upon improving access to services in the community, but with greater focus on individual practices | Focus upon improving access to services in the community, with particular focus upon collaboration between practices and new ways of providing services |
This comparison demonstrates that there are many similarities between the work currently being undertaken by CCGs under primary care co-commissioning and the work previously undertaken under PBC. The most obvious difference between the two is that CCGs undertaking primary care co-commissioning also carry responsibility for GMS, PMS and APMS contracts. Work to harmonise (i.e. reduce funding differentials) between PMS and GMS practices began under the auspices of PCTs, was continued by NHSE and now falls to CCGs to complete. The money freed up by the equalisation of funding forms a large part of the investment fund that CCGs have used to support their various incentive and ‘add on contract’ schemes. In addition, CCGs have been responsible for making decisions about APMS contracts. This latter work has been complicated by: the need to avoid conflicts of interest, which has limited the ability of local GPs to contribute; the fact that some CCGs lack the required expertise with respect to estates and contract management; and some confusion over what was or was not done by NHSE with respect to these contracts. However, the core GMS contract remains nationally negotiated, and we have observed little enthusiasm in our case study CCGs for changing its basic provisions. In addition, CCGs involved with the Vanguard programme are focusing their efforts in primary care around additional ‘contracts’ rather than making changes to the core contract.

We asked those involved with primary care co-commissioning to reflect upon the similarities with PBC which we had observed. The differences that were highlighted were differences in tone and scale, rather than in direction of travel or focus:

| **Clinical engagement and legitimacy** | Clinical engagement variable. PBC groups led by GPs. PBC voluntary, which supported its perceived legitimacy amongst practices. Legitimacy enhanced by successful service improvement schemes, by good communication and by allowing local determination of approach and focus. Formal sign up to incentive schemes valuable | Clinical engagement complicated by the need to avoid perceptions of conflicts of interest. PCCC led by non-GPs, and GPs required to leave the room during meetings for some items. Practice engagement with the CCG compulsory. Most CCGs held votes as to whether or not the CCG should take on primary care co-commissioning – support mostly strong. Formal sign up to additional ‘contract’ schemes seen as valuable |
| **Performance management** | Surprising appetite amongst PBC groups for peer-surveillance and performance management of the quality of care provided, with acceptance by practices that this was legitimate. Practice visits and incentive schemes used. Formal performance management responsibilities remained with PCT | Performance management complicated by division of formal responsibilities between CCG, NHSE and CQC. CCGs undertaking some performance management of practices, with a focus on ‘levelling up’ quality of care using performance incentives as well as practice visits and support |
| **PPI and engagement** | Limited | Limited, other than around formal consultation for practice closures or mergers. Some CCGs engaged the public in their development of strategy |
| **Health inequalities** | Some evidence of attempts to reduce inequalities by differential investment in deprived areas, but patchy and non-systematic | Some CCGs targeting investment to ‘vulnerable practices’, usually in deprived areas |
| **Demand management** | Incentive schemes focused upon reducing demand for secondary care, with explicit attention to practice referral rates and A&E attendance | Focus upon proactive management of at-risk patients, with attention to A&E attendance and other metrics |
The fundamental... the biggest difference is we’ve got more GPs seeing a bigger picture and being more strategic if you like. PBC was about small scale, little pet projects about half a whole time physiotherapist in a couple of practices or a bit of a path... a bunion pathway or a .... You know? [...] PBC was not about big transformational change, it was about... it was almost GP fundholding. You know it was GPs who saw that it was about their business [Manager ID12]

And I just think co-commissioning is a reinvention of practice-based commissioning, to be fair. But it needs to be under a different guise. The NHS is always reinventing themselves, but they call it something different. But historically they go round in circles, and end up where they have come from. I think that’s what is co-commissioning, to be fair. [NHSE representative ID48]

However, whilst some of our case study CCGs is currently engaged with broader programmes to introduce new ways of delivering services, this has not yet translated into significant change on the ground. Furthermore, there is no a priori reason why such programmes could not have evolved out of the smaller scale changes occurring under PBC.

### 4.3 Comparison with other research

Primary care co-commissioning is a relatively new approach, and there is as yet little published research. NHSE has produced a number of ‘case studies’ which set out the benefits of delegated responsibility for primary care co-commissioning (NHS England, 2017b). These are intended to encourage CCGs currently not taking full delegated responsibility to move to full delegation; they are therefore focused upon the positive aspects of the transition. Benefits claimed include:

- The development of clearer, more joined up visions for primary care, aligned to wider CCG and STP plans for improving health services;
- Improved access to primary care;
- Improved quality of care being delivered to patients;
- Improved CCG relationships with member practices, including greater local ownership of the development of primary care services;
- Increased clinical leadership in primary care commissioning, enabling more local decision making;
- Greater involvement of patients in shaping services;
- A more sustainable primary care system for the future.

These claimed benefits fall into three main categories: **service improvements**, arising out of CCG plans or strategies; benefits arising out of the **closer relationship** between the CCG and member practices necessary to commission primary care services; and **longer term potential** benefits associated with clinical involvement in commissioning primary care. These claims to benefit depend upon the baseline being used. If the comparison is with primary care commissioning undertaken by NHSE, then it is clear that the greater local knowledge and understanding of CCGs is important in ensuring that primary care services meet local needs, and our findings are consistent with this. In addition, our study found some evidence to support the claim that GP practices, as CCG members, had become more engaged with their CCG as a result. In particular, the opportunity to tailor additional contract/incentive schemes to meet local needs was valuable in engaging practices and supporting change. However, our comparison with PBC above suggests that the improvement to services is qualitatively similar to that which was being pursued by PCTs under the PBC initiative.

Research by the Kings Fund and the Nuffield Trust has explored the engagement of GPs with their local CCG. The most recent findings from this study (Robertson et al., 2015) suggest that GPs are supportive of their CCG taking over responsibility for commissioning primary care, and are happy for the CCG to have a role in improving the quality of care provided. However, they were less happy
with the CCG having a more formal performance management role, and were keen for primary care co-commissioning to be led by local clinicians. This latter point highlights the issues with endemic conflicts of interest which we have explored: clinical leadership brings with it inevitable conflicts of interest.

A review of evidence relating to NHS estates was carried out by the King’s Fund (Wenzel et al., 2016) to support the Naylor review of NHS estates policy (NHS & DoH, 2017). This review highlighted a number of issues explored in this report, including: lack of clarity over many aspects of NHS estates management, with no over-arching strategy and a ‘patchwork’ of bodies having responsibilities for different aspects of estates; lack of expertise in CCGs and more broadly; and a lack of linkage between funding mechanisms and relevant local strategies.

Previous studies of PBC were mixed in their findings. Our own research (Miller et al., 2015) suggested that GP engagement with commissioning via the PBC initiative was feasible and could potentially add significant value, but its practice was dependent to a large degree, on the attitude and approach of the host PCT. We found an appetite amongst GPs for peer-review of performance, and evidence of increasing attempts to improve the quality and range of services provided in the community, although we found little evidence of wider impact on commissioning of secondary care services. Other studies highlighted the variable nature of engagement by GPs and practices (Curry et al.), a finding mirrored by the recent Kings Fund/Nuffield study of CCGs (Robertson et al., 2016). A report published in 2010 (Smith et al., 2010) highlighted the need to consider the scale at which particular types of services needed to be commissioned, with a focus upon setting up structures which would allow pooling of resources between commissioning bodies in order to commission secondary care services which required a significant population base, whilst retaining local responsiveness for primary care and other community-based services. This has resonance with this study, which highlights the perceived importance of local involvement in primary care commissioning.

4.4 Strengths and weaknesses of the study

The strength of this study lies in the bringing together of evidence from senior policy makers as to the overall objectives for the policy with both telephone survey and case study evidence as to how it is playing out in practice. In addition, the fact that the study represents a third stage in a series of projects which look longitudinally at the development of CCGs means that the evidence we present rests upon a deep understanding of the context. Our case study approach, which combines observational evidence with interviews means that we have not only captured evidence about issues voiced by interviewees, but we have also watched these issues unfold in real time in a variety of meetings. This detailed observational evidence has provided insights which would not have arisen from interviews alone.

The ethnographic approach does, however, mean that we were only able to collect data in four case study sites. The generalisability of our findings from these sites rests upon two things: the two rounds of telephone survey data, which confirmed that the issues arising in our case studies were also issues relevant more widely; and a theoretical generalisation arising from our broader engagement in organisational theory. This report does not focus upon this aspect of the study, but this will be addressed in subsequent publications exploring issues such as accountability and governance.

The study provides detailed evidence about the experiences of CCGs as they took on delegated responsibility for primary care commissioning. It remains early days in this policy area, and it is therefore not yet possible to straightforwardly point to impacts arising from the policy. It will be important for subsequent studies to follow up on the areas that we have highlighted here, in particular exploring the extent to which the schemes for incentivisation of and investment in primary
care services lead to genuine improvements in care. In addition, the rapidly moving wider policy environment means that some policy initiatives (such as STPs) have developed whilst the study was underway, and we have therefore been relatively limited in the extent to which we have been able to investigate them. It will be particularly important to follow up how CCGs are engaging with their local STPs, and how the local voice which was highlighted as being so important will be heard in the wider process.

4.5 Conclusions and implications for policy

Our study shows that the commissioning of primary care requires detailed local knowledge about services and providers alongside expertise in the unique domain of primary care, and that delegated responsibilities have the potential to provide this more effectively than was the case when NHSE retained full responsibility for primary care commissioning. It is likely that the potential for these benefits to be realised will depend crucially upon the provision of sufficient managerial expertise. In addition, primary care co-commissioning by CCGs carries within it the potential for investment that will break down barriers between primary, secondary and community service. However, it is as yet too early for this to have been realised. The involvement of GPs in the commissioning of primary care services is regarded as positive, both in terms of engaging local GPs and in ensuring that new services meet local needs. However, conflicts of interest are inherent to this process, and will require ongoing management.

Our evidence suggests that primary care co-commissioning by CCGs is likely to more effectively support the development of primary care services than would be the case had NHSE retained the responsibility. However, our comparison with PBC also shows that what is happening under primary care co-commissioning does not differ in fundamental ways from the work that was being undertaken by PCTs via the PBC initiative prior to the HSCA12. This similarity suggests that the approach being adopted – i.e. local development of plans alongside strategic use of funding to incentivise desired behaviours by GP practices – is the approach most suited to the current contractual landscape of general practice. Current broader policy initiatives such as the Vanguard programme suggest an appetite amongst policy makers to change this contractual landscape (NHS England, 2014a), but our study has not found a significant appetite amongst GPs for this.

Our study has the following implications for policy and for management of primary care co-commissioning by NHSE:

**Current legislative arrangements may need to be reconsidered**

Statutory responsibility for primary care commissioning remains with NHSE. This brings with it a number of complications, in particular cumbersome governance structures, with NHSE retaining ultimate responsibility for a number of areas of work and the need for local flexibility in working out where particular responsibilities lie. This limits how far CCGs can collaborate either with each other or with other organisations. Hence current legislative arrangements may need revisiting.

There is also a lack of clarity over where particular responsibilities lie. This is particularly true in the realm of estates management and performance management of GP practices, with responsibility for the latter split between CCGs, NHSE and CQC. Consideration should be given to whether or not some streamlining of current arrangements is possible, and CCGs would benefit from clear guidance as to who is responsible for what.

**Knowledge about and expertise in the management of primary care services is urgently required, both in CCGs and in NHSE.**

The transition to CCGs led to significant loss of expertise in primary care, as PCT primary care commissioning teams were disbanded and staff moved into other roles or left the NHS. NHSE could usefully undertake a skills audit, identifying staff with relevant expertise, and providing CCGs with
access to them. In the longer term, dedicated training in the history, commissioning and management of primary care service would be of value to staff in CCGs and NHSE. Engagement with academics with expertise in the longer term history of primary care services may be of value.

*Future approaches to commissioning need to support the setting up of structures and processes that function at the optimum geographical scale.*

As we have highlighted, the direction of travel more broadly in NHS policy is towards a regional planning approach (embodied in STPs) in which commissioners and providers come together across a sizable geographical footprint to ensure appropriate services for the population. However, our study highlights the benefits of fine-grained local knowledge about primary care services and providers, which is unlikely to be available at this large scale. Furthermore, our respondents reported feeling distanced from the STP process, and voiced concerns that both their local needs and the needs of primary care more generally were not sufficiently visible. There was also a concern that integration between health and social care would erode clinical leadership which is inherent in CCGs. STP leadership and governance processes need to be established in ways which take account clinical input and the need for locality structures which remain responsive to local concerns and issues, and this is particularly true for primary care services.

*Wholesale contract redesign is probably less important than approaches which facilitate the negotiation and management of ‘add on’ contracts and incentives.*

We have highlighted the durability of approaches which focus upon using financial incentives alongside managerial support in order to improve services in primary care and community settings, with clear continuity between current approaches and those emerging under PBC nearly ten years ago. Our study and this history together suggest that such schemes are acceptable to practices and are capable of bringing about change. The facilitation of collaborative working by these mechanisms should continue to be supported. There is, as yet, no clear evidence that wider scale contractual change is desired. Finding ways to monitor the outcomes of such ‘add on’ contracts will be important.

*Expertise in and knowledge about primary care history, contracts, finance, and management is vital, alongside adequate managerial resources.*

Our study reveals both a general and a specific lack of expertise and resources. In general, the disbandment of PCTs and the establishment of CCGs led to a significant loss of managerial staff with expertise and experience in primary care commissioning. More specifically, we found a loss of expertise in estates and contract management. The secondment of managerial staff with relevant expertise from NHSE was helpful, but CCGs will require an increase in the amount that they can spend on management if primary care commissioning is to be successful in the longer term. One of the facilitating factors which CCGs had found helpful was having memoranda of understanding between NHSE and CCGs. Whilst some of our sites did have such a document, it was not something which was highlighted by our sites as particularly helpful or otherwise. In fact we found that the relationship between CCGs and NHSE was one of continual negotiation and interaction, with particular value placed upon known individuals who attended meetings or who could be easily contacted. Our over-arching impression is of the complexity of the ongoing relationship, with ‘delegation’ of responsibility from NHSE to CCGs not really providing an adequate description.

CCGs in our case studies also highlighted that it would be helpful if they could be provided with clear guidance as to the range of skills and expertise that they require, alongside support in accessing such skills if they do not already have them. For example, NHSE could identify a bank of staff with relevant expertise (e.g. estates) who could be seconded to CCGs as required. In the longer term, dedicated training in the history, commissioning and management of primary care service would be of value to staff in CCGs and NHSE. Engagement with academics with expertise in the longer term history of primary care services may be of value.
Conflicts of interest management is fundamental to the commissioning of primary care by CCGs

There is an irreducible tension between the desire to utilise GPs local knowledge and specific expertise in primary care and the need to minimise conflicts of interest. This tension is fundamental and cannot be removed by procedural means. Acknowledging the tension, and highlighting areas of work in which the benefits of specific expertise outweigh concerns about conflicts of interest may be helpful. In particular, it may be useful to distinguish between areas of work in which GP knowledge is fundamental (e.g. designing services to be delivered in the community or strategic issues relating to estates) and those in which it is less important (e.g. decisions about particular practice contracts, day to day decisions about funding for estate development). In those areas where clinical input is essential, consideration could be given to obtaining such input from GPs without a direct financial interest in the service involved. Whilst transparency will continue to be important, mandating that PCCC meetings take place in public does not necessarily achieve this and could be reconsidered. Robust lay involvement in decision-making is important, although such people may also have conflicts of interest.

Recognition of continuities with previous NHS structures may be beneficial

We have clearly demonstrated how closely current primary care commissioning resembles previous initiatives. There has been loss of organisational memory in the NHS as managerial budgets have been cut and systems changed, but individuals still exist within NHSE, CCGs, and the wider NHS who were involved in previous clinical commissioning initiatives, alongside academics who have experience of researching these issues over many years. Explicit initiatives to harness that working knowledge and history of working together to learn from what went before may be of value.

Investment in primary care infrastructure and services requires careful management

Development of primary care services requires accommodation between local strategic needs, wider regional strategy led by STPs and national priorities. Approaches such as the Estates and Technology Transformation Fund were welcomed, but hampered in their operation by very tight timescales. Greater flexibility in allowing CCGs to spend central funding according to their needs and priorities may be helpful, alongside guidance in designing appropriate assurance processes to ensure return on investment. It is important that the need for investment in primary care services is championed within STPs.

Patient and public involvement and engagement remains difficult to operationalise

The most robust public engagement that we observed revolved around specific service provision, such as practice closures, mergers or relocations. Such engagement tends to highlight the premium that members of the public place upon local services. CCGs have worked hard to engage their members (i.e. GP practices) in their plans and strategies, but it is less clear how members of the public can be engaged in this more strategic work. We found very limited routine engagement by the public, with most meetings not attended by any members of the public. Our case study CCGs did not have explicit strategies for encouraging such engagement. The STP process has further highlighted the issues surrounding public engagement; it may be helpful to include issues surrounding primary care services in future initiatives to engage the public with STPs, to avoid duplication.

Primary care co-commissioning represents a policy ‘workaround’

Current legislation and distribution of statutory responsibilities does not fully support primary care co-commissioning by CCGs. Current arrangements represent a ‘policy workaround’, that brings with it a number of complications, in particular in defining where responsibilities lie. This may need revisiting.
5 References


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