Understanding the new commissioning system in England: contexts, mechanisms and outcomes
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Executive Summary

Introduction and background
Healthcare commissioning is the process by which population needs are assessed, and appropriate health care is purchased to meet those needs from organisations providing care. Introduced in the NHS in 1990, this separation between the roles of planning and purchasing care on the one hand and providing care on the other, is claimed to support an effective and efficient health system. In 2012 there was a significant reorganisation of the NHS in England (enacted in the Health and Social Care Act 2012 (HSCA12)), with the abolition of some organisations, the creation of others and a significant redistribution of responsibilities for commissioning different types of healthcare. The changes were comprehensive, affecting most types of organisation in the NHS. Not only was there a wider variety of types of organisation in the new system, but also responsibilities for commissioning some types of services were divided between a number of different organisations. Prior to the HSCA12, organisations known as Primary Care Trusts (PCTs) were responsible for commissioning most types of healthcare. After the HSCA12, different organisations assumed responsibility for different types of care. For example, responsibility for public health services was transferred to Local Authorities (LAs), whilst responsibility for commissioning care for rare diseases ('specialised services') was transferred to the new national body, NHS England (NHSE). PCTs were replaced by new commissioning organisations known as Clinical Commissioning Groups (CCGs). These were constituted as ‘membership organisations’, with the membership consisting of local general practices (family doctor groups). These changes (and other aspects of the reorganisation) were intended to: give front line NHS clinicians more freedom and a greater role in commissioning; increase the efficiency of the NHS by promoting greater competition between providers; focus commissioning activity upon achieving particular outcomes rather than on counting activity; create a new Arm’s Length Body (NHS England) to oversee the running of the NHS; and to transfer responsibility for public health to elected Local Authorities. In order to investigate the impact of the changes in respect of commissioning, we undertook a three year study using qualitative and quantitative methods to explore how the new commissioning system was functioning.

Study aims, objectives and research questions
This research aimed to assess the impact of the reforms on the operation and outcomes of the commissioning system. We aimed to explore:

i. The new system at local level, investigating how the new organisations were developing, assuming their responsibilities, interacting, holding one another to account, and relating to new national-level bodies.

ii. The main effects of the new system, seeking to demonstrate the changes that may be associated with elements of this system, as well as explicating factors which may have enabled or inhibited these changes.

In order to meet these aims, we addressed the following research questions:

1) Understanding system complexity:
   a) How are the different organisations managing their new roles and responsibilities in practice, and how are they dealing with areas of overlap and omission?
   b) What are the mechanisms by which the different parts of the health and care system are working together locally and how are they interacting with national level bodies?
   c) To what extent do local actors perceive themselves to be autonomous?
   d) To whom do they feel accountable?
   e) What is the performance regime being applied, and what is its impact?
2) The conduct of commissioning:
   a) What were the drivers for the service changes being made?
   b) What is the effect on commissioning processes of the division of commissioning
      responsibilities in new ways between new organisations?
   c) How are commissioners responding to the need to ensure better integration of services?
   d) How is external commissioning support being used, and what is the impact of this?
   e) What is the effect of ‘commissioning for outcomes’ on the commissioning process?
   f) How far is the new system enabling/inhibiting service change and development?

3) Quality & outcomes:
   a) What claims to ‘success’ are made by actors in each different organisation, and what
      evidence is there to back up these claims?
   b) What does each organisation/group of organisations claim as its main ‘outcomes’ and
      how are the new ‘outcomes frameworks’ operating?
   c) How have quantitative outcomes changed in the new system, and what explanatory
      factors can be identified?
   d) Are any aspects of the new commissioning arrangements associated with improvements
      in quality, reductions in health inequalities and improvements in factors which affect overall
      system efficiency?

Methods
The study was underpinned by a realist theoretical framework, in which the initial intentions and
assumptions underlying the legislation (known as ‘programme theories’) were ascertained from
publicly available policy documents. These assumptions were then tested against the reality of the
implementation of the Act, with careful exploration of the local factors which influenced what
happened. The case studies took place in two local areas of England. These were large geographical
areas, allowing us to study the interactions between all of the different commissioning organisations
and between commissioners and providers. The study included four inter-related work streams:

Workstream 1
The aim of this work stream was to understand how the new organisations in a geographical area
were building relationships and approaching their new responsibilities. We conducted interviews
with a range of individuals working in all of the organisations with significant responsibilities relating
to commissioning in each of the AT areas. These included: CCGs; CSUs; the AT; and Local Authority
commissioners. Interviews focused upon experiences since the implementation of the new system,
including their interactions with other organisations and the performance management regime to
which they were subject.

Workstream 2
This workstream explored commissioning in more detail, through the medium of ‘tracer’ service
areas. These included:
   • Sexual health – in order to explore services where commissioning responsibilities were
     widely dispersed between organisations
   • Dementia – in order to explore services where integration with the Local Authority was
     required
   • Orthopaedics – in order to explore a service area in which there had been little change to
     commissioning responsibilities
   • Specialised services - in order to explore the commissioning of services by the new national
     body, NHS England
   • Screening services – in order to explore a complex commissioning area
Interviews with both commissioners and providers, and observation of some commissioner meetings were used to explore in detail how commissioning was conducted in the new system.

**Workstream 3**

In this workstream outcomes were explored both qualitatively and quantitatively. For the qualitative interviews, respondents were asked to reflect upon the ways in which they felt they had been successful. We then sought to measure the impact of the changes. Firstly, we explored an issue which had arisen in the interviews – cervical screening – using a difference-in-differences approach to test if areas more affected by the changes to commissioning had suffered a greater decline in uptake than those less affected. We then expanded this analysis to explore a wide range of potential outcomes. We created three different measures of what we call ‘dose of reform’. These are elements of the reforms which affect some areas more than others. Our three measures included: the extent to which new commissioning organisations had different boundaries and membership than the previous organisations; the extent to which clinicians were involved in senior leadership in commissioning organisations; and the number of Local Authorities with which commissioning organisations were required to interact. We then tested these measures against a range of outcomes derived from administrative data sets, including: measures of hospital activity; patient experience measures; and aspects of primary care quality. We used a continuous difference-in-differences approach to account for differences in outcomes that pre-dated the policy reform.

**Workstream 4**

In this workstream we combined the findings from the other three workstreams to generate an over-arching narrative about the impacts of the HSCA12 on the commissioning system.

In total across all of the workstreams we carried out 143 interviews, with individuals from a broad range of commissioning backgrounds, including CCGs, Local Authorities and NHS England. In addition we interviewed staff from Public Health England and selected provider organisations. We also observed a number of meetings relevant to commissioning.

**Findings**

**Commissioning system complexity**

We found that the new system was considerably more complicated than what had gone before. In particular, we found that splitting responsibility for commissioning some types of service between multiple commissioners had led to considerable difficulties in coordination, often referred to in our interviews as ‘fragmentation’. This was particularly evident for services for a particular condition that ranged from preventive services, through locally commissioned NHS services to more specialised services. Examples include services for HIV, child mental health, and obesity. The new system divided responsibility for commissioning parts of these services between a variety of commissioners, and this had led to problems, with potential gaps in service provision.

We also found that the local commissioning landscape had become increasingly complicated, with a proliferation of new local organisations with which local commissioners were required to engage. Some of these new organisations were created by the HSCA12 (e.g. Health and Wellbeing Boards), whilst others were created in order to compensate for the loss of regional oversight consequent upon the abolition of Strategic Health Authorities. Within this more complex system, respondents described the need for ‘workarounds’ to make the system work coherently, and the importance of longstanding local relationships in this process. More recent moves towards new regional collaborative structures such as Sustainability and Transformation Partnerships/Plans (STPs) suggest recognition by policy makers of these complexities.
The loss of managerial expertise resulting from the reduction in managerial spending and the creation of CSUs was keenly felt, and the value of managers who had worked in the local area for some time and who knew each other well was frequently highlighted. It was intended that CCGs would be more autonomous than PCTs. In practice, the oversight regime for CCGs was more stringent than that for PCTs because of the fiscal pressures facing the NHS, amongst other factors. Respondents described an initial feeling of freedom, which quickly receded as the CCG assurance process developed, and oversight and assurance processes were complicated. This process, led by NHS England, put CCGs under increasing scrutiny, and required them to meet a number of national-level priorities, with limited local discretion. In the context of increasingly constrained resources, CCGs were required to maintain financial balance, and those which did not were at risk of being put into ‘special measures’ by NHS England.

The conduct of commissioning
We used ‘tracer’ services to explore commissioning practices in depth. Across all of the tracers, the fragmentation of commissioning identified in initial interviews was an issue, with particular issues affecting sexual health services. The changes embodied in the HSCA12 had acted to both facilitate and impede service developments, depending upon the exact local contextual conditions. Where there were good local collaborative relationships, the reorganisation had caused disruption and delay; where local services were felt to be suboptimal and difficult to change, the reorganisation had provided an impetus for change. The incentives to increase secondary care activity embedded within the Payment by Results system continued to dominate many areas of commissioning, driving activity and requiring commissioners to put in place specific approaches to counteract their effects. For example, much of the focus in orthopaedic commissioning was upon measures to reduce secondary care activity.

The greater involvement of clinicians in commissioning did not appear to have led to any clearly identifiable changes to commissioning practice, other than at the margins. Commissioning at national level for specialised and screening services was problematic, with particular issues identified with the move away from commissioning specialised services for particular populations towards an approach focused upon commissioning particular providers. Integration of services became an increasing focus throughout the study, with multiple new initiatives established. In general the fragmentation of commissioning responsibilities between different organisations was unhelpful in facilitating integration, although local commissioners were working hard across organisational boundaries to overcome these difficulties. Good local relationships between individuals who understand the local health and care landscape were seen as vital in this.

The creation of a market in commissioning management support services intended in the HSCA12 did not occur. We found mixed approaches to the provision of commissioning support, with some CCGs seeking to do this work themselves, whilst others contracted much of it out to their local CSU. In some areas staff from CSUs were seconded to CCGs, creating some confusion over line management.

Commissioning for outcomes proved difficult to operationalise, with the various outcomes frameworks (which changed during the study) not found to be particularly helpful in directing commissioning activity. The role of commissioners in influencing some of the outcomes in the framework was felt to be limited, and in practice the need to remain in financial balance tended to dominate. Overall, the new system appeared to have made service change more difficult, although as we have indicated in specific local contexts some aspects of the Act were found to have acted to catalyse change.

Quality and outcomes of commissioning
Focusing upon quality and outcomes that could be attributed to commissioning, interview respondents were asked to identify their perceived successes and the factors underpinning these. Increased clinical involvement in commissioning was felt to have been a positive development, although there were few concrete claims for improvements in outcomes associated with it. In general, claims to success in this area focused upon improvements in relationships between commissioners and their local providers, with clinician to clinician relationships highlighted as proving invaluable in achieving particular service improvements. However, such improvements tended to be driven by the personal interests of the clinicians involved, and only appeared to be successful where there were provider representatives also interested in the same issue.

Respondents also highlighted their success in establishing their CCGs as new organisations and maintaining financial balance, and suggested that their relationships with their Local Authority colleagues had improved. Success in taking on new responsibility for primary care commissioning in 2015 and 2016 was also referred to, with respondents highlighting success in supporting quality improvement in general practices.

Prompted by the findings from initial qualitative research, the first analysis using quantitative data examined trends in cervical screening in detail in order to investigate whether the more complex commissioning arrangements for this service following the HSCA12 had had an impact on outcomes. We combined quantitative and qualitative evidence, and showed that the local issues identified by interview respondents (relating to lack of clarity over budgets, division of responsibility for commissioning and lack of mechanisms to overcome these issues) was associated with a small but larger than expected decline in screening rates in the areas most affected. This increase in commissioning complexity was, as previously discussed, an unintended consequence of the HSCA12. It arose from a number of unrelated decisions, each of which could, in its own terms, be justified. However, the net result was a system with multiple commissioners each of which was responding to their own set of incentives and drivers, the sum of which had the potential to generate adverse consequences for the system as a whole.

We then expanded this analysis to examine the effects of three different measures of the ‘dose’ of the reform on 40 indicators of a wide range of outcomes. These were likely to be associated to different degrees with the changes in the commissioning system that took place after HSCA12. The three ‘dose’ measures reflected variability in the extent of clinical involvement in commissioning, the disruption of general practice membership of commissioning organisations and the number of LAs with which CCGs needed to coordinate commissioning activity. We used our understanding of the changes introduced to target our analysis, testing each dose of reform against those outcomes which could plausibly be associated with the underlying mechanism being explored. This analysis showed little evidence of significant impacts of the reform and, where the effects were statistically significant, the patterns were not consistently positive or negative. There is some suggestion in our findings of poorer public health or social care related outcomes associated with more complex CCG-Local Authority relationships (ie CCGs relating to more than one LA), and this requires further study. Most importantly, we found no evidence that more involvement of clinicians in CCG commissioning at Board level was associated with greater improvements a range of outcomes, including measures of hospital activity, primary care quality and patient experience.

We found some differences between the two geographical areas studied. Area 1 was perhaps less affected by the HSCA12, with the new local organisations created by the Act mapping in relatively straightforward fashion to the boundaries of the old organisations. This was found to be particularly helpful in terms of managerial support, with trusted local managers who were well known regarded as especially helpful. In Area 2, by contrast, the new organisations took on quite different configurations from their predecessor organisations, meaning that GP practices were expected to work together in different ways. There had been some problems associated with CCG formation in
this Area, and towards the end of the data collection period some CCG mergers were being discussed. The increased disruption associated with the creation of new organisations had been significant, but respondents in this Area also spoke about the advantages of now working with what they regarded as ‘more like-minded’ peers. In Area 1, there were good pre-reform collaborative arrangements and area-wide forums, which were, to some extent, disrupted by the HSCA12. However, these previous collaborations were also useful in supporting the development of mitigating strategies to offset some of the changes. For example, the area-wide sexual health group in Area 1 was able to negotiate a cross-charging policy for out of area patients, whereas in Area 2 no such system was put in place, with Local Authorities unsure whether they would be able to obtain reimbursement for patients who had obtained services outside their home area. In Area 2, there were fewer pre-existing collaborative forums. In some service areas, the disruption associated with the HSCA12 acted to support the redesign of services which were regarded as having become ‘ossified’ in an unhelpful way.

Both areas struggled with funding pressures, with particular issues associated with the pressures on Local Authority funding, which had knock on effects for services commissioned across the NHS/Local Authority boundary, such as dementia services. The reorganisation of NHSE had been experienced as particularly problematic in Area 2, with respondents highlighting a loss of local attention as NHSE refocused its activity at the level of large regions to accommodate the reduction in staff and resources available to NHSE. In Area 1, by contrast, some local NHSE activity remained and was found to be helpful.

In both Areas, pre-existing and ongoing relationships between commissioners in different organisations, and between commissioners and providers were particularly helpful in navigating the new complexities; knowing who to call was felt to be important in supporting commissioning activity in a more fragmented system.

The study design allowed exploration of changes over time. In the early phases of data collection (2015), CCGs were relatively new organisations, having been fully established only in 2013. Clinicians had genuine enthusiasm for their new roles, but their initial sense of freedom and increased autonomy became tempered by increasing performance management and financial pressures. By the end of the data collection period in July 2017, the initial turbulence created by any major reorganisation had dissipated, but rapid policy developments such as the development of new integrated care collaborations under the auspices of the Five Year Forward View (NHS England 2014) meant that commissioners were continuing to have to respond to a rapidly changing environment. We have highlighted the proliferation of new co-ordinating structures and programmes, such as Urgent Care Networks, System Resilience Groups and the Better Care Fund. In early 2016, local CCGs were required to co-operate with local Providers and Local Authorities to establish regionally-based Sustainability and Transformation Plans/Partnerships (STPs) (NHS England, NHS Improvement et al. 2016). STPs cover a large area, with 44 established across England. Many cover as many as ten or more CCGs. STPs were not prominent in interviewees’ accounts of their work, in part because their role and remit was not yet clear, and in part because focus of the study was upon the day-to-day role and activities of CCGs. However, they formed the background context against which our later data collection occurred, with interviewees often highlighting their uncertainties about how the STP plans would affect them.

**Discussion and conclusions**

The changes embodied in the HSCA12 were complicated and far-reaching. Our study used a realist approach to explore how far the claimed benefits of the changes were realised in practice, and the contexts and mechanisms affecting this process. We found that the Act was successfully implemented, with a great deal of hard work and enthusiasm evident amongst our respondents.
However, few of the potential benefits claimed were evident. The fragmentation of commissioning responsibilities was experienced as a particular problem, with respondents referring to complicated ‘workarounds’ required to manage the new complexities. There was no clear evidence that the creation of CCGs as GP-led organisations had led to tangible improvements in commissioning, although both clinical and managerial respondents were enthusiastic about the role played by local clinicians. The loss of Strategic Health Authorities as a regional tier of co-ordination was experienced as problematic. The exact impact of the changes was context-dependent, with local organisations responding to their particular local and historical contexts. Quantitative analysis did not demonstrate any consistent improvements in outcomes associated with aspects of the changes. Our study was completed before any impact of STPs had been felt, but our findings suggest that, without clear statutory roles and authority, the creation of new regional-level organisations will not automatically lead to improvements in commissioning, nor will it solve the problems that we have highlighted associated with fragmentation of commissioning responsibilities.

Recommendations for further research

This study suggests a number of issues which require further substantive research, as well as providing some methodological avenues to explore:

- The ‘dose of reform’ approach allowed us to explore the impacts of a large scale reform which was implemented simultaneously across a whole country. Further exploration and testing of this approach in other large scale system changes would be valuable;

- The use of qualitative evidence analysed within a realist framework allowed the explicit testing of claims made about mechanisms of action. We would recommend this as an approach, alongside more conventional pre-determined quantitative designs;

- The approach that we took, exploring interactions across health economies, provided useful information about the meso-level of inter-organisational collaboration. Cross-UK comparisons between the NHS in England, Scotland, Wales and Northern Ireland (with devolved systems taking different approaches to meso-level co-ordination and collaboration) would be of value;

- Building upon this, we have highlighted the importance of a statutory regional tier of co-ordination of service commissioning. Further study could use historical and international evidence to explore the optimum approach at this level including: responsibilities; accountabilities; and governance;

- We have highlighted the complexity of accountabilities within the commissioning system. Further study is required of how best to operationalise accountabilities, in particular, the balance between local determination of desired outcomes and national/regional requirements;

- Further study is required of integrated approaches to commissioning, in particular, between Local Authority commissioners and CCGs. Further study of how commissioners with different statutory roles and in systems with different funding models (e.g. universal versus means tested services) can work together is required. Our study suggests a possible association of poorer outcomes with more complex CCG-Local Authority relationships and this also requires further study;
The outcomes that we studied were those available in national administrative data sets. Further study could usefully explore the most relevant outcomes to test approaches to service integration;

We have confirmed existing evidence which suggests that general practitioner clinical involvement in commissioning requires careful management and is most likely to deliver benefits to the design and management of community-based services. Further research is required to elucidate the best approaches to this sort of clinical involvement, with a particular focus upon how such involvement should be targeted and how outcomes can be optimised at a time when GPs are under significant workload pressures.

Recommendations for policy

- The re-integration of commissioning responsibilities for geographical populations would carry with it significant benefits, with the potential to support approaches more focused upon population health and well-being as well as upon care provision. This would require legislation to adjust statutory responsibilities for commissioning.

- Our study does not support a policy focus upon involving GPs in commissioning acute care services, but there is some evidence that they may add value in commissioning community and out of hospital services.

- CCGs require adequate managerial resources to deliver their commissioning responsibilities, and this requires sufficient locally-based staff able to build relationships across organisational boundaries.

- Managers with long-term experience in a local area should be valued and rewarded. It is important that the new emphasis upon system ‘transformation’ and new approaches to service delivery do not prevent lessons from being learned from past initiatives.

- If the role of commissioners becomes more strategic, with providers undertaking the service design aspects of the role, the choice of outcomes against which to hold providers to account becomes even more important. The balance between patient experience, activity-based and clinical outcomes needs to be carefully considered.

- As new approaches to commissioning and new forms of contract are developed and used, attention needs to be paid to the embedded incentives at system level.

- Statutory regional oversight has a role to play in supporting local health economies to work together to deliver coherent services to their population.

- It is important that existing evidence is understood and taken into account. In particular, it is important that current moves towards greater integration takes account of the weight of evidence that integration initiatives, whilst improving patient experience, are unlikely to generate significant savings nor reductions in service activity overall.
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<td>CSU</td>
<td>Commissioning Support Unit</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DsPH</td>
<td>Director of Public Health</td>
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<td>FYFV</td>
<td>Five Year Forward View</td>
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<tr>
<td>FTs</td>
<td>Foundation Trusts</td>
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<td>HEE</td>
<td>Health Education England</td>
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<td>HWB</td>
<td>Health and Wellbeing Board</td>
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<td>ITT</td>
<td>Invitation to tender</td>
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<td>LA</td>
<td>Local Authority</td>
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<td>LAD</td>
<td>Local Authority District</td>
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<td>LINKS</td>
<td>Local Involvement Networks</td>
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<td>LHW</td>
<td>Local Healthwatch</td>
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<td>LSOA</td>
<td>Lower Super Output Area</td>
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<td>NHSE</td>
<td>NHS England</td>
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<td>NHSI</td>
<td>NHS Improvement</td>
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<td>PBR</td>
<td>Payment by Results</td>
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<td>PCTs</td>
<td>Primary Care Trusts</td>
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<td>PH</td>
<td>Public Health</td>
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<td>PHE</td>
<td>Public Health England</td>
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<td>QoF</td>
<td>Quality Outcomes Framework</td>
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<td>SHAs</td>
<td>Strategic Health Authorities</td>
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<tr>
<td>SoS</td>
<td>Secretary of State for Health</td>
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<tr>
<td>SRG</td>
<td>System Resilience Group</td>
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<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnerships</td>
</tr>
<tr>
<td>TDA</td>
<td>Trust Development Authority</td>
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<tr>
<td>WP OR WS</td>
<td>Work programme or Work stream</td>
</tr>
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</table>
1 Chapter 1: Introduction and background

1.1 Invitation to tender and proposal
This study was a response to a call from the Department of Health Policy Research Programme which was originally issued in 2013, focused upon the evaluation of the new health system introduced under the Health and Social Care Act 2012 (HSCA12). The study was commissioned in September 2014, and commenced in January 2015.

This study responded to part a. (commissioning) of the original brief:

_The Department has identified seven broad areas for research. Each of these includes some key questions to further indicate what the Department is looking for._

a. The new commissioning system:
   i. Has the quality of commissioning improved?
   ii. What is the role and effects of each part of the new commissioning system, and how do they work together?
   iii. To what extent are the changes in the commissioning system resulting in changes in services and care pathways that benefit patients? (Invitation to tender 2013)

1.2 Commissioning in the English health system
The split between the purchasing and the provision of health care services was introduced into the NHS in 1990 following the policy White Paper, Working for Patients (Department of Health 1989). It was argued that separating the functions of assessment of population need from the provision of care would improve efficiency and reduce excessive waiting times for treatment. Since 1990 this separation has been maintained, but there have been repeated reorganisations of the organisations responsible for assessing need and purchasing (later renamed commissioning) care. A number of common themes underlie these reorganisations:

- Ongoing debate about the optimum size of commissioning organisations (Wilkin, Bjoke et al. 2004)
- The role of clinicians in the commissioning process (Miller, Peckham et al 2015)
- Concern about the effectiveness of commissioners (House of Commons Health Select Committee 2010)

Prior to 2012, health care commissioning was undertaken by Primary Care Trusts (PCTs). These organisations covered populations of approximately 300,000, and were responsible for commissioning all forms of health care for their resident populations, including primary, secondary, community and public health services. Groups of PCTs worked together to commission specialised services, defined as services for rare diseases which require commissioning for larger populations. Clinical involvement was secured in two ways. Firstly, each CCG had a Medical Director, who led a committee known as the Professional Executive Committee (PEC). The PEC provided clinical advice to the PCT board. Secondly, elements of the PCT budget were devolved to groups of GPs, known as Practice-based Commissioning groups (or consortia). These groups were given discretion over elements of commissioning, although decisions had to be signed off by the PCT board. Any monetary savings made by the groups could be reinvested in patient services, providing an incentive for efficient referrals and for streamlining services. The system was overseen by a regional organisational tier, known as Strategic Health Authorities (SHAs), responsible for performance oversight of commissioners and for ensuring appropriate population coverage of services.

Commissioning is conventionally said to follow a cycle (see figure 1), involving planning, procuring and monitoring service provision.
The HSCA12 maintained the underlying approach of separating commissioning of care from provision, but made significant changes to the organisations involved in commissioning (see chapter 2).

### 1.3 Study aims and objectives

In order to provide evidence to the Department of Health relating to the impact of the changes made following the HSCA12, this research aimed to assess the impact of the reforms on the operation and outcomes of the commissioning system. We aimed to explore:

i. The new system at local level, investigating how the new organisations were developing, assuming their responsibilities, interacting, holding one another to account, and relating to new national-level bodies.

ii. Relevant effects of the new system, seeking to demonstrate changes which may be associated with elements of this system, as well as explicating factors which may have enabled/inhibited these changes.

The study then combined this evidence to explore the extent to which the intentions underlying the current reorganisation of the commissioning system were achieved in practice, and to develop an understanding of the impact of the new system complexity.

The study was designed to explore both qualitatively and quantitatively the operation of the commissioning system following the enactment of the Health and Social Care Act (HSCA12) in 2012 and its full implementation in April 2013. In keeping with the ITT, the focus of the research was to understand the original, explicit intentions underlying the HSCA12 (known as ‘programme theories’
(Weiss 1998)), and to explore how far those had been realised in practice, both qualitatively and quantitatively. Based upon our reading of the White Paper, ‘Equity and Excellence: Liberating the NHS’ (Department of Health 2010), and our understanding of the changes enacted by the HSCA12, we initially identified two significant features of the new system: an increase in organisational complexity, with the establishment of a number of new types of organisations, including Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards (HWBs) and the NHS Commissioning Board (later renamed NHS England (NHSE)); and an increase in commissioning complexity, with a move from a system in which one organisation held responsibility for commissioning a full range of services for a geographical population, to one where different organisations carried responsibility for commissioning different types of services. Appendix 1 (p170) provides an overview of where commissioning responsibilities lie in the new system (NHS Commissioning Board 2012).

In order to investigate this new system, we proposed a mixed-methods approach. Initial qualitative interviews would be used to explore system complexity and interactions, in order to understand the roles of each type of organisation. This would be followed by an in depth exploration of the commissioning of different types of services. These ‘tracers’ were chosen to illustrate different aspects of the new system, including: commissioning by the new national body, NHS England; commissioning across organisational boundaries; and commissioning which was essentially unchanged. Utilising an approach known as ‘realistic evaluation’ (Pawson 2013), we proposed to explore in depth the contexts and mechanisms affecting the outcomes achieved by these different types of commissioning. In order to explore commissioning outcomes in more depth, a quantitative approach was proposed. This requires the establishment of some sort of counter factual, allowing achieved outcomes to be contrasted with what would have occurred had the system not changed. This is not straightforward, as there is no part of the NHS in England which was left unchanged, and the systems in Scotland and Wales were deemed by the research funder to be too dissimilar to the system in England in other ways to yield useful comparisons. We therefore opted for an approach which sought to operationalise the concept of ‘dose of reform’. As we have argued, the new system is both organisationally and operationally more complex than that which went before. However, not all areas of the country and not all types of commissioning have been affected by these changes to the same degree. Thus, for example, in some areas newly established CCGs had boundaries very similar to those of the Primary Care Trusts which preceded them, whilst some types of commissioning are unaffected by the increase in commissioning complexity. We therefore proposed to construct measures which operationalised these differences, using difference-in-difference techniques to compare outcomes between areas which had experienced different degrees of change. The final phase of our research was designed to bring quantitative and qualitative strands together. In further interviews with commissioners, we set out to explore commissioners own perceptions of ‘success’ and follow these up with a quantitative exploration, looking for any evidence to support the claims made. A final synthesis phase was proposed to bring the quantitative and qualitative findings together in order to provide a comprehensive account of the operation of the new commissioning system and of the factors affecting the outcomes achieved.

Having been commissioned to carry out this research, the study commenced in January 2015, and concluded in December 2017. Data collection took place from early 2015-mid 2017, with quantitative outcomes taken from data published by NHS Digital up until 2016.

1.4 Report structure
Based upon our reading of relevant policy documents, and an in depth analysis of the policy objectives, we formulated three groups of research questions, which aimed to meet the requirements of the ITT. The three areas we addressed in these questions were:
- Understanding system complexity
- The conduct of commissioning
Quality and outcomes

This report is structured around these areas. An initial section explores the policy environment, examining in depth the changes enacted by the HSAC12 and identifying the programme theories (Weiss 1998; Pawson 2013) underlying those changes. We also identify changes which were not the primary intention of the HSAC12, but which occurred later (including what seem to be ‘knock on’ changes required to ensure that the system was able to function), and discuss the ongoing rapid policy development which has occurred since 2013. We then provide an overview of our methods, before going on to address each of the research questions in turn. We finish with a final discussion section which reflects upon the overall impact of the HSAC12 on the commissioning system in England, as well as discussing the strengths and weaknesses of our approach and considering the lessons for future policy. The report seeks to bring quantitative and qualitative evidence together, highlighting the value of detailed qualitative exploration of how the system is functioning in understanding quantitative evidence of outcomes. In addition, we reflect upon the challenges associated with studying a rapidly changing system such as the NHS in England, and consider the implications of this for research and policy.
2 Chapter 2: Policy analysis and programme theory

2.1 Introduction
In 2010, the newly elected Coalition government issued a health White Paper, ‘Equity and Excellence’ (Department of Health 2010). The far-reaching reforms outlined in the document were implemented as the Health and Social Care Act 2012 (HSCA12 or Act). The detail of the reforms and the process by which they came about have been outlined elsewhere (Asthana 2011; Timmins 2012). Table 1 sets out the most significant changes accomplished by the Act.

In this section we explore these changes, set out the arguments that were made in the policy documents for them, and seek to establish their underpinning programme theories (Weiss 1998). In this context, programme theories refer to explicit or implicit theories about how particular policies will lead to desirable changes. In exploring these theories we use an approach consistent with our overall orientation towards a realist approach to evaluation (see section 3.2 p39) (Pawson 2013). For each significant aspect of the Act we set out the contextual change enacted, highlight the outcomes which it was claimed that would result, and explore the mechanisms by which these desired outcomes would be obtained.
<table>
<thead>
<tr>
<th>Change</th>
<th>Details</th>
<th>Subsequent changes</th>
</tr>
</thead>
</table>
| Abolition of Primary Care Trusts (PCTs)    | • 152 organisations responsible for commissioning primary, secondary, community and specialised (in concert with neighbouring PCTs) services  
• Covered a geographical population  
• PCTs were reorganised into 51 clusters in October 2011 and operated in this way until being abolished in March 2013 |                                                                                   |
| Abolition of Strategic Health Authorities (SHAs) | • 10 organisations responsible for taking a strategic overview of services provided across a region, holding commissioners and providers to account and ensuring compliance with national targets  
• SHAs were reorganised into four clusters in October 2011 and operated in this way until being abolished in March 2013 |                                                                                   |
| Establishment of Clinical Commissioning Groups (CCGs) | • Responsible for commissioning community and secondary care services for a geographical population  
• Membership organisations. All GP practices required to join one | • Delegation of responsibility for commissioning primary care services from NHS England to CCGs in 2015. Statutory responsibility remains with NHS England  
• Greater involvement of CCGs in co-commissioning certain specialised services and devolved responsibility over others |
| Establishment of NHS Commissioning Board (later renamed NHS England (NHSE)) | • ‘Arms’ length’ body  
• Responsible for ensuring the provision of NHS services under a ‘mandate’ from the Department of Health  
• Responsible for commissioning some specialised services  
• Responsible for commissioning primary care services  
• Responsible for ‘assuring’ the performance of CCGs  
• Initially established with 27 Local Area Teams responsible for overseeing geographical areas | • Primary care commissioning responsibility delegated to CCGs in 2015  
• Discussions under way about delegation of some specialised commissioning responsibilities  
• Merger of Area Teams in 2014/15 and consolidation into four regional teams, with significant reduction in managerial budget  
• Five Year Forward View (NHS England 2014) policy document encouraged establishment of ‘new models of care’ to improve efficiency and effectiveness of services. These subsequently established as ‘vanguards’ |
| Establishment of | • Responsible for taking a strategic overview of health | • Establishment of the Better Care Fund, by which CCGs mandated |
| **Health and Wellbeing Boards (HWBs), led by Local Authorities (LA)** | and wellbeing needs across a local area  
- Responsible for Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy | to share budget with LAs in order to better integrate care and reduce admissions |
| --- | --- | --- |
| **Establishment of a market in managerial support services** | PCT managerial staff encouraged to set themselves up as ‘standalone’ commissioning support organisations | Commissioning Support Units (CSUs) hosted by NHSE rather than becoming independent organisations, with the intention that they would become independent by April 2016  
- CSUs assessed in 2015 for their readiness to be established independently and join the Lead Provider Framework; some failed this assessment |
| **Reduction in spend on management** | CCGs provided with a ‘running cost’ allowance of £25/head | Reduced progressively to £22/head in 2015/16  
- NHSE required to reduce running costs by 15% |
| **Transfer of Public Health services to Unitary / top tier LAs (i.e. those with social care responsibilities)** | LA responsible for commissioning Public Health services including sexual health, drug and alcohol and health checks | Public health funding initially ring-fenced, ring-fence due to be removed, timing uncertain  
- Assumed responsibility for commissioning 0-5 children’s services from April 2015 (e.g. health visitors, immunisations, school nurses) |
| **Establishment of Public Health England (PHE)** | Responsible for health protection  
- Mandate to reduce health inequalities  
- Responsible for providing public health advice to the Department of Health (DH)and providing analytical and other support to LAs, NHSE and the NHS  
- Division of responsibilities between PHE, NHSE, LAs and CCGs for some aspects of health protection and screening | Reorganisation of PHE |
| **Monitor established as regulator with responsibility for encouraging competition and integration** | Aspiration for all Trusts to become Foundation Trusts (FTs), with those unable to meet the standards merged with existing FTs  
- Monitor charged with ensuring fair competition within the framework of EU competition law  
- Subsequent duty to promote integration and collaboration ‘when in patient interests’ | Monitor and the Trust Development Authority (TDA) (and a number of other organisations) merged to become NHS Improvement in April 2016 |
| **Establishment of National Healthwatch** | To provide leadership, advice and support to local Healthwatch  
- To provide advice to the Health and Social Care |  |
<table>
<thead>
<tr>
<th>Information Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To provide advice to the NHS Commissioning Board, Monitor and the Secretary of State</td>
</tr>
<tr>
<td>- To collate patient and other feedback and powers to propose Care Quality Commission (CQC) investigations of poor services.</td>
</tr>
<tr>
<td>- Statutory powers to ensure voice of consumer strengthened and heard by those who commission, deliver and monitor health and social care services.</td>
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<tr>
<td>Replacement of Local Involvement Networks (LINks) with Local Healthwatch</td>
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<tr>
<td>- Replacement of LINks with local Healthwatch: 152 local Healthwatch based on each top tier / unitary LA footprint</td>
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<tr>
<td>- Local Healthwatch (LHW) commissioned by LA to:</td>
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<tr>
<td>- Provide insight into people’s experiences of local health / social care</td>
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<tr>
<td>- Statutory powers to enter and view health and care services locally.</td>
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<td>- LHW have seat on HWB</td>
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<tr>
<td>Establishment of Clinical Senates</td>
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<td>----------------------------------------------------------------------------------</td>
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<tr>
<td>- 12 Clinical Senates created to provide advice and guidance to CCGs and others.</td>
</tr>
</tbody>
</table>
2.2 Programme theories underlying the Act

The HSCA12 was perhaps one of the most comprehensive reorganisations the NHS has ever seen, with almost no aspect of the service left untouched (Exworthy, Mannion et al. 2016). In the sections that follow, individual aspects of the changes are examined in turn. Relevant references to policy documents are provided at the start of each section.

2.2.1 Overall argument

The fundamental intention of the Act, reflected in the title of the 2010 White Paper, was to ‘liberate professionals and providers’ from top-down control (Department of Health 2010). It sought to do this by placing clinicians at the heart of commissioning decisions, complemented by an emphasis upon localism to bring commissioning decisions closer to individual patients. The argument made was that ‘this is the only way’ to achieve the necessary quality, innovation and productivity to enhance clinical and cost outcomes. The 2010 White Paper broadly set out the case for change, proposals for what would be different in the changed system, and the outcomes expected as a result. This overarching “programme theory” (Weiss, 1998) can be summarised in realistic evaluation terms using the following Context-Mechanism-Outcome (CMO) configuration. More detail of the realist approach is given in the methods section, p 39.

<table>
<thead>
<tr>
<th>Context: making the case for change</th>
<th>Mechanisms: properties of the proposed new system that will enable results</th>
<th>Outcomes: the expected results</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NHS is recognised as a world-class health service that has an increasing focus on evidence-based medicine. However, some clinical outcomes are relatively poor compared to other countries, and there is a lack of a genuinely patient-centred approach. This is because the NHS is overburdened by excessive bureaucratic and political control and because the architecture has developed in piecemeal fashion, which means there is duplication of work, and too many ineffective middle managers who lack clinical expertise and local knowledge</td>
<td>Reduction in middle management, and the creation of CCGs led by GPs who will use their professional and local knowledge to shape health services for local populations Economic regulator Monitor to promote competition Transfer of public health responsibilities from the NHS to Local Authorities Increase in NHS spending in real terms in each year of the 2010-2015 Parliament, coupled with efficiency gains made by local NHS organisations including cuts in administrative costs Creation of new NHS Commissioning Board [now NHS England] National approach to primary care and specialised commissioning</td>
<td>Genuine patient-centred care, increased innovation, improved patient outcomes, increased transparency, increased efficiency, increased stability and sustainability with less politically motivated interference, reduced fragmentation with better working across health and social care boundaries</td>
</tr>
</tbody>
</table>
This broad CMO configuration can be explored in closer detail: the mechanisms and outcomes may be subject to their own CMO analysis.

**Clinical involvement: creation of CCGs**
(Department of Health 2010 p9; 27-29; 34; 49)
The Act established CCGs as responsible for commissioning health services. These are comprised of GPs and other clinicians, with some managerial and lay input, and all local GP practices were required to become members. This was intended to lead to improved outcomes because clinicians would be afforded greater autonomy to use their professional experience to make judgements about which services to commission. The CMO configuration may be written as:

<table>
<thead>
<tr>
<th>Context: what the new system will look like</th>
<th>Mechanisms: properties of the new system that will enable results</th>
<th>Outcomes: the expected results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abolition of PCTs, and creation of CCGs</td>
<td>Relaxation of central control and greater autonomy for clinicians; increased accountability to patients; more effective dialogue and partnership with hospital specialists; removal of activities that do not have benefits for health or healthcare</td>
<td>Redesign of services to suit local populations; increased efficiency and reduction in bureaucracy</td>
</tr>
<tr>
<td>Managerial functions undertaken by autonomous Commissioning Support Units</td>
<td>A market in commissioning support will reduce costs and increase efficiency</td>
<td></td>
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</table>

The precise mechanisms by which these beneficial outcomes would be achieved were left somewhat vague in the 2010 White Paper; further detail emerged in a suite of follow up documents. In particular, it was argued that clinical involvement in commissioning would be beneficial because it would:

- Strengthen knowledge of the needs of individuals and local communities and the variation in the quality of local services, by harnessing the unique role of general practice to be in everyday contact with patients, their families, and carers;
- Increase capability to lead clinical redesign and engage other clinicians based on the understanding of clinical risk and evidence of best practice;
- Better involve and engage local people to adopt improved services and move from familiar but out-dated services based on the focus on quality and outcomes and the trusted positions held in communities;
• Improve uptake of quality based referral options across practices based on greater involvement in priority setting and redesign;
• Enable a greater focus on improving the quality of primary medical care as a key part of clinically-led redesign of care systems (NHS Commissioning Board 2012).

Thus, the ‘everyday contact’ between GPs and their patients was lauded as providing unique expertise and insight, as well as providing moral authority in persuading the public of the need for service reconfigurations and improving the quality of GP services. Subsequent research has suggested that it is possible for some of these mechanisms to operate, but they do not occur automatically, and require quite specific conditions and management (McDermott, Checkland et al. 2016).

In addition, it was argued that there needed to be a reduction in the number of managers in the NHS, and a reduction in expenditure on managerial functions. CCGs were established with managerial budgets significantly lower than had been the case for PCTs (Department of Health 2011), and there was an expectation that these would be further reduced over time. At the transition, PCTs were mandated to create new Commissioning Support Units (CSUs). These would be autonomous bodies, offering a menu of managerial support functions for CCGs to choose from. It was intended that these would rapidly move to become established as social enterprises. It was argued that a market in support functions would lead to increased efficiency.

2.2.2 Creation of NHS England and commissioning for outcomes
(Department of Health 2010)
The 2010 White Paper outlined a new NHS Commissioning Board (now NHS England), intended to reduce the abilities of the Secretary of State for Health (SoS) to ‘micromanage and intervene’. The SoS would provide a ‘short mandate’ to NHSE but would lose powers to intervene in relation to any specific commissioner. The NHS Commissioning Board would be held to account by the Department of Health via an Outcomes Framework, which would be used by the Board, in turn, to inform the development of a Commissioning Outcomes Framework to hold CCGs to account. It was argued that previous NHS target regimes had focused too much on process targets (measuring throughput and activity), which prevented a more meaningful focus on desired outcomes. A new outcomes-focused accountability regime would give local commissioners more discretion, and would enable a more creative approach to improving outcomes.

<table>
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<tr>
<th>Context: what the new system will look like</th>
<th>Mechanisms: properties of the new system that will enable results</th>
<th>Outcomes: the expected results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation of NHS Commissioning Board (now NHS England)</td>
<td>Statutory status: ‘lean and expert organisation free from day-to-day political interference’</td>
<td>Reduce ability of SoS to intervene</td>
</tr>
<tr>
<td></td>
<td>New NHS Outcomes Framework determined by SoS will be used to hold NHSE to account, and will be translated into a Commissioning Outcomes Framework for CCGs</td>
<td>Promote equality and tackle inequalities in access to healthcare; Address inequalities in outcomes from healthcare services; Champion patient and carer involvement; Determine technical and data standards for commissioners and providers; Promote and extend choice and control; Support</td>
</tr>
</tbody>
</table>
more comprehensive set of indicators, reflecting NICE quality standards
Develop and agree with SoS guarantees for patients about the choices they can make
Responsible for structure of payment systems; calculate practice-level budgets allocated directly to CCGs
Responsible for holding CCGs to account
Responsible for commissioning GP services, dentistry, community pharmacy, primary ophthalmic services, and regional & national specialised services

CCGs to focus upon delivering improved outcomes.

NHSE was explicitly created as a national body with no regional sub-structure. Local offices of NHS England (initially known as ‘Local Area Teams’) were to be established as ‘outposts’ of the central organisation, without policy or substantive decision-making powers. It was argued that this would ensure a consistent national approach, which it was felt had been lacking in the era of Strategic Health Authorities. Within a year of NHS England being established, Local Area Teams were abolished, with NHS England reorganised into a regional structure with four regions and a reduction in the number of managerial posts.

**Localism & decentralisation**
(Department of Health 2010 p28-29)
The White Paper was clearly couched in the language of localism and decentralisation, with an emphasis on freeing CCGs from central control, allowing them to establish themselves in ways best suited to local conditions (including limited initial specification as to required organisational forms) and to work out local solutions, in partnership with Local Authority colleagues. Indeed, the distribution of commissioning responsibilities in the new system required greater collaboration, for example between CCGs and their LA commissioning colleagues. This was new localism was intended to lead to improved outcomes because of a focus upon local needs, in which ‘local’ is defined as a size sufficient to operationalise contracting and to manage financial risk. In addition, the 2010 White Paper proposed to build on the power of Local Authorities to promote wellbeing by establishing statutory bodies called ‘Health and Wellbeing Boards’, which would provide local democratic oversight and support joint working between the NHS and Local Authorities.

<table>
<thead>
<tr>
<th>Context: what the new system will look like</th>
<th>Mechanisms: properties of the new system that will enable results</th>
<th>Outcomes: the expected results</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCGs working in partnership with local communities and Local Authorities</td>
<td>Greater focus upon needs of local population; where local = geographical sizes sufficient to agree and monitor contracts for</td>
<td>Improved clinical and cost-effective outcomes for local populations</td>
</tr>
</tbody>
</table>
locality-based services, and manage financial risk; Healthwatch to provide evidence about local communities’ needs and aspirations

Greater local autonomy, allowing solutions to be designed to meet local needs

### Creation of Health and Wellbeing Boards (HWBs)
Statutory arrangements within local authorities; allow LAs to take strategic approach and promote integration across health and social care

Simplified and extended powers that enable joint working between LAs and the NHS: easier to adopt partnership arrangements and adapt them to local circumstances; LAs and NHS will have mutual influence over each other’s commissioning

Strengthen local democratic legitimacy; join up commissioning of local NHS services, social care and health improvement

This improved local autonomy was initially manifest in a significant degree of freedom for CCGs to organise themselves how they wished. There was no central blueprint for the size of CCGs, nor for their constitution, and practices were encouraged to organise themselves into groups which suited their local circumstances (Checkland, Coleman et al. 2012). The result of this is considerable complexity in CCG structures and functioning (Checkland, McDermott et al. 2016).

### Competition
(Department of Health 2010 p37; Health and Social Care Act 2012 section 62)
The 2010 White Paper advocated competition between providers as the best means to increase innovation and productivity, and specified a role for regulator Monitor to promote competition and prevent anti-competitive behaviour. It was argued that:

“We aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market.’ (Department of Health 2010)

During consultation on the White Paper and during the passage of the Bill through Parliament, concerns were expressed about the singular emphasis upon competition. The eventual Act modified the role of Monitor to include a focus on cooperation as well as competition.

| Context: what the new system will look like | Mechanisms: properties of the new system that will enable results | Outcomes: the expected results |
CCGs with autonomy to commission services from ‘any willing provider’ (later ‘any qualified provider’)

Monitor to promote competition/prevent anti-competitive behaviour, and to enable healthcare services ‘to be provided in an integrated way’ where this would improve service quality and reduce personal inequality of access and outcomes

Effective competition to stimulate innovation, improvements and productivity; Effective integration to improve quality and reduce inequality

This approach was in harmony with the approach which had gone before, with NHS policy consistent in encouraging increased provider competition since the early 2000s. However, the HSCTA12 went further by enshrining EU competition law into the NHS.

### 2.2.3 Transfer of responsibility for commissioning specialised services to NHS England

**Specialised Commissioning**  
(NHS Commissioning Board 2012)

Specialised services are those of low volume but high cost, for which risk-sharing requires planning for larger populations. Historically the definition of specialised services was based upon planning for a population size of one million, with those services identified as ‘specialised’ were commissioned by PCTs working together across a wider footprint. The Act altered the basis for deciding what constitutes a specialised service; rather than reflecting planning populations of over one million, the decision is now based on an assessment of four ‘factors’. These include:

1. The number of individuals who require the provision of the service or facility;
2. The cost of providing the service or facility;
3. The number of persons able to provide the service or facility;
4. The financial implications for Clinical Commissioning Groups (CCGs) if they were required to arrange for the provision of the service or facility. (NHS England 2014 p8).

It was also argued that there was too much variation in the way that specialised services were commissioned and provided. To address this, NHSE was given responsibility for setting the specialised commissioning budget and for commissioning specialised services. Rather than focusing upon geographical populations, commissioning was to focus upon services provided by specialised service providers (often known as ‘tertiary providers’, as they receive onward referrals from less specialised hospitals), with a focus upon building relationships between commissioners and providers in order to support better contract management.

<table>
<thead>
<tr>
<th>Context: what the new system will look like</th>
<th>Mechanisms: properties of the new system that will enable results</th>
<th>Outcomes: the expected results</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSE takes over commissioning of specialised services from the now-abolished PCTs</td>
<td>Commissioning is conducted for the country as a whole, rather than for smaller geographical populations</td>
<td>Increased standardisation of care and reduced geographical variability</td>
</tr>
<tr>
<td></td>
<td>Priority and strategy set by NHSE at national level; contracting and relationship management is done at a local level through NHSE Area Teams [now regional teams and hubs]</td>
<td>Central oversight with sensitivity to local contexts</td>
</tr>
</tbody>
</table>
Changes to Public health [role of Local Authorities and creation of Public Health England]
(Public Health England 2010)
The 2010 White Paper was followed later in the year by a Public Health White Paper “Healthy Lives, Healthy People (HLHP)” and, following consultation, the HLHP update and way forward paper. The proposal was to transfer many public health factors to local authorities, and to create Public Health England as an executive agency of the Department of Health.

<table>
<thead>
<tr>
<th>Context: what the new system will look like</th>
<th>Mechanisms: properties of the new system that will enable results</th>
<th>Outcome: the expected results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health responsibilities moved from NHS to Local Authorities</td>
<td>Directors of Public Health (DsPH) employed by LAs but required to work closely with CCGs; Ring fenced public health budget within LAs</td>
<td>Greater joint-working between LAs and CCGs to take into account wider ranging local interventions to support health and wellbeing across the life-course; Admin cost savings</td>
</tr>
<tr>
<td>Creation of Public Health England as an integrated public health body</td>
<td>Distinct identity with status as an executive agency of the DH Joint role in appointing DsPH Carry out functions including generating information, building evidence-base, communicating intelligence to local leaders, providing surveillance and response</td>
<td>Preservation of scientific independence from Whitehall Ensure appropriately-qualified appointments of DsPH who have appropriate status within LAs Unite a fragmented public health system; become global leader in translating evidence into practice</td>
</tr>
</tbody>
</table>

These changes were perhaps the least contentious of all the changes brought about by the HSCA12, with some talking about public health ‘returning home’ (Gorsky, Lock et al. 2014), and others highlighting the opportunities for refocusing public health upon the social determinants of ill health and inequalities (Marks, Hunter et al. 2015).

2.3 Changes not underpinned by any programme theories
One consequence of the scale of the changes enacted is the development of what might be called ‘knock on’ effects – i.e. effects which were not the primary objectives of the Act (and therefore are not underpinned by any identifiable programme theory), but which arose out of its provisions.

Three of these stand out. Firstly, the new system is organisationally more complex than previously. Prior to the Act, most NHS commissioning functions were carried out by PCTs, overseen by SHAs. The HSCA12 introduced a number of new organisations carrying some significant commissioning...
responsibilities, including the NHS Commissioning Board (NHSE), Health and Wellbeing Boards and PHE. Furthermore, the professed commitment to localism and decentralisation raised the potential for CCGs to be more diverse in organisational form than PCTs had been (Checkland, McDermott et al. 2016).

Secondly, the knock on effect of these changes was for commissioning responsibilities to be spread amongst a larger number of organisations. Whereas PCTs had carried full commissioning responsibility for a given geographical population, CCGs were only initially given responsibility for commissioning secondary and community care services. This dispersal of commissioning responsibilities was not specifically heralded in the White Paper or subsequent guidance; rather it emerged as a consequence of a number of incremental decisions, including transfer of responsibility for specialised commissioning to national level, and transfer of public health commissioning to Local Authorities. Whilst each of these decisions was justified by relevant programme theories, in practice they introduced significant complexities, particularly for those service areas where the distinction between public health, primary, secondary and specialised services was not particularly clear. Some significant areas of care – such as women’s health – include the full range of services from prevention (public health, transferred to LAs), through primary and community services such as GP care and Health Visiting, to highly specialised foetal medicine services. The new system, therefore, demonstrates an increase in operational complexity, and carried with it a significant additional need for co-ordination between the different commissioners and providers of these different types of services. This operational complexity was such that in 2012 NHSE published a guide for CCGs which set out where particular commissioning responsibilities lay in the new system (included as Appendix 1) (NHS Commissioning Board 2012).

Finally, PCTs had historically been responsible for commissioning all services for their geographical populations, including primary, community, secondary and (with neighbouring PCTs) specialised services. Whilst there were a number of mechanisms in place for engaging primary care clinicians in the commissioning process, potential conflicts of interest were managed by ensuring that all decisions were signed off by a PCT board which had a majority of Non-Executive members. The creation of CCGs as clinically-led membership organisations constituted by local general practices made it difficult for them to be given responsibility for commissioning primary care services due to the associated conflicts of interest – GPs in CCGs would effectively be commissioning themselves. Responsibility for primary care commissioning was therefore given to NHSE. An argument was made that this would allow greater consistency; however, it is clear that the primary driver for this change was the perceived impossibility of allowing CCGs to fulfil this role, rather than it being seen as intrinsically desirable. In addition to the additional complexity introduced into the system by this decision (see above), the initial exclusion of primary care commissioning from CCG’s remit and its establishment as a national function had a number of knock on effects. These included: the loss of managers with expertise in primary care from CCGs; the loss of local knowledge from the primary care commissioning process; and a disconnect between responsibility for primary care quality improvement (a responsibility of CCGs) and responsibility for primary care commissioning (the responsibility of NHSE).

2.4 Subsequent modifications and changes

The policy environment in the English NHS has moved quickly since the enactment of the HSCA12. The initial passage of the Act was contentious (Timmins 2012), but in fact most of the policy proposals in the initial White Paper were enacted into law with only minor modifications. However, as noted in Table 1 (p21), subsequent experience led to modifications of some aspects of the system, and some proposals have not played out as originally intended. In this section we briefly summarise the most significant changes and modifications.
2.4.1 Autonomy, accountability and localism
The initial laissez fair approach to CCG structures and governance resulted in the establishment of commissioning organisations which varied more in size, structure and governance arrangements to a greater degree than had been the case with CCGs (Checkland et al 2016). However, this permissive approach was soon replaced by formal guidance that not only specified the required constitutional arrangements of CCGs, but also put in place an exhaustive framework against which nascent CCGs were assessed in order to be ‘authorised’ to become fully-fledged statutory bodies. This framework contained six domains, with each broken down into a number of subdomains, each of which included three or four assessment criteria (NHS Commissioning Board 2012). Following CCG authorisation, this framework became the basis of an extensive ‘CCG assurance framework’ (NHS England 2013). A monitoring process was put in place which included quarterly assurance meetings and an annual assessment. If this assessment raised concerns, a CCG might find itself in a more stringent monitoring regime, with the ultimate sanction being so-called ‘special measures’. Overall this represents a more rigorous monitoring regime than that experienced by PCTs, which were subject to an annual assessment under the ‘World-class Commissioning’ framework (Department of Health 2009). Potential motivations underlying these changes include: a desire to manage financial risk in the face of the ‘austerity’ approach to public finances; and a concern that The role of HWBs as strategic overseers of local health and care systems has not been realised to a significant extent. The impact of HWBs has been mixed, and relationships between CCGs and their local HWB are variable (Coleman, Checkland et al. 2014), with some arguing that the new system in fact reduces the opportunities for public engagement (Tritter and Koivusalo 2013). Overall, these arrangements have led to a complex accountability regime for CCGs (Checkland, Allen et al. 2013).

2.4.2 Managerial resources and creation of a market in commissioning support
CCGs have been subject to an ongoing reduction in their managerial budgets, with a reduction from an initial allowance of £25/head of population to £22/head of population. The initial allowance was itself a reduction from the amount spent on managerial overheads by PCTs, who had freedom to set their own managerial budgets (http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSmanagementcosts/DH_4000338) which could be as much as £35/head of population. It was intended that this reduction in spend would be accommodated by the increase in efficiencies obtained from a developing market in commissioning support services, led by and catalysed by the creation of CSUs. However, CSUs were hosted by NHS England until 2016, and no appreciable market in managerial support for commissioning has developed. CSUs have merged so that there are a small number of very large geographically-based providers, with CCGs having little choice of provider.

2.4.3 NHS England, commissioning for outcomes and competition
NHS England has developed into a powerful policy actor. The mandate from the Department of Health under which it operates remains broad and lacking in any substantive metrics. In 2014, NHS England (along with other Arms’ Length Bodies including Monitor, HEE etc) issued their ‘Five Year Forward View’ (FYFV) (NHS England 2014), which set out a blueprint for the development of new forms of service delivery. The vision included integration between health and social care services, and between primary, secondary and community services. Local health economies are being encouraged to develop such ‘new care models’ at a rapid pace, overseen by the establishment of geographical ‘Sustainability and Transformation Partnerships’ (STPs) (NHS England, NHS Improvement et al. 2016). These are non-statutory bodies, consisting of a partnership between all of the commissioners and providers in a local area. They have no formal responsibilities, but the intention is that these will form the vehicle for closer co-operation between commissioners and providers. Such an approach of necessity downplays the idea of competition between providers.
Further developments include the development of Integrated Care Systems, in which commissioners and providers collaborate closely together to provide integrated care for populations (see Kings Fund website www.kingsfund.org.uk for full explanation of this rapidly moving field).

In addition, there has been little substantive movement towards commissioning for outcomes. Whilst some outcome indicators have been developed, they have not been used in any formal way in holding CCGs to account for their activities, nor have they been applied to the mandate between NHSE and the DH (Taunt, Alcock et al 2015). It is suggested in the FYFV that outcomes-based contracts may become the norm within new care models, and some providers are beginning to establish so-called ‘prime provider’ contracts with their local CCGs, in which one provider is held accountable for the outcomes achieved by a group of providers working in partnership. However, it is not yet clear how such contracts will operate in practice (Sanderson, Allen et al. 2016), nor what outcome indicators will be applied.

2.4.4 Changes to commissioning responsibilities

The HSCA12 came into force in April 2013. In 2014, the new Chief Executive of NHSE, Simon Stevens, announced that CCGs would be offered the opportunity to take on greater responsibility for commissioning primary care services. The programme theory offered was that CCGs had the required local knowledge about primary care services, and that the opportunity to integrate the commissioning of primary care with community care and secondary care services would be beneficial (McDermott, Warwick-Giles et al. in press). The legislative underpinning of the commissioning system was not changed; NHSE retains statutory responsibility, which has been delegated to CCGs. Potential issues of conflicts of interest remain, but these are deemed to be outweighed by the advantages associated with the potential associated with population-based approaches to commissioning (McDermott, Warwick-Giles et al. in press). At the same time, CCGs have been encouraged to start taking responsibility of aspects of specialised services, although this has not been formalised as yet. There is growing encouragement for CCGs to consider combining their commissioning functions with those of Local Authorities (see: https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward view/integrating-care-locally/), but current legislative arrangements may make this problematic.

2.4.5 Nicholson challenge

Soon after the HSCA12 was enacted, the then Chief Executive of NHSE, David Nicholson issued what has come to be called the ‘Nicholson Challenge’ (Torjesen 2012), to deliver £20 billion in efficiency savings, as NHS income growth slowed to below inflation levels. At the same time, Local Authority budgets were being cut, as the Government sought to deal with the fallout from the 2008 financial crash. As a result, all of the changes enacted in the HSCA12 occurred within a resource-constrained environment; this must be borne in mind in interpreting the findings of this research.

2.5 Research questions

It can be seen from this brief description that the changes resulting from the HSCA12 were extensive, and that the new system included significant new complexities. Taking account of these programme theories and the resultant changes enacted, we formulated the following research questions in order to investigate the impact of the HSCA12 on the commissioning system and to meet our research aims of exploring the operation of outcomes of the new commissioning system:

1) Understanding system complexity:
   a) How are the different organisations managing their new roles and responsibilities in practice, and how are they dealing with areas of overlap and omission?
b) What are the mechanisms by which the different parts of the health and care system are working together locally and how are they interacting with national level bodies?

c) To what extent do local actors perceive themselves to be autonomous?

d) To whom do they feel accountable?

e) What is the performance regime being applied, and what is its impact?

2) The conduct of commissioning:

a) What were the drivers for the service changes being made?

b) What is the effect of the division of commissioning responsibilities in new ways between new organisations on commissioning processes?

c) How are commissioners responding to the need to ensure better integration of services?

d) How is external commissioning support being used, and what is the impact of this?

e) What is the effect of ‘commissioning for outcomes’ on the commissioning process?

f) How far is the new system enabling/inhibiting service change and development?

3) Quality & outcomes:

a) What claims to ‘success’ are made by actors in each different organisation, and what evidence is there to back up these claims?

b) What does each organisation/group of organisations claim as its main ‘outcomes’ and how are the new ‘outcomes frameworks’ operating?

c) How have quantitative outcomes changed in the new system, and what explanatory factors can be identified?

d) Are any aspects of the new commissioning arrangements associated with improvements in quality, reductions in health inequalities and improvements in factors which affect overall system efficiency?
3 Chapter 3: Methods

3.1 Research design
To address the aims and objectives of this study a longitudinal mixed methods realist approach was adopted. Fieldwork took place from January 2015 to December 2017. The research combined a national level quantitative study of outcomes of commissioning with qualitative study in two areas exploring the factors that contributed to any changes in the health system.

Following our policy analysis of the HSCA12, we formulated three sets of research questions (see section 2.5 p33), addressing system complexity, the conduct of commissioning, and the outcomes associated with the changes brought about by the Act. The overall design was to use initial qualitative data collection and analysis to help to define relevant quantitative analyses to explore the outcomes of the HSCA12. The results of these analyses then fed into ongoing qualitative data collection, with a final phase of the study asking participants to reflect upon ‘successes’ that they felt had been achieved. It was our intention to follow this up with quantitative analysis of relevant outcomes to reflect these claimed ‘successes’; however, it proved impossible to quantify the types of outcome identified by our participants (see section 6.2 p112). Collecting data from the same individuals over an extended time period allowed us to explore how priorities and approaches changed, and to capture the thinking behind these changes. At the same time, the conduct of commissioning was explored using five ‘tracer’ service areas. These were chosen to reflect the different aspects of the new system that we identified from our policy analysis.

For the qualitative study, a case study approach was adopted. This approach was chosen because it allows for the in depth exploration of the work associated with commissioning in particular contexts. This approach is particularly suited to a realist approach, in which contexts and mechanisms are explored in detail. For the realist researcher, context is not a variable to be controlled for or eliminated, it is the substrate upon which policy acts and within which is enacted (Pawson 2013). An approach is therefore required in which the full richness of context can be appreciated. Yin highlights the value of case study research for situations in which ‘investigators desire to...cover contextual conditions and not just the phenomenon of study’ (Yin 1993 pxi). However, defining what constitutes a relevant ‘case’ is not necessarily straightforward. In keeping with current approaches to case study research (Kushner, Russell et al. 2015; Segar, Checkland et al. 2015), we defined ‘case’ in two ways:

- Geographical case - we chose geographical areas covered by two Area Teams (AT) of NHS England. ATs were large enough to allow mapping of interactions between multiple commissioners/other organisations. ATs were chosen from different regions including one health economy facing particular financial stress. Site selection was informed by complementary studies undertaken by the team, and focused upon ATs with specialised commissioning responsibilities. However, in April 2015 NHSE underwent a re-organisation, whereby area teams were abolished and regional teams were introduced. Although area teams were no longer in operation under the regional teams, the practical day to day working was still undertaken within the same geographical boundaries and therefore it was decided to continue with the original two metropolitan sites based on their geographical footprints.

- ‘Cases’ of commissioning different types of services, theoretically chosen to illustrate different aspects of the new system including key relationships between NHS organisations and local authorities. We call these ‘Tracer services’, and they were studied within the two AT areas. Identified ‘tracer services’ included:
Orthopaedic commissioning is the responsibility of CCGs, ostensibly involving purchasing relatively short-lived, discrete episodes of care. Thus, it should be most responsive to the agenda of increasing diversity of provision and commissioning for outcomes. However, it can also be argued that a more holistic view of services might include significant preventative services. Furthermore, orthopaedics is a service area least affected by the increase in commissioning complexity, with responsibility passing straight-forwardly from PCTs to CCGs.

Sexual health This is a service area significantly affected by new operational complexities. Commissioning different aspects of sexual health services is divided between Local Authority Commissioners, CCGs and NHSE. Studying this allows investigation of how overlaps between organisations are being managed, how new organisations are working together, and operational complexity.

Adult cardiac surgery services/other specialised services Responsibility for commissioning specialised services rests with NHSE. It was the explicit objective of the new system to standardise specialised commissioning, with improved national oversight.

Dementia care Responsibility for commissioning dementia care is distributed between CCGs and Local Authorities. Successful commissioning will depend upon them working together. Studying this was intended to allow us to explore partnerships ensuring we captured the development of integrated services between health and social care.

Screening responsibility for commissioning screening services lies with NHS England. However, there is also a significant role played by national institutions such as the UK National Screening Committee and Public Health England in its Health Protection role. We set out to explore how NHSE approached their role.

For the quantitative study, an approach was required which allowed the identification of impacts which could plausibly be attributed to the changes brought in by the HSCA12. This is not straightforward, as the changes mandated in the Act were brought in simultaneously across England. In order to try to identify the impact of the changes, we adopted an approach which sought to differentiate areas of the country dependent upon the ‘dose’ of reform which they were expected to receive as a result of the Act. Our rationale was that, whilst the administrative changes took place at the same time and under the same legislation, in practice there was considerable variation in the extent of change required in different areas and the way in which the legislation was interpreted and enacted in different settings. In particular, there was variation in:

- How far the new commissioning arrangements resembled those which went before;
- The extent to which local CCGs embraced the concept of ‘clinical leadership’, with significant variation in the numbers of clinicians on the Governing Bodies of CCGs (Checkland, Coleman et al. 2012);
- The number of Local Authorities that CCGs were required to interact with in order to manage complex commissioning tasks (Coleman, Checkland et al. 2014).

We hypothesised that any impact (positive or negative) from the HSCA12 would be greatest in those areas either with the largest amount of organisational change among commissioners, or the highest level of inter-organisational coordination required to commission services, or where clinicians were most involved in leading the commissioning process. We therefore constructed measures of these variations in what we have called the ‘doses’ of reform. We then tested these measures of dose against a broad range of outcome measures using continuous difference-in-difference methods. This allowed us to explore whether or not the programme theories underlying the Act (e.g. that clinically-led commissioning organisations would be more efficient and effective than managerially led organisations) were associated with improvements in outcomes. The detailed methods used are set
out in section 6.5. This approach is similar to that used by Gaynor et al (2010) in their study of hospital competition.
Programme theories: if we do X, Y will result.

Health and Social Care Act 2012

Specific changes to organisations and redistribution of commissioning responsibilities:
- Increased organisational complexity
- Increased operational complexity

Tracer service areas – chosen to illustrate different aspects of the new system WP 2

Observable and measurable outcomes WP3a, b & c

Organisations’ and individuals’ experiences of the changes – WP 1

WP 4: synthesis – what have been the specific impacts of the HSCA12, and what are the causal mechanisms at work in which contexts?
3.2 **Realistic evaluation approach**

Realist approaches to evaluation sit within the general category of theory-based or theory-driven approaches (Chen and Rossi 1980), seeking not only to explore whether a particular programme or intervention has worked, but also to uncover causal mechanisms, seeking to answer the question: what works, for whom, by what mechanism, and in which circumstances? First postulated by Pawson and Tilley (1997), this approach starts from the premise that all interventions, policies or programmes are underpinned by ‘programme theories’ (Weiss 1998) about how a particular intervention will generate a beneficial outcome. These may be explicit or implicit. The first job of an evaluator, therefore, is to seek to uncover the programme theories at work in a particular situation. These include implicit or explicit understandings of mechanisms by which a particular intervention will affect what happens in a particular context. Pawson and Tilley (1997) identify what they call ‘triads’ (ibid p215) of contexts, mechanisms and outcomes, with programme theories broken down to specify what precise mechanism will be at work in particular contexts to generate desired outcomes. Evaluation then becomes an exercise in exploring and refining programme theories and context-mechanism-outcome triads in order to better understand how particular interventions can be linked to observed outcomes (Pawson 2013).

Mechanisms are “underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest” (Astbury and Leeuw 2010 p368). Pawson and Tilley emphasise the importance of human reasoning, highlighting the fact that mechanisms act because humans react and make choices in particular circumstances and when provided with particular resources (Pawson and Tilley 1997 p216). Whether or not mechanisms produce expected outcomes will depend upon the presence of local contextual conditions which will enable or constrain the mechanisms. The distinction between contexts and mechanisms is not necessarily clear or absolute – a contextual condition in one situation may go on to become a causal mechanism in the future (Pawson 2013). However, in spite of this potential fluidity and lack of clarity, realist approaches have been found to be useful in health systems research (Marchal, van Belle et al. 2012). Our previous research explored in detail the mechanisms and contexts by which the involvement of clinicians in commissioning might lead to improved outcomes (McDermott, Checkland et al. 2016). We found that, in certain circumstances, clinician involvement could change the nature of commissioning decisions, but these circumstances were by no means always present. We found that engagement between CCG clinicians and clinicians from provider organisations could generate useful outcomes, but that it was important for clinicians to be properly prepared for commissioning meetings. In the absence of such preparation, desired outcomes were less likely to be achieved.

In our previous study, our focus was on the micro-level of how particular mechanisms played out in detailed commissioning decisions. For this study, by contrast, our focus was at the macro level of policy interventions. Taking a pragmatic approach based upon realistic evaluation principles, (Marchal, van Belle et al. 2012), we analysed policy documents to understand the programme theories underlying the changes enacted under the HSCA12. This provided us with a framework which we used to structure our data collection instruments and our approach to both qualitative and quantitative analysis. In Work stream 2, we took this approach one stage further, identifying specific programme theories relating to our tracer service areas, which had themselves been chosen based upon our initial understanding of the programme theories underlying the Act as a whole. Work stream 2 could thus be considered to be a nested exploration of the playing out of the programme theories underlying the HSCA12 in particular contexts. This provides the important contextual information which allows us to understand how the outcomes observed in our quantitative work came about. This provides policy makers and senior managers with more detailed evidence about whether and when the assumption underpinning policy proposals hold true.
3.3 Data collection and analysis

Qualitative data was collected at 141 interviews with 118 participants (see Table 2 p42), from documents and, from 10 hours of inter-organisational commissioning meetings. Interviews were conducted either face to face or by telephone to suit the needs of the respondents. The three groups of research questions (see section 2.5 p33) were used to develop topic guides for each type of organisation (see Appendix 2 p179). Data from interviews, documents and observations were analysed together using Nvivo 10 software:

- To develop a contextual understanding of the practice of commissioning in the new system, focusing upon roles, situations, and interactions between commissioning bodies
- To explore causal mechanisms, highlighting embedded local understandings of causation (‘we can’t do this because’ or ‘this works well because..’) alongside higher-level official programme theories (e.g. ‘contracting out commissioning support will improve efficiency’) and to understand the operation of these in different contexts.

Data collection/analysis was conducted simultaneously, allowing incorporation of emerging findings in revised interview guides. Initial data reduction involved coding data extracts, using a frame developed from our existing understanding of the commissioning system, supplemented by emerging concepts. A3-sized diagrams mapping interactions between organisations helped visualise the process of commissioning in each area and for each service. We made systematic comparisons between sites and across service areas, refining our understanding of the interaction between mechanisms and contexts. Emerging findings were discussed at team meetings and analytic memos prepared to record conceptual development. The quantitative and qualitative researchers met regularly to ensure the two streams of data collection were linked.

The research included four work streams. Figure 2 shows the timing of these work streams, setting them in the policy context at the time.
<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Significant event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>May</td>
<td>'Nicholson challenge', to make £20 billion of NHS efficiency savings by between 2011-2014, launched</td>
</tr>
<tr>
<td>2010</td>
<td>Jul</td>
<td>'Equity and excellence: liberating the NHS' White Paper published</td>
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<tr>
<td>2011</td>
<td>Apr</td>
<td>'Pause' in passage of legislation. Future Forum created to make recommendations</td>
</tr>
<tr>
<td>2011</td>
<td>Jun</td>
<td>All but one of Future Forum’s recommendations adopted by Government. Central elements of the Bill remain unchanged</td>
</tr>
<tr>
<td>2011</td>
<td>Jun</td>
<td>Dilnot review on funding of adult social care. Major reforms suggested</td>
</tr>
<tr>
<td>2011</td>
<td>Sep</td>
<td>Health and Social Care Bill clears the House of Commons</td>
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<tr>
<td>2012</td>
<td>Mar</td>
<td>Health and Social Care Bill clears the House of Lords. Bill becomes an Act of Parliament</td>
</tr>
<tr>
<td>2012</td>
<td>Sep</td>
<td>Jeremy Hunt replaces Andrew Lansley as Secretary of State for Health</td>
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<tr>
<td>2012</td>
<td>Oct</td>
<td>NHS Commissioning Board is formally launched</td>
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<tr>
<td>2012</td>
<td>Nov</td>
<td>NHS Commissioning Board receives first mandate from government</td>
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<tr>
<td>2013</td>
<td>Apr</td>
<td>The Health and Social Care Act 2012 comes into force. Various organisations take on statutory roles, including: Clinical Commissioning Groups (CCGs), NHS Commissioning Board (renamed NHS England), Health and Wellbeing Boards, Commissioning Support Units (CSU), Public Health England</td>
</tr>
<tr>
<td>2013</td>
<td>Jun</td>
<td>Better Care Fund announced. Pooled budget between NHS and local government intended to better resource social and community care and thus reduce hospital admissions</td>
</tr>
<tr>
<td>2013</td>
<td>Nov</td>
<td>Department of Health publishes NHS Outcomes Framework</td>
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<tr>
<td>2014</td>
<td>Apr</td>
<td>Simon Stevens replaces Sir David Nicholson as Chief Executive of NHS England</td>
</tr>
<tr>
<td>2014</td>
<td>May</td>
<td>Care Bill receives royal ascent</td>
</tr>
<tr>
<td>2014</td>
<td>Oct</td>
<td>‘Five Year Forward View’ published. Introduces two new care models: multi-specialty community provider, and primary and acute care system</td>
</tr>
<tr>
<td>2015</td>
<td>Jan-</td>
<td>First 50 new care model Vanguards selected</td>
</tr>
<tr>
<td>2015</td>
<td>Sep</td>
<td>NHS England launches the CSU Lead Provider Framework</td>
</tr>
<tr>
<td>2015</td>
<td>Apr</td>
<td>Primary care co-commissioning introduced</td>
</tr>
<tr>
<td>2015</td>
<td>Apr</td>
<td>NHS England merges Area Teams with Regions and makes redundancies in an attempt to realise efficiency savings</td>
</tr>
<tr>
<td>2015</td>
<td>Dec</td>
<td>Sustainability and Transformation Plans (STPs) introduced in ‘Delivering the Forward View: NHS planning guidance 2016/17–2020/21’</td>
</tr>
<tr>
<td>2016</td>
<td>Jan</td>
<td>The Cities &amp; Local Government Devolution Bill is passed</td>
</tr>
<tr>
<td>2016</td>
<td>Mar</td>
<td>44 STP ‘footprints’ announced across England</td>
</tr>
<tr>
<td>2016</td>
<td>Apr</td>
<td>NHS Improvement (bringing together Monitor, NHS Trust Development Authority, and others into one organisation) launched</td>
</tr>
<tr>
<td>2016</td>
<td>Apr</td>
<td>GP Forward View published. Commits to an extra £2.4 billion a year to support general practice services by 2020/21</td>
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<tr>
<td>2017</td>
<td>Mar</td>
<td>‘Next Steps on the NHS Five Year Forward View’ published</td>
</tr>
<tr>
<td>2017</td>
<td>May</td>
<td>NHS computer systems affected by a ransomware cyber attack</td>
</tr>
<tr>
<td>2017</td>
<td>Jun</td>
<td>NHS England announces eight Vanguards will become Accountable Care Systems</td>
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<tr>
<td>2018</td>
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<td>Accountable Care Systems renamed ‘Integrated Care Systems’</td>
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Table 2 Summary of interviewees

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<th>Area 1</th>
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<th>Managers interviewed</th>
<th>Clinicians interviewed</th>
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Work stream 1: Understanding the new commissioning landscape (Year 1. RQ 1&2)
The aim of this work stream was to understand how the new organisations in a geographical area were building relationships and approaching their new responsibilities and to generate candidate ‘causal mechanisms’ to underpin quantitative comparisons.

We conducted interviews with a range of individuals working in all of the organisations with significant responsibilities relating to commissioning in each of the AT areas. These included: CCGs; CSUs; the AT; and Local Authority commissioners. The following areas were addressed during interviews:

a) How the different organisations managed their new roles and responsibilities in practice, and how they are dealing with areas of overlap and omission?
b) What are the mechanisms by which the different parts of the systems are working together locally and how are they interacting with national level bodies?
c) To what extent do local actors perceive themselves to be autonomous?
d) To whom do they feel accountable?
e) What is the performance regime being applied, and what is its impact?

We explored the factors that enabled the organisations to carry out their responsibilities, and the things which they were finding difficult. We explored their priorities, and asked how they came to choose them and what their strategy was for fulfilling these priorities. We asked them to identify the biggest challenges facing them, and asked them how they saw themselves meeting those challenges. We also asked them to characterise what they thought would be key indicators of ‘success’, and explored their understanding of commissioning in the five tracer areas. In particular we explored their understanding of local commissioning roles and responsibilities for each of the tracer areas.

Finally, we asked commissioners to discuss with us the local provider landscape, identifying their important contacts and asking them to identify individuals who may have valuable information either about the tracer service areas or more generally about the new commissioning system. The interviews were analysed in order to do the following:

- Get a clear overview of commissioning activity in the area, including interactions and approaches to working together and the overall provider landscape;
- Look for commonalities and differences in their approaches and in the factors that they identify as being helpful or unhelpful;
- Identify informants’ personal programme theories – what do they see as the mechanisms by which improvements in commissioning care can be delivered in the new system.

An interim report was completed and submitted to the Department of Health

Work stream 2: Commissioning in the new system: mechanisms in action (Y1-2)
The aim of this work stream was to use tracer services to explore the operation of the new system.

We explored interactions between commissioning bodies, evaluated the extent that official goals of the reforms were being met and explored causal mechanisms underpinning changes.

We explored the commissioning of each of our 5 tracer services, using them to shed light on different aspects of the new system. For each tracer area we sought to define contexts and mechanisms which may be linked to particular outcomes. We explored commissioners’ approaches and experiences using interviews, document analysis and targeted observations of meetings. Where relevant, we interviewed a small number of informants in significant providers in order to explore their experience of being commissioned in the new system.

1. Orthopaedics
We explored orthopaedic commissioning in a CCG in each AT area. The focus was on the approach being taken, the issues that had arisen and the factors which have enabled or inhibited their work. In the WS 1 interviews we will asked the interviewees to provide details of the approach they took to
commissioning orthopaedic services, and ask them to provide details of who is involved and how they are linking with the wider commissioning system (e.g. social care commissioners). Within those chosen for the more detailed study, we interviewed key informants, focusing upon:

- Their orthopaedic priorities;
- Their strategy for achieving these priorities;
- A detailed description of the commissioning mechanisms they use, including contracts and their approach to contract monitoring;
- Problems that they have encountered and factors which have been facilitative. This will particularly focus upon things which have been identified as ‘programme theories’ or mechanisms underlying the reforms, such as the use of external commissioning support, the role of clinicians, provider diversity, the value of having GP practices as ‘members’ and the impact of commissioning for outcomes;
- They will be asked to reflect upon what they see as any differences and similarities to what went before;
- Their interaction with other groups within this stream of work.

2. Sexual health commissioning

The landscape of sexual health commissioning is complex with a variety of organisations involved. Deciding who to interview within this tracer was complex, we adopted an exploratory, snowballing approach, asking each informant to suggest who we should speak to. The first task was to define exactly who holds responsibility for which aspects of sexual health services. The focus was upon services falling under the heading of ‘sexual health services’ as set out in the PHE guidance for commissioning sexual health services. We focused upon one Local Authority in each AT area, along with its associated CCGs. We then interviewed informants from each group, asking them:

- To explain their own and their organisation’s role;
- To explain the ‘pathways’ for which they are responsible, with a focus upon pathway development, procurement, contracting, performance management and outcomes;
- To discuss the mechanisms that they use under each of these headings – how do they develop pathways, what kinds of contract do they use and how do they monitor outcomes? What commissioning support do they have?
- To give their perceptions of other organisations’ roles, and to explain how they work together with these organisations;
- To reflect upon the opportunities and challenges associated with the new system, and to discuss any experience they may have had in this area prior to the reforms.

3. Specialised services

Specialised services commissioning seeks to ensure that the needs of people with relatively rare conditions (e.g. specialist kidney conditions, cystic fibrosis, rare cancers) are met. The equipment and skills for providing specialised services are often only available in certain regional or national centres, and the costs of providing such services are often high. In 2015-16, specialised services cost around £14bn, approximately 14% of the NHSE budget, and are set to increase to around £19bn, approximately 16% of the NHSE budget, by 2020-21. The key aim in this part of the study was to explore the ‘programme theory’ that commissioning of specialised services would be better done at national level. We explored respondent’s experiences, including:

- Approach to pathway development, procurement, contracting, contract monitoring etc.
- Experience of old system;
- Their understanding of the issues, and how they reconcile national contracting with the need to be locally responsive;
- Their experience of facilitating and inhibiting factors and contextual issues.

4. Dementia services
These require close co-ordinated work with social care and the focus of this tracer was on exploring the operation of the programme theories identified earlier. In addition, it is clear that ‘integrated care’ and the Better Care Fund (BCF) are important drivers of commissioning activity, alongside emerging outcome frameworks. We chose two CCGs (and their associated LA commissioners) in which to explore this tracer. When undertaking the initial interviews in workstream 1 we obtained as much intelligence as possible about this area of commissioning and about the work they are doing on the BCF. We interviewed those with roles in this area of commissioning, addressing the following areas:

- How is this area of work managed?
- What structures are there in place for joint working between health and social care?
- How has the BCF affected what they do?
- In what ways are they commissioning for outcomes?
- How are GP practices engaged with this work, and how does the fact that CCGs are membership organisations affect what they do?
- What are the facilitative or inhibitory factors operating in the system?

5. Screening
Responsibility for commissioning screening services lies with NHS England. However, there is also a significant role played by national institutions such as the UK National Screening Committee and Public Health England in its Health Protection role. Information gathered in the WS1 interviews helped us to frame our approach to this tracer. We started by interviewing a small number of senior individuals from the national teams, in order to understand the landscape as a whole. We followed this up by interviewing local NHS England managers in each of our study areas who had responsibility in this area in order to explore how they are approaching their role. We interviewed commissioners of screening services in our two case study sites asking:

- Who has responsibility for different screening programmes?
- How do the different agencies work together?
- How are CCGs engaging with the NHS Health Check screening programme?
- How are national goals for screening being implemented at a local level?

Analysis
For each tracer, we analysed the data to produce a narrative highlighting the structures and processes associated with commissioning. Roles, responsibilities and mechanisms were described for each. We then constructed for each tracer context-mechanism-outcome triads. ‘Outcomes’ in this exercise were qualitative outcomes, such as ‘successful establishment of a new contract’ or ‘decision to decommission a particular provider’. These informed the quantitative analyses by, for example, identifying potential outcomes that might be worth including if suitable routinely available data could be found.

Short reports on each tracer were completed and shared with respondents and with the Department of Health, and are included as Appendix 3 (p184)

Work stream 3. Relating commissioning arrangements to outcomes (addressing RQ 3, year 1-3)
The aim of this work stream was to examine whether the new commissioning arrangements produced differential effects on quality, health inequalities and aspects of system efficiency in different health economies and service areas.

1. Identification of ‘key causal theories’ about how or why the new system is affecting commissioning from: official statements; previous commissioning research; and WS 1 & 2. For each we developed quantitative measures reflecting the explanatory factors in the causal theories. Using nationally-available administrative data, we generated measures of the extent of reform for all
health economies in England under the new arrangements. These measures, together with other concepts identified from previous literature and interviews, were used to measure the expected ‘dose’ of reform in each health economy.

2. Collation of a range of national datasets on outcomes and costs before the reforms and for the first three years of the new arrangements. We obtained these datasets at the smallest available levels of aggregation, so that measures of outcome and costs could be mapped to different organisations at different levels within the new system. We used quality, health inequalities and efficiency measures included in the CCG Outcome Indicator Set (CCGOIS), and other routinely-collected measures not in the CCGOIS, to examine whether the reforms had had differential impacts on monitored and unmonitored measures of performance. We also obtained more detailed measures of potential impact relevant to the tracer services.

3. Analysis was carried out to relate the changes in outcomes to the measures of commissioning arrangements developed in stage 1. The initial analysis was descriptive; we summarised how the monitored and un-monitored outcomes had changed over time and how the outcomes were associated cross-sectionally with the measures of reform ‘dose’ that we had previously developed. The full analysis was more explanatory, seeking to estimate the causal impact of the new commissioning arrangements on outcomes and costs in general and for the tracer services in particular. To cope with the fact that the reforms were introduced at the same time across the country, we used a continuous difference-in-differences design following Gaynor et al (2010) to estimate the effect of inter-hospital competition on quality of care. Similar to their approach, we pre-specified a measure of the expected ‘dose’ of the reform and tested whether changes over time in indicators of outcomes and costs before and after the reform were larger in the areas experiencing larger ‘doses’ of the reform. Furthermore, we exploited the variation in expected effects across different service types to assess the plausibility of the underlying mechanisms. The use of impact measures directly informed by the qualitative findings provided more robust evidence than previous studies of NHS reform that had relied on quantitative evidence only.

Work stream 4. Linking outcomes to mechanisms, in particular contexts (year 2/3, RQ3)
The purpose of this work stream was to further explore outcomes and causal mechanisms using qualitative methods. We undertook repeat interviews with 25 informants from WS1 at 18-20 months asking for key ‘successes.’ These were compared with initial statements of goals/priorities. We intended to then seek quantitative measures for these in order to test whether perceived successes had generated expected improvements in outcomes. However, the ‘successes’ identified by our informants were generally process-based, and were consequently not amenable to quantitative examination. In addition, the broader national context set by austerity in the public finances, along with multiple additional policy initiatives meant that claims to success tended to focus upon surviving without a significant deficit, or establishing new service models, rather than anything which could easily be related to the initial programme theories underlying the Act. This section of the work therefore focused upon qualitative exploration of outcomes, linking these to aspects of context and associated mechanisms identified during WS2.

3.4 Area profiles

Area 1
Area 1 is a metropolitan area with a population of over 1 million. It is demographically diverse with pockets of severe deprivation and affluence. A quarter of the city live in income deprived households and over 35% of children are living in poverty. Data from the 2011 census suggests that over 10% of the population in Area 1 are represented by BME groups, with 200 different languages being spoken in the largest city area. Life expectancy for both males and females is lower than the national average.
There are multiple LAs in Area 1 with (at the time of the study) slightly more CCGs; this means that the organisations are not co-terminous. There are multiple NHS Trusts that serve the area. Area 1 has an historical reputation for inter-organisational working that is not as well established in Area 2.

Area 2
Area 2 is one of the most heavily urbanised areas in the UK with a total population of over 1 million people. Similar to Area 1, Area 2 has both pockets of deprivation and affluence. One of the most deprived LAs in the country is situated within Area 2. Area 2 is ethnically diverse, with over 20% of the population represented by BME groups. Like in Area 1, life expectancy for both males and females lags behind the national average.

Area 2 has multiple LAs with slightly more CCGs, like in Area 1; the organisations are not co-terminous. However, there are fewer organisations in Area 2 than in Area 1. There are also multiple NHS Trusts serving the area.

Table 3 Comparison between the two areas

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<tr>
<th></th>
<th>Area 1</th>
<th>Area 2</th>
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</thead>
<tbody>
<tr>
<td>Population</td>
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<td>Over 1 million</td>
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<tr>
<td>Number of LAs</td>
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<td>6-10</td>
</tr>
<tr>
<td>Number of CCGs</td>
<td>11-15</td>
<td>6-10</td>
</tr>
<tr>
<td>Number of NHS Trusts</td>
<td>15-20</td>
<td>10-15</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Over 10% BME</td>
<td>Over 20% BME</td>
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<tr>
<td>Child poverty</td>
<td>Over 35%</td>
<td>Over 30%</td>
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<td>Vanguards</td>
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3.5 Study management and oversight

At the outset of the study we established an independent external advisory group (for composition, and membership of this group see Appendix 4 p231). The group met three times during the course of the study: initially, to agree the study approach; in year 2, to discuss emerging findings; and at the end of year three to discuss the composition of the final report. The group members were chosen to provide a wide variety of perspectives, in keeping with the broad aims of the study. In particular, it was our intention to ensure that we had expertise covering: patients and the public; CCGs; public health; local government; NHS England; and academics. The minutes of the advisory group meetings were shared with the Department of Health Policy Research Programme. The group had an independent chair, and were tasked with ensuring that the study was both fulfilling its aims and objectives and meeting the needs of the wide range of relevant stakeholders. This was seen as particularly important given the complexity of the new system. The meetings proved to be extremely valuable for the study team in broadening our perspective and in understanding how to focus our data collection. For example, in the early stages of the study members of the advisory group highlighted the need to explore some of our tracer service areas at national level, moving beyond the role of commissioners at the local level to understand how both screening and specialised services were organised nationally, and how those with a national role interacted with local commissioning systems. At the final meeting (in November 2017) we were able to test our findings and this provided useful perspectives which have informed the preparation of this report. The group were also able to advise us via email at intervals during the study.

In addition to regular progress reports as required by the Policy Research Programme, we provided the Department of Health with an interim report in spring 2016. This report was shared with Department of Health policy makers, but was not published. In summer 2017 we issued five short
reports based upon our study of the five tracer service areas. Draft reports were shared with our advisory group, and with our participants, and edited taking account of their feedback. They were shared with the Department of Health, and subsequently published via the University of Manchester website, with associated social media activity. The aim of this was to provide useful feedback to support commissioners in their work. Our further dissemination plans are detailed in Section 7.6 (p162).
4 Chapter 4: Understanding system complexity

4.1 Introduction

In this section we address our first set of research questions. These were largely addressed in Work stream 1, which ran from Jan-Dec 2015, and comprised 78 interviews. We sought views from commissioners responsible for the full range of service types, including CCGs, NHS England and Local Authority commissioners. This set of questions were intended to provide an overview of the realisation of the changes to the commissioning system embodied in the HSCA12, with a focus upon how the system complexity that we have identified played out in practice for commissioners. In this section we do not address changes to the provider system directly, as this topic area was the subject of another study commissioned under this call. The questions addressed are set out in Box 1

Box 1: Research question 1

1) Understanding system complexity:

a) How are the different organisations managing their new roles and responsibilities in practice, and how are they dealing with areas of overlap and omission?

b) What are the mechanisms by which the different parts of the health and care system are working together locally and how are they interacting with national level bodies?

c) To what extent do local actors perceive themselves to be autonomous?

d) To whom do they feel accountable?

e) What is the performance regime being applied, and what is its impact?

These findings were reported in our interim report (Feb 2016).

4.2 RQ1a: The distribution of responsibilities in the new system

In our interviews we explored how each organisation was seeking to carry out its responsibilities, and asked questions about areas of complexity. We were particularly keen to understand the practical ways in which CCGs, and others, were approaching their roles, and sought examples of issues that had arisen in the transition, as well as asking about factors which had supported them in their work.

Respondents told us that the changes brought in under the HSCA12 were significant in magnitude. They embodied two main aspects: the formation of new organisations covering new footprints; and the distribution of commissioning responsibilities in new ways. Either one of these changes would have been significant; the combination of both changes at the same time made the adjustment required more significant. One CCG manager described it thus:
The changes themselves were really monumental, and really the landscape now is much more complex than it was, with what’s gone before. I think what happened in previous reorganisations, it was just a bit of sort of moving the deckchairs around a bit, and shifting some things from there to there, but this felt like moving beaches as well as moving the deckchairs, it kind of went completely to a different place, it kind of took away a lot that used to be. And if you read it at the time, you could say, oh yeah, I can see the logic for that, and then to try and make it work is really complicated, and it’s just settling down now [3666, CCG manager, Area]

S/he went on to explain that the combination of changing organisations and changing responsibilities made it difficult to be clear who was responsible for what:

So I think it’s taken a long time, and I think you lose sight of some things, you don’t know who’s doing what, I think there’s still a lack of complete understanding about who’s doing what, and where, and of course, the work’s moved and every organisation is having to form itself.
[3666, CCG manager, Area 1]

In addition to providing general opinions and experiences of system complexity, interviewees were asked to provide concrete examples of things which had changed since the HSCA12. We collected a number of vignettes covering services from flu injections to alcohol services. Comparative analysis across thee vignettes provides useful evidence of emerging common issues. Boxes 2-8 set out a number of these vignettes, illustrating complexities arising from this fragmentation and redistribution of roles:
Box 2: Influenza services

<table>
<thead>
<tr>
<th>The issue:</th>
<th>Lack of clarity over who is responsible for what</th>
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<tbody>
<tr>
<td>Pre HSCA12:</td>
<td>Primary Care Trusts (PCTs) took an overview of winter resilience planning, including monitoring vaccination uptake</td>
</tr>
<tr>
<td>Post HSCA12:</td>
<td>It is unclear who had over-arching responsibility in this area.</td>
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And I can remember we called a meeting, it was a telephone call of everybody we thought had some responsibility around flu vaxs, and we got everybody on the phone and everyone agreed that they were all...yeah, okay. So the CCG’s there and the local authority public health team were there and Public Health England were there and the hospital was there because they do community services and everyone... **And I can remember quite clearly that there was...** Okay, so we all recognise there's a bit of an issue, so whose job is it to sort that out? And we couldn’t work it out, is the answer. Well, no, hang on, I’m here to assure myself that you’re doing... Well, I’m here to assure myself that... Well, who’s actually going to do the work? But it was a clear articulation I guess of some of the uncertainty and some of the thinking through hadn’t worked out. So whose job is it to sort out flu vaccinations, we just couldn’t...no one could answer it that clearly. Yeah, it was just really clear that we...yeah, we all agree, there’s no one else we need to get on the phone. **We all agree there is a problem, none of us can agree who takes the action!** That was the thing.

3271, CCG manager, Area 1
Box 3: Anti-obesity services

The issue:
Lack of clarity over who is responsible for what, and ensuring complex pathways are integrated when different commissioners are involved

Pre HSCA12:
Nice recommends the provision of services for obesity at four levels: Tier 1 includes general population interventions to improve population health; Tier 2 includes community weight management programmes, including diet and exercise; Tier 3 services are more specialised and intensive weight management services; and Tier 4 services include intensive weight loss programmes (e.g. residential services) and bariatric surgery.
Both PCTs (via Public Health) and LAs commissioned Tier 1 services and supported voluntary sector providers. PCTs commissioned local Tier 2 and 3 services, and worked together to commission specialised bariatric surgery (Tier 4).

Post-HSCA12:
LA Public Health teams took on responsibility for Tier 1 and 2 services. Responsibility for Tier 3 services was unclear, and some CCGs argued that these were not their responsibility. An NHSE/PHE task force issued a joint report in 2014, suggesting that Tier 3 services should be the responsibility of CCGs:

well obesity’s really complicated in that actually there was quite a lot of conflicting stuff in the act, the white paper and some of the supporting stuff around whose commissioning responsibility Tier 3 weight management was.

One of the... I think one of the disrupting things around that uncertainty meant that actually because the Tier 4 was designed around NICE criteria... One of the NICE criteria is that patients should only undergo bariatric surgery if they have been...if they’ve been through a Tier 3 service... In many parts of the country local authorities and CCGs both considered Tier 3 to be the other party’s responsibility and lots of Tier 3 services nationally were decommissioned, which meant that actually there was no patient pathway that actually then led patients into the Tier 4 service. We’ve seen quite a significant reduction in referrals to...for bariatric surgery as a result of the pathway being fractured by effectively kind of ambiguity in the act.

I think we have the... So the taskforce reached a conclusion about whose responsibility it should be but that was advisory rather than mandatory because it’s not embedded in legislation. So actually there is no compulsion on anybody to commission a Tier 3 service. I think we are seeing Tier 3 services developing but actually kind of there is no lever to pull to make sure it happens consistently throughout the country.

4438, NHSE, Area 1
Box 4: HIV and sexual health services

**The issue:**
Transfer of commissioning responsibilities, where decisions made in one sector have knock-on effects elsewhere.

**Pre HSCA12:**
Sexual health services commissioned by PCTs. Provision mixed between community clinics and GP surgeries. HIV services commissioned by PCTs working together for specialised services, moving towards devolution of commissioning to individual PCTs as HIV becomes more normalised as a chronic disease. HIV services often delivered via Genitourinary Medicine (GUM) clinics.

**Post-HSCA12:**
Responsibility for HIV service commissioning transferred to NHSE, and responsibility for commissioning contraception and GUM services transferred to LA Public Health teams.

We’re also, to an extent, working with local authorities and the interface with local authorities at the moment is predominantly around the commissioning of HIV and GUM services. So as part of the Health and Social Care Act there were a range of services that went to local authorities to commission and genitourinary medicine going to local authorities was part of sort of the Public Health bit.

The local authorities have had a very...well seemed to have had a very particular view about competition and the need for everything to go out to market testing and tendering. That has posed us quite considerable challenges in relation to how we sustain effective provision of HIV treatment and care services when they’re delivered in the same setting as genitourinary medicine. In some cases that’s worked really well where actually kind of the local authorities talked to us at an early stage and we’ve worked together around, well what do we do about this? At others it’s worked really badly where actually the local authorities have gone out, market tested, awarded a new provider and then told us, sort of after the fact really, that the GUM service at Hospital X is closing because we’re moving the service somewhere else.

4438, NHS England, Area 1
Box 5: Child and Adolescent Mental Health Services (CAMHS)

The issue:
Ensuring complex Pathways are integrated when different commissioners are involved.

Pre HSCA12:
Services designated Tier 1-4, with: Tier 1 including preventative services delivered by all those in contact with children; Tier 2 representing mental health workers in any setting, e.g. schools, community paediatric teams etc.; Tier 3 including specialised CAMHS, delivered by locality-based multidisciplinary teams; and Tier 4 representing highly specialised day and in patient units, forensic services etc. All of these commissioned by PCTs (either alone, for Tier 3, or in concert with other PCTs for more specialised services), with additional funding provided to LAs for preventative and school-based services. Some areas initiated joint commissioning arrangements for Tiers 1 and 2, bringing together LA and PCT commissioners.

Post-HSCA12:
Responsibility for Tier 2-3 commissioning transferred to CCGs (working together with Local Authorities [http://www.cypiapt.org/site-files/jcpmh-camhs-guide.pdf]), with Tier 4 commissioned by NHSE. Tier 1 services commissioned by LA, NHSE and CCGs

Examples of outcomes:

1. New system working well, supported by good local relationships

   We’ve redesigned that in conjunction with the Foundation Trust. It’s been really effective, reduced waiting times from up to six months in some places, down to a maximum wait of four weeks….Significantly improved outcomes for individual patients. We’ve redesigned the service. We’ve changed the eligibility criteria. We’ve made sure that we’ve…that it’s very much…it’s very comprehensive around transition of children to adult services as well. And we’re also looking then at the links. We’ve really improved the links with the specialist commission Tier 4 and also with the services provided by the Council for Tier 1, low level behavioural problems. And we’re designing a programme of then reaching to schools, to support that.

   4095, CCG manager, Area 1

2. PCT Cluster initiated comprehensive service redesign, which has continued to be developed

   and there was something about building on the head of steam, and I think that a lot of us were having trouble with CAMHS and realised that the old boundary just wasn’t working. But mobilisation will be a challenge. So I think, I’m not sure about that one, it may have taken longer maybe, or not happen at all. It certainly didn’t happen, even though there was a requirement, when people wanted to do it. But I think it was something that was started under the cluster, and in fact, quite a few things were started under the cluster. So the cluster may have been, in a strange sort of way, we probably got to the point where PCTs, in the way that they were distributed in our area, have done what they could do, had sort of run out of clinical credibility, managerial credibility, and actually quite a few things were started in the cluster, and they appointed a team, and they started a number of things.

   7412, CCG manager, Area 2

3. Problems arising out of the split between CCGs and NHSE

   So one of the areas and, sort of, we’re not getting the kind of right response we need to take the whole pathway approach, so if you take [Tier 4] CAMHS [which is an NHSE responsibility] for example, there’s a short fall in people capacity, , as a consequence of that short fall, we have children delayed in other facilities and NHS England have, so far, not been able to address that. So that’s a really good example where we need a pathway approach and there’s been various attempts to try and resolve it, but so far it’s been a problem and the split in commissioning responsibility hasn’t really helped to resolve that.

   7160, CCG manager, Area 2
Box 6: Commissioning maternity services and immunisation

**The issue:**
Division of commissioning responsibility where block contracts are in place

**Pre HSCA12:**
Maternity services, immunisations and school health services commissioned by PCTs. In some areas these were provided according to block contracts, along with funding within core GP contracts

**Post-HSCA12:**
School nursing and immunisations provided in schools commissioned by LAs, NHSE have responsibility for commissioning immunisations provided in GP surgeries, CCGs have responsibility for commissioning maternity services.

So there’s that, there’s also for antenatal and newborns screening programme and the immunisations that we do with maternal service .....that money sits within what’s called the maternity payments pathway which again CCGs commission. So again the money for some of our services sits within CCGs within big maternity contracts but actually we’ve got commissioning responsibility. So it has made it really, really difficult because technically the money’s in the wrong place and if you haven’t got the money you haven’t got the power...if you haven’t got control of the money [its really difficult to] really dictate what happens around that pot of money. And it’s very, very difficult to unpick things. That’s what I was saying about the legacy stuff, it’s very...we know that additional money was added, in [Local Area] into the maternity services to support immunisations but then we haven’t really got that as an audit trail. So actually we’ve got people in the team who know that happened but actually there’s no proper audit trail that you can demonstrate that that’s happened. So we know that the maternity payments were uplifted but we can’t demonstrate that, so it makes it very, very difficult. And in the end sometimes what you just have to do is we’ve had to take on quite a lot of additional budget pressures because we haven’t been able to find the money in the system, so it’s become a budget pressure for us. We’ve never had the money for commissioning something it’s been too hard to prove it’s elsewhere and therefore we’ve had to take the hit in terms of the budget pressures. So it’s a very, very complex system to work within.

4058, NHSE, Area 1

Box 7: Drug and alcohol services

**The issue:**
Transfer of commissioning responsibilities, where decisions made in one sector have knock-on effects elsewhere

**Pre HSCA12:**
Drug and alcohol services commissioned by PCTs

**Post-HSCA12:**
Drug and alcohol services commissioned by LAs

That’s been a nightmare. So alcohol and drug misuse went over as the local authority, they’re contracting in a very different way, it’s all about abstinence and if patients don’t want to come off drugs or alcohol then they’re just discharged. The problem is then primary care picks up the tab and primary care doesn’t have access to resources anymore.

Patients go into hospital without the whole services, we’ve had to recommission those services, because the local authority doesn’t commission services in hospital, the hospital services don’t talk to the local authority services, because they don’t, because the local authority services are not commissioned to talk to the hospital services.

Drug services and alcohol services recommend treatment to primary care, but because they don’t commission it, they don’t think they have to do shared care guidelines like the rest of the world. I got a letter yesterday from alcohol services saying, this patient needs Disulfiram, now, that’s a drug that you use for abstinence, but no one in the rest of the world would accept...would expect a GP to prescribe that without a shared care guideline, without initiation by the prescriber, but because it’s commissioned by local authority, they don’t seem to think they have to work with us on it and we’ve been banging on their door for well over a year.

3391, CCG GP, Area 1
Box 8: Complex oncology services

The issue:
Integrating complex pathways

Pre HSCA12:
Investigations and surgical treatments commissioned by PCTs, oncology services commissioned by PCTs working together across a wider footprint. Co-ordination overseen by regional Cancer Networks

Post-HSCA12:
Commissioning responsibilities divided between CCGs and NHSE; Cancer Networks subsumed into Strategic Clinical Networks.

If you’re commissioning a breast cancer pathway the number of commissioners of that pathway doesn’t make sense. At the beginning point a patient enters primary care and that’s commissioned by what was the Local Area Team [NHSE]. The patient then goes on for investigations that’s commissioned by the CCG. The patient then if they’re found as positive have to go for some form of treatment so a lumpectomy or mastectomy plus oncology. Some of that is commissioned by the CCG. So the surgery is commissioned by the CCG, the oncology’s commissioned by specialist commissioning. Then the patient returns back to their DGH for follow up care, that’s commissioned by the CCG and then they return back to primary care for onward travel. Treating cancer is a long term condition after you’ve had cancer, that’s back to the Local Area Team. That’s really complicated, isn’t it?

Q: So there’s a lot of handovers in the chain.

A lot of handovers, a lot of changes in responsibilities, with new advances. There is a new test that can verify whether your cancer is suitable for oncology or not. That test is paid for by specialist commissioning as is the oncology but it could knock out a whole load of ladies who would never need to have oncology but to get those commissioners to commission that it’s just...it’s a crazy pathway that. I think it’s the best example of fragmentation that makes the least sense and I forgot to mention the screening part of the pathway is commissioned by Public Health England. The breast screening section that we get monitored and performance managed on, how many ladies turn up for screening, is all commissioned by NHS England. So there’s another commissioner thrown into that as well.

4519, CCG manager, Area 1

Role of strategic clinical networks:

Q: the role of Strategic clinical networks?
A: Well I’m sure they’re nice I’m not really sure what they do apart from their assurance role in large scale change.
Q: You don’t have much contact with them then?
A: I’m not really sure what they do. Do they know what they’re doing? I don’t know.

4110, CCG GP, Area 1

Across these examples, a number of issues recur. It is clear that, whilst the Act introduced significant new complexity into the system, some patient service pathways were already extremely complicated before the HSCA12. In these service areas, the reforms acted to disrupt the local systems set up to manage existing complexity, as well as introducing new organisations and shifting responsibilities. In particular, the division of responsibility between NHSE taking a national approach, and local CCGs covering a geographical area, was found to be problematic in these complex service areas. Prior to the Act, Primary Care Trusts (PCTs) worked together over a wider area to commission more specialised services. This commissioning was provider focused, with regional specialised centres covering geographical populations within which were nested the populations covered by local PCTs. This meant that those commissioning local services were working together with specialised commissioner colleagues on a network of services covering a geographical area. In the new system, specialised commissioning has been removed from the local geography, and there is no
longer a clear link between local and specialised services. This has caused problems of co-ordination, which have been made more difficult by the limited managerial capacity within NHSE. Local and national systems which had been set up to manage complexity and co-ordinate between commissioners, such as regional Cancer Networks, were disrupted by the Act, and new systems had not yet been universally established.

Secondly, there is evidence that in some areas, for some services, these issues have been mitigated. In particular, Box 5 (p54) provides an example where a PCT Cluster acted to initiate a significant service change which endured beyond the abolition of the Cluster. A similar story was told from the other site for a wider reconfiguration of a number of services. PCT Clusters were formed in 2011 to facilitate the transfer of responsibilities from PCTs to CCGs. Neighbouring PCTs effectively merged, covering a larger area. Their existence was time-limited, ending when CCGs went live in April 2013. The two examples which we were offered told a story of small groups of individuals recognising a particular service issue across the geographical area, and acting quickly to put in place a service review process which was sufficiently well established to endure when the transition to CCGs occurred. The important elements appeared to be:

- A service issue which was widely recognised as being significant;
- A coherent local geography affected by that issue which retained a degree of coherence post-HSCA12, allowing existing work to be adopted and continued by new organisations;
- The availability of managerial capacity to support such service development reviews. The ongoing reorganisation of NHSE was experienced as a problem in many areas.

Not all such programmes of work continued uninterrupted, and in Chapter 5 (p92) we seek to clarify factors which supported ongoing work such as this, and the factors which had a negative impact.

The division of commissioning responsibilities between different organisations brings with it issues wider than complexity alone. Incentives within systems and pathways can have an important impact on service development, and both Drug and Alcohol services and Sexual Health services have been affected by these issues. Whilst ‘pathways’ form a useful shorthand way of conceptualising linked sets of treatments, in reality, a better metaphor might be a map. For example, patients with HIV are also at risk of other sexually transmitted diseases for which they will require treatment, whilst patients unable to remain abstinent from drink or drugs will require ongoing medical care. In the examples given above, it is possible to identify perverse incentives whereby commissioners responsible for one part of a pathway or one pathway amongst a group of linked pathways have an incentive to design services in ways which actually increase pressures elsewhere in the system. Focusing drug services on abstinence, for example, may be cost-effective for commissioners of those services, but unless fall back services for those unable to abstain are also commissioned, other parts of the system must commission and pay for services for which they receive no funding. Moreover, where previously there may have been an opportunity to invest in one part of a pathway to save money elsewhere, those incentives have gone:

*I think it is a real challenge because we don’t have the opportunity to make decisions to invest in one part of the system to save in another. So you might invest in a public health thing that actually in the end saves money in specialist commissioning. Neither of which do we control anymore, you know, and it just means that it takes a lot of influencing to sometimes get what you think might be the right thing to happen, because you’re influencing another body to see that there’s value in it for them to do that, you know.*

3262, CCG manager, Area 1

Such issues are magnified by financial pressures. In the example given above of anti-obesity services, lack of clarity over who was responsible for commissioning Tier 3 services led to their
decommissioning in some areas, as all those involved in the pathway tried to balance their books. As our interviewee highlighted, the subsequent task force recommendation that this responsibility should sit with CCGs carries no statutory authority, and unless some means can be found to create shared incentives, pathways with multiple commissioners will be at risk of cost-shifting manoeuvres.

In addition, we have identified a lack of clarity over where ultimate responsibility lies for some areas of care. In the ‘flu vaccination example above, the division of statutory authority between multiple organisations seems to have created the potential for issues to fall between the cracks. At the time of the Act, it was argued that it was important to give statutory authority to GP-led CCGs (rather than the role played by GP groups as sub-committees of a wider statutory body in the past) in order that those groups would have the freedom to innovate. This is an issue we will return to later, and it is an argument that has some validity. However, the side effect that we have identified is a lack of clarity over where the ‘buck stops’ for some issues. An over-arching commissioner for a geographical area such as a PCT at least provides clarity over who is responsible for what; the new system would seem to require local organisations to work together more intensively to ensure that important issues are effectively dealt with.

This reorganisation, like others before it generated significant issues associated with loss of capacity. Personal relationships were highlighted again and again by our interviewees as vital resources in allowing local actors to navigate the new reality. In addition, the large scale of this reorganisation generated particular problems with loss of organisational memory and knowledge of geographical context, as has the ongoing reorganisation of NHSE. As highlighted in Box 5 above, decisions made by the previous commissioners could not always be traced in available paperwork, and complex service areas that had perhaps operated according to custom and practice rather than being clearly set out in contracts generated difficulties as managers tried to separate revenue streams and divide resources between new actors.

Finally, all of these examples taken together highlight two important issues. Firstly, the HSCA12 attempted to rationally divide commissioning responsibilities between the relevant commissioning organisations. However, the inter-linked nature of the care pathways that we have identified meant that this rational approach inevitably generated a number of unintended consequences, as decisions which were rational in one context had unintended and potentially negative consequences in other service areas. Thus, for example, those responsible for setting service specifications for drug services did not necessarily consider the ramifications of their decisions for services for which they were not responsible in a related field. This speaks to the need for some sort of co-ordinating function across a geographical area which provides the necessary strategic overview to plan interdependent services. Secondly, our evidence so far highlights the need for commissioning organisations to work together across different scales and different footprints. Such a necessity has always been present, but before the HSCA12, the number of actors involved was more limited, with LAs and PCTs the main players on the commissioning side. The new system brings in a number of new players, including NHSE and local CSUs, and has changed the scope of required collaborations between existing partners. The extent to which new organisations have the same geographical footprint as their predecessors varies, with some CCGs in Area 2 quite different from the previous PCTs. Our interviewees suggested that the impact of these changes on the work of CCGs seemed less than might have been expected; this assertion will be tested quantitatively in Chapter 6. It may be that the presence of individuals with longstanding knowledge of local issues mitigated any negative impacts. Many of these individuals have moved into new roles and new organisations, and have brought to these roles the wealth of their existing knowledge to support their new organisations, thereby acting as an informal ‘glue’ to hold the new system together.
In the next section of this report we explore in more depth the concrete mechanisms by which the necessary co-ordination and collaboration are being achieved.

4.3 RQ1b: How are the new organisations working together?
There were a large number of collaborative arrangements between and within commissioning and other organisations in both Areas 1 and 2. Some of these were centrally prescribed, applied nationally and emerged directly from or evolved from the HSCA12 itself, while others were developed after the implementation of the Act. Many arrangements were developed locally at a range of scales, some of which were facilitated by the HSCA12 or intended to mitigate issues associated with it and manage the structures that it created. In this section, we consider these collaborative arrangements and reflect, in particular, on differences between Area 1 and Area 2.

Of fundamental importance to collaborative arrangements, both national and local, were the geographical areas for which individual organisations had responsibility, often referred to by our interviewees as their ‘footprints’. However, ‘footprints’ also applies more broadly to statutory administrative boundaries, and to demarcations or areas within organisations, between, for example, localities to which certain responsibilities were devolved. Interviews and observations revealed a multitude of pertinent footprints for commissioning work in both Areas. These will also be discussed in the sub-sections below, although they often resist being neatly compartmentalised by scale.

4.3.1 Centrally prescribed collaborative mechanisms

Health and Wellbeing Boards

The most notable collaborative mechanism required in the commissioning system as a result of the HSCA12 was the development of Health and Wellbeing Boards (HWBs). Every top and single tier LA\(^1\) was required to create a HWB as a statutory sub-committee with a minimum membership including directors of adults’ services, children’s services and public health; local CCG representatives; a representative of the local Healthwatch; and an elected member of the council, each having voting rights.\(^2\) The explicit purpose of each HWB is to identify the particular health and social care needs of its related population, facilitate joining up services to meet such needs, and oversee commissioning strategy. HWBs have to produce a Joint Strategic Needs Assessment—a document which sets out current local and predicted health and social care needs—every three years. From this document, and in collaboration with local CCGs, each HWB has to produce a Joint Health and Wellbeing Strategy setting out how the identified needs might be met. CCGs must take account of both documents when developing their commissioning plans. For more detail see Coleman et al (2014)

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\(^1\) In two-tier areas, upper tier authorities are responsible for around 80% of services, including education, social services etc. whilst the district councils provide functions such as housing, planning and leisure services. Unitary (single-tier) authorities are responsible for all such local services (Local Government Association 2011): The LGA quick guide to local government. Available from: [http://www.local.gov.uk/c/document_library/get_file?uuid=a5b2c920-8f40-4eae-9852-8b983724f5bc&groupId=10180](http://www.local.gov.uk/c/document_library/get_file?uuid=a5b2c920-8f40-4eae-9852-8b983724f5bc&groupId=10180)

\(^2\) Most LA committees allow only elected members to vote, having taken guidance from officers. However, on HWBs elected members, officers and others who are full members all have an equal entitlement to vote on decisions taken.
The most common sentiment expressed about HWBs by CCG interviewees in both Areas was that they had been largely ineffective so far:

*Health and Wellbeing Boards, nice, potentially can be useful depends on how we view their role [in the future]. I think the last five years not really much use at all.*

4110, CCG GP, Area 1

*we had a […] Health and Wellbeing Board, which I actually was the chair at one time, we alternated chair with myself and each of the councillors, to be honest, I’m not sure it was entirely effective, it was a useful talking shop…*

6775, CCG manager, Area 2

Some of the issues identified by CCG interviewees to explain this ineffectiveness included a lack of consistency caused by the local councillors that chaired them losing their seats, with subsequent change of leadership and approach. LA interviewees, some of whom were involved in running their local HWB, tended to be more positive about the value of the forum, and the most optimistic about it playing a more prominent role in the future, but many expressed similar sentiments to those above.

In one LA patch of Area 1, within which there were multiple CCGs, CCG interviewees were the most complimentary about their HWB but this was still caveated with comments about how it could improve:

*Yeah, I have to say I’m a real fan of the Health and Wellbeing Board, I think in [this area] it was part of the glue that helped the new world embed so I’m a real fan of it. We were one of the few that had provider partners around the table, so the […] hospitals again and the mental health trust around the table with the city council. And I think it’s still got a little bit of a way to go but it has…to be honest, it’s created that health and social care agenda and also that other stuff that affects people’s lives like work and worklessness and all the rest of it.*

2623, CCG GP, Area 1

*Health and Wellbeing Board I think has got a bigger role to play. I don’t think it’s developed as well as it could have done. I think the leadership is brilliant. It’s excellent. [HWB Chair] is really a fantastic leader but I think what it needs underneath it is commitment and structure.*

4519, CCG manager, Area 1

As the above extract illustrates, in this LA area, there were a number of locally-specific aspects of the HWB structure which were perceived as facilitating its work. These included: the co-option of providers onto the board; a highly regarded leadership; and the historical establishment of a local collaborative forum featuring chief officers of the statutory organisations represented on the HWB which predated the HSCA12 by a year and a half. Various other LA areas in Areas 1 and 2 had also tailored their HWBs by, for example: including providers; ensuring equality of representation between council and CCG(s); rotating chairing between the council and CCG(s); and using the HWB as a platform to create and run other local integrated forums with different purposes. In some cases, the HWB provided a label or container for arrangements that predated the Act, and the benefits of the HWB were often discussed in terms of the locally specific integrated forums that its existence facilitated.
Better Care Fund

The Better Care Fund (BCF)¹ is a national Governmental initiative introduced in June 2013 to increase integration between health and social care and to allow some resources to be transferred from health to social care (Bennett and Humphries 2014). NHS organisations and LAs were required to identify a portion of the NHS budget that would be pooled with that of the Local Authority for projects that would enhance the well-being of their local populations. However, there was a strong emphasis within the guidance for the scheme that the focus should be upon reducing overall service costs, with a particular focus on reducing admissions and lengths of stay in hospital. The responsibility for signing-off Better Care Fund plans lies with HWBs. Every LA area in Areas 1 and 2 had established some kind of joint CCG-LA board or team to administer their BCF projects. Funded programmes focused on various domains of care, such as reducing A&E admissions, or improving dementia services.

There was general positivity about the Better Care Fund and the joint working that it necessitated from CCG and LA interviewees in both Areas 1 and 2. One LA interviewee talked about how it provided a framework for inter-organisational discussions about how certain services should be organised and rationalised, which led to specifying formal joint working arrangements between the LA and CCG through Section 75 arrangements⁴ [8247, LA manager, Area 1]. A GP CCG Chair suggested that the Better Care Fund had been an important component in the post-HSCA12 improvement in relations between the CCG and council [4785, CCG GP, Area 1]. While the sentiment from some interviewees was that the Better Care Fund provided a platform for larger integrated projects to take off from, others felt that the Fund just served as a convenient means of packaging work that was already underway:

[We have] More involvement with the local authority than we had as PCTs... Partly driven by The Better Care Fund, although we do just put a label to things we were doing with them anyway.
6814, CCG manager, Area 2

Or, more critically, that it was a ‘transactional’ [7160, CCG manager, Area 2] distraction from the larger scale health and social care integration that needed to take place:

I think the Better Care Fund is a bit of a distraction because it was a small amount of money and we spent loads of time on it and actually what we probably need to start really thinking of is, just pool our budgets and that will come with the risks that it comes with but there’s then a story to the population about how we really allocate and manage our budgets.
4519, CCG manager, Area 1

System Resilience Groups

³ The original BCF (initially referred to as the Integration Transformation Fund) was identified as being £3.8 billion. This was money carved out of the NHS budget rather than being new money. An additional £1.5 billion of the NHS budget was identified as being available for BCF projects in the 2015 spending review.
⁴ Section 75 of the NHS Act 2006 allows for NHS organisations and local authorities to establish partnership arrangements to carry out the functions of either body. This includes the capacity to pool budgets and share staff.
Another post-HSCA12 national collaborative arrangement was the introduction of System Resilience Groups (SRGs), which evolved from Urgent Care Working Groups (elective care was added to their portfolio in the process), introduced in NHSE’s A&E improvement plan (NHSE England, 2013 -- https://www.england.nhs.uk/wp-content/uploads/2013/05/ae-imp-plan.pdf) in May 2013 following the strain suffered by the A&E system during the winter of 2012/13. SRGs are operational groups working on geographical footprints corresponding to established flows of urgent and emergency care activity in particular areas—a local “health economy.” Although non-statutory in nature, a wide range of stakeholders are expected to attend, including local CCGs, LAs, NHSE and relevant service providers. SRGs are usually chaired by a senior representative from one of the CCGs. SRGs must produce operational resilience and capacity plans, which include specific plans to manage fluctuations in demand for urgent and unscheduled care. These were assessed by NHSE and Monitor. Additional resilience funding to support these plans is then allocated to SRGs from NHSE via CCGs. One CCG manager expressed a feeling that SRGs had become increasingly prescriptive and pressured, with strong performance management by NHSE:

[SRGs were introduced] I think, about two years ago, but their role has evolved quite dramatically. So, they were, initially, set up on a...you can put in place what works for you locally, and it was quite permissive, their remit, and, now, it’s much more about this is who we expect to be on there, this is what we want you to do, this is how we can expect you to monitor it, this is by when, and there’s a cascade of, almost, weekly edicts for the SRGs to provide assurance. ... then there’ll be a meeting to check what you’re saying is right, and this kind of environment, it, increasingly, feels adversarial, and the level of expectation feels quite unrealistic as well.
6120, CCG manager, Area 2

Urgent Care Networks

In November 2013, another, more regional level of inter-organisational operation was proposed in the form of Urgent Care Networks. These strategic groups were established as a result of recommendations contained in NHSE’s Urgent and Emergency Care review (NHSE England, 2013: http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf). The report focused upon the need to ensure that patients are seen in the most appropriate place, and that the system overall is ‘joined up’ and simple to navigate. Networks are composed of multiple SRGs, and each one covers a population of between one and five million patients. Urgent Care Networks were in the process of becoming established during much of the data collection reported here. However, one CCG clinician was critical of the Urgent Care Network model on the basis that the Network to which his CCG was associated did not correspond to any other relevant geographical footprint on which they worked, and represented yet another responsibility for the CCG at a particularly broad scale:

But then you’ve got your SRGs, which sits around [Place X] and [Place Y], so that maps reasonably well. You’ve got these new unfathomable urgent care networks over a geography that makes no sense whatsoever... They sit above the SRGs, but there’s no logical sense to my mind as to why they exist and what they’re going to exist to do, and how they can be of any use in the footprints that they sit at.
[6165, CCG manager, Area 2]
As can be seen, in the early years following the HSCA12, the requirements for CCGs to co-operate with each other and with other organisations across a wide variety of geographical footprints proliferated. Each of the collaborative arrangements discussed here was centrally prescribed – i.e. CCGs were told that they must engage, and were performance managed on that engagement, with NHSE assurance of CCGs monitoring this. Interviewees expressed some frustration at this, with a particular concern that not only did many of these collaborative footprints not correspond with each other, but also the logic for the variation between them was unclear:

So we’ve got CCGs working together across, say, [sub-region], which is [number of] CCGs. We’ve got Better Care Funds. So we’ve got one in [LA area A] and one in [LA area B] and one in [LA area C]. [Multiple] CCGs that are working together with [number of] city councils. And we’ve got strategic [/system] resilience groups, and they’re on a different footprint. Then we’ve got the clinical senate that’s on a different footprint with [sub-region]. Then we have specialised community hubs, which are [CCGs working] together. Now the exact footprint of the specialised commissioning hub I’m going to struggle with, because I just can’t remember. I mean, it’s about 20 CCGs.

[7101, CCG GP, Area 2]

The functions carried out by these newly prescribed collaborative arrangements were often co-ordinative or designed to support CCGs to collaborate with each other and with other organisations. It is noteworthy that functions such as these were, prior to the HSCA12, carried out by Strategic Health Authorities (SHAs). Fourteen SHAs each covered a large geographical population, and carried responsibility for ensuring co-ordination between the NHS organisations commissioning and providing care for that population. SHAs were abolished under the HSCA12.

4.3.2 Locally developed collaborative arrangements

In addition to these nationally-mandated collaborative mechanisms, we found a large number of locally developed collaborative forums and mechanisms. Data collection revealed that within both Areas 1 and 2 these can be thought of as operating at three (sometimes overlapping) levels: Area—the former NHSE Area Team footprint made up of 8-12 CCGs, LAs, a broad range of providers and stakeholder groups (see Area profiles beginning on page 47); sector—sub-Area groupings of CCGs and/or LAs based around shared providers, programmes of work, and/or historical allegiances; bilateral—collaborative working between commissioning organisations at a sub-sector level.

Area

Area 1 had a CCG Assembly with regular meetings attended by the clinical and managerial leads from each CCG. This body did not have formal decision making power—individual CCGs retained their rights in this respect and any decision made by the Assembly required unanimous agreement from all CCGs or for the possibility of a non-unanimous decision to be binding agreed to by all CCGs before any voting takes place:

...there’s also the [Area 1 CCG Assembly] which meets up every month where the clinical chairs and the chief officers meet together, and we develop some collective fire power, really, and also we’re learning to work together. So whilst yes, we were set up to work individually, as small organisations, very local, keep your eye on what you need to do locally, [but current new developments], everything else, absolutely pushes us into a different conversation about working on a bigger scale.

[3950, CCG manager, Area 1]
So that’s something that’s we’ve been a part of, so we’re used to working at that level, so the governing board at [Area 1] has got a level A, level B almost permission, so level A everybody has got a vote out of it, but level B everybody has got to be in, it’s unanimous otherwise it doesn’t happen.

[5345, CCG manager, Area 1]

The CCG Assembly replaced the PCT Assembly, which was in operation for approximately ten years before PCTs were abolished as a result of the HSCA12. The PCT Assembly was recognised by multiple interviewees as being successful in facilitating cross-Area initiatives, including a significant service reconfiguration, and considered sufficiently valuable to continue with. The CCG Assembly also had two sub-boards with regular meetings specifically for Heads of Commissioning and Directors of Finance. The Chief Officers of each CCG also meet on a weekly basis. At Assembly some issues, such as specialised commissioning, were delegated to individual CCGs to lead on. Area 1 also had a well-established LA Assembly that predated the PCT Assembly. Interviewees from all organisations in Area 1 talked about the strong history of this Assembly and the collaborative achievements that it had realised for the Area at large. The existence of these strong local collaborations was felt to have mitigated some of the disruption associated with the reorganisation.

Area 2 was less well-advanced in working together. All of the CCGs in Area 2 worked collectively on some issues, such as redesigning certain services, but these arrangements did not have the same level of formality as Area 1 and the sense of collective identity that Area 1 CCGs had was not shared in Area 2. In part this is not surprising, in that the footprint established for the NHSE Local Area Team in 2012 did not correspond exactly to previous administrative boundaries. Area 2 was in the very early stages of discussing the potential of LA devolution which would again operate on a footprint encompassing and going slightly beyond the Area. This plan includes some aspects of health and care services, although not the full range of such services. One CCG GP leader stated that the efforts of the LAs in Area 2 to unite in order to secure a devolution deal was a force that was encouraging CCGs in the Area to do more together:

Our local authorities...there’s [all of the] local authorities in the [Area] clubbing together trying to form a super authority, which is mainly around economics and transport. They explicitly really don’t want health in it, it would seem, but we’re sort of thinking, hmm well we need to relate to this thing, don’t we, so what could we do more at that bigger level, so get ourselves organised at that level, so we can influence and impact on that.

[5998, CCG GP, Area 2]

These area-wide issues highlight some broader trends in the English NHS, in particular a renewed role for geographical place, with coherent services for populations seen as desirable. Indeed, NHSE planning guidance issued in late 2015 (NHS England 2015) explicitly contains guidance as to how coherent geographical ‘units of planning’ can be determined. Our findings suggest that the geographical area covered by our Area 1 meets the requirements of such a coherent area, whilst that determination is somewhat more complex for our Area 2, because there is less agreement about where appropriate boundaries lie, and a less cohesive system of Local Government.

Sector

Both Areas had established sub-Area groupings—commonly referred to as ‘sectors’—for CCGs and LAs. These were often based around common interactions and interests with particular providers as well as historical partnerships. In both Areas, some services were commissioned on a sector basis with particular CCGs or LAs taking a lead on the process. One of the four CCG sectors in Area 1 was particularly well established. CCGs in this sector had signed a partnership agreement that specified
details of collaboration, such as resource and staff pooling as well as the basis on which collaboration would occur and which things, such as primary care, would be done separately. An interviewee referred to it as “a statement of intent around how we do things” [3950, CCG manager, Area 1] and said that it had been important in facilitating the successful operation of the sector. However, even for the organisations bound to this sector, there were additional inter-CCG/organisational footprints that were of particular importance:

_We operate here in what’s called the [name] Sector of [Area 1] along with [CCG X], [CCG Y], [CCG Z] and ourselves, and for example, our acute trust which is [Provider 1] has four hospital sites across each of those CCGs, so it’s absolutely essential that we work as a four for that particular piece of commissioning. The [Provider 2] which is the mental health and community services organisation, they have a seven borough footprint so it’s really important that we keep close to the seven, and so it goes on._

3950, CCG manager, Area 1

**Bilateral commissioning**

Some form of integrated commissioning arrangement between LA and CCG pairs (usually) was common in both Areas. These arrangements included official pooled budget arrangements (over and above Better Care Fund agreements), joint/integrated commissioning boards and/or joint commissioning units. Some of these arrangements meant that staff from both organisations shared the same physical office space, others worked at a distance. In some cases, these integrated structures preceded the HSCA12 but the majority were established afterwards. One CCG manager suggested that the HSCA12 had expedited the realisation of integrated commissioning arrangements that were emerging between the PCT and LA:

_I think the integrated commissioning arrangements were things that we were probably on that path towards in the PCT, and like I say, they are in the process of accelerating, as has been the clinical involvement in the work. So yeah, I don’t think it’s fundamentally different to what we’re doing in the PCT._

3271, CCG manager, Area 1

There was considerable variation in which services were subject to integrated actions and which organisation took a lead on this as the following extract illustrates:

_I don’t think there’ll be a one size fits all. So I spoke to a couple of other CCGs in the region because they’ve got a service that we’re looking at. And they said oh no, that’s someone in our joint commissioning team that’s leading on that. And actually I thought oh, okay. Here it wouldn’t be someone in our joint commissioning team who’s leading on that. It’s just interesting that they’ve got joint commissioning arrangements that are a slightly different scope._

3271, CCG manager, Area 1

Most organisations reported that they were intending to extend integrated commissioning arrangements in the future:

_And obviously, with things like the Better Care Fund, the national policy, and with developments like proactive care and more care outside hospital, that area is an area that’s increasing. So we’ll look to increase the size of that pooled fund and look to further integrate our commissioning arrangements with them._

3665, CCG manager, Area 1
CCG and LA interviewees in both Areas talked about some of the challenges associated with joint working. Some of these were specific to the particular history of the locality but many related to differences in commissioning-related processes and language between NHS organisations and local government. The following extract from a CCG manager encapsulates this:

Yeah, because you can sit in a room and write specs together, but you can’t really do proper joint commissioning until you integrate the functionality of it. So that’s what we’re doing and I think that’ll be interesting going forward, because we’ve got different contract mechanisms, different procurement approaches, culture will be very different, because I think we commission, using the commissioning cycle, whereas, the council is mostly spot purchase and don’t do enough strategy....There’s something really fundamental as well and basic about sharing the same language, so sit in a room with four people I’ve met before, from the council, yesterday who were using acronyms and phrases that I just didn’t...so I had to say them, listen guys, I know I’m just as bad, but I don’t understand what you’re talking about here and I’m [a senior manager], so if I don’t understand, imagine...so we got to a place where...we had a fascinating conversation, you know, the housing people were facing a 20 per cent cut with no notice for next year, which is just huge.

[5345, CCG manager, Area 1]

Some inter-organisational arrangements amounted to more than simply an agreement to work collaboratively and pool a budget. One CCG in Area 2 had donated a significant sum of money to its LA to fund adult social care. A CCG manager explained that they felt this was necessary in order for the LA to sustain social care provision and because the impact of their inability to do so would be significantly detrimental to the CCG. The magnitude of the financial challenge that LAs were dealing with because of funding cuts from central Government was recognised by interviewees from all organisations. The disinvestment decisions that LAs were forced to make were difficult. In one LA area, this was a source of friction between the LA and CCG. An interviewee from the CCG reported that LAs cutting certain services had detrimental impacts on the CCG but the LA had not sufficiently recognised this and had not discussed its plans with sufficient forewarning.

In Area 2, an integrated care project, started some years before the HSCA12, featured a plan to redesign some local hospital services. The partners in the project included a CCG; providers of acute, community, and mental health services; LA; Healthwatch; NHSE; and GP federations. The footprint of the nascent CCG was itself delineated on the basis that it fitted well with this plan. This illustrates how the HSCA12 provided an opportunity to redraw organisational boundaries in a way that corresponded to the logic of a pre-existing and on-going project. However, a CCG manager interviewee believed that, although the HSCA12 had provided an opportunity in this respect, the benefit was offset by the fragmentation of commissioning responsibilities and disruption that the reforms had caused:

None of these things have helped, none of them. All they’ve done is distract us so we’ve had to find a way to work around them. So it is absolutely in spite of reorganisation and change, not because of it.
[6010, CCG manager, Area 2]

4.3.3 Changes subsequent to the Act
NHSE reorganisation and changes to CCG responsibilities

In April 2015, NHSE was restructured to increase its organisational efficiency and reduce running costs. Three organisational tiers were reduced to two as 27 Area Teams were absorbed into the four pre-existing Regional Teams, which continued to sit below the National Team. As part of these changes, NHSE were required to reduce its running costs significantly. The impacts of this were not evenly distributed between Areas 1 and 2. In part, this is because Area 1 senior managers explicitly designed the new structures to leave the local managers working with CCGs in place, making changes and staff reductions instead at the level of senior management. In Area 2, by contrast, changes were perceived as permeating the whole structure, with some instability at senior management level.

One of the issues that the reorganisation created, particularly for NHSE staff, was uncertainty over their organisational identity and function. This was compounded by a period where the official name of sub-regional units was changed multiple times, which caused some confusion.

Sub got dropped, so we were a sub region a couple of weeks ago, the word sub got dropped and we are now NHS England ([Super-Area 1])...but having said that I’m referring, it's difficult I was at a regional meeting on Thursday, for example, and I’m trying to describe ourselves, the actions we have to do and the actions of what our regional colleagues are going to do for us. It gets difficult in that terminology, so I call a sub regional team and SRT, that's easy, kind of, shortened version of what we are, but we are not called a sub region any longer. [3994, NHSE, Area 1]

R: So I think we’re still evolving. There are still areas of uncertainty and lack of clarity about what we do at this tier, what the regional tier does. I think what CCGs do is becoming a bit more clear, but there’s still very rapid policy change and directive from above, so I don’t think we have a period of stability yet. What we’ve seen in the last two years is very much incessant change and turmoil.

I: So is there a term for what’s replaced area teams or is it just...?

R: There isn’t, and that’s probably one of the real... It’s minor, but it shows a lack of planning really. I think they were initially called sub-regional teams, which was probably a little patronising. My view is that the [Area 2 plus an additional locale] is a region, and we could probably define the four big regional teams as super-regional, as it were. Terminology’s important. [5823, NHSE, Area 2]

One of the consequences of the reorganisation in Area 2 was a high number of staff choosing to leave NHSE. Several interviewees had recently, or were planning to, take up posts in a local CCG. For some, this was motivated by the feeling that NHSE was becoming less of a commissioning organisation and moving to a CCG was a logical progression in order to continue to employ their skills. As a consequence of this, and as a result of the extended footprint covered by NHSE sub-nationally, interviewees reported their resources being spread more thinly and this meant having to be more selective about contact with CCGs and attending collaborative forums:

...because we have thinned out teams and thinned out talent, we can’t do it in the way that we used to, so we can’t attend every health and wellbeing board, it’s just not possible for us to do that...So for some CCGs, talking about CCG assurance and performance, it’s going to be a more hands off approach, for some, it’s going to be much
more in your face, because we are moving much more into a, you know, working very closely, shall we say, with CCGs that have got problems.

[4214, NHSE, Area 2]

This change in approach was keenly perceived by CCGs in Area 2. However, CCGs in Area 1 also reported a more targeted and prescriptive performance management approach post-reorganisation from NHSE, which suggests a broader change in the approach from the centre of NHSE. CCGs in both Areas had positive things to say about their relationships with NHSE, both the Area Team and the sub-regional team that had replaced it. Personal relationships with known individuals were an important part of this.

NHSE interviewees identified additional challenges that the reorganisation had created. In the extract below, an NHSE manager highlights how the fact that PHE had also been subject to a reorganisation meant that the two organisations were now operating on different footprints. One of the ways of mitigating the complication that this caused was by leaning on pre-existing personal relationships.

"Public Health England are, again they’ve reorganised, and they are on an old [sub-region A] footprint, just to complicate matters. So they think, old [sub-region A], so they’re finding it really complicated. So that Public Health lead [Name] deals with the whole lot, but obviously we’re only a bit of it, so [sub-region B] is separate. So the Public Health Local Authorities meet as an old [sub-region A], but we don’t. ...So you have to get your head around what’s old [sub-region A], and not. And again I’d go back to personal relationships, we know [Name] well, so it’s easier to manage, a little bit."

5930, NHSE, Area 2

CCGs in Area 1 reported a greater degree of continuity in terms of the people in NHSE, with many of them having occupied high-profile roles in other local organisations before NHSE was established and garnering significant good will from many people working in the Area.

"I think in [Area 1] we’ve been very lucky with our local area team...
When PCTs were abolished a lot of the chief execs took early retirement and went, so there was a new cohort of us, in a way, who were like the next layer. And the local area team was formed from some of the staff in the ex PCT, which meant that we already had links, we knew people. We were already starting to form, as a body, and work together, and we have been lucky with our local area team, they’ve always been very supportive, and we’ve had good relationships with the people that worked in it."

3666, Manager CCG, Area 1

The fact that CCGs were being asked to take on greater responsibilities, such as primary care co-commissioning and collaborative commissioning of specialised services, but without additional resource was identified by some interviewees as a pressure towards operating over larger geographical areas in collaboration with a larger number of other organisations. This was framed as a pressure that needed to be balanced against the need for CCGs to retain their local nature—being both attuned to local needs and issues as well as available to residents and others within the CCG patch:

"CCGs are growing. Unfortunately we are growing in terms of our scope at a time when the money to enable organisations to get bigger isn’t there, so the only other alternative, really, is to work in a smarter way, isn’t it, and to consider working across bigger boundaries without necessarily the need for a formal merger because there’s a..."
real dilemma, I believe, between maintaining your focus on your local, which is really important to local people, and looking at how you work smartly across a bigger footprint right up through to [Area level].

3950, CCG manager, Area 1

And, to be quite frank, we don’t have the time to participate, you know, management...you know, if I think about the challenges that we face at work, with trying to do...also have the time to really commit the resources to participate in a regional process where the benefit to my organisation or my population might be marginal at a time when my management costs are a quarter, or something like that, of what the PCT used to, my predecessors, you know, how can I afford the time to participate in that process, it’s very difficult to be able to see that to be honest.

7160, CCG Manager, Area 2

The discussion of interactions between local and national organisational bodies is developed more fully in the following sections answering elements C, D, and E of research question 1, which focus particularly on issues of accountability and autonomy.

Five Year Forward View
The Five Year Forward View (NHS England et al, 2014)—published by, and presenting a joint position from, NHSE, Public Health England (PHE), Health Education England, Care Quality Commission, Trust Development Authority (TDA), and Monitor—was of particular significance to collaboration within the system. It proposed the creation of a number of New Models of Care to facilitate integration between different NHS organisations, and between health and social care. A Vanguard programme—where locally developed arrangements could obtain funding in order to forge this path and create exemplars of inter-organisational relations—was launched in January 2015 with the first successful sites announced that March. Importantly, these new collaborations cut across the purchaser-provider split, with commissioners encouraged to develop partnerships with their local providers. Vanguards could initially apply for a portion of a £200 million Transformation Fund and were afforded developmental support from NHSE. Five different types of Vanguard were approved nationally by NHSE: integrated primary and acute care systems (PACS); enhanced health in care homes; multi-speciality community providers (MCPs); acute care collaboratives (ACCs); urgent and emergency care systems. As of January 2016, there were four Vanguard sites in Area 1 and three in Area 2, with most of the five models represented.

During data collection, Vanguards were in a developmental phase and, consequently, interviewees were not able to discuss their operation in detail. Vanguards were often highlighted in response to questions about local inter-organisational relationships as an indicator of the health of such relationships. The following extract from a senior CCG manager shows how the local Vanguard was part of an existing programme of integration and the decision to apply for it was predicated on this:

So Vanguard came out of...so I said before that we had developed this partnership arrangement. So that's under the umbrella of a programme called [Programme name], which is where we sort of said, well, that's the funding available in this locality, here's the issues, priorities, how do we develop things. ...So Vanguard and [Programme name] are one and the same. So we saw that as a way of, you know, getting access to some additional support and advice from that national programme. But it was very much, you know, we think we've got a good story to tell here, so that's why we've put ourselves forward for it. [3665, CCG manager, Area 1]
Sustainability and Transformation Plans

In December 2015, the same septuplet of organisations that authored the *Five Year Forward View* (albeit TDA and Monitor had merged to become NHS Improvement) published a guidance document entitled *Delivering the Forward View: the NHS planning guidance for 2016/17 to 2020/21* (NHS England 2015). The document outlined a ‘Sustainability and Transformation Fund’ worth £2.1bn in 2016/17 and rising to £3.4bn in 2020/21 intended to help get hospitals out of deficit, enable delivery of the *Five Year Forward View* and allow greater investment in priority areas such as primary care, mental health and cancer services. The report made it clear that ‘place-based planning’ would be the way of the future in the NHS.

*Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn’t make sense to staff or the patients and communities they serve.*

(NHS England 2015:p4)

All NHS organisations were to produce operational plans for this coming year but, in addition, health and care economies had to produce a Sustainability and Transformation Plan (STP) running from 2016 to 2021. Plans should include improved health and wellbeing, transformed quality of care delivery and sustainable finances. The guidance also outlined nine ‘must dos’ for every local area in England in 2016/17, agreed by the leading health bodies in England. These included:

- Returning the system to financial balance
- Introducing a local plan to address the sustainability and quality of general practice
- Reducing waiting times for A&E, cancer and mental health
- Improving quality – particularly for organisations in ‘special measures’ (i.e. under particular surveillance and required to improve because of previous poor measured performance).

Each STP had to present responses to 60 nationally determined questions in addition to setting out locally specific priorities. The perceived strength of each plan would be the main factor in groups successfully accessing transformation funding.

The associated Sustainability and Transformation Fund was introduced to be spent at the beginning of the 2015 spending review settlement (£1.8bn). NHSE facilitated access to the Fund and reviewed applications but HM Treasury was be responsible for signing off allocations. In order to progress, health care economies first were required to define their boundaries and constituent organisations. Monitor (renamed NHS Improvement), issued ‘non prescriptive’ guidance to help ‘local health and care systems to determine their planning footprints’ (Monitor 2015: p2). This 78 page document contains appendices full of regional maps which include information about CCGs and their populations, acute providers and their revenues, other providers, patient and funding flows, clinical senate footprints, existing *Five Year Forward View* models of care (such as Vanguards), and specialised commissioning hubs.

One difficulty that this process poses stems from the fact that there are multiple levels of “health and care economies” across England and strategic planning and transformational change is likely to require working arrangements at several different levels. Planning footprints should be large enough to enable the strategic planning decisions needed by 2020/21 to deliver sustainable health and care services, as outlined in the *Forward View*. This suggests that local agreement is required to determine the level, shape and size of specific planning footprints.

The key actors in a defined “health and care economy” could include:

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• acute, mental health, community, ambulance, specialist, independent and social enterprise providers;
• CCGs;
• NHS England specialised commissioning;
• LAS;
• local HWBs;
• local Healthwatch.

Taking account of all these different actors and organisations, local health and care economies cover different or overlapping geographical areas, depending on how they are defined. However, for planning purposes and to allow comparisons between different local health and care economies, Monitor (2015:p4) states that it is ‘helpful to define them using discrete geographical areas aligned to existing administrative boundaries.’ They also suggest that ‘Local health and care economies/systems should be aligned to the requirements set out in national guidance and should demonstrate the scale needed to deliver and transform services’ (ibid p7). In practice, the large majority of the available ‘transformation’ funding was used to fund provider deficits. It is beyond the scope of this report to explore STPs in more detail, as our data collection occurred before they were fully enacted. However, it is important to be aware of the direction of travel of policy towards local geographical cooperation between commissioners and providers.

4.3.4 Discussion
One of the most striking similarities between Areas 1 and 2 was the sheer volume and variety of collaborative arrangements, many of which pre-dated the HSCA12 in some form. These were fundamental to the work of CCGs, in particular. One CCG manager in Area 2 said that he was not able to think of a single domain of activity that the organisation engaged in that did not involve some form of organisational partnering:

Given half an hour, you could make a list of 15, 20, 30 of these things. If I try to make a list of all our partnerships, it would literally run to hundreds, because as I say, I don’t think there’s a single line of activity which we don’t have with somebody somewhere, and that ranges from buying bits of kit to planning services to simply organising and sharing services. We all collaborate, for example, to commission services from the commissioning support organisation, the CSU, and we do that in a whole variety of different footprints, so there are loads.

The big ones probably are the ones that I’ve mentioned. They’re the ones that are uppermost in my mind, but actually we could make a list quite quickly, I think, given a bit of quiet space and time, that could run to dozens.
6010, CCG manager, Area 2

These arrangements spanned an array of different, sometimes overlapping, geographical footprints. Many of these were versions of valued arrangements that predated the HSCA12, modified to account for the new organisations in operation, others (such as SRGs and Urgent Care Networks) were centrally imposed or encouraged (such as the New Models of Care outlined in the Five Year Forward View). This multiplicity of footprints and their evolving layers creates a challenge for commissioners.

...we’ve got so much complexity, and in fact we keep adding to it, so the FiveYear Forward View has now introduced a whole bunch of new types of ballgame, we’ve got Vanguards, we’ve got different collaborations, we’ve now got new networks, we’ve got...
Senates. There’s been a proliferation of organisational arrangements and network arrangements which must make it almost bewilderingly complex, I would have thought, to anyone who’s got to try and partner with the NHS. It’s making us a very difficult partner to work with, despite our best efforts.

6010, CCG manager, Area 2

As the extract above notes, these footprints are a factor that makes comprehending and navigating the system, including understanding the relative roles and responsibilities of new and reshaped organisations, an extremely challenging task for anyone but those most intimately involved in it:

And I have to say, hospital providers, practitioners, just find this mind boggling… Completely mind boggling, I just don’t think they can relate to who is where, and to be honest they tend to focus on those people that have remained and they know, to help them navigate through.

5930, NHSE, Area 2

In response to this, one CCG in Area 2 had developed its own hotline to assist the public and other organisations in identifying the appropriate body or individual to speak to with queries and complaints. A CCG in Area 1 was developing a co-ordination centre in order to provide system navigation advice, better integrate services, and simplify patient journeys. This speaks to a sentiment expressed by CCG interviewees from both areas who perceived that an important part of the role of CCGs was to generate and orchestrate collaboration:

I do feel that the role of the CCG is to bring the partners together and act as the system...we’re like the coordinators. So we’ve got all the...the way I see it is it’s almost like one of these circle diagrams where you’ve got the CCG and then you’ve got NHS England, you’ve got the local authority, you’ve got the acute hospital, you’ve got...and linked to that community services, you’ve got primary care and our member practices, you’ve got public, you’ve got other providers maybe private and you’ve got third sector bodies, and community groups, and that sort of thing linked to the public and other providers as well. And then the ambulance service and the out of hours provider. Our job is to bring all these bodies together for different reasons, we’re the bit in the middle.

3393, CCG manager, Area 1

The key difference between Areas 1 and 2 was that, when asked about the most significant inter-organisational collaborative arrangements, interviewees in Area 1 talked about their well-established Area level initiatives. Area 2 did have some forums at the Area level but these were not presented as being of primary importance to the operation of their organisations and were less formalised.

More generally, this proliferation of multiple layers of organisation and patchwork of overlapping geographical areas of responsibility speaks to a need for multilevel governance systems which are sensitive to these complexities and which do not impose unnecessary burdens. Thus, for example, interviewees told us of instances when they were required to produce reports on outcomes or activity for different forums, including slightly different data, covering slightly different geographies and over slightly different time periods. This is time consuming and of dubious benefit to the system overall. It also suggests a need for some form of over-arching coordination of such demands, such as that which used to be provided by SHAs. It may be that NHSE can fulfil this role, but this would require regional outposts of NHSE to have authority over all of the organisations in their area.
4.4  **RQ 1 d and e: To whom do local actors feel accountable, what is the performance regime being applied, and what is its impact?**

One of the important arguments made in the White Paper which preceded the HSCA12, and in subsequent guidance documents was that commissioners in the new system would both have more autonomy and be more accountable:

> *We will give responsibility for commissioning and budgets to groups of GP practices; and providers will be freed from government control to shape their services around the needs and choices of patients. Greater autonomy will be matched by increased accountability to patients and democratic legitimacy, with a transparent regime of economic regulation and quality inspection to hold providers to account for the results they deliver.* (Department of Health 2010: para 4.1)

It is thus a focus of this study to explore how these aspirations were operationalised, and how the arrangements put in place impacted on the work that is done. Our previous research on CCGs identified clearly the complexities of the accountability regime to which CCGs were subject (Checkland, Allen et al. 2013). In particular, we highlighted the possible tensions between being accountable to NHS England and at the same time being accountable to their members, and also the other audiences who have the authority to ask CCGs to ‘provide an account’ of what they are doing, such as Monitor and Local Healthwatch. In this study we aim to look more broadly, exploring accountability across the local commissioning system. In pursuit of this aim, all those interviewed from all the different types of organisation were asked about their conceptualisation of accountability, who they felt accountable to and the currency of accountability. In addition, we explored the extent to which they claimed to feel autonomous.

‘Accountability’ is a complex concept, with many different definitions. Bovens defines accountability thus: ‘[accountability is] a relationship between an actor and a forum, in which the actor has an obligation to explain his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences’ (Bovens 2007). The aspects of performance for which an account may be required may encompass the full range from simple financial accountability for managing a budget, through to more sophisticated assessments which encompass some kind of test of quality (Leat 1988). Day and Klein (1987) make a distinction between ‘managerial accountability’, in which the criteria against which performance is to be judged are clear and decided in advance, and ‘political accountability’, by which actors are called upon to ‘give an account’ of their actions to some kind of authority, but crucially the criteria against which judgements are to be made are open to negotiation. This allows those involved to make an argument to justify what they have done. Thus, for example, politicians may be ‘held to account’ by the public for their conduct in office, and may be voted out if they do not satisfy the audience, but they are free to at least try to set the terms by which that judgement may be made, emphasising their successes and making an argument that puts their performance in a positive light. In a managerial context, by contrast, a set of performance indicators will have been agreed in advance, and the process of accountability is focused upon the extent to which these have been met.

Taking these basic concepts as a starting point, the study explored with respondents from each of the organisations involved their perceptions of their accountability relationships, and the criteria by which any judgements were made.

### 4.4.1  **CCG accountability: to whom do you feel accountable, for what?**
Amongst respondents from CCGs, we found a relatively consistent story: they believed that they were accountable to NHS England, to their member practices and to the public:

Well, it’s very clear: there’s a CCG; currently we’re accountable to NHS England, so that’s our statutory and formal accountability. That’s fine but, actually, I’m elected by the membership and they can remove me. And the board can remove me; we’re talking about the chair rule now; our constitution is very robust. And, just talking about my own role; in terms of accountability, the board can have a motion of no confidence; that’s very clear, that they can remove me. It’s also very clear that the membership can start off the process of no confidence in the chair; there’s a process for that – and then, of course, there are elections. But, personally, I feel I’m accountable to the population of [local town]. At the end of the day, whatever we do, the buck stops with me and they look to me to see whether I’ve done the things appropriately or not. And I see that happening all the time. So professionally, I think I’m accountable to the public in [local town]. That’s the way I see it.

3632 CCG manager, Area 1

So, I think, we’ve got this triumvirate of accountability. There’s, obviously, the external NHS England through our local area team. There’s the accountability to our GPs via our governing body, and then there’s the accountabilities to our local publics, and so it’s about trying to make sure that that triumvirate works well, and that’s where the tensions are if the local constituents are wanting, as ours do, a much greater shift of resources away from secondary care to primary care.

6120, CCG manager, Area 2

The accountability to NHS England was described as being relatively straightforward, embodied in regular quarterly ‘assurance’ meetings at which performance against a range of indicators was assessed. These indicators included financial performance, standards such as those set out in the NHS constitution (e.g. maximum waiting times in A&E etc.), and standards set in the ‘commissioning outcomes framework’. Interestingly, when asked what aspects of performance they felt most accountable for, CCG staff (both clinical and non-clinical) tended to focus upon financial issues, with many saying that the extent to which they were in financial balance affected the degree of scrutiny that they received:

Well, we’re definitely accountable to NHS England. We feel very accountable to NHS England because they’re all over everything especially because of our financial situation.

5732, CCG GP, Area 2

Many described the assurance regime as somewhat onerous:

We feel very performance managed, yes, and it sometimes feels that you’re so busy filling in things time and time again to prove that what you’re doing is robust that you don’t actually have any time to do anything because you’re so busy doing returns, so I do feel that is very trying. I mean, how many times can you tell people that actually yes, you have got robust governance in place and yes, just here’s the evidence, look at it and there are so many times you can tell people. So we’re definitely accountable to NHS England in that way.

5732, CCG GP, Area 2
And we’re not as refined as we should be. We’ve just created, I think, a whole industry of performance management that is around the accountability. As far as being an accountable officer, to be honest, the main accountable area is finance, delivering a balanced budget, that’s the thing that the people at the top are really interested in, is, what is your bottom line? If your bottom line’s okay, the chances are that, obviously they’re going to look at some of the other performance issues, but over and above that, it should be about outcomes, and delivering improved outcomes for your populations. How you go about it, is our job, not a centrally driven thing. Yes, they can offer some guidance and some help, but sometimes it just seems too heavy handed, in we’re having to concentrate on what appears quite often as a tick box exercise. As long as we’ve ticked those boxes, we’ll keep them off our back.

4785, CCG GP, Area 1

Others suggested that, whilst the performance regime by which they were held to account was clear, it was difficult to deliver because many of the targets involved required action by many different actors working together. This was particularly true for some of the aspects of the commissioning outcomes framework:

So we absolutely have domains of assurance that we are responsible for. Some of those things we won’t achieve on our own. So the infection control example that I used, things around CDif, MRSA rates, absolutely our accountability. We can’t deliver without the right relationship with public health. The things around A&E performance targets. The outcome measures around non-elective admission rates. We absolutely can’t deliver on our own, we’ve got to do it in conjunction with all of our provider partners.

5375, CCG manager, Area 1

Others argued that the focus on those things which are measurable – which tend to be those associated with the hospital sector – were acting to prevent them from concentrating on other approaches, such as community-based care:

And there are a number of targets or standards on the national framework which…and our performance against that is part of that discussion with NHS England. I think the...how do I put it? A lot of those it feels to me...so a lot of those are hospital based. A lot of that’s based on numbers because we have the best information about hospitals, so a lot of it’s hospital based stuff. And if our ambition is not necessarily to...well, obviously we need a strong hospital, but if our ambition’s around community based care and management of long term conditions, they don’t get much of a look in, in terms of that accountability framework if you see what I mean.

3271, CCG manager, Area 1

A metaphor which kept recurring in the interviews was that of a family. When discussing the relationship between CCGs and NHSE, respondents from both CCGs and NHSE talked about ‘adult to adult’ or ‘parent-child’ interactions.

It is, compared with how it was in the old regimes with PCTs, it’s a much more adult to adult relationship and that’s one of the things, certainly [locally], we worked on that it needed to be and that had expectations of all of us as well as...because if you behave like a child, you’re going to get treated in the same way.

3027, CCG manager, Area 1
To some extent these relationships were determined by CCGs’ performance with respect to financial balance – i.e. those CCGs with good financial performance were more likely to be treated as adults – but there were also some aspects of local relationships which had an influence. Thus, those CCGs describing longstanding relationships with known individuals from NHSE were more likely to describe themselves as being in an equal relationship. The reorganisation of NHSE which took place in 2015 removed the local tier of management, and some respondents told us that this process had made the accountability relationship more transactional and less personal:

I think now the patch is bigger, isn’t it, because it’s [merged two area teams], so I think sometimes because you’ve got a bigger patch, you’ve got a slightly different dynamic. It’s more arm’s-length, but it’s a stricter arm’s-length….I guess the further away you are, you almost have to ask more questions, don’t you, because you can’t rely on that sort of close relationship, and we do have a sort of close relationship with one of the account managers, almost, but there’s still that…we all know that our next checkpoint meeting will be difficult. So it’s going to be that side of the table and this side of the table and it’s how you try and change that dynamic a bit.
3804, CCG manager, Area 1

Being accountable to the CCGs’ member practices was described as a key difference from the NHS in the past:

I think the differences... ’cause some people say to me, aren’t you really a chief exec and I say, well no, because we’re a membership organisation. If we had no members, we wouldn’t exist, so PCTs were very different in that respect, weren’t they? They were statutory bodies covering a geographical area. If no GPs wanted to engage, then they’d still exist as a statutory body, but if all my GP practices wrote to me tomorrow and said, next year we want to join [neighbouring CCG] this organisation wouldn’t exist. So I feel very...that’s the big difference, I think, in terms of the accountability and the role these chief execs/accountable officer from PC to CCG, because there were PCTs in the old days where GPs had absolutely no confidence in them, but it didn’t change anything. You know, if mine were to have no confidence in me, my governing body could dismiss.... me, they could all want to go and join another CCG. So that leads you to a different type of behaviour, I suppose, a different view of where your accountabilities actually lie, ’cause I think you’d find very few PCT chief execs, even the good ones, who would consider themselves directly accountable to their own front line clinicians.
5998, CCG GP, Area 2

Some felt this to be a relatively strong form of accountability, with the membership having an important role and some clear sanctions:

But we’ve got some quite scary stuff in our constitution and it wouldn’t take much to get rid of a board member if you didn’t like what they’d done, you know. So we’ve got some real stuff in there for the members.
3262, CCG manager, Area 1

However, others felt that practices were yet to really understand this power:

So [the practices] comprised a clinical commissioning group. They elect a governing body of 12. And that governing body is accountable for setting and driving and delivering the strategy. We do have our annual general meeting, and theoretically we’ve got a council of members that can call us to account through the locality leads
and the GP membership. I say theoretically, it hasn’t ever exercised or wielded the stick, which may be a good thing, but at the same time, I think might just be a recognition that, you know what, actually...deep down, I’m not sure that clinical commissioning groups as membership organisations have ever really been bought into by the membership. I think they just think, do you know what, it was kind of imposed, we’re always going to have one because there was nothing left if we didn’t.

2778, CCG manager, Area 1

Accountability to the membership is political, in that the criteria by which members might judge their officers to be failing are not defined. As detailed above, governing body members may be asked to ‘give an account’ at an annual meeting with members, but none of our interviewees described a formal performance management regime by which the membership set their officers targets to meet. Across England there have been at least two instances where CCG leaders have come into conflict with their membership and have left. In both of these instances, the trigger was not a general concern about performance, but a specific decision with which the membership disagreed (https://www.liverpoolecho.co.uk/news/top-bosses-wirral-health-authority-8252002). This suggests that the political accountability to the membership that we have identified is most likely to be exercised in response to a specific conflict.

Many CCG leaders interviewed also expressed a sense of being accountable to the public:

*Then we feel a strong accountability to the [local] public for every decision we make basically. I think we feel that possibly more powerfully than anything else.*

3262, CCG manager, Area 1

This type of accountability was expressed by many in terms of being accountable for spending public money, and accountable for ensuring that high quality services were available locally. However, there were few concrete mechanisms by which such accountability could be operationalised. Some respondents argued that the fact that members of the public could attend some governing body meetings and ask questions was an important mechanism by which they could be held to account, but others disagreed, arguing that, whilst they wanted to see themselves as accountable to the public, the structures as set up did not support that:

*My naive view when we first set up is that we were accountable to our population but I don’t think that’s true. ....so one’s accountability to one’s patients should be our primary purpose but I’m not sure that the Act really supports that. There is...I do accept that as a fact that we are accountable to our local patients and I accept it probably more on a personal level because I live here, I’m a registered patient in [this area]. So in that sense in my view if I’m commissioning for service improvement I’m commissioning for myself so I feel I’ve got a stake in it. But I don’t actually feel that as a CCG we have a clear relationship with our patients, it’s quite unclear. We don’t have ....as I say [when I worked] in local government I would attend public meetings and I would do all sorts of things that enshrines and improves relationships between the accountable body and the people to whom it’s accountable. That doesn’t really happen in the NHS in the same way. So in that sense we’re accountable to our local patients in a very odd way because it’s back up to NHS England and then back down again to the local people.*

3393, CCG manager, Area 1

However, this CCG leader took a different view, pointing out that, whilst there may be few formal mechanisms for public involvement, making major service changes depended upon obtaining ‘buy in’ from a broad coalition of politicians and the public.
I think the important thing there is that’s a huge accountability because you can’t just make changes and not take the people with you. If you’re gonna make changes you must take the people with you, patient, public, politicians and so on. I think you’ve got to sell it as a quality thing if you’re improving quality.
7290, CCG GP, Area 2

Whilst these ideas could be conceptualised as an aspect of political accountability – those trying to make service changes needed to provide a convincing account to those concerned – it is debatable how far it fits within any formal definition of accountability, in that failing to convince the public would result in constraints on the ability to act, rather than any more direct sanctions. We will return to the question of autonomy and constraint in the next section.

In addition to these three clear accountability relationships, CCG staff highlighted a number of other bodies to whom they were in some way accountable. These included: Health and Wellbeing Boards; local Healthwatch; the Local Medical Committee; the General Medical Council; and even the local coroner:

Yes and I guess if...so we had a preventable future death letter from the Coroner which was based on services that we commissioned from [local] Hospital. All of that accountability comes back to me so if we fail to act upon it I would be held responsible for another future death alongside the hospital. So there’s lots of layers of accountability isn’t there, corporate manslaughter. I hold all of the accountability.
4519, CCG manager, Area 1

Accountability to HWBs was not seen by most of our interviewees as particularly strong. This CCG leader suggested that the differences between the NHS and local government were at the root of this:

I suppose in some ways we’re accountable to the Health and Wellbeing Board, but that feels more nebulous. It’s like I don’t feel that’s quite got the traction it should have, so that’s something that hasn’t worked as well as I think it could do because I think it’s such a steep learning curve for colleagues who are councillors to understand how the NHS works so this is quite difficult for the future, so we’re trying to work closely with colleagues in the Local Authority, round the Better Care Fund plans and just integrated commissioning generally. So that’s fine working with the executives in the Local Authority but because it works in such a different way in Local Authorities because of democratic accountability and because of the councillors, it feels like quite a struggle to get robust debate around the things that we need to talk about, because their meetings, council meetings are so structured and so formal and people tend not to ask challenging questions in them. So I don’t think it works as well as it could do.
5732, CCG GP, Area 2

One or two were more positive, describing elected members taking a lead role in asking CCGs to account for their actions. However, this was a minority view, and would seem to be driven by local experiences of the particular approaches taken by those involved.

The breadth of the list of potential accountability relationships speaks to another issue that came across strongly in all the interviews: the complexity of the accountability relationships to which CCGs are subject. It was clearly identified by respondents that this complexity had increased significantly
as a result of the HSCA12. This respondent felt the need to draw diagrams or show the complexity using gestures:

But everyone’s place has shifted so it’s then about finding your space and that relationship with others because obviously you had people who were PCTs and then you think, oh, [its] just the same [as] PCGs but it was fundamentally different because the accountability has changed, the governance structure of the organisation, and the governance structure of other organisations and you become accountable to different people, and really, to be accountable to 140-odd GPs is quite a different dynamic, isn’t it, than being accountable to a tier above. You’ve got that sort of...I don’t know, I can’t think of a word, you know, I’m using my hands and you can’t see that, can you? You’ll have to take a photograph of it or... It’s just a different dynamic of relationships and accountabilities so I think that was one of the big changes.

3804, CCG manager, Area 1

This NHSE manager highlighted the contrast with the pre-HSCA12 system:

Yeah. I think having been around in Strategic Health Authority (SHA) days we had a pretty good system there, because both PCTs and providers were accountable to the SHA, so we had a pretty good grip on both the commissioning and the delivery architecture. I think it is now quite fragmented. So CCGs are accountable to NHS England, which works reasonably well now. I think we’ve gone through a year of change getting used to it, but it works reasonably well now. On the other hand, providers have an accountability to Monitor or the TDA, so there is a slightly fragmented approach to life. And then the regulators come together as a tripartite TDA, Monitor, and then NHS England above that. So why we couldn’t get together almost before that and deliver regulation and accountability collaboratively I don’t know.

5823, NHSE, Area 2

Another CCG leader argued that the HSCA12 had fragmented the system such that complicated ‘workarounds’ were required to make the system work:

It is but it’s all a bit of a... It’s an irony, isn’t it, really? So having broken it all up, I think the realisation...well, in fact I’m sure the realisation at the time was it was a stupid thing to do, but it couldn’t be stopped for one reason or another, it seems, so now of course we spent the last two years trying to work out how to make the NHS work in spite of it all, and we came up with all of these weird and wonderful ways of delegating things back to a single body that can be accountable for an area. But it’s not quite as good as it was before when you had a single body accountable for things in an area, so, you know, it seems cumbersome, but we’re doing our best, I think, to get round the problems.

6010, CCG manager, Area 2

Some, however, felt that this increased complexity was not necessarily a bad thing, as it made CCGs more responsive to the real needs of the population than had been the case for PCTs:

I think the one thing which does feel different with CCGs to PCTs is that I think we do see ourselves as having more of an outward accountability than just an upward accountability. PCTs did feel like they had quite a big upward accountability and there was that very wonderfully named exercise Look Out Not Up, wasn’t there, that kind of perfectly epitomised this sense of stop doing what you’re told and start doing what matters locally. Think about your other accountabilities. And I do think CCGs have got
more of a sense of that outward accountability in relation to local government, to Overview and Scrutiny Committees, to our own GP members, to carers, you know? I think we have a much more multifaceted sense of accountability than the Primary Care Groups did, which felt at times very...accountability to government through the Secretary of State through the chairman who was a publicly elected member. It was a bit uni-directional.

6010, CCG manager, Area 2

The complexity of the system is continuing to increase, as the previous section of this report has made clear. In particular, ways of working are changing, and new networks created. Where organisations are working in new ways, there is some concern that existing accountability arrangements fail to take account of the changed reality:

I think some of those with the Better Care Fund and things like that, the national arrangements are trying to reflect some of that integrated working and those kind of accountabilities. But I think it still feels like...well, it feels like the national accountability arrangements probably haven’t caught up to some of that partnership working yet.

3271, CCG manager, Area 1

Thus, for example, Vanguards established following the Five year Forward View were collaborations between a variety of organisations, each organisation making up the Vanguard continues to be regulated and inspected separately. Furthermore, the proliferation of new collaborative arrangements discussed in the previous section resulted in additional accountabilities – for example, one interviewee involved with the local System Resilience Group for urgent care described the group as having a role in ‘holding the system to account’ for its performance in this area. The danger articulated by some was that such a proliferation resulted in a proliferation in requests for data, placing additional burdens on staff already working to capacity.

4.4.2 NHS England: holding to account and being held to account

Whilst CCG interviewees were clear about their accountability to NHSE, some of those employed by NHSE were somewhat reluctant to use this language. When we asked this manager about his/her role in holding CCGs to accounts/he tended to deflect this to use the term ‘assurance’ rather than accountability:

Okay, so CCGs are...they have probably an accountability to their member practices and the public. We... They don’t really...they’re not accountable to us, although we have the power to intervene if they’re not delivering, if that makes sense?... So although they...although I would suggest that most CCGs feel that there’s some...that there’s a line to us, you know, and that’s fair enough, but you wouldn’t...the Health and Social Care Act doesn’t say they’re accountable to us.

4251, NHSE, Area 1

In fact, the HSCA12 specifically sets out the duty of NHSE to conduct performance assessment of CCGs:

**Performance assessment of clinical commissioning groups**

(1) The Board [i.e. NHSE] must conduct a performance assessment of each clinical commissioning group in respect of each financial year.

(2) A performance assessment is an assessment of how well the clinical commissioning group has discharged its functions during that year. (HSCA12 Para 14Z16)
It is unclear why some NHSE employees should be coy about their role in holding CCGs to account. Others were happier to use the language of accountability, although suggested that this did represent something of a change from the original spirit of the reforms:

So generally... CCGs are statutory bodies in their own right and the CCG accountable officer is responsible to their governing body and, you know, that’s personalised in the form of their chair, so that’s very clear. ....but we are undoubtedly moving more towards [an accountability] relationship ..... rather than the, sort of, arrangement that was envisaged in April ’13...... in other words, we assure ourselves that CCGs are doing a good job, but I think increasingly we have a performance role with CCGs as well.

4214, NHSE, Area 2

In addition to holding CCGs to account, NHSE staff also believed themselves to be accountable. In general, NHSE staff discussed accountability in terms of a vertical hierarchy, with those at local level held to account by those above. In 2015, NHSE was reorganised, removing an organisational tier and giving over-arching responsibility to four regional teams, in theory, at least, reducing the layers within the hierarchy. A common metaphor used to describe these relationships was that of ‘marking homework’:

There is much more of a - the whole idea was not to remove a layer but previously...the example that gets talked about is that our regional colleagues were marking our homework, so we were submitting something into somebody to mark our homework before it went off nationally and that element of marking homework perhaps wasn’t the best use of a layer in the NHS which is the regional layer.

3994 NHSE Area 1

When asked who they felt accountable to, NHSE staff tended to describe their line management arrangements, with an upward accountability to the next level in the organisation. However, some CCG staff explained that NHSE was also accountable to CCGs for the commissioning that it did:

I think that it took NHS England a while to realise that they weren’t a strategic health authority and they had difficulty taking responsibility for the fact that they were doing primary care and specialist commissioning and we were trying to hold them to account for that and they always thought it should only be a one way holding to account. So it was quite...at first it was very interesting, but I think we’re now at a level where we sit round the table.

3262, CCG manager, Area 1

However, others argued that CCGs were struggling to make this a reality:

So that will be an interesting relationship because we never hold them to account for specialist commissioning. ...I’m not sure it’s as two-way, and do we ever say, right, specialist commissioning, why aren’t we getting...why is the pathway...what are you doing about it...why have you got...why are you overspending...whereas we get your performance is rubbish in obesity or in neurosciences but what are you doing about it, NHS England? That relationship, I don’t think it’s, from my perspective, it’s not a two-way relationship. We don’t hold each other to account, it still feels for me a top-down, that parental...rather than a partnership.

3804, CCG manager, Area 1
For some service areas, accountability was complicated, with responsibility divided between different organisations. Thus, for example, NHSE has a role in the oversight of public health services:

There’s a couple of people left with...as part of the region that have public health in their title. And what we tend to do is all the heads of public health for the region get together with [senior managers] from the region...we get together and we meet and we discuss things and then one of us might act on behalf of the others. And then as a region we have to provide a formal report to the public health oversight group and then...there’s a very complex, I’m waiting...they’re just redoing the terms of reference for the...I went to a meeting the other day around the national governance structures. So there’s almost some internal oversight groups and ones...the senior one of those is called the health oversight group and then outside of that there’s like tripartite board arrangements, I mean really complex, really muddy and I think it needs to be looked at. So we have to provide a formal report in to the [NHSE national] public health oversight group.

4058, NHSE, Area 1

However, these services are delivered by LAs, and NHSE has no authority to oversee their work:

we don’t have an assurance role with local authorities generally. I think that’s off the table now and again it’s a bit unclear about what the accountability in governance is going to be for those services.

4058, NHSE, Area 1

4.4.3 Local Authority accountabilities

The NHS accountability relationships described so far could be described as evolving, with new organisations working out their respective roles and responsibilities. LA commissioners, by contrast, were able to describe longstanding and well-established accountabilities:

My lines of accountability would be, obviously firmly drawn through our line management hierarchy, and technically I report through my manager to the Chief Exec, and she’s accountable to the leader of the Council.

5808, LA manager, Area 1

However, LA staff were very much aware of the political aspects of working in local government, making a distinction between their everyday managerial accountability via the organisational hierarchy, and the need to ‘give an account’ in a political sense:

So, my lines of accountability are very firmly to the Chief Exec, but to the elected members, who, at any given time, can ask me to give an account, which, for example, they have done very furiously last week, asked for information and a view on the consultation that’s just been released around the reduction in the public health grant. So they have to give an account to their elected public, the public want to know, what’s [area] Council doing about x, y and z? They ask an elected member, and an elected member asks me. And that’s how it goes. That’s the nature of working in local government.

5808, LA manager, Area 1

Both CCG staff and those working in LAs acknowledged the challenges of working across the NHS/local government boundary:
Yeah I mean I think that probably is one of the differences and at times one of the challenges between the local authority and CCG colleagues, for example that we’re a local democratic organisation where, you know as officers we’re accountable to elected politicians who obviously in turn are accountable to their constituents and our decision making processes are therefore governed by that, and are very different to the CCGs and that political dimension of the role and work of the local authority, I think at times is not that understanding within health organisations for example, when it almost becomes instinctive when you work within a local authority that that’s something that you’re constantly sort of sense checking.

6119, LA manager, Area 1

So, there’s a real drive from the political leaders of councils that they want to be in charge and be accountable for the health and social care budgets, but actually I don’t think they understand what they’re taking on, and the levels of accountabilities that are associated with that. And there are really quite low levels of understanding, I think, about how health systems run and what statutory responsibilities we have for our population, that the people that are having and leading these discussions don’t necessarily understand.

5375, CCG manager, Area 1

Whilst such issues have always arisen as NHS and LA commissioners have worked together, the new distribution of commissioning responsibilities discussed above (with LAs responsible for services which previously fell under the NHS and which intersect with NHS-provided services) made them more acute. For example, the provision of sexual health services may be complicated if politicians have socially conservative views about these issues.

Those with experience in both types of organisation reflected thoughtfully on the differences in cultures, arguing that personal relationship, joint programmes of work and shared responsibilities (such as delivering savings under the BCF) were all important in bridging the ‘gap’. One experienced manager also argued that GPs and elected councillors both occupied public-facing roles, and that this could be a useful starting point for developing relationships:

So, there’s a sense that, you know, a local councillor will be a significant part of the ward that they represent, is understood that, you know, they live there and they’re never likely to leave there. So, there’s a realism to the accountability that sits there…… Actually, it feels very similar to a GP role….So, we’ve got lots of GPs, considerable leaders in the CCGs, but, actually, are considerably recognisable to councillors and the population in individual wards because they’ll have given 30 years of a career to a very specific place. 4487, NHSE, Area 1

The value of individuals knowing a local place and having a history there arose in many contexts in the interviews, and will be returned to later in the Discussion.

4.4.4 Commissioning Support Unit Accountabilities

CSUs were created to provide commissioning support services over a larger area than CCGs (Petsoulas, Allen et al. 2014). CCGs contract with their local CSU for a package of services, which may range from back office functions such as HR or payment processing, to contract negotiation and management. We found considerable variation in how these relationships and contracts work in practice. In some cases CSU staff may spend much of their time working for a particular CCG, and
may be ‘embedded’ to the extent that they have desk space in a CCG building; in others, CCGs may simply contract for a service which will be delivered by whichever staff the CSU has available. In the following interview extract, a CSU manager described the experience of working in an embedded way with the CCG:

On the CSU side, which is obviously my employer, I'm accountable to the Service Director, and she's the Service Director for [this] CCG, but she's also the Service Director lead for contracting and procurement as well. So I'm lucky, I've got the same person that looks after my CCG and also my professional side as well, it just happens to be the same person. From a day to day operational point of view, this is my own view, I wouldn't say I'm accountable to but I work very closely with the head of contracting and finance for the CCG and we just work together all the time. I sometimes refer to her as my, in inverted commas, boss. I also work very closely with the Chief Finance Officer as well. Again I consider him as much of a boss as anybody else as well, because I'm here all the time, and at the end of the day there's this demarcation between what I can do as a CSU member and what I have to do with the permission and the authority of the CCG, because I have to be aware that I don't have a lot of authority to sign off money to make agreements and that type of thing. I have to do it in consultation with the CCG.

In the 2010 White Paper (Department of Health 2010), it was suggested that commissioning support organisations would fairly rapidly become standalone organisations, and that a market in such services would develop (Petsoulas, Allen et al. 2014). However, in practice this proved difficult to realise, and CSUs are to be ‘hosted’ by NHSE until April 2016. They are encouraged to see themselves as ‘businesses’, developing a portfolio of services for clients, but at present they remain formally part of NHSE and remain bound by NHSE processes and accountable to NHSE:

so NHS England, the business development unit, in a sense they...you know, we are accountable to them, our managing director...you know, we operate. And I think it’s fair to say it’s one of our major constraints, yeah, because we have to...we can’t move as quickly as we want to because any kind of major decision that we want to make as a business has to be signed off and authorised by NHS England. [7831 CSU]

4.4.5 Discussion

We have described a complicated and changing environment of accountability. In many ways, the issues raised here mirror those raised in the previous section: multiple organisations, with overlapping roles and footprints, working hard to understand their new responsibilities. CCGs, in particular, were required to ‘give an account’ to an increasing number of organisations and forums, and are trying to reconcile the demands of a hard-edged managerial accountability to NHSE with a strong desire to be responsive to the local public and to their members. Their approach to these sometimes conflicting demands continued to develop throughout our data collection period. The relationship between CCGs and their LA colleagues was also developing. Whilst health and social care commissioners have worked together for many years, the transfer of the public health function to LAs, and the development of HWBs has brought NHS staff into closer contact with local elected politicians than ever before, with associated issues of both culture and process. The creation of new bodies such as System Resilience Groups has generated further complexity, with many respondents noting the problem of an increasing volume of requests for CCGs to ‘provide an account’ of what they are doing. Mapping and rationalising such requests would be a useful service.
We found a commonality of concern between those working in each of the different organisations. Reassuringly, these public sector employees demonstrated a keen sense that they are and should be held accountable for the public money that they spend, and wrestle with how best to be responsive to the public that they serve. However, few were able to demonstrate any concrete mechanisms by which this local accountability was being realised. They also described a confused and complicated landscape, in which the complexity that we identified generated additional work. The reorganisation of NHSE, which removed from the scene managers with a specifically local focus, was seen by many as a potential issue, as navigating this complexity required there to be someone with an overview of system accountability who could support CCGs and LA commissioners by adjudicating between competing demands. For example, as set out in Box 2 above, disputes about who was responsible for commissioning Tier 3 obesity services were, in the absence of a local adjudicator, referred to an NHSE task Force. However, the findings of the Task Force (that LAs should commission such services) had no statutory force.

The role of NHSE as both a commissioner and as a system regulator, overseeing CCG performance whilst itself carrying statutory responsibility for some forms of commissioning was described as a further complication, with CCGs keen to start to hold NHSE to account for its performance as a commissioner. Changes in the system meant that NHSE had handed over responsibility for primary care commissioning and for some aspects of specialised commission to CCGs. However, NHSE retained statutory responsibility for these areas of activity, raising questions as to which organisation was ultimately accountable for primary care commissioning and to whom.

4.5 **RQ 1c: To what extent do the local actors feel autonomous?**

The term autonomy can be used in a number of different ways. In this report we use it as defined in the Cambridge online dictionary ([http://dictionary.cambridge.org/dictionary/english/autonomy](http://dictionary.cambridge.org/dictionary/english/autonomy)):

> the right of an organization, country, or region to be independent and govern itself:
> or: the ability to make your own decisions without being controlled by anyone else

One of the key pillars of the Act was to give greater autonomy to front line clinicians as demonstrated in the 2010 White Paper, *Equity and Excellence: Liberating the NHS*:

> The Government’s reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level (Department of Health, 2010, #4: para 6.0)

CCGs in general did feel themselves to have some autonomy:

> Generally speaking, they’ve allowed us to develop our own priorities and areas of work to focus on, if you like, and then they’ve assured that [we are doing it] in the way I described. It felt very different in the last government because it would nearly always be a top down sort of thing.  
> 2623, CCG manager, Area 1

> I think we are reasonably autonomous to do things that actually as an organisation we want to do, we are accountable for delivery of the Constitution and areas like that.  
> 7830, CCG GP, Area 2
The CCGs felt they had autonomy primarily because of their position as statutory bodies, which give them a sense of legitimacy and the right to choose their own priorities and make decisions:

I think we’re more autonomous now. ...I guess for a lot of us it was a morphing from the role we had into something else but you just step up a bit and the relationships were different because you’ve got a different relationship with NHS England because that structure changed...so it’s not just how you feel as an organisation, it’s how you feel within, I don’t know, a planet of other change and all sorts of constellations and you’ve got a new organisation, NHS England...then you’ve got the different dynamic of the Local Authorities, and I think there was something about almost we’re now legitimate. There’s that legitimacy in terms of an organisation and that’s what we’ve tried really hard to work at in terms of we’ve all had to step up and look out and develop, and it’s about having a different level of relationship, I think.
3804, CCG manager, Area 1

However, there are a number of factors that constrained this autonomy. Firstly, the CCGs were required to be performing well with a particular emphasis on good financial performance. If they were not performing well, then their room for manoeuvre became very constrained:

Last week we were [autonomous], there’s national concerns about activity levels, we were asked to increase our activity levels that we planned to deliver, even though it goes against our financial plan. So we said, this goes against our financial plan, which do you want us to do, do you want more activity or to balance the books? We have a lot of authority and a lot of autonomy because we are a statutory body, but we are working within the confines of the system, and that sets parameters to us, and sometimes they’re rigid.
3666, CCG manager, Area 1

So we’re in the exceptional class in terms of the degree to which NHS England are monitoring us, so we just have a monthly call, I do the call with one of my colleagues, with NHS England and it’s a fairly light touch at the moment. Clearly if any of these parameters don’t continue to be performing in the same way then that could change and you move onto a heavier performance management.
8959, CCG manager, Area 2

This autonomy also existed within an over-arching framework. This framework consisted of the myriad of things the CCGs must demonstrate that they were doing. This ‘must do’ list included: meeting external targets (e.g. 95% target on 4-hour wait at the A&E, improving prescribing and looking at cancer pathways), addressing national priorities and an increasing framework of issues they had to report on to other people such as performance reports and data returns.

We have commissioning diktats put down to us, so the operational plan tells us what they expect us to commission or give us a long list of things that they have prioritised for us. I think our flexibility is very limited because we get performance managed on the performance of our local hospital rather than our performance on the things that are the most important to us. So making a decision about Healthier Together, if that was one of the things that we’ve done, we’re not performance managed on that. We’re performance managed on, did the hospital achieve a 95 per cent target on A&E?
4519, CCG manager, Area 1

It’s a strange old world. In name and in statute we’re an autonomous organisation. On a day-to-day basis it quite often doesn’t feel that way. We have very strong steers,
particularly from our local team of NHS England. We are constantly given returns to do, data returns, this information, that information. Usually with a 24-hour return if you’re lucky and never in the format that you usually produce your information.

7679, CCG manager, Area 2

This framework started off flexible and permissive, but became increasingly constraining over time, as monitoring requirements tightened and central demands increased.

I think we did [have autonomy], I don’t think we do anymore, not really. Our observation is that the central bureaucracy, and they’re pushing us to be bureaucratic, is really gearing up. We’re expecting some very big central direction in the commissioning guidance that will come out sometime before the end of January, or maybe Christmas. The End of Year Planning Guide, and although… and as I say, for the first two years, they were just hopeless actually, I think they are, very soon, I think they will have decided what models they want and we will be directed to go on and do it. And whether you like it or not, whether you think it’s a good idea or not.

7412, CCG GP, Area 2

This fits with findings from our previous study (Checkland, Coleman et al. 2012). One of the things which acts to increase the constraints which make up the framework is external political pressure, which is itself cyclical.

…if you’d asked me this 18-months ago, I might have been giving you a different answer, there are certain periods in the political cycle when there is more command and control from the centre and you’re probably speaking to me at the peak of that time. It’s more adult to adult relationship and less command and control, but there are periods where it moves.

3027, CCG manager, Area 1

I think just to reflect, we started with the issue of clinical autonomy, clinical leadership, that was the promise, the ability to transform the system, not to get bogged down in some of the bureaucracies of the past and a freedom to behave or act slightly differently to the history, I think. Yes, we inherited some good stuff, we inherited some bad stuff and I guess most CCGs are in a similar position and I’d be relatively sanguine and pragmatic about all of that, that’s life, that’s what we inherited. It wasn’t necessarily what we were promised but then I guess most of us who’d been in this a few years guessed that we weren’t going to get what we were promised anyway because we were dealing with politicians. So it became heavily political, and I think probably the biggest problem was actually the lack of autonomy, because what we were promised was quite high level autonomy to get on and deliver this but actually NHS England came in with a very clunky old-fashioned dictatorial style and started trying to control the whole system down and lock it down.

6165, CCG manager, Area 2

Some people told us that they saw the picture positively, i.e. they understand the contexts and the framework and can make it work for them by doing what they have to do but also pursuing the things they want to do. They appear to have a clear understanding of the wider NHS context.

I’ve always felt pretty autonomous anyway, certainly since being in a director’s role, because I’ve been in a director’s role for 10 years now and I’ve always felt a good amount of autonomy to execute whatever I needed to do without too much interference by somebody else saying, you can’t do that, because I think the NHS has got a pretty well
established authority system. So, you’ve got a licence to do your role and there’s a framework in which to do it and if you stick within that framework, you’ve got the autonomy to do whatever you want to do within that framework. I’m sure you’ll talk to other people and they’ll say, no, I think it’s far too regulated and authoritarian and every time I want to move I’ve got to ask for somebody’s permission, but I don’t feel that, because I plan very carefully, so I’ll take a long time to think about… or a reasonable time to think about the strategies and then operational tactics to deliver those strategies and it’s all within a framework. So, if you keep within the framework, you’ve got a lot of authority and autonomy to make your decisions.

4446, CCG manager, Area 1

...the attitude that the CCG has taken has been a positive one actually towards organisations like NHS England and the Department generally and so on, just to work with people, not to, sort of, create...put up the barriers and say, you know, this is our territory, keep off, you know, quite the reverse actually. What we’ve done, I think [CCG leaders] are very good at it actually, is saying, you know, we’ve all got out jobs to do, let’s work with you, with NHS England, whether it’s area team or a bigger grouping or whatever, because they do have a genuine role to play.

6775, CCG manager, Area 2

Others said that that wasn’t the case, and the ‘must do’ things acted to crowd out the things that they want to do, reducing their autonomy.

Well, obviously we’re very...you know, it’s the National Health Service and you’ve got to deliver on NHS mandate, NHS constitutional things. So, that balance between the sort of national priorities and the local ones is always a real issue. There are some key targets, but if you look at the planning guidance, by the time you’ve worked through all the things that you need to do, your ability to invest in locally identified schemes and those sorts of things is really, really limited actually; really limited.

3665, CCG manager, Area 1

Over the last couple of years, the process has moved much more into CCGs, essentially, assuring that its providers are delivering to its contract. So, the role has crowded out, I think, the opportunity for clinicians to develop new services to start very much from local needs. It has become much more about a whole system challenge around money, around hitting targets, and CCGs really have lost quite a lot of their autonomy, and we’ve all been moved along this.

6120, CCG manager, Area 2

One area in which CCGs seem to lack autonomy is in their inability to refuse to do things. New responsibilities such as membership of local System Resilience Groups, or assuming responsibility for primary care commissioning have arisen and they have had to comply and take part. Such new responsibilities have not been accompanied by any additional management resources, and so CCGs have been stretched. This has fed into a further constraint – the fact that there are increasing numbers of bodies who have a ‘finger in the pie’ and require some sort of account from the CCG as to what they are doing. As we have discussed, CCGs operate across overlapping footprints and in crowded landscapes. These include people who can potentially raise objections, for example, HWBs, Local Authority Scrutiny Committees – and those who have over-arching local plans with which CCGs must comply (System Resilience Groups).
Yeah, it’s reducing, yeah [autonomy]. I think a lot of the guidance, perhaps leading up to future policy changes, it’s requiring a lot more sign off through the Health and Wellbeing Boards, so, you know, in some instances a lot of scrutiny from NHS England and in some cases there’s a requirement of sign off through the Health and Wellbeing Board.

3392, CCG manager, Area 1

In addition, the regulatory landscape is more complex than it was, with Monitor, the former TDA and Care Quality Commission (CQC) all having a potential right to intervene in CCG decision-making. Respondents offered a number of examples of disputes which had arisen, with both NHSE and Monitor or the TDA having a role in arbitration. Other research has shown that the lack of clarity governing the rules by which such interventions might occur has acted as a constraint, in that CCGs are sometimes unclear as to what they are allowed to do (Allen and Osipovic in press).

A further constraint is in the fact that more and more of the work that CCGs do is in partnership with others – this is a ‘soft’ constraint, but it means that they have to engage with lots of people in order to achieve what they want to achieve.

We do have autonomy. But, I think we demonstrated that with [local health and social care initiative]. But what we haven’t done is, we haven’t done most things that we are doing is in partnership with the Council. So, even though we’re putting all the investment in for [new initiative], it’s a health and social care package.

9240, CCG manager, Area 1

Finally, CCGs experience what might be called local contextual constraints on their autonomy. These relate to the characteristics of the CCG, such as size, its footprint in relation to other CCGs and in relation to providers – are they perceived to be important and to have power/influence, and do they perceive themselves to have it? This may be an issue, for example, where CCGs are particularly small in relation to their neighbours. In one of our study areas, a CCG which is average in size when compared with the rest of country has a much larger CCG as a neighbour. As a result it perceives itself to be ‘small’ and its staff commented that it was relatively lacking in influence with providers compared to its neighbour. In another example, a CCG told us that it felt it lacked autonomy to act in regard to a particular provider because its patients made up a small proportion of the total treated by the local Trust.

Overall, therefore, CCGs clearly identified their status as a statutory body as supporting them to be autonomous. This status was felt to give them legitimacy within the local health and social care economy. However, they also describe a progressive erosion of that autonomy, and we have identified a number of different types of constraint upon them. The final picture is variable between CCGs, as they have different local contexts and different approaches, but in general we found that their ‘space’ to manoeuvre was being gradually limited by a combination of external pressures and local realities.

4.6 Conclusions
This chapter presents results from Work Stream 1, addressing research question 1. Using CCGs as an orientation point, we have highlighted how commissioning organisations in the two Areas have been dealing with their responsibilities and systemic complexities, working together and interacting, and how they perceive issues of autonomy and accountability. This final section will bring these findings together, highlighting commonalities and emerging issues between the different study sites.

Firstly, our respondents generally were clear as to the magnitude of the changes which they had experienced: ‘not just moving deck chairs, but moving beaches as well’ [3666, CCG manager, Area 1],
as one respondent told us. One aspect of the HSCA12 which seems to have been important in generating this sense of significant change is the extent to which responsibility for different service areas has been distributed in new ways. The HSCA12 not only changed organisational boundaries but also split responsibilities in significantly different ways. This was identified in advance as an important issue, and our data confirm its significance. The vignettes that we have presented highlight the issues arising, with common problems including: perverse incentives; confusion across organisational boundaries with difficulty in defining where ultimate responsibility for an issue lies; and the loss of the ability of individual organisations to invest to save across an entire service pathway. Mitigating factors included: the existence of coherent geographies with long-established ways of working together; pre-existing collaborative programmes of work; pre-established personal relationships with other people that had worked in the area over an extended period; and managerial capacity to do the work required to bring different organisations together.

One of the key tenets of the HSCA12 was to establish CCGs as the new statutory bodies responsible for commissioning hospital and community services. Our CCG respondents affirmed the importance of their status as statutory bodies, describing this as giving them legitimacy to make change happen. This new sense of responsibility acted to enthuse a cadre of clinical leaders and their managerial colleagues, who expressed a place-based commitment to serve their local public. Many had been active in the local health economy in the past, but argued that the establishment of CCGs as statutory bodies offered new opportunities for local clinicians to shape local services. However, this narrative of autonomy and opportunity was tempered by a sense of gradually increasing constraint, with national ‘must dos’, the imposition of new organisational layers and an increasingly bureaucratic performance regime cited as issues.

The complexity of the new landscape and the developing overlapping accountability regimes leads to a third significant issue. The HSCA12 removed SHAs. These had previously acted across a geographical area, having a role in overseeing both commissioners and providers. The loss of this geographically-situated strategic oversight was visible in the issues raised in our vignettes, and in the complex accountability regimes described, with respondents lamenting the lack of a framework within which disputes about where particular responsibilities lie and competing accountability requirements could be adjudicated. A number of respondents told us that they hoped that NHSE would be able to perform this role, but that the recent reorganisation into four high-level regional teams had not yet seen significant improvement in its operation. The difficulty that those we spoke to had in naming the local NHSE organisation may seem trivial, but may also be important, as an organisation which cannot be named is likely to struggle to develop a meaningful identity. The associated reduction in NHSE personnel may also be an issue.

We also found a system in a state of ongoing flux and change. The HSCA12 came into force in 2012, and since then there have been a significant number of new initiatives, programmes and shifts in emphasis and responsibilities, against a background of fiscal challenge. These have included: the reorganisation of NHSE and reduction in its management capacity; the introduction of the Better Care Fund; the Five Year Forward View, heralding Vanguards and new integration projects; the introduction of System Resilience Groups and Urgent Care Networks; the development of GP Federations; and the redistribution of commissioning responsibilities, with both primary care commissioning and aspects of specialised services transferred to CCGs. All of the organisations that we have been studying have therefore not only had to deliver their statutory responsibilities, but also engage with an array of neighbouring organisations to respond to these new initiatives. Many of these initiatives are underpinned by a growing consensus around the need for what is being called a ‘place-based approach’ to commissioning, with a move away from competition and greater emphasis on co-operation (Hammond, Lorne et al. 2017). Many of those we have interviewed so far would agree with this as a desirable goal. However, our explication of the multiple over-lapping
footprints upon which commissioning organisations must collaborate to tackle different issues draws attention to the complexities inherent in this approach. The publication by Monitor of guidelines for defining a ‘local health economy’ (Monitor 2015) acknowledges this complexity. Working out the best level at which to plan for different services is complicated, and managers and clinicians involved discussed the flexibility required to navigate the developing landscape. Personal relationships, experienced managers who know their local NHS landscape, and strategic oversight at an appropriate geographical level were all highlighted as important by those we interviewed. Developing relationships at all levels with LAs are of increasing importance, with the particular challenge associated with cultural differences between local politicians and those in the NHS more used to a hierarchical system acknowledged by many. The role of HWBs was generally regarded as being potentially important, but as yet unrealised, with many expressing disappointment at the failure of HWBs to take a strategic oversight role.

As these new developments occur, it is clear that there is no appetite nationally for further legislative change. Respondents therefore described to us what were often called ‘workarounds’, by which statutory responsibilities might be shared or co-operative working enabled. Such workarounds are again facilitated by trust between those involved, built upon local histories of co-operation and shared programmes of work. The danger that some highlighted is in the layers of additional complexity that may ensue, with lack of clarity over who is responsible for what. The need for appropriate managerial support, both within CCGs and in NHSE, arose repeatedly in interviews. The reduction of managerial capacity within NHSE was highlighted as problematic, and for the same reason CCGs expressed some concern about their ability to continue to respond to multiple new initiatives.

Managers and clinicians involved in CCGs told us that they value their close working relationships, with managerial expertise nicely complemented by the clinical knowledge brought by GPs and other clinicians. The evidence about the operation of CSUs was mixed. No market in commissioning support services has developed, but some CCGs told us that they had developed excellent relationships with their local CSUs, valuing the opportunity to act more quickly to buy in appropriate support as required rather than being committed to employing staff. Others expressed concerns, with a particular dislike of the requirement for CSUs to generate an operating surplus, a requirement which some felt was inappropriate in a publicly-funded system. Some have developed a model whereby CSU staff are embedded in local CCGs. This approach may raise issues of accountability, and relies on good personal relationships. Overall, managerial support for commissioning remains an important and not fully resolved issue.

This chapter focuses upon the viewpoint of commissioners. This is deliberate, as it is intended to explore the impact on the work of commissioners of the increased complexity associated with the HSCA12. The issues arising out of these complexities for providers are addressed in the following chapter, in which we use our ‘tracer’ conditions to explore how the changes to the commissioning system played out in practice in different types of services, and the contexts and mechanisms underpinning the outcomes achieved.
5 Chapter 5: The conduct of commissioning

5.1 Introduction

In this chapter we address our second set of research questions, which focus on the conduct of commissioning, set out in box 9 below.

Box 9: Research question 2

2) Conduct of commissioning:

   a) What were the drivers for the service changes being made?
   b) What is the effect of the division of commissioning responsibilities in new ways between new organisations on commissioning processes?
   c) How are commissioners responding to the need to ensure better integration of services?
   d) How is external commissioning support being used, and what is the impact of this?
   e) What is the effect of ‘commissioning for outcomes’ on the commissioning process?
   f) How far is the new system enabling/inhibiting service change and development?
   d) To whom do they feel accountable?
   e) What is the performance regime being applied, and what is its impact?

To address these questions, this chapter focuses primarily on Work stream 2 (Nov 2015—Mar 2017), which comprises forty interviews and 10 hours of meetings observation, but also incorporates data and analysis from Work streams 1 (Jan-Dec 2015) and 4 (Feb-Dec 2017). For Work stream 2, in order to better understand the operation of the post-HSCA12 commissioning system, we undertook a detailed exploration of commissioning and contracting processes over time across five service areas:

- Sexual health
- Screening
- Specialised
- Orthopaedics
- Dementia.

These ‘tracer’ areas were selected with the expectation that they would illuminate different aspects of the new system. We investigated and compared the commissioning of tracers in Area 1 and Area 2, and also considered broader geographical levels (i.e. regional and national) where this was specifically appropriate to a particular tracer. Many of the 78 Work Stream 1 interviews also contained data of relevance to the tracers. We have produced a report for each tracer, included in full in Appendix 3 (p184).

In this chapter, we utilise a similar approach to that employed in chapter 2 (p20) (Policy analysis and programme theory) in keeping with our orientation towards a realist evaluation approach (Pawson 2013). For each tracer, we discuss whether there was an identifiable policy programme theory, and, where helpful, we have presented these theories in context, mechanism, and outcome (CMO)
configurations. We then focus on the actual implications of changes to commissioning the tracer in Areas 1 and 2 using CMO configurations. Outcomes describe aspects of the observed policy enactment in Area 1 or 2; mechanisms describe aspects of the context triggered to realise that outcome.

The rest of the chapter is divided into three sections. First, in ‘Tracer area realist evaluation’, we outline the tracer findings from Work stream 2 and use CMO configurations, which are particularly relevant to addressing research question 2) a), b), c) and f). The tracer reports (Appendices A-E) provide additional context and detail. Second, in ‘Commissioning integration, support, and outcomes’, we incorporate findings from Work streams 1 and 4, which are particularly relevant to addressing research question 2) d). Thirdly, in the Discussion we summarise and explore the preceding findings and explicitly highlight how each of the research questions has been addressed. During the study, the concept of ‘commissioning for outcomes’ was not explicitly referenced in regard to the conduct of commissioning. We therefore do not address RQ2e here, but return to the concept of commissioning for outcomes in the next chapter.

5.2 Tracer area realistic evaluation

5.2.1 Sexual health – programme theory
We found no identifiable programme theory for the specific shift of sexual health commissioning responsibility to LAs, but the explicit policy objective for the more general move of public health commissioning to local government was “[t]o realise administrative cost savings, and achieve greater alignment with local government responsibilities for local health and wellbeing” (Department of Health 2010 p47). Connected to this objective was a suggestion that LAs, responsible for public health, each led by a Director of Public Health overseeing a specialist team, would be more attuned to the needs of their local populations, more able to influence a broader range of factors affecting the health of those populations, and more democratically accountable. The change was accompanied with a promise from government of a ‘ring fenced’ public health budget (Department of Health 2012). This broad theory, detailed further, can be articulated in a CMO configuration as follows:

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>(Anticipated) Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Movement of public health commissioning responsibility to LAs</td>
<td>1. Ring fenced public health budget within LAs</td>
<td>Better join up with LA local health and wellbeing responsibilities and make administrative cost savings</td>
</tr>
<tr>
<td>2. Appointment of DsPH, employed by LAs but required to work closely with CCGs</td>
<td>2. Ensure high quality public health input into the NHS</td>
<td></td>
</tr>
<tr>
<td>3. Creation of Health and Wellbeing Boards</td>
<td>3. Greater joint-working between LAs and CCGs to take into account wider ranging local interventions to support health and wellbeing across the life course</td>
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5.2.2 Sexual health – Area 1

Area 1 had a sexual health forum which pre-dated the HSCA12. Prior to the HSCA12 it was attended by public health professionals/commissioners based in PCTs and post-HSCA12 LA employed public health professionals/commissioners attended, alongside their colleagues from providers of sexual health services. The forum had been working for some time to develop a common tariff so that the sexual health service offer across the whole of Area 1 was consistent. Because sexual health service services are open access and available to patients in England irrespective of where they live, a recharging mechanism has been employed so that when a patient accesses a service in an area other than where they live the provider (or commissioner) of that service can then invoice the commissioner where that patient resides to recoup the costs of their treatment. Post-HSCA12, concerns were raised in the forum that pre-existing arrangements for recharging between NHS organisations were no longer applicable. The forum recognised this as a potential problem because without a robust mechanism for recharging there would be a systemic incentive for LAs within the area to provide a less comprehensive service so that patients would go elsewhere, thus shifting the costs of treatment inequitably between LAs. The forum consequently agreed a recharging process for the Area. The following CMO configuration describes this:

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sexual health commissioning moved to local authorities...</td>
<td>• Sexual health forum recognised potential problem of race to the bottom in service provision because SH services open access (one LA could decide to pay for poor service so patients go elsewhere) – agreed a recharging mechanism for SH services across LA boundaries, and a common service specification</td>
<td>• Recharging mechanism was agreed and implemented and uncertainty about whether bills for treatment sent to other LAs in the Area was avoided</td>
</tr>
<tr>
<td>• Services remain open access: patients free to access services wherever they wish, irrespective of commissioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• LAs experiencing significant budget cuts creating strong incentive to reduce activity and make savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Most sexual health providers on block contracts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No legal minimum level of service</td>
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<td></td>
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Interviewees from the Area 1 forum described how their pre-HSCA12 progress towards developing a common sexual health service specification had been delayed by the disruption associated with the reorganisation established by the HSCA12, but suggested that the existence of the forum have allowed them to make continued progress towards their aims in spite of it effects.
5.2.3 Sexual health – Area 2

Area 2 had no similar inter-organisational sexual health forum. Interviewees recognised the same concerns around recharging but did not have any mechanisms place to ensure that invoices were paid.

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| • Sexual health commissioning moved to local authorities...  
• Services remain open access: patients still free to access services wherever they wish, irrespective of commissioner | • NHS cross charging arrangements no longer legally apply between local authorities, and no formal arrangements to respect or replace these were made in Area 2 – LAs sent invoices to other LAs in the Area for sexual health services accessed by their residents | • Uncertainty over whether invoices sent to other LAs for sexual health services used by their residents would be paid |

Where Area 1 experienced the HSCA12 as an unhelpful and constraining force, commissioners in Area 2 felt that it, and the constricted financial circumstances LAs were dealing with, provided an opportunity to change an ‘ossified’ set of sexual health services where there previously had not been sufficient impetus or opportunity to do so. They perceived the consequence of this to be a more ‘holistic’ and improved sexual health service that was better able to cater to the needs of patients.

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| • Sexual health commissioning moved to local authorities...  
• Perception of an ‘ossified’ set of sexual health services split between powerful providers with little institutional incentive for change in Area 2 | • LA commissioners perceived change in commissioning responsibility as an opportunity to change sexual health service offer and retender the sexual health service | • A more ‘holistic’ sexual health service commissioned within Area 2 |
5.2.4 Sexual health – summary
The sexual health tracer was chosen because it was a service area that became significantly more operationally complex as a consequence of the HSCA12 with commissioning responsibilities in the new system amongst CCGs, LAs, and NHSE. We anticipated that we would explore, in particular, the management of overlapping responsibilities between organisations and the dynamics of joint working. We found notable differences between Areas 1 and 2 in terms of the pre-HSCA12 sexual health commissioning landscape, and this had particular implications for the arrangements that developed following its enactment. Area 1’s pre-existing sexual health forum provided a mechanism for mitigating some of the complexities and challenges created as a consequence of the Act, such as recharging between LAs, but also experienced the reforms as a constraint to their ambitions for more developed joint commissioning across the Area. Various interviewees reported that Area 2’s pre-HSCA12 sexual health commissioning arrangements were not ideal but also ‘ossified.’ The HSCA12, and the broader environment of austerity, provided the opportunity and impetus to tender a more ambitious, ‘holistic’ service that was broadly considered to be preferable to previous arrangements. The lack of an overarching forum for joint working, however, meant that Area 2 commissioners were more exposed to potential problematic consequence of the HSCA12, such as budgetary uncertainty due to ambiguous cross-charging arrangements.

5.2.5 Screening – programme theory
There were two main implications for screening arising from the HSCA12: the creation of PHE to bring together a range of public health professionals and specialists from more than 70 organisations into a single public health service and host the National Screening Committee, which sets out national screening service specifications; and the allocation of commissioning responsibility over national programmes away from PCTs to NHSE via its regional teams, with LA public health teams taking responsibility for ensuring that adequate screening and immunisation plans are in place within their areas and to challenge NHSE if this is not the case. There is no identifiable programme theory for these changes to screening programme commissioning, however, it is notable that in contrast to the valorisation of localism associated with the creation of CCGs, screening commissioning (like specialised services commissioning) became more centralised as a consequence of the HSCA12.

As another public health service change, the programme theory CMO configuration presented in ‘Sexual health – programme theory’ above should be considered relevant here.

5.2.6 Screening – National
As a result of the HSCA12’s changes, screening, more so than other tracers, is particularly relevant to consider at the national level. Consequently, we conducted a number of interviews with commissioners and others at regional and national levels for this tracer, which are reported here, and the other issues identified were of relevance to both Areas 1 and 2 and have thus been incorporated into a single section below. Some interviewees involved in PHE at a national level reported that the reorganisation of screening commissioning resulting from the HSCA12 had been positive because it meant that PHE’s National Screening Committee now only dealt with a small number of individuals corresponding to the sub-regional NHSE Screening and Immunisation teams...
rather than 152 screening leads in each of the PCTs. This had improved communication between national and more local levels and also made it easier for good local practice to be incorporated into national guidance.

Multiple national level interviewees raised concerns about NHSE’s accountability in the new system, arguing that it was effectively assuring itself for its performance as the commissioner of national screening programmes.

One national level PHE interviewee highlighted how much more complex the system had become with a plethora of organisations involved in some way in screening service commissioning and delivery, either directly or indirectly because screening services are connected to other services commissioned and provided by others. There is a current lack of an effective system leader with the power to compel relevant organisations to behave in a particular way. This is problematic but for making use of established relationships with individuals in order to negotiate responses to issues, allocate responsibility, and present a coherent message to the public: “…we do use all those personal relationships shamelessly in order to get round the system where you don’t have any...you don’t really have any power to make anybody do anything.” [19974, National level, Mar 2017]. This following CMO articulates this:

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
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<tbody>
<tr>
<td>• Changes to screening commissioning responsibilities resulted in a perceived lack of system leadership and ambiguity over organisational accountability</td>
<td>• Importance of established relationships with individuals working in other organisations to negotiate responses to issues, allocate responsibility, and present a coherent message to the public</td>
<td>• Pre-existing inter-organisational arrangements and operational forums facilitated collaborative work to mitigate some of the fragmentation and leadership deficit within the system</td>
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5.2.7 Screening – Area 1 & 2
For CCG interviews in both Areas, there was considerable variety in terms of how much screening was considered to be an issue for CCG involvement. Where some were financially incentivising GP practices to increase screening uptake, others did not recognise it as something to which they should devote specific attention.

As part of the reforms, NHSE’s regional teams took over responsibility for commissioning national screening programmes but PHE employees were ‘embedded’ within their sub-regional Screening and Immunisation teams in order “…to provide accountability and leadership for the commissioning of the programmes and to provide system leadership” (NHS England and Public Health England 2013, p.7). We interviewed NHSE and PHE employees at the two sub-regional levels which encompassed Areas 1 and 2 and found some consistent issues, which are described in the following CMOs.

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PHE employees embedded in NHSE screening an immunisation teams</td>
<td>• National Framework and Operating Model not sufficiently detailed to be of practical value locally</td>
<td>• Significant local variation in relative roles and relationships between NHSE and PHE employees</td>
</tr>
</tbody>
</table>
Framework and Local Operating Model sketched out the roles and responsibilities of NHSE and PHE in terms of screening.

so local NHSE screening and immunisations teams devised their own arrangements.

In addition, embedded PHE employees reported information governance processes as a problem. Because PHE, as an executive agency of the Department of Health, is part of the Civil Service it has different information governance policies and ‘gateways’ than NHSE, an executive non-departmental body of the Department of Health whose staff are not part of the Civil Service. This has necessitated local strategies and workarounds to deal with the issue but a national solution to the issue had not been devised at the time of data collection.

A number of challenges were created by the size of the footprints that the Screening and Immunisations teams were covering, which were notably larger than the PHE-employed public health professionals were used to dealing with pre-HSCA12. PHE employees reported that this created practical difficulties which hamstrung efforts to exert influence over local providers because of sheer numbers. Some noted that just dealing with assurance requests from local Directors of Public Health was hugely time consuming:

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
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<tbody>
<tr>
<td>• Directors of public health in LAs have a statutory health protection role</td>
<td>• DPHs seek assurance from NHSE on the suitability and quality of local screening programmes</td>
<td>• Responding to the volume of these requests challenging for the NHSE screening and immunisations team</td>
</tr>
<tr>
<td>• NHSE Screening and Immunisations teams cover large geographical patches containing many LAs</td>
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5.2.8 Screening – summary

Screening was selected as a tracer because it represented a significant set of responsibilities for NHSE, which were to be discharged through an interface with PHE both nationally and at more local levels. It thus offered potential for insights into commissioning activities across geographical scales. We found that the reformed system was perceived as advantageous to some working at the national level but also involved a complex distribution of responsibilities between organisations that some public health professionals found confused. Some of those in CCGs were uncertain about which organisation was responsible for screening commissioning two years after the HSCA12’s implementation. The fragmentation of commissioning responsibilities, within and beyond screening, had implications for the ability of commissioners to exercise influence over providers due to the distribution of organisational ‘levers’, and established personal relationships proved important in working around the lack of hierarchy. The arrangements whereby PHE employees were embedded in NHSE Screening and Immunisation teams created a number of issues in both Areas, including: uncertainties around accountabilities; localised variation in joint working practices due to vague national guidance; practical challenges of working in large geographical ‘patches’ containing numerous organisations; information governance incompatibilities; and identity dissonance and confusion.
5.2.9 Specialised services – programme theory

The specialised commissioning programme theory was that a centralised commissioning approach, orchestrated by NHSE, would enhance equity for patients through increased standardisation of care and reduced geographical variability in service provision. NHSE’s Operating Model for Specialist Services Commissioning (NHS Commissioning Board, 2012) explicitly differentiated between commissioning (establishing priorities and strategy), which was to be done at a national level, and contracting (relationship management), which was to be done at a local level (initially through the Area Teams; now through the NHSE regional teams and hubs). The Operating Model thus aimed to facilitate a standardised and equitable approach to specialised services commissioning through centralised oversight, whilst retaining sensitivity to local contexts.

This theory can be articulated in a CMO configuration as follows:

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>(Anticipated) Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Specialised commissioning is a ‘post-code lottery’ and inequitable for patients</td>
<td>• NHSE take responsibility for specialised and adopts a national commissioning approach</td>
<td>• Patients with rare conditions will have access to the same level of care irrespective of where they happen to live</td>
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</table>

5.2.10 Specialised – Area 1

An Area 1 service provider interviewee reported that she had become aware of a problem relating to musculoskeletal referrals in one CCG area after auditing several months of them. She found that many of the referrals by GPs were to specialised services when this was unnecessary as the patients could have been treated in the local community service. She stated: “there’s no incentive on GPs or health visitors to do the right referral, they just do the referral and the problem is solved. There is an incentive at [Area 1 hospital Trust] to flood themselves, because they get the specialist tariff for every patient they see and there isn’t the same incentive on the CCG to manage it, because the budget is paid by NHS England who don’t know what’s going on.” [12580, Area 1, provider, May 2016]. This highlights how Trusts have an economic incentive for providing specialised rather than non-specialised services, since NHSE pays Trusts on a specialised tariff based on the referral practices of GPs who are disconnected from the economic consequences of the type of referral that they make.

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>• GPs and health visitors are gatekeepers to MSK services</td>
<td>• GPs and health visitors sometimes refer to specialised services when patients could be treated in the community at lower cost</td>
<td>• An unnecessarily high volume of specialised activity, at greater cost to the NHS, is undertaken on more expensive specialised tariffs. Trusts welcome the additional from this; GPs are disconnected from the financial consequences of the referrals because NHSE pays for it, and NHSE has no</td>
</tr>
</tbody>
</table>
5.2.11 Specialised – Area 2

In Area 2, an interviewee reported a specific problem relating to Child and Adolescent Mental Health Services (CAMHS). Non-specialised tier 1-3 CAMHS services (community and outpatient) are commissioned locally by CCGs to meet the needs of the local population, but specialised tier 4 services (inpatient) are commissioned at a national level by NHSE. This separation of local and national commissioning created problems for local commissioners, as described in the CMO configuration below.

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| • Specialised commissioning is a ‘postcode lottery’ and inequitable for patients  
• NHSE take responsibility for specialised and adopts a national commissioning approach | • NHSE utilises Area 2’s capacity of CAMHS Tier 4 beds to accommodate patients from outside Area 2 | • Local commissioners report a consequential capacity shortage. They report a loss of control over local resources and the creation of ‘fragmented care pathways’ |

In 2015, NHSE underwent a reorganisation in order to realise administrative cost savings. This involved the absorption of Area Teams into regional levels. The consequence of these changes proved difficult for some of those working in specialised commissioning in Area 2.

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| • NHSE is forced to reorganise in 2015, 18 months after its creation, in order to reduce running costs | • Specialised commissioning is reorganised – teams now cover a significantly broader geographical footprint, working with many more providers and traveling greater distances | • NHSE specialised team with Area 2 responsibility perceived established relationships with providers and local knowledge were now less relevant and their autonomy diminished  
• Provider Trust perceived that NHSE’s decision-making had become centralised, more remote, and it was largely unsuccessful acting as a strategic mediator for the system |

At the same time, ‘collaborative commissioning’ was launched as an attempt to overcome some of the tensions between the local commissioning of CCGs and the national, specialised commissioning
of NHSE. This initiative involved CCGs and NHSE working together in Specialised Collaborative Commissioning Oversight Groups in order to design and develop commissioning pathways to mitigate issues of fragmentation. An Area 2 CCG interviewee questioned to what extent this what actually being realised in practice and highlighted a number of substantive issues, including: lack of pooled budgets; powerful incentives for NHSE and CCGs to protect their own budgets; and little capacity for CCGs to engage with collaborative processes around specialised services that might offer only marginal benefits to their local population [7160, Area 2, CCG, Oct 2015].

5.2.12 Specialised – summary
Specialised commissioning arrangements were altered significantly as a consequence of the HSCA12. NHS England’s adoption of responsibility and a nationalised commissioning approach in an attempt to reduce an inequitable ‘post code lottery’ in service availability by standardising the offer for patients made this a particularly important tracer area to consider. We found that the new, evolving, arrangements were associated with various complex inter-organisational issues. In Area 1, concerns about inappropriate specialised referrals were highlighted. Incentives, penalties, and accountability arrangements between organisations and health professionals were not sufficiently co-ordinated so as to be able to provide a systemic push towards preventing inflated specialised referrals. In Area 2, which is home to particularly high concentration of specialised providers, NHSE’s national commissioning approach and activities were perceived as disconnected from the activities of local commissioners and responsible for fragmenting care pathways.

Specialised commissioning has clearly been challenging for NHSE, and it has struggled to keep control over its budget. NHSE’s reorganisation in 2015 was driven by an attempt to reduce management costs, and the introduction of co-commissioning can be understood as an attempt to better connect NHSE’s national commissioning approach with the activities of local commissioners. However, CCG interviewees highlighted a number of issues militating against fully committed participation in such arrangements, and NHSE specialised commissioners reported experiencing difficulties with the new, more regional, commissioning model which involved a shift from commissioning as a relationship-based activity to a more management-orientated role over a broader, less intimately familiar, geographical area. Furthermore, Area 2 interviewees reported experiencing NHSE as more remote and not sufficiently fulfilling the co-ordination and system leadership role that was required.

5.2.13 Orthopaedics – programme theory
There was no explicit programme theory identifiable for the changes to the commissioning of orthopaedics, which was a straightforward handover of responsibility from PCTs to CCGs. Of relevance, however, is the overarching programme theory of the HSCA12 and the assumed value associated with GP-led commissioning (see Chapter 2 p20). GP-led CCGs would be more efficient and effective commissioners than PCTs because of their enhanced clinical leadership, with clinicians assumed to have a greater understanding of population needs (Checkland, Coleman et al. 2014).

5.2.14 Orthopaedics – Area 1 & 2
In both Areas plans to create MSK pathways were at various stages of development. The CMO below reflects the expressed outcomes of those that were already operational and the intended outcomes of those under development.

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning</td>
<td>Commission MSK pathways or referral</td>
<td>Control provider activity</td>
</tr>
<tr>
<td>budgets within</td>
<td></td>
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</tbody>
</table>
5.2.15 Orthopaedics – Area 1

One CCG in Area 1 reported challenges associated with the behaviour of a large provider Trust within its ‘patch.’ The Trust significantly increased its capacity for orthopaedic activity and also reportedly ran events where local GPs were invited and encouraged to refer patients for orthopaedic procedures. The CCG’s contract with the Trust was based on ‘Payment by Results’, which meant that payments to the Trust align with the volume of activity it undertakes, and as a consequence the CCG spent significantly more than forecast on orthopaedic activity and overspent its budget.

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>• Orthopaedic activity is attractive to providers as a source of income because of Payment by Results contracts (i.e. higher volume = more payment)</td>
<td>• Provider Trust in Area 1 CCG’s ‘patch’ significantly increases capacity for orthopaedic activity and encourages GPs to refer</td>
<td>• CCG sees a significant increase in orthopaedic activity, and associated bills, from the Trust and overspends budget</td>
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</tbody>
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5.2.16 Orthopaedics – Area 2

In Area 2, attempts by a CCG to save money by retendering an orthopaedic contract was not well received by the local Trust undertaking the majority of orthopaedic activity and an arbitration process was initiated by the Trust.

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<tr>
<th>Context</th>
<th>Mechanisms</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>• Commissioning budgets within the system are constrained – CCGs are trying to do more with less resource</td>
<td>• Area 2 CCG retenders orthopaedic contract</td>
<td>• Major provider Trust expresses unhappiness about this – initiates an arbitration process</td>
</tr>
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</table>

5.2.17 Orthopaedics – summary

Of all the tracers, orthopaedics experienced the least amount of change as a consequence of the HSCA12 – with a seemingly straightforward handover of commissioning responsibility for short, discrete episodes of care from PCTs to CCGs – and this is why it was selected. Given the policy programme theory which emphasised the value of clinical leadership and expertise that would be introduced into commissioning by CCGs, we were interested to explore whether this was noticeable in regard to orthopaedics and whether orthopaedic commissioning might be adapted to, for example, focus more on prevention or patient experience. We found that commissioners in both Areas were at various stages of implementing MSK pathways, or ‘honest broker’, models to better control orthopaedic activity, which was seen as potentially costly due to the discrete, low-risk nature
of most orthopaedic surgical procedures, and their attractiveness to providers given the prevalence of Payment by Results contracts. Many of these, however, were being developed by PCTs prior to the HSCA12 and continued under the CCGs, and there was little evidence of a marked change in approach as a consequence of greater clinical involvement. In Areas 1 and 2 we heard examples of how commissioning budgets were pressured, both in general and as a result of the activities of provider organisations attempting to generate under income through Payment by Results contracts, and how this created strain in the relations between commissioners and providers which had to be carefully managed.

5.2.18 Dementia – programme theory
Following the HSCA12, responsibility for commissioning dementia care is distributed between CCGs and LAs. There was no specific programme theory for changes to dementia commissioning in the HSCA12 and related documents. A number of policy initiatives aimed at, or facilitating, integration of dementia services orchestration and delivery pre-date the HSCA12. The National Dementia Strategy (Department of Health 2009) (and subsequent, related policies) explicitly aimed to increase rates of diagnosis, improve knowledge and reduce stigma associated with the condition, in addition to improving dementia related training for a people in a host of roles that involve working directly and indirectly with people with dementia, and their families, in health and social care. Of particular significance is Section 75 of the NHS Act 2006, which allowed for partnership agreements and budget pooling between LAs and NHS organisations. The Better Care Fund (BCF), introduced in 2013, made use of this with the intention of focusing on the health and wellbeing of local people and shifting care away from acute settings to the community. This is particularly relevant for dementia as the responsibility for commissioning relevant services straddles health and social care boundaries.

One of the responsibilities of the 151 HWBs, created as part of the HSCA12 and hosted by LAs to provide local strategic oversight of health care, social care, and public health, was to produce a BCF plan for sign off by NHSE. The broad programme theory underpinning HWBs was that their creation would improve LA and CCG joint-working and foster wider ranging local health and wellbeing interventions, including those aimed at dementia. Enhanced integrated working of this kind was presented as a desirable means of realising administrative cost savings, improving care quality, and reducing the burden on acute services. A number of other initiatives aimed at integrating commissioning and provision have been developed since the HSCA12, including: new models of care; Sustainability and Transformation Partnerships; and, most recently, Accountability Care Organisations/Systems.

5.2.19 Dementia – Area 1 & 2
This tracer elicited responses from interviewees which were common across both Areas, and these are discussed here before Area specific findings below. Interviewees pondered, and presented different perspectives on, the merits of pursuing increased diagnosis rates given the nature of dementia as a condition and the limited options for treatment.

A variety of opinions on Health and Wellbeing boards were offered from CCG and LA interviewees in both Areas. Some interviewees, as much as two years after their implementation, seemed uncertain about their purpose and sceptical about their merit. No-one suggested that the boards were of any notable significance in the commissioning or integration of dementia services. Interviewees highlighted Section 75 budget pooling and the BCF as more relevant initiatives for joint dementia commissioning and integrated care. Various CCGs and LAs reported undertaking joint work under the BCF and some interviewees reported that it had helped to strengthen relationships between the organisations. However, some cast doubt on its value and suggested it was a “cash shunting process” [19313, LA, Area 2, Feb 2017] involving “smoke and mirrors” [18967, CCG, Area 1, Jan 2017] for the benefit of appearances more than substance.
An interviewee from a national dementia focussed third sector organisation reported attempts made by the organisation to appeal directly to GPs in the services it offered. However, interviewees from CCGs and LAs in both Areas reported some challenges in working with the sector and suggested that there was some reluctance towards meaningful partnership working.

The development of STP plans, and their relationship to dementia services, were issues identified during data collection in both Areas. Interviewees highlighted a range of concerns including the potential incompatibility of local integration plans and STP integration plans, and the uncertain presence of dementia as a priority within an STP plan, which was contingent on the involvement of a specific individual with a particular interest. As post-HSCA12 policy developments, these are not focused on here. Further detail can be found on the dementia tracer report in Appendix 3 (p184).

5.2.20 Dementia – Area 1
Within Area 1 there were at least two established arrangements for dementia service integration. One was a joint dementia steering group, which included one CCG and its corresponding LA, and predated the HSCA12, but interviewees reported some problems with its operation which are highlighted in the CMO below.

The other was an integrated commissioning team between an LA and CCG with staff jointly appointed between the two organisations, working on service contracts held by either the CCG or LA, and working to a single governance structure agreed by the two organisations. The BCF made up only a part of the total pooled financial resource. For a CCG interviewee, the BCF had been a time consuming distraction within the overall project which was more ambitious in scope. The extent of budget pooling could perhaps have been more ambitious but for being tempered by commissioners concerns that the public might perceive the arrangements as risky.
5.2.21 Dementia – Area 2

Two different localities in Area 2 reported particular tensions between the CCGs and LAs involved in BCF arrangements. In one locality, those in the CCG were reportedly unhappy because they felt that they had contributed a lot financially yet “not seen an awful lot for it”, and this friction with the LA was in danger of undermining joint commissioning arrangements more generally [19314a, CCG & LA, Area 2, Feb 2017]. In the other, a CCG interviewee suggested that some elected members of the LA had political misgivings about the reorganisations of the NHS as a result of the HSCA12 and this was a factor in creating a sense of “unease” between LA and CCG, despite the CCG contributing to the LA’s social care budget [6010, CCG, Area 2, Aug 2015].

5.2.22 Dementia – summary

This tracer was selected because dementia appeared to be a condition that straddled a boundary of commissioning responsibility between CCGs and LAs, and thus provided a logical focus for an exploration of integrated service development and joint commissioning. We found that HWBss, a key feature of the HSCA12, were recognised as being of little significance to this endeavour. The BCF and Section 75 arrangements were of greater salience, although interviewees from both Areas expressed frustration at the fact that the BCF was presented as new resource, when in fact it represented resource transfer from health to social care. Area 1, which had a more established history of joint working than Area 2, had at least two pre-HSCA12 mechanisms for joint dementia commissioning and service integration. For one, budgetary pressures, particularly those experienced by the LA, contributed to a sense of distrust between the CCG and LA which was hindering effective collaboration. For the other, servicing their BCF requirements was perceived as a distraction to their more ambitious integration aims. Two Area 2 localities reported friction in the BCF collaboration between CCG and LAs relating to financial contributions and organisational legitimacy.

5.3 Commissioning support

In this section, findings from Work streams 1 and 4 are considered in order to provide additional data relevant to addressing RQ2d): how is external commissioning support being used, and what is the impact of this?

Commissioning Support Units (CSUs) were established by the HSCA12 and formally launched in April 2013. Envisaged as commercial organisations, but bound by NHS financial regulations (including the need to make a 5% annual surplus), CSUs were to provide a broad range of services which CCGs were expected to procure. It was intended that, over time, these organisations would lead the development of a ‘market’ in commissioning support services. Many people that took up posts in CSUs had previously worked in PCTs. Twenty-three CSUs were accredited in 2013 but this number was reduced significantly through mergers. In 2014, NHSE introduced a process whereby CSUs were required to apply to become accredited onto a Lead Provider Framework. The results of this process were announced in February 2015. Two CSUs were unsuccessful, meaning that they would be ‘wound down’, reducing the number to seven overall. A number of private firms were also added to the Framework. CSUs are currently hosted by NHSE but there is still an aspiration that they will become autonomous third sector bodies at some point in the future.

There was a significant difference between Areas 1 and 2 in terms of how their respective CSUs fared, and the dynamics between CSU and CCGs. The CSU covering Area 1 was struggling to attract sufficient business whereas the CSUs covering Area 2 was more successful. The high level of Area wide inter-organisational collaboration between commissioners that predated the HSCA12 in Area 1 facilitated the ability of CCGs to plan the in-house, and shared, provision of services that might have
otherwise been provided by the CSU. This meant that the CSU began life facing an uphill battle to acquire adequate business from CCGs in the Area. A CCG manager explained this:

[A group of Area 1 CCGs] would have been a third of the size of the CSU’s catchment population. We retained a shared service between ourselves and established that we wanted to do that quite quickly. So the CSU in [Area 1] [struggled]. It isn’t very effective or efficient. I think they have focused on the wrong things. They tried to do everything and they failed to deliver quite significantly. So that’s sort of in a bit of a failure regime at the moment but it doesn’t impact on the [group of Area 1 CCGs] significantly because we never really bought into it. [4519, Area 1, CCG manager, Jun 2015]

A greater number of CCGs in Area 2 bought in a greater proportion of their initial services from their local CSU than was the case in Area 1. A CCG manager in Area 2 explained that they understood that they were somewhat obligated to do so:

If we could have had more in house at the time, we probably would have done, we were slightly misinformed by the [PCT] cluster as to what would happen for authorisation, so lots of people did everything in house, we weren’t aware of that. [6814, Area 2, CCG manager, Sep 2015]

In Area 1 another CCG reported resisting pressure against hosting more services in house rather than buying them from the CSU and doing it anyway:

And when we were forming, we were all asked, as [Area 1], well in fact we weren’t asked, we were told, basically you have to put your...this is part of the structure. And then we got this directive that said, you can decide for yourselves what services you want to buy. ...I felt that I would be vulnerable if we bought our services in, so we resisted. We said, we will buy only those services that we think it makes sense to...
... So basically, now that’s one of the few times that I came under immense personal pressure, to say, well you won’t get through your authorisation if you don’t find the bulk of your services from the CSU. In not as many words, but it was, you will struggle to convince the panels. [3666, Area 1, CCG manager, May 2015]

The majority of CCG GP and manager interviewees from both Areas had similar opinions about the CSU model in general.

I think the CSU was largely a waste of space to be quite frank, in a sense that I think the model of the CSU is actually flawed and I don’t quite know how long it’s going to take to get...there’s a couple of things actually, the first one is that the business model of CSUs, they’re trying to provide a customer service to us, but they still don’t really know what customer service is and I’m not sure we, as CCGs, know what it means to be a customer either to be quite honest. [7160, Area 1, CCG manager, Oct 2015]

This impression was shared by a CSU manager from Area 1 who felt that the CSU struggled to resolve a tension between operating in a commercial manner while being constrained by NHS governance and regulations as well as being staffed primarily by people that had spent most of their career working in NHS organisations.

Absolutely, everybody was NHS pretty much through and through, so not used to that sort of business, knowing your market, getting your unique selling points and all that. ...I think you either had NHS people like me trying to get their heads around all of that, I’m not the
most obvious commercial person in the world. Then you have people coming in from the commercial backgrounds, non NHS really struggling with the system. ... The CCGs [don’t] like all the commercial bit, so when we talk about profit or customers or all those kinds of quite commercial words, if you like. They find it really uncomfortable, because they’re obviously quite cross that we have to make a 5 per cent surplus, so everything we charge them has a 5 per cent surplus. [7541, Area 1, CSU manager, Oct 2015]

There were also practical issues associated with trying to establish a market in commissioning support simultaneously with a fundamental reorganisation of commissioning organisations. An Area 1 CCG manager noted that CCGs were encouraged by NHSE to be employment ‘light’ and buy in services from the CSU. He found, however, in the early post-authorisation period, that the CSU could not offer the services that the CCG needed which interfered with the organisation’s development and prompted them to hastily produce and develop plans to take on more staff to provide some of these services in house [3950, Area 1, CCG manager, May 2015].

Several CCGs in Area 2 had arrangements with CSU staff embedded in their teams and working in the same office as CCG employed staff:

Everything we can outsource to CSU, we’ve outsourced it to them, so most of the staff you see here don’t work for us, they work for the CSU. ...So in terms of that business model, in terms of being wholly outsourced, about being flexible, lean and adaptive as a result of that, is working and therefore for me, it’s a good relationship between me and the senior people in the CSU. ...One of my big issues with them is, you know, come on, you need to be quicker, more adaptable or flexible, bringing in new skills for the 21st century, more quickly... I think, sometimes I feel they’re a bit still old style NHS bureaucracy, whereas we’re the ones that have actually loosened ourselves up a bit, because we’ve been able to. [5998, Area 2, CCG GP, Aug 2015]

The above extract from a CCG GP leader is notable because this CCG had availed itself of CSU services more than any other in either Area. Whilst the arrangement was perceived as successful, he still expressed some frustrations that the CSU was not sufficiently responsive. Furthermore, he suggests that this was indicative of the CSU being constrained by a legacy, or enduring mind-set, of NHS bureaucracy.

Approximately two years later, the CCG changed to a different CSU to supply the majority of its services. Staff that were employed by the CSU and embedded in the CCG found that their employer became a different CSU but the nature of their day job continued remarkably unchanged:

I think we just got a letter back saying, you do this particular post. From such and such a day you will continue doing that particular post, same terms and conditions. However, your employer will be...and then we had to sign a letter or something. And that was it. [22324, Area 2, CSU staff embedded in CCG, May 2017]

5.4 Discussion

The data presented in this section, primarily from Work stream 2 interviews and conveyed using CMO configurations, address our second set of research questions, which focus on the conduct of commissioning. We will now consider these questions in turn and summarise the data most relevant to addressing them.
a) What were the drivers for the service changes being made?

Interviews and observations provided a window onto a range of service changes at various stages of planning, tendering, and (re)organisation. We focus particularly on the findings from our sexual health tracer to address this question.

The retendering of sexual health services in Area 2 was a particularly notable service change. There was recognition amongst LA and sexual health provider interviewees that the pre-Act status quo of service provision in the Area did not meet a desirable level of efficiency or coordination. It had emerged as a consequence of an iterative evolution of contracts and arrangements over time. The result of this was a system that was described as ‘ossified’, with respondents suggesting that a range of dispersed actors had an interesting in maintaining the system, and that there was a lack of sufficiently concentrated will and authority to unpick the complexity of the established arrangements. When LAs took responsibility for sexual health commissioning, some LAs retendered for a new service in Area 2 which, from the perspective of commissioners, dramatically modernised the service offered to patients and rationalised the system of provision. Interviewees were clear that the driver for the change was the decreasing public health resource available to local government and the need to maintain or improve services. The financial constraints that sexual health commissioners were working with meant that continuing to fund the same system of provision in Area 2 was not feasible. However, alongside this, the HSCA12 and the re-allocation of responsibility for public health from NHS to LAs was perceived by some as an opportunity to ‘unstick’ the system of sexual health provision in Area 2 and utilise the skills of local government to run a successful, publicly inclusive tendering process.

Public health commissioners in Area 1, working through their pre-existing sexual health Association, had embarked on an initiative to establish an integrated sexual health service before the HSCA12 came into effect. This process involved first developing a common tariff and service offer agreed by commissioners across the Area. Interviewees reported that the HSCA12, and the shift in commissioning responsibility from NHS to LAs, had been an unhelpful distraction that had arrested the Association’s development of their plans, but they also perceived the need for it to be ever more pressing given that LA public health budgets were constrained and likely to be further reduced in the future. The Association also recognised that, as a consequence of the HSCA12, it would be necessary to agree a mechanism for genitourinary service cross-charging (i.e. for bills to be sent between LAs, and subsequently paid, for residents using open access sexual health services in an area other than where they live) as pre-HSCA12 this was handled via an NHS-wide Payment by Results mechanism. The Association agreed that existing genitourinary recharging arrangements would continue and agreed a local tariff for CASH (Contraception And Sexual Health services). The express intention of this was to simplify the process of cross-charging and avoid the possibility of a ‘race to the bottom’ whereby any incentives for LAs within the Area to reduce some of the services that they offered so that patients would use services provided by other LAs would be nullified.

Through our orthopaedics tracer we discovered that in both Areas plans to institute MSK pathways or ‘honest broker’ models were at various stages of development and implementation. The aim of these was to better control orthopaedic activity by providing a means of triaging referrals to specialised orthopaedic services and/or providing orthopaedic clinics outside hospital settings. The driving force behind these initiatives was a need for commissioners to manage constrained budgets by exerting more control over provider activity, which was simply billable according to volume as a result of Payment by Results contracts. While the genesis of many of these initiatives pre-dated the HSCA12 itself, commissioners were increasingly motivated to pursue them as a result of the financial challenges that they were attempting to address.
Thus, we found that the main drivers for significant service changes were financial, with constrained resources creating an imperative to find ways to sustain services in a more complex, challenging environment. Notably, given that one of the central programme theories of the HSCA12 was that commissioning and health care services would be enhanced by the increased involvement of clinicians in commissioning, we did not find any clear examples in any of our tracers of changes in services brought about by greater clinical involvement in CCGs.

Our realist orientation allowed us to further explore the changes we found. Whilst financial constraints formed a common backdrop in both areas, the exact contextual conditions were different. Thus, Area 2 had a specific set of circumstances, which meant that the changes associated with the HSCA12 created an opportunity to ‘unstick’ the sexual health system. In contrast in Area 1, which had a high degree of pre-HSCA12 collaborative activity between those involved in sexual health service commissioning and orchestration, the HSCA12 was seen as a disruptive force that constrained progress in developing greater consistency in the sexual health service offered across the Area. A key driver for working towards this objective was perceived as the challenges associated with offering adequate services within the context of austerity and constrained budgets. However, Area 1’s pre-established collaborative commissioning arrangements facilitated the development of a cross-charging mechanism intended to reduce uncertainty for LAs over reimbursement for services provided and protect the composition of the services offered across the whole Area.

Thus, the impact of the significant changes associated with the HSCA12 varied depending on the exact local context. As we have shown in our example, the Act both disrupted and facilitated service developments, depending upon the pre-existing state of relations between local organisations. Existing well-functioning collaborative arrangements were disrupted in an unhelpful way, whilst ossified and dysfunctional services were helpfully ‘un-frozen’. This variation points to the difficulties in ascertaining the impacts of such complex policy changes, and highlights the importance of local context.

b) What is the effect of the division of commissioning responsibilities in new ways between new organisations on commissioning processes?

Two issues from the study of our tracers are particularly illuminating in considering the consequences of the division of commissioning responsibilities in the post-HSCA12 system.

One significant issue was identified through our specialised services tracer where not only was allocation of responsibility changed but the basis on which commissioning was conducted was also altered. Pre-HSCA12, PCTs had held responsibility for commissioning these services for their local populations but worked collaboratively with each other to provide for broader populations and pool financial risk. Post-HSCA12, NHSE took over responsibility but rather than commissioning for local populations NHSE adopted an approach of commissioning for the national population with the express intention of reducing variability in the services available to patients. This meant contracting specialised service providers for all of the relevant services that they provided, regardless of where patients lived, rather than seeing each specialised provider as having a geographical ‘catchment area’. This meant that specialised providers had an incentive to increase their overall activity levels, particularly by accepting patients who would previously have been deemed to be ‘out of area’. Simultaneously, the basis on which services were classified as specialised or not was changed, resulting in an increase in the number of specialised services overall and thus further altering the division of commissioning responsibilities between specialised commissioner (i.e. NHSE) and non-specialised commissioners (i.e. CCGs).

The implications of this were articulated by interviewees in Area 2 and the problems relating to the commissioning of CAMHS. Where it is the responsibility of CCGs in Area 2 to ensure tier 1-3 CAMHS (community and outpatient) were provided for their resident populations, NHSE is responsible for the specialised tier 4 services (inpatient) services for all patients nationally. The practical
consequence of this arrangement was that the number of tier 4 patients treated who came from outside the Area increased which reduced bed capacity overall and created difficulties for non-specialised commissioners to fulfil their responsibilities to local residents. Interviewees referred to this as resulting from a ‘fracturing of a pathway of care’ created by this new division of commissioning responsibility. Multiple interviewees, from NHSE as well as providers and CCGs, expressed dissatisfaction with the perceived mismatch between non-specialised commissioning for local populations and specialised commissioning of services for the population of the country as a whole.

Another issue of particular relevance is cervical screening commissioning, which crossed the boundaries of our sexual health and screening tracers, and proved to be a source of confusion and contestation post-HSCA12. In summary, before the HSCA12 both cervical screening (smear tests) and sexual health services were commissioned by PCTs. GP practices provided smears but patients could generally also go to sexual health clinics for them. Post-HSCA12, NHSE became responsible for cervical screening and LAs for sexual health services. In both Areas, we found LAs re-commissioning sexual health services in the context of highly constrained budgets and commonly excluding routine cervical smears from the services provided. This led to protracted disagreements between NHSE and LAs. Some NHSE interviewees argued that the public health budgets afforded to LAs were set on the basis of cervical screening that was previously being conducted by PCT-commissioned sexual health services and therefore this included ‘disaggregated’ funds for smears. In addition, it was argued that it was impractical for NHSE to directly commission the multitude of local sexual health services provided by LAs to also provide smears. Some LA commissioner interviewees argued that they simply could not afford to include routine cervical screening in their new contracts nor justify such an inclusion in the context of LA governance processes. These practical challenges of funding and provision were accompanied by significant confusion amongst interviewees from a broad range of organisations over where commissioning responsibility lay in the system. Concerns were raised by some interviewees that the consequence of this fragmentation would be a reduction in cervical screening uptake with potentially adverse population health outcomes. We explore this issue further in Chapter 6 (p 121).

In summary, we found that the HSCA12 fragmented commissioning responsibilities in a way that was generally unhelpful. Where previously a single organisation, the PCT, had overarching responsibility for the care of a geographical population, now different organisations have responsibilities established in statute and this presents a number of issues. The difficulties in specialised commissioning experienced in Area 2 in relation to CAMHS are also notable because of the significance of the concept of a care ‘pathway’ to interviewees. Individuals frequently require a range of health and care services across organisations that resist conceptualisation as a linear process. The artificiality of the pathway construct is perhaps rendered more problematic in the post-HSCA12 system where commissioning responsibilities have been subjected to such revision and dislocation (Checkland et al, in preparation)

c) How are commissioners responding to the need to ensure better integration of services?

The dementia tracer was selected specifically to address this question. We hypothesised that because of the nature of dementia itself, and the logical need to join together health and social care services to provide dementia care and support, that the tracer would likely illuminate commissioning activities relating to service integration. We found that the most common integration mechanisms identified, and made use of by commissioners across health and local government in both Areas, were Section 75 budget pooling and the Better Care Fund (BCF). However, these were relatively modest in scope. Commissioners had mixed opinions about the BCF – some suggested the substance of the policy was less noteworthy than how it had been presented, but others pointed to some benefits from the BCF in facilitating service integration and relationship improvements between CCGs and LAs. While every BCF plan is required to be signed off by the relevant Health and
Wellbeing Board (HWB), we found that, beyond this, HWBs held little relevance to interviewees as a forum for integrated commissioning in either Area. One of the most pressing issues for dementia commissioning overall was a lack of social care funding, and this put strain on some of the relationships between NHS and local government commissioners. In one case in Area 1, CCG commissioners engaged in a local joint dementia steering group reported a growing distrust of the LA because the LA had disinvested in relevant services at short notice and expected the CCG to pay in more to address the consequences. In Area 2, one CCG commissioner expressed unhappiness at the limited amount of progress made in terms of service provision through the BCF given the extent of funding that the CCG had provided.

Over the course of this study, the idea of service integration has become progressively more prominent in policy rhetoric and found form in a range of initiatives announced by NHSE, including: Better Care Fund, Integrated Care Pioneers, New Care Models, Sustainability and Transformation Partnerships, and Accountable Care Organisations/Systems. Although the study was not designed to specifically address such new post-HSCA12 developments, we have touched on some of these in the dementia tracer section above. Overall we observed that attempts to integrate have been limited by the fragmentation of statutory responsibilities introduced by the HSCA12.

d) How is external commissioning support being used, and what is the impact of this?

As the ‘Commissioning support’ section above illustrates, there were broad differences between Areas 1 and 2 in terms of how commissioning support was utilised. In Area 1 commissioners had a stronger history of joint working which allowed them to resist what they perceived as pressure to avail themselves of a range of CSU services in the early days of the HSCA12’s enactment. Instead they made arrangements to pool resource and undertake these services in collaboration with other commissioner organisations. This had a detrimental effect on the development of the local CSU and ran counter to the expectations of NHS England. The engagement of Area 2’s CCG’s with CSUs was more varied, with some contracting a large number of services and embedding CSU staff within CCGs’ headquarters. In both Areas, the attempt to create commercial service providing organisations, largely staffed by individuals that had been employed in PCTs and inured to NHS working practices, to immediately begin offering services to CCGs created problems. Some interviewees talked about this in terms of a constraining legacy, or enduring mind-set, of NHS bureaucracy, which was identified as an issue even for those CCGs that were relatively enthusiastic adopters of the CSU provision model.

e) What is the effect of ‘commissioning for outcomes’ on the commissioning process?

Commissioning for outcomes was a prominent feature of HSCA12 programme. As noted above, however, the concept of ‘commissioning for outcomes’ was not explicitly referenced in regard to the conduct of commissioning. We therefore do not address RQ2e here, but return to the concept of commissioning for outcomes in the next chapter.

f) How far is the new system enabling/inhibiting service change and development?

When considering our findings overall, we see that the fragmentation of commissioning responsibility, the statutory basis of some of the new arrangements, and the extent of associated disruption to the health care system at large as a consequence of the HSCA12 has acted to make service change and development more difficult. However, we have shown how, in some local contexts, where particular conditions were present, the disruption and change associated with the HSCA12 has acted to support innovation and development. The realist evaluation approach, and the process of developing the CMO triads above, has proved valuable in allowing us to identify and highlight aspects of contexts that have acted to mediate the consequence of the HSCA12 in some way.

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6 Chapter 6: The impact of commissioning

6.1 Introduction
In this chapter we address our third set of research questions. We do this by bringing together evidence from both quantitative and qualitative research. From the qualitative work, we combine evidence from WS 1 & 2 with evidence from a second round of interviews with the interviewees from WS 1 (see methods chapter p35 for full description). In these interviews we asked respondents to tell us what they felt their organisation had achieved, and to reflect upon the impact of the changes brought about by the HSCA12. We provide a full description of the quantitative exploration of outcomes in section 6.5 on p134 below. The questions addressed are set out in Box 10 below:

Box 10: Research question 3

3) Quality & outcomes:
   a) What claims to ‘success’ are made by actors in each different organisation, and what evidence is there to back up these claims?
   b) What does each organisation/group of organisations claim as its main ‘outcomes’ and how are the new ‘outcomes frameworks’ operating?
   c) How have quantitative outcomes changed in the new system, and what explanatory factors can be identified?
   d) Are any aspects of the new commissioning arrangements associated with improvements in quality, reductions in health inequalities and improvements in factors which affect overall system efficiency?

We address each of these questions in turn. RQ 3a and 3b are addressed using evidence from the qualitative part of the project. RQ 3c looks at outcomes as a whole across the country following the HSCA12, and RQ 3d explores these outcomes in more depth, utilising our measures of ‘dose of reform’ to explore whether there is any evidence of associated changes in outcomes. We do this in two ways. Firstly, we explore a number of different approaches to measuring ‘dose of reform’, using our initial policy analysis (Chapter 2) to derive measures to test some of the programme theories underlying the reforms as well as exploring the impact of the organisational and operational increase in complexity which we have highlighted and the claims made by interviewees. We then use these measures to test a range of potential outcome measures, including those highlighted in our qualitative work. Secondly, we explore one of our outcome indicators in more depth. Our interviewees highlighted cervical screening as an area in which the new structures had significantly changed the commissioning system. We therefore explore this in more depth, as a further tracer service potentially sensitive to the HSCA12’s changes and bringing together quantitative and qualitative evidence relating the ‘dose’ of reform to changes in the performance of the cervical screening service.

6.2 RQ 3a: What claims to ‘success’ are made by actors in each different organisation, and what evidence is there to back up these claims?

In the WS 4 interviews, we went back to our original interviewees to ask them to reflect upon what had been achieved since the HSCA12. There was little consistency in their responses, either in terms
of the topic areas they highlighted, or in the extent to which the things claimed were actually related to the HSCA12.

6.2.1 Intended consequences of the HSCA12 – programme theories acting as claimed

One of the most important programme theories underlying the HSCA12 was the claim that giving clinicians leadership and ‘ownership’ of the commissioning process would lead to better quality commissioning decisions. As we highlighted in Chapter 2, a number of claims as to the beneficial effect of clinically-led commissioning were made, including better clinical knowledge supporting decision making, better engagement with the public and improved approaches to utilising services. In our case study areas, interviewees were consistent in their belief that clinical involvement in commissioning was a good thing. However, most claims to success in this area were lacking in specificity, and focused more upon a general sense of better engagement rather than a specific claim to improvement. There were two exceptions to this. Firstly, a number of interviewees highlighted improved relationships between commissioners and providers, and argued that the role of clinicians had been crucial in this:

When I look at things like our cancer outcomes, then certainly the way that we have commissioned with the clinical focus on cancer, I think is a success and the lesson from that is we, kind of, didn’t...we didn’t really set out to really focus on cancer, but what we have is we have a good clinical leader in on the commissioning side and a good clinical leader on the provider side and when you get a coincidence of strong clinical leadership, then actually you get some really good outcomes. 21185, CCG manager, Area 1

However, this quote also highlights the fact that such beneficial outcomes depend upon the particular interests of particular clinicians. The focus had not been planned, but the serendipitous coincidence of ‘good leaders’ on both commissioner and provider side had delivered benefits. This particularity of clinical focus was also evident in another ‘success’ claimed by one CCG in the area of finding and treating patients with ‘latent’ (i.e. not manifest) TB. Such treatment is important in preventing later complications, and the successful collaboration of the CCG with PHE was hailed as a success:

All of that was...our big interest in TB was really driven by, do you remember a few years ago, just as we started as a CCG there was an inquest for a 15-year-old girl that had died of TB and not been diagnosed. So it’s really set us all on a mission really to, you know, the frontline practitioners, simply to identify TB and latent TB and treat it. So that’s a great programme so I think there’s a great partnership between us and Public Health England that’s worked really well and we’re leading on that for the region and it’s very successful. 21000, CCG manager, Area 2

However, whilst our respondent highlighted the fact that TB was known to be an issue in their local area, their interest in the topic was not driven by aggregated statistics about incidence or prevalence, but by a single emotive incident. Whilst this is only an isolated example, it is an illustration of what existing research evidence shows about clinical involvement in commissioning: clinically-led commissioning tends to be driven by particular clinical interests rather than by a systematic appraisal of the needs of populations (Miller, Peckham et al. 2015). Furthermore, as the example below shows, whilst strong clinical leadership from the CCG side could be valuable, it may not be sufficient alone to make change happen. In this data extract, the manager quoted above contrasted their success in the area of cancer (where they had reciprocal clinical engagement from their local provider) with less success in the area of urgent care:
...linking that across to urgent care, I think on the commissioning side, we absolutely have got that clinical leadership in that space, I don’t think it’s reciprocated and that’s why we haven’t got the improvement that we need to. 21185, CCG manager, Area 1

This implies that, in realist terms, strong clinical leadership has the potential to improve commissioning practice, via the mechanism of improved relationships with local provider clinicians. However, this mechanism requires reciprocity, with equal engagement from provider clinicians.

Secondly, we collected numerous claims as to the beneficial impact of clinical involvement in commissioning on primary care commissioning and service provision:

Yes, so much has happened in that time, but I think I’ve already touched on some of them, but I think the development of our outcomes framework for primary care has been a fantastic success because it is enabling primary care, our GPs, to work more effectively and more efficiently and deliver a clear set of standards across those three themes of access, long-term conditions management and care coordination in a way that wasn’t in place before. 21998, CCG manager, Area 2

As we discussed in Chapter 2, this could not be said to be an outcome from the HSCA12, as the Act explicitly gave responsibility for commissioning primary care to NHS England, underpinned by a claim that greater national consistency was required. However, as we have discussed elsewhere (Checkland, McDermott et al. In press), it quickly became obvious that primary care commissioning required local knowledge and focus, and subsequent policy delegated this responsibility back to CCGs. Our respondents were clear that this was a good thing, and located many of their successes in this area, arguing that the involvement of primary care clinicians in commissioning primary care had resulted in improvements in the quality and consistency of primary services. This is in keeping with the literature on previous forms of clinically-led commissioning, with all previous schemes showing a greater propensity to lead to improvements in primary care services than secondary care or other types of services (Coleman, Checkland et al. 2009; Miller, Peckham et al. 2015).

Respondents did not highlight any other of the initial programme theories embodied in the HSCA12 as underpinning any perceived successes

6.2.2 Relationships with Local Authorities
There was an explicit expectation in the HSCA12 that, driven by the strategic role of HWBs, relationships between CCG commissioners and their Local Authority colleagues would improve, and HWB would bring in a democratic approach which would support better NHS commissioning. Many of our respondents in both CCGs and LAs did point to improved relationships as their most important successes. However, rather than arising out of the role and work of the HWB, the improvements seen appeared to be driven by the practical effect of having worked together on joint programmes of work, either using existing Section 75 funding streams, or driven by the Better Care Fund.

Over the last couple of years, we have done a lot of work in terms of integrating our commissioning arrangements with the local authority. So that was something that we had always done but in quite a small way. And we have aspirations to increase that, and we have now. We've got a much, much bigger pooled fund, we have overhauled the integrated commissioning governance arrangements. And we've really started to work on some commissioning projects together in a way that we perhaps hadn’t done previously. So, you know, in terms of how we manage care home quality and development, and homecare capacity, and those sorts of things. So that's been really, really good. 21748, CCG manager, Area 1
I think the development of the relationships over the past two years, of building relationships, trust and really mutual respect and understanding what each other does and understanding each other’s strengths, and actually what we’re good at. And I think particularly it’s often felt that we’ve now developed some really good networks of the senior leaders from across organisations and started to do some really good works and empowering teams on the group to make some of the changes in a more trustworthy way, in a way that they know that they can trust the leaders, that we’re all on the same page together and that we will support the bottom up work as well. 23389, CCG manager, Area 1

Respondents acknowledged the very constrained funding regime under which LAs were operating during the period of the research, and highlighted their mutual survival within this constrained environment as a key success:

So, neither of us are in quite such a bad financial position as we were, both have done a lot of work. I think that the local authority obliviously had to make a lot of cuts and a lot of savings, but they are getting on with their programme of work… I mean, that is not to say that it’s fine, because it is clearly not fine, going forwards there is this gaping hole looming. But, we are in as good as position as anybody else. 22541, CCG clinical manager, Area 2

In Area 2, respondents pointed to a specific service re-specification and procurement as an important success, and argued that the disruption associated with the HSCA12 had acted to support a more radical service redesign than might have otherwise been considered.

6.2.3 Meeting financial targets and assurance requirements
As we highlighted in Chapter 2 all of the changes enacted by the HSCA12 have played out against a background of constrained funding. A number of respondents highlighted their achievement of financial balance as the greatest success:

I think [it’s] difficult to achieve but retaining and sustaining financial balance is a massive achievement in an era that’s economically challenged, we retained a really strong financial position in the face of significant economic challenges, I think is a good achievement. 19110, CCG manager, Area 1

So I think probably the main thing has been just embedding all of the new operating models that we had specialised after we went through the sort of re-organisation with NHS England, to create the region and the DCOs and specialised commissioning became managed across the whole region rather than the individual what was then area teams…So I think we’ve spent a year really making sure that we’ve embedded that and that’s working, and I think it is working quite well now. So I think we’re in a reasonably mature state from a functional point of view, and I think we’ve got – when I spoke to you we’ve probably had a year of quite difficult times for specialised commissioning in terms of the financial environment and there’s still the legacy of having transferred money and budgets from PCTs and how that hasn’t worked very well for specialised and so we’ve gone through a difficult period, and I think we’ve really nailed that now, so I think certainly in [this area] we’re in a much better financial position 24020, NHSE manager, Area 2

Others highlighted their achievement against the standards set out in the NHSE CCG assurance process:
So that one, I suppose the challenge there is not slipping back and getting back onto that position. So certainly last financial year, we achieved green star status, which is the, sort of, highest assurance level and we were one of only 10 in the country. 22077, CCG manager, Area 2

These claims are not extravagant or ambitious; rather they speak to a sense of having ‘survived’:

We’ve survived a couple of contracting rounds, I choose that language deliberately because it’s never easy, but for the last two years we’ve avoided arbitration which is, I think, quite a success when you compare us to peers and when you look at where we were three years ago when we did go to arbitration with our main provider and I think the success there, if I were to pin it down on anything, again, it’s about relationships with the providers. We’ve invested a lot of time and energy into building those, so we still have the difficult conversations, we still have some really challenging times with them, but there has been a definite shift in the dynamic, I think, in terms of that relationship. 22077, CCG manager, Area 2

When asked to reflect upon their ‘successes’, respondents focused upon those things which they felt they could clearly influence, and this may explain why primary care and financial issues figured prominently in their accounts. In the next section we move on to explore the broader context of commissioning for outcomes.

6.2.4 Summary
Claims to ‘success’ tended to be broad and diffuse, and did not appear to be related to specific improvements in particular services associated with ‘better’ commissioning processes. The successful establishment of a CCG, survival in a resource constrained environment, and the development of good relationships with other local organisations all featured significantly. The most specific claims to success were made in the area of primary care commissioning, an area of commissioning which was not initially the responsibility of CCGs. This is not unexpected, given the evidence relating to previous forms of clinically-led commissioning (Miller, Peckham et al. 2015). In particular, it would seem that primary care commissioning is the area in which CCGs feel themselves most able to act, and is an area in which they have significant expertise. Furthermore, it is an area in which a direct connection between the actions of the CCG and the outcomes achieved are easier to specify than in other types of commissioning activity. In the next section this will be addressed further.

6.3 RQ 3b. What does each organisation/group of organisations claim as its main ‘outcomes’ and how are the new ‘outcomes frameworks’ operating?

As discussed in the previous chapter and in Chapter 2 (policy) the concept of ‘commissioning for outcomes’ was prominent in the programme theories underlying the HSCA12. It was argued that PCT commissioning had been too dominated by measures of process – number of procedures carried out, waiting time targets etc. – as opposed to the outcomes achieved. ‘Commissioning for outcomes’ was conceived of as a chain, whereby the DH would establish a clear ‘mandate’ for NHSE, which specified the overall outcomes which would be achieved by the NHS as a whole, and NHSE would then translate these into a framework of commissioning outcomes against which CCGs would ultimately be held to account. It was argued that CCGs would be freer to achieve these outcomes however they chose, operationalising the ‘greater autonomy’ promised by the HSCA12.

In practice, CCGs are mainly held to account via the CCG Assurance process. This process changed in 2016/17, when it was renamed the CCG Improvement and Assessment Framework (CCGIAF). Our data collection spanned this change. The CCG Assurance Framework prior to 2016/17 was organised
across six domains. Within each domain, CCGs were asked to provide evidence of their performance. The domains included:

- Domain 1: Are patients receiving clinically commissioned, high quality services?
- Domain 2: Are patients and the public actively engaged and involved?
- Domain 3: Are CCG plans delivering better outcomes for patients?
- Domain 4: Does the CCG have robust governance arrangements?
- Domain 5: Are CCGs working in partnership with others?
- Domain 6: Does the CCG have strong and robust leadership?

Some domains explored performance against outcome indicators established as part of the NHS Outcomes Framework, whilst others focused upon traditional process indicators, such as the % of patients waiting more than 4 hours in A&E. The CCG outcome indicator set (https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/) includes both process and outcomes indicators, such as under-75 mortality from heart disease (an outcome indicator) and percentage of patients with diabetes who received a structured education programme (a process indicator). From 2016/17 the CCGIAF (https://www.england.nhs.uk/wp-content/uploads/2017/07/ccg-iaf-mar16.pdf) was similarly organised in domains, but these were reduced in number to 4:

- Better Health: this section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve;
- Better Care: this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas;
- Sustainability: this section looks at how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends;
- Leadership: this domain assesses the quality of the CCG’s leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.

Within these domains, 57 indicators across 29 areas were to be reported on by CCGs. These again include both process and outcome indicators, with examples including the percentage of deaths occurring in hospital, and the proportion of patients with a learning disability receiving an annual health check from their GP. Traditional measures of commissioning performance – 4 hour waits in A&E, delayed transfers of care – are also included.

Figure 4 sets out the interlinked processes by which the various performance frameworks and metrics relate to one another.

*Figure 4 Key policy priorities, performance frameworks, indicator sets and tools relating to CCG areas (from Ham, Raleigh et al 2015 p12)*
It was hoped that holding CCGs to account for outcomes (rather than processes) would encourage them to develop new commissioning approaches which focused upon population health rather than on processes. However, finding outcome indicators which can meaningfully be used to hold CCGs to account is not necessarily easy, and many indicators remain focused upon process. Furthermore, the result for CCGs of the NHSE assurance process can be very significant with, for example, an overall ‘inadequate’ rating resulting in the CCG effectively being taken over by NHSE. The ‘account’ required to satisfy this process is very detailed, and we found that, like PCTs before them, CCGs tended to focus their efforts on the areas required to satisfy the assurance framework, rather than focusing more broadly upon population health, as the initial HSCA12 programme theory suggested that they would.

Our interviewees were asked to reflect upon the outcomes which they felt were good measures of their performance, and to discuss how they experienced the assurance process and the various outcome indicators they were expected to meet. Some told us that they felt they had little power to influence some of the indicators for which they were held responsible:

Yeah, we’ve been having this debate quite regularly at finance and performance committee actually, because we’ve had a new chair and one of his questions every month is, well, I can see that these are going off trajectory and I can see all these things, but tell me, which ones ... are we going to be able to do anything about? And it’s, like, well...I mean, we monitor so much and some of it, yes, we have power to influence, sometimes we don’t have the power to make the difference, but we can certainly get involved in the debate and help to do something about it, so things like A&E and R[eferral] T[reatment times] are the big constitutional ones there. 22077, CCG manager, Area 2

Others explained that, whilst they accepted the rationale underlying the indicators used to monitor their performance, their power to influence provider behaviour had been reduced over time, in part because of new policies which, for example, allowed large providers to receive additional funding from regional ‘transformation’ funds:
I don’t think there’s any performance indicators we particularly rail against as completely inappropriate to CCGs. But our ability to influence performance in some of those areas is more constrained now than it was 18 months ago because of the things we traditionally have tried to lever to do that we can’t use any more and hence I guess getting another reason to move to a more sort of strategic commissioning piece, and there’ll be a performance aspect to that, but it can’t be like it is now. 20952, CCG manager, Area 2

Some indicators could be problematic because they were measured at the wrong level. Thus, for example, in one of our study areas one CCG was held to account for performance against mental health indicators, the measurement of which included patients belonging to a different CCG:

There’s a few issues in terms of how [local area] is set up around some of the mental health indicators, the lowest super output areas and where the patients is in a different CCG to us but the performance target sits with us, that’s a very local issue. 20952, CCG manager, Area 2

Some of the aspects of CCG performance assessed under the domains – such as quality of leadership – are somewhat subjective, and some CCGs found this to be problematic, disagreeing with NHSE’s assessment of their performance. However, others highlighted the differential approach taken by NHSE, with more highly performing CCGs given a more ‘light touch’ approach. Performance comparisons between CCGs were felt to be legitimate, as long as difference between populations was recognised in the process:

So, if you’re going to be benchmarked, let’s get the right peer groups, and be really quite savvy about that. So, if you are in an urban, deprived city, with a high Asian population, let’s make sure you benchmark against a very similar city, whether that’s [city w] or [city x], or somewhere, but don’t start benchmarking against [city y], ’cause it’s very, very different. Or even [city z] is very different isn’t it, and so it’s about being really clear that where you’re looking at, at health that is largely influenced, or things that can influence, are around, sort of other things, like your ethnic mix, and your deprivation, that you benchmark that, mark that properly. 21891, CCG manager, Area 2

The quality of data was also felt to be crucial, with some issues noted over the lag between work done and the relevant data being available:

So, some of them are flawed and need some proper work on them. A lot of the other clinical indicators, the data is so old, it’s two or three years old. Some of it, we weren’t even in existence….and then this is data that you’re being assessed on. So, there’s something about, if you’re going to be assessed on data and outcomes, those outcomes have to be able to be easily collected and relatively recent. So, some of the cancer outcomes are three years old…And that can’t be a meaningful measurement. If you’re going to assess people on something, they, a, have to be able to influence it, but, b, you have to be able to see whether you’re making any progress. And, anything that you can’t measure in the relatively recent past, you can’t judge progress, you can’t judge improvement. So, there’s something really critical, I think, about what data you can get, but that’s relatively up to date…So, dementia and the cancer ones are the really critical ones, I think, where we’re really unhappy with them. Where we’re really unhappy with the way they’ve been set up. 21891, CCG manager, Area 2

Interviewees were not averse to moving towards a more population outcome-focused approach to measuring CCG performance. However, they felt that there were a number of issues with this.
Firstly, they wanted to see a broader range of outcomes assessed, including how people in a local area experience their lives. These were described as ‘broader’ or ‘more rounded’ outcomes, for example:

And so somebody might say, actually I just want to go and visit my husband’s grave, and that will make me feel better. 21757, LA manager, Area 1

Secondly, they reflected upon the time lag between changes that commissioners might make to contracts, and changes to relevant outcome measures:

but actually, you know, what are we going to do about the fact that [four hour wait in] A and E is 78 per cent yesterday, we’re not going to do much about that, but today you might do something that might affect it in three or four years’ time. 21673, CCG manager, Area 2

Thirdly, they reflected upon the fact that most meaningful measures of population outcomes require collaboration between a number of different organisations, and it makes little sense to hold one organisation to account for things which require joint working:

I think, as I said earlier, it feels more and more as if the focus is on the system rather than the individual organisations and if we are working as a system, then the issues about whether we can control what we are measured on become less relevant, because we are commissioning and providing everything and therefore we are responsible for everything. So I think the more we integrate, the more responsibility for our outcomes, as opposed to some of the performance measures feels like the right thing. 21185, CCG manager, Area 2

Finally, they recognised the compromises inherent in any performance measurement system, and highlighted the fact that true ‘commissioning for outcomes’ would only be possible if organisations work together and new approaches to commissioning are adopted.

So, it’s a difficult one really, we try not to moan about it, and just get on with it really, but it is tricky I think. You end up with a series of input measures if you’re not careful, because we could easily end up with only being judged by the things that we directly do or don’t do, rather than the resource that they have. So, it’s always going to be a compromise I think, it’s very difficult, because truthfully, there are almost no outcomes that are wholly within the gift of any partner, whether that’s a council or a commissioner, or provider or primary care practice, if you’re really going to look at, I mean the key outcome probably that we would look at is, how happy is the population? Nothing else really matters, it doesn’t matter how long people live or not, does it, who cares frankly? What really matters is how well people feel, and how good they feel about themselves. So, judged on that one measure, no one person could be held to account, but as a system, we ought to be concerned about it. 24581, CCG manager, Area 2

Mm…that’s a really interesting one…I think at the moment, we’re still in a world where it’s easier to count inputs and outputs rather than outcomes and I do think we need to get smarter at defining outcomes and being able to measure them better, that’s not easy, is it, let’s be honest?…And it’s one of the things that we’re starting to explore actually with this new models of care and what might a different way for contracting look like, because NHS gets stuck in this annual cycle, doesn’t it and you’ve got to be able to contract manage in year and you’ve got to be able to tick the boxes to say you’ve achieved something, whereas, actually a lot of the things we want to do, you might not see an outcome for
patients for maybe even five or 10 years on some of the schemes we do around atrial fibrillation, you know, how do you prove if you’ve avoided a stroke or not, you know, that sort of thing. 22077, CCG manager, Area 2

This suggests that the stringent performance assessment of CCGs embodied in the CCGIAF may require some adjustment to move beyond annual cycles and measurements to assess performance over a longer timescale. However, this is risky, as reducing the detailed monitoring of CCGs may result in developing problems going unnoticed.

6.3.1 Summary
The move towards commissioning for outcomes rather than processes was a prominent feature of the HSCA12, with the associated programme theory asserting that allowing autonomous organisations to commission as they saw fit to improve population health would improve commissioning practice. Research question 2e sought to explore this, but our detailed study of commissioning tracers did not reveal any clear evidence that commissioning for outcomes was happening. It would seem that, in practice, commissioning for outcomes proved hard to operationalise, with relatively few indicators identified that could be clearly associated with commissioning activity. At the same time, an assessment and accountability regime was put in place for CCGs that was more detailed and stringent in its requirements than that to which PCTs had been subject in the past. Our study suggests that the impact of this has been to focus CCG activity on meeting the Assurance Framework requirements, rather than a broader focus on population health.

Our interviewees clearly identified the difficulties associated with holding commissioners to account for outcomes which arise out of a complex interplay between socio-economic factors, individual behaviour, public health interventions and service provision. Policy changes subsequent to the HSCA12 such as the Five Year Forward View would seem to recognise these difficulties, with moves towards ‘place based’ approaches in which organisations across a geographical area are collectively held to account for achieving population health outcomes.

6.4 RQ 3c: How have quantitative outcomes changed in the new system, and what explanatory factors can be identified?

6.4.1 Introduction
A key element in our study design was to bring together qualitative and quantitative explorations of contexts, mechanisms and outcomes in order to explore how particular changes enacted as part of the HSCA12 had led to observed changes in outcomes. In WP 2 we identified a particular issue with cervical screening uptake, which our respondents identified as originating specifically in the changes in responsibilities for aspects of sexual health services brought about by the Act. We therefore decided to use this as an exemplary ‘tracer’ in order to bring together:
- Quantitative evidence about changes in outcomes
- Qualitative evidence about the causal mechanisms underlying those changes in outcomes

As set out in Chapter 5, (p92), responsibility for cervical screening services changed significantly following the HSCA12. Table 4 sets out these changes.
**Table 4 Organisations with commissioning responsibility for cervical screening pre and post HSCA12**

<table>
<thead>
<tr>
<th>Pre-HSCA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Trusts</strong></td>
<td>Responsible for all public health commissioning, including sexual health services; Responsible for commissioning national screening programmes, including cervical screening</td>
</tr>
<tr>
<td><strong>UK National Screening Committee</strong></td>
<td>Provision of advice and support to NHS organisations on population screening programmes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-HSCA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Authorities</strong></td>
<td>Responsible for most public health commissioning, including most sexual health services (contraception over and above GP contract, testing and treatment of sexually transmitted infections, sexual health advice and promotion)</td>
</tr>
<tr>
<td><strong>NHS England (NHSE)</strong></td>
<td>Responsible for commissioning national screening programmes, including cervical screening, and some sexual health services (notably contraception through GP contract, and HIV treatment)</td>
</tr>
<tr>
<td><strong>Public Health England (PHE)</strong></td>
<td>Hosts UK National Screening Committee secretariat, which retains the same role; PHE staff embedded in sub-regional NHSE screening and immunisation teams to provide expertise and ‘leadership’</td>
</tr>
<tr>
<td><strong>Clinical Commissioning Groups (CCGs)</strong></td>
<td>Responsible for improving clinical outcomes for their patients and prevent premature death (as part of the NHS Outcomes Framework, which CCGs are held to account on by NHSE); GP members are funded to carry out cervical screening through the GP Contract</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6.4.2 Methods</th>
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<tbody>
<tr>
<td>In the sexual health and screening tracers we explored our respondents’ experiences of these changes. The interviewees told us that the HSCA had introduced some confusion into the commissioning of cervical screening services, with LAs taking different views as to how its provision in sexual health clinics should be approached (see Qualitative Findings, below). We wished to test whether or not this confusion had an impact on cervical screening rates. As the Act was implemented in all areas simultaneously, we sought to identify a measure of variability in the extent to which the Act would have been expected to affect commissioning in each area. One of the features of the post-HSCA12 system was that some, but not all CCGs were established which crossed LA boundaries (Peckham, Gadsby et al. 2017). Some CCGs related to as many as three separate LAs. As each LA developed its own approach to cervical screening provision in local sexual health clinics, we explored the possibility that GP practices located in CCGs which had to work with more than one LA might experience a reduction in screening rates compared with practices located in CCGs which had only to deal with one LA.</td>
</tr>
</tbody>
</table>

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**Table 5 CCG demographic characteristics**
One Local Authority | More than one Local Authority
---|---
Number of CCGs | 119 | 89
Population (millions) | 29.5 | 26.9
Female | 50.0% | 50.5%
Aged 0-9 | 12.3% | 11.4%
Aged 10-19 | 11.2% | 11.2%
Aged 20-39 | 30.0% | 24.8%
Aged 40-59 | 26.5% | 27.7%
Aged 60-79 | 16.0% | 19.7%
Aged 80 and over | 4.1% | 5.3%

We compare the demographic characteristics of these two groups in Table 5. The 89 CCGs needing to deal with more than one Local Authority had a slightly older population profile than the 119 CCGs who needed to deal with only one Local Authority.

Because cervical screening rates may be influenced by other factors that we cannot observe and change over time in different ways between the two groups of CCGs, we also compared screening rates with an indicator that was likely to have been unaffected by the introduction of HSCA. We used unassisted births (i.e. uncomplicated deliveries which did not require any obstetric intervention) as a percentage of all maternal deliveries as the indicator for comparison, as the commissioning of maternity services was largely unchanged by the Act.

We applied a triple difference-in-differences (DiD) approach. The triple difference represents the change over time in cervical screening rates for CCGs working with only one LA minus the change over time in cervical screening rates for CCGs working with more than one LA minus the change over time in unassisted birth rates for CCGs working with only one LA minus the change over time in unassisted birth rates for CCGs working with more than one LA.

The intervention indicator is the percentage of women aged between 25 and 64 years who had received a cervical screening test in the preceding five years. This indicator was produced using annual, practice-level data from the Quality and Outcomes Framework (QOF) for 2009-10 to 2015-16. The comparison indicator is unassisted births as a percentage of all maternal deliveries. This indicator was produced using operation codes in Hospital Episode Statistics (HES) for 2009-10 to 2015-16. We aggregated the spell-level data by general practice and financial year.

The key assumption underpinning the triple difference estimator is that, conditional on the other variables in the model, the differences in the changes over time in the intervention indicator between the more and less ‘exposed’ (to reform) areas would have been the same as the differences in the changes over time in the comparison indicator between the more and less ‘exposed’ areas in the absence of the intervention. This is a more complex version of the ‘parallel trends’ assumption required for the double-difference, or difference-in-differences, estimator (Imbens and Wooldridge 2009). A popular test of this assumption in the double-difference case is that there are parallel trends over time in the outcomes in the intervention and comparison group in the pre-intervention period. For our triple-difference case, we applied the equivalent of this test using two alternative approaches. First, we estimated the triple-difference model using data from the pre-intervention period only with a ‘placebo’ time intervention point equal to one for 2011-12 and 2012-13. Second, we ran a triple-difference model in the pre-period only and tested the joint significance of interactions between the year effects and the binary variable representing the combination of exposed area and treated indicator.
We also used the lagged dependent variable (LDV) estimator. This estimator provides less biased estimates of treatment effects when the assumption of parallel pre-trends does not hold (O’Neill, Kreif et al. 2016). We set up a triple difference-in-differences LDV model, which includes: dummy variables for year; values of the dependent variable in the pre-intervention period; a dummy variable classifying practices depending on whether they are located in CCGs working with more than one LA; interactions between year and condition dummies; interactions between values of the dependent variable in the pre-intervention period and the condition dummy; an interaction between the dummy variable classifying practices depending on whether they are located in CCGs working with more than one LA and the condition dummy. This can be written algebraically as:

\[ y_{cj} = \alpha + \phi L_j + \rho \pi_c + \delta_1 t_1 + \cdots + \delta_T t_T + \beta_1 y_{cj-2} + \cdots + \beta_4 y_{cj-5} + \psi_1 t_1 \pi_c + \cdots + \psi_T t_T \pi_c + a_1 y_{cj-2} \pi_c + \cdots + a_4 y_{cj-5} \pi_c + \varepsilon_{cj} \]

in which \( y_{cj} \) is the value of indicator \( c \) in practice \( j \) and year \( t \), \( L_j \) is a binary indicator for practices located in exposed CCGs, \( \pi_c \) is a binary indicator for the intervention indicator, \( t_1 \) to \( t_T \) are dummy variables for years, and \( y_{cj-2} \) to \( y_{cj-5} \) are lagged values of the dependent variable in the pre-period. This model is estimated only on data in the post-intervention period.

We estimated the regression models in Stata 14.1 using dummy variable least squares regression with fixed effects for practice-indicator combinations. We clustered the standard errors at the GP practice level.

6.4.3 Qualitative findings

Our analysis identified two main themes – differing perspectives on budgets and responsibilities, and potential impacts on cervical screening rates – both of which relate directly to confusion surrounding the commissioning and provision of cervical screening post-HSCA.

Differing perspectives on budgets and responsibilities

Before the HSCA, both cervical screening and sexual health services were commissioned by PCTs. As one screening and immunisations lead outlined, cervical screening tests (sometimes referred to as smear tests) were provided by GP practices, but patients could usually also have them at sexual health clinics [17685, NHSE, Area 2, Dec 2016]. The HSCA separated the budgets for cervical screening and sexual health, meaning that the LA budget and responsibility for sexual health did not extend to cervical screening. One LA public health consultant reported that, in spite of this, PHE was sending letters to patients explicitly stating that they could choose to attend either their GP practice or their local sexual health clinic for their cervical screening test, thus highlighting confusion regarding commissioning arrangements and budgetary responsibility:

> Public Health England were writing around to people saying ...you’re due your smear, you can go to your general practice or you can go to your local sexual health clinic. And we said, but we don’t have the money for them to do that, they can’t come here routinely unless you’re going to pay us for that. Public Health England, the screening people, they have the money to pay for the smears. But in all the moving around of the budgets, the money for smears that were taken outside general practice doesn’t seem to be anywhere [8384, LA, Area 1, Nov 2015].

One participant from NHS England offered a different perspective. He argued that the public health budget of each LA reflected the levels of cervical screening activity that had taken place in its sexual health clinics pre-HSCA. However, this is not clear because, in the past, the funding was not
“disaggregated” [4058, NHSE, Area 1, Jun 2015]. Therefore, it is not possible to establish what the
pre-HSCA sexual health component of the public health budget covered.

...they [LAs] think they’re not being paid for it [cervical screening]. But actually in truth
whatever they were doing at the point of transition if they were doing loads of cervical
smears they were just doing loads of cervical smears, so they had the money. There wasn’t
a problem when they were doing them before, it’s just the money wasn’t disaggregated.
However local authorities have been put under significant pressure in their public health
teams to reduce their budgets. So these kinds of things are examples where you can say it’s
not our responsibility so therefore we’re taking that element out [4058, NHSE, Area 1, Jun
2015].

The above quote illustrates a phenomenon reported by a number of participants: LAs have re-
procured their sexual health services and have taken a position that they will not commission their
sexual health provider(s) to do routine cervical screening, because it is not their commissioning
responsibility. However, as one member of a screening team in Area 2 illustrated, NHSE is also
reluctant to commission sexual health services to provide cervical screening, seemingly because of
administrative challenges relating to numerous low-value contracts with providers:

So cervical screening we could go to every sexual health provider and have a separate
contract. The difficulty again becomes around commissioning capacity. So I think we’ve got
[x] local authorities, so we have [x] separate contracts all very low value, it’s about 1,000
screens in each, so you’re talking maybe [x] £20,000 contracts or something. So it’s a very
bitty way of doing stuff. So we could still do it and we could pay for it, but in terms of the
amount of paperwork or the amount of outcomes it becomes potentially unmanageable.
[17685, PHE/NHSE, Area 2, Dec 2016]

This participant went on to indicate that he would prefer LAs to commission cervical screening as
part of their sexual health contracts, but acknowledged the political difficulties for LAs to justify
spending money on an area of service that was not formally their responsibility:

In a way wouldn’t it be so much easier if the local authorities just included it as part of their
normal service? But their argument would be that’s not our role, and how can we defend
to the [elected] councillors that we’re spending money on stuff that we don’t have to, that
someone else is meant to be spending money on? And our argument is well, it’s just so
much simpler and it’s not a lot of money. That’s the kind of discussion. And it eventually
ends up with them withdrawing money and us saying well, we’re not buying it either then.
[17685, PHE/NHSE, Area 2, Dec 2016]

Potential impacts on cervical screening rates
One LA commissioner suggested that the policy of his LA was to continue to facilitate opportunist

cervical screening tests at sexual health clinics, but not routine tests, because to provide the latter
would have a detrimental impact upon other sexual health services that the LA was now obligated to
commission (“If we don’t say no to [routine] smears, we’ll be turning [other] people away,
symptomatic patients away, or women needing contraception away. And that’s our duty” [8384, LA,
Area 1, Nov 2015]). He reported that local CCGs complained about this discontinuation of routine
cervical screening at sexual health clinics, because there was insufficient capacity within general
practice for CCGs to meet their cervical screening targets, and thus they required sexual health
clinics to provide a proportion of cervical screening activity. One screening consultant developed this
picture by suggesting that some localities would see a substantial reduction in screening activity
because of a lack of capacity within primary care:
...in some Local Authorities where the sexual health service is no longer doing cervical screening [it] will have a small impact but not a huge impact, in other areas, it will have a big impact on coverage, we’ll see activity go down around it, because the workload is just going to come straight back to primary care, and in different areas primary care didn’t realise this was happening, the recommissioning, hasn’t got the capability and the capacity... [18352, PHE/NHSE, Area 1, Jan 2017]

Another screening consultant reflected that changes to NHSE footprints (i.e. the abolition of Area Teams and the new, more regional focus of the organisation) had implications for the provision of cervical screening:

...say we wanted to sort out cervical screening coverage in GP practices, in [name of PCT] you’ve got [x] GP practices, bottom 20 per cent you could talk to the [y] practices. In my new patch we’ve got [much more than x] practices. So you have to think in a completely different way. [17685, NHSE, Area 2, Dec 2016]

Several participants from different localities in both of geographical areas pointed to long-standing challenges in ensuring good uptake rates for screening amongst their diverse local populations. There were concerns that these challenges would be exacerbated by a reduction in choice for women about where they could go for cervical screening tests:

...you should have an integrated sexual health service where predominantly women can go in and get seen in one episode, in one place for all their sexual health needs, be that sexually transmitted infection testing and treatment and contraception. So I think probably in the past people worked very hard to get things like cervical screening into these services so that the needs of those women who perhaps wouldn’t go to their local GP could be met in an environment they felt happy with. My feeling is now... that perhaps the type of women who traditionally would have gone for cervical screening [at their sexual health clinic] might not feel so comfortable in that environment [of the GP practice]. So particularly, say, a lady from a South Asian background who goes to a single handed male GP with no practice nurse, that’s the kind of traditional person who might have gone to a family planning clinic for their cervical screening. [9742, LA, Area 2, Jan 2016]

Summary
The qualitative analysis showed that the changes to the commissioning of sexual health and screening services introduced by the HSCA created ambiguity and confusion regarding cervical screening in the English NHS. Interviewees from various organisations revealed multiple, conflicting understandings of commissioning responsibility in the reformed system, but there was broad agreement that the system had become more fragmented due to the disruption of the pre-HSCA (largely tacit) arrangements for commissioning and providing cervical screening tests. Some interviewees predicted that a consequence of this confusion would be a reduction in cervical screening activity in some areas. These findings prompted us to explore this prediction quantitatively.

6.4.4 Quantitative findings
There were 14.12 million women eligible for screening in England in 2016 (NHS Digital 2016). Cervical screening rates decreased over time (Table 6) and the decline pre-dates the implementation of the HSCA in April 2013. Unassisted delivery rates also declined over time. The relative decline between the first year (2009/10) and the last year (2015/16) for unassisted deliveries (-4.17%) is larger than for cervical screening (-2.70%).
The changes in cervical screening rates over time were apparently similar for practices in CCGs dealing with a single LA (-2.53%) compared with practices in CCGs working with multiple LAs (-2.87%).

Figure 3 illustrates the trends in rates of cervical screening in the pre and post intervention periods for CCGs depending on the number of LAs they work with. There is a noticeable and sharp decline in the rates in both groups between 2011-12 and 2012-13.
### Table 6 Descriptive statistics by year and by number of LAs

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of practices</th>
<th>Cervical screening rate (%)</th>
<th>Unassisted delivery rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 LA</td>
<td>2+ LAs</td>
<td>All</td>
</tr>
<tr>
<td>2009/10</td>
<td>4,260</td>
<td>3,399</td>
<td>7,659</td>
</tr>
<tr>
<td>2010/11</td>
<td>4,261</td>
<td>3,403</td>
<td>7,664</td>
</tr>
<tr>
<td>2011/12</td>
<td>4,260</td>
<td>3,400</td>
<td>7,660</td>
</tr>
<tr>
<td>2012/13</td>
<td>4,249</td>
<td>3,399</td>
<td>7,648</td>
</tr>
<tr>
<td>2013/14</td>
<td>4,199</td>
<td>3,355</td>
<td>7,554</td>
</tr>
<tr>
<td>2014/15</td>
<td>4,125</td>
<td>3,302</td>
<td>7,427</td>
</tr>
<tr>
<td>2015/16</td>
<td>4,026</td>
<td>3,236</td>
<td>7,262</td>
</tr>
<tr>
<td>Relative Change between 2009/10 and 2015/16 (%)</td>
<td>-2.53</td>
<td>-2.87</td>
<td>-2.70</td>
</tr>
</tbody>
</table>

*Notes: Mean cervical screening and unassisted delivery rates are weighted by the denominator.*
Cervical screening rates decreased by 0.39% more for GP practices located in CCGs working with multiple LAs compared to practices in CCGs working with a single LA. Unassisted birth rates decreased by 0.40% less for GP practices in CCGs working with multiple LAs compared to GP practices in CCGs working with a single LA. Therefore, relative to the decreases in unassisted delivery rates, GP practices in CCGs working with multiple LAs experienced a decrease in cervical screening rates of 0.79% compared to practices in CCGs working with a single LA.

The results are qualitatively similar for the triple difference models (for all years and 2011/12 onwards only) and for the lagged dependent variable estimator. The triple DiD estimates show that there was a differentially larger decline of 0.72% [95% confidence interval: -1.036 to -0.404] (Model 1) in cervical screening rates for practices located in CCGs working with more than one LA. The decrease is smaller over the shorter pre-period (0.327%; 95%CI -0.662 to 0.001, Model 2).

The direction of result is robust to the model specification, and although we rejected the assumption of parallel trends for Model 1 (all years), we could not reject the assumption for Model 2, and we found the same direction and a relatively similar size of result for Model 3 (estimated using LDV) which yields unbiased estimates when pre-trends cannot be assumed to be parallel.

The results are also robust to different groupings of the number of LAs that CCGs work with. Table 7 includes model estimates comparing CCGs working with one or two LAs with CCGs working with more than two LAs. The direction of results is equivalent; and the scale and significance are either equivalent or increased. The same pattern is repeated in terms of tests of parallel trends. The trends are shown to be parallel for Model 2 and LDV estimation is preferable to Model 1 which cannot reject the hypothesis of non-parallel trends.
Table 7 Rates of cervical screening and unassisted birth for CCGs working with one and more than one LA, before and after the introduction of HSCA

<table>
<thead>
<tr>
<th>Condition</th>
<th>CCGs working with one LA</th>
<th>CCGs working with more than one LA</th>
<th>Difference-in-differences</th>
<th>Triple difference-in-differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td></td>
<td>Pref Post Change</td>
<td>Pref Post Change</td>
<td></td>
</tr>
<tr>
<td>Affected</td>
<td></td>
<td>82.09 81.09  -1.00</td>
<td>83.84 82.45</td>
<td>-1.39</td>
</tr>
<tr>
<td>(Cervical screening rates)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unaffected</td>
<td></td>
<td>62.80 60.82  -1.98</td>
<td>63.56 61.98</td>
<td>-1.58</td>
</tr>
<tr>
<td>(Unassisted birth rates)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: values for pre and post are averages for all years in pre and post periods. The triple difference represents (the change over time in cervical screening rates for CCGs working with only one LA minus the change over time in cervical screening rates for CCGs working with more than one LA) minus (the change over time in unassisted birth rates for CCGs working with only one LA minus the change over time in unassisted birth rates for CCGs working with more than one LA). Differences are between raw figures.
<table>
<thead>
<tr>
<th></th>
<th>Difference-in-differences</th>
<th>Lagged dependent variable‡</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All years (1)</td>
<td>2011/12 onwards (2)</td>
</tr>
<tr>
<td></td>
<td>Coefficient 95% CI</td>
<td>Coefficient 95% CI</td>
</tr>
<tr>
<td>Triple DiD‡</td>
<td>-0.720*** [-1.036; -0.404]</td>
<td>-0.327* [-0.662; 0.001]</td>
</tr>
<tr>
<td>Triple DiD‡ (Sensitivity®)</td>
<td>-0.889*** [-1.236; -0.542]</td>
<td>-0.515*** [-0.882; -0.148]</td>
</tr>
<tr>
<td>N</td>
<td>105,745</td>
<td>75,099</td>
</tr>
<tr>
<td>Test of parallel trends</td>
<td>F (3, 7672) p-value</td>
<td>F (1, 7667) p-value</td>
</tr>
<tr>
<td></td>
<td>6.87 0.001</td>
<td>9.4 0.3316</td>
</tr>
</tbody>
</table>

Notes: ***indicates p < 0.01; *indicates p < 0.1.
†Values are regression estimations from weighted OLS models including practice-condition specific fixed effects, full interaction of year with condition; and full interaction of year with the dummy for (N of LAs). Robust standard errors. Weighted by denominator. Clustered by practice.
‡ The triple difference represents (the change over time in cervical screening rates for CCGs working with only one LA minus the change over time in cervical screening rates for CCGs working with more than one LA) minus (the change over time in unassisted birth rates for CCGs working with only one LA minus the change over time in unassisted birth rates for CCGs working with more than one LA).
§ LDV also contains values of dependent variable in each of the pre intervention years. Estimated only on post intervention years.
* The sensitivity model uses an alternative grouping of CCGs based on the N of LAs they work with [(1 or 2) vs. (more than 2)].
6.4.5 Discussion
In this section we have combined qualitative and quantitative findings to explore underlying causal mechanisms contributing to outcomes post HSCA12. Some interviewees predicted that there would be a detectable reduction in cervical screening rates following the Act, and that this reduction would be concentrated in particular areas. We subsequently sought to test this prediction via a difference-in-differences analysis of publically available data for cervical screening activity. To control for unmeasured confounders, we compared trends in cervical screening rates with trends in unassisted birth rates since the commissioning of maternity services was not affected by the Act in the same way.

The interview participants highlighted a number of factors they believed might contribute to a reduction in cervical screening activity. Sexual health service commissioning responsibility now lies with LAs while NHS England is responsible for commissioning national screening services, which includes cervical screening. In a context of austerity and cuts to LA budgets, many LAs are retendering their sexual health services and not including routine cervical screening as part of the bundle of service which they commission from sexual health providers. NHS England is also seemingly reluctant to commission sexual health clinics to perform cervical screening tests because this would entail a multitude of low-value contracts with numerous providers. This would be administratively laborious and practically difficult given the large size of the administrative areas they operate on and the relatively low levels of staff they have attending to these areas.

As a result, there were predictions that cervical screening activity might decline in some areas, either because of a lack of capacity in primary care (which had previously been relied upon the additional capacity in sexual health clinics), or because there was now a lack of choice for women who may have preferred to attend sexual health clinics rather than their GP practice. The quantitative analysis supports these interview findings. GP practices located in CCGs dealing with multiple LAs experienced a larger decrease over time in cervical screening rates compared with practices in CCGs dealing with a single LA. The opposite pattern was observed for unassisted births, which decreased more over time in the CCGs dealing with a single Local Authority. The triple difference-in-differences analyses confirmed that the effects were statistically significant and robust to different model specifications.

In our initial policy analysis (p33), we highlighted the impact of the HSCA12 in increasing commissioning complexity. In our sexual health and screening tracers, respondents highlighted their view that the changes would lead to a decline in performance with respect to cervical screening. Our quantitative analysis has confirmed this, showing that not only have cervical screening rates continued to decline, but they have declined more than we would have expected in areas where the commissioning complexity in sexual health services increased the most.

Taken together, our findings suggest that there is an urgent need for clarification as to who holds the budget, and therefore who should be commissioning, cervical screening in the English NHS, and for local agreements to ensure that issues over funding and budgets do not disrupt screening programmes. It would also be useful for research to explore where women would prefer to have their cervical screening tests, and for services to be developed to meet these preferences.

6.4.6 Potential confounders and study strengths
We took 2009 as a starting point for our pre-HSCA cervical screening activity. At that time there was the high-profile case of Jade Goody, a 27-year-old reality TV star who was diagnosed with cervical cancer in August 2008 and died in March 2009. The contemporaneous media attention and publicity has been linked with a substantial increase in cervical screening rates (around half a million). Any
interpretation of our findings needs to take this spike in screening activity into account. However, previous impacts of high-profile cases of celebrity cancer diagnoses upon population behaviour has tended to be brief and immediate rather than longer-lasting, and therefore we are confident that from 2010 onwards, rates of cervical screening returned towards underlying trends (Lancucki, Sasieni et al. 2012).

The UK’s Human Papillomavirus (HPV) vaccination programme, introduced in 2008 (Public Health England 2015), might also be expected to affect screening rates, as those immunised might feel less inclined to attend for screening due their reduced risk of cervical cancer. However, the first cohort of women in the programme were around 21-22 years old in 2016/17, and hence at the time of our study were too young to have been invited for routine cervical screening (which begins at age 25). We can therefore be confident that any changes to cervical screening rates cannot yet be attributed directly to the HPV programme, but any future research into cervical screening rates needs to account for this programme.

We considered whether the results were sensitive to the groups that CCGs were assigned to on the basis of the number of LAs they work with. The direction of results was equal, and the strength and significance was increased when comparing CCGs working with one or two LAs with those CCGs working with more than two LAs. We also considered whether the results were sensitive to the choice of comparison indicator (unassisted births) for maternity services. We tested whether the results would hold for another indicator of maternal outcome: the rate of deliveries by caesarean section. We observed the same direction and significance of results for this indicator as well.

We are unable to tell who undertook the cervical screening tests from the data. Historically these tests were conducted by both GP practices and sexual health clinics. It is possible that some sexual health clinics are continuing to offer the same level of service even though they are not being paid for it; our data cannot determine if this is the case. However, if this were the case it would be expected to reduce the impact of the reforms (i.e. patterns of screening continued as before regardless of commissioning processes). The fact that we do see a significant effect suggests that this is not happening to any large degree. A further limitation is that the data used do not consider populations unregistered with GPs.

Our mixed methods approach and realist research orientation have allowed us to pick up a potential contextual mechanism claimed by respondents to be affecting outcomes, and to demonstrate quantitatively that this is the case. We have shown that the increase in commissioning complexity introduced by the Act does, in this particular service area, impact negatively upon outcomes. In the next section we apply similar methods to a broader set of outcomes and a wider range of measures of the extent of reform.
6.5 **RQ 3d: Are any aspects of the new commissioning arrangements associated with improvements in quality, reductions in health inequalities and improvements in factors which affect overall system efficiency?**

6.5.1 **Background**

In this section we use quantitative methods to investigate whether there is any evidence that the changes associated with the HSCA12 resulted in improved outcomes. As discussed earlier, the principal programme theory underlying the creation of CCGs was that clinical involvement in commissioning would result in better commissioning decisions and therefore improved outcomes. However, there is little evidence that clinical involvement in commissioning has historically improved outcomes (Miller, Peckham et al. 2015). There is also mixed evidence on the best size of local purchasers (Wilkin, Bjoke et al. 2004) and few studies have provided evidence that major NHS reforms impact on outcomes (Lale and Temple 2016).

One of the major challenges with evaluating the impact of national reforms is that all areas of the country are affected at the same time. This universal, simultaneous introduction precludes comparisons of reformed areas with control areas in a difference-in-differences framework. It would be possible to analyse temporal changes at country level in an interrupted time-series framework but there is always the concomitant risk of confounding by other unmeasured factors that changed at the same time. Comparisons with other countries pose similar challenges and introduce additional problems with finding measures of activity and outcomes that are comparable across countries.

To estimate the impact of the 2013 reorganisation, we develop three ways of measuring variations in the dose of the reform across the country. These dose measures are based either on what mechanisms of improvement the Act claimed or the effects of the reform highlighted by interview participants. We then examine whether these dose measures are associated with changes in a wide range of indicators of activity, quality and outcomes using a Lagged Dependent Variable methodology (O’Neill, Kreif et al. 2016). We used our understanding of the changes introduced to target our analysis, testing each dose of reform against those outcomes which could plausibly be associated with the underlying mechanism being explored.

6.5.2 **Methods**

**Measures of dose of reform**

Building upon our policy analysis of the programme theories underlying the HSCA12, we developed measures of the dose of reform in three broad areas:

1. Clinical contribution to decision-making
2. Disruption of the practice membership of commissioning organisations
3. The number of local authorities that NHS commissioners need to collaborate with.

**Clinical contribution to decision-making**

The information on the clinical contribution to decision-making in each CCG was obtained from CCG websites in September 2016. We sought to count only voting members of the governing body. Where there was no indication of the voting status of governing body members, we assumed all listed members had voting rights. CCG governing bodies generally include a chair (typically a GP), clinical leads (also typically GPs), locality chairs (typically GPs from member practices), a nurse representative, lay members and managerial/administrative roles. Some boards have established sub-committees with a variety of devolved functions (Checkland, McDermott et al. 2016). We obtained data for 210 CCGs and calculated the proportion of voting board members with listed clinical qualifications.
The Act was presented as a means of increasing the involvement of clinicians in commissioning in order to realise more equal and informed negotiations with a range of care providers and better value from contracts. It was also suggested that clinicians would focus on priorities of importance to patients and the public, such as quality and patient-focused care, rather than bureaucratic concerns with process. However, the literature on clinical involvement in commissioner decision-making suggests that GPs have a very limited influence, affecting primary care provision but not specialist care or public health. Although CCGs were originally excluded from directly commissioning core primary care, they had a specific accountability to NHS England to improve the quality of primary care and controlled contracts for Directed Enhanced Services and Local Enhanced Services. From 2014, they began co-commissioning primary care. The tightness of the accountability regime for CCGs may have limited the extent to which clinical involvement could really affect outcomes.

Disruption of the practice membership of commissioning organisations

The information on the disruption of the practice membership of commissioning organisations was taken from administrative files for 2011-12 describing which PCTs general practices were located in and data on which CCGs practices were members of in April 2013. We merged these files at practice level and calculated the numbers of practices in each PCT and the number of practices in each PCT-CCG combination. We then calculated the proportion of practices remaining in the same group.

Disruption of practice membership between PCTs and CCGs is expected to have a negative effect in the short-term, relative to areas that experienced less disruption. However, changes in practice membership may have a positive effect in the longer-term as CCGs were designed to allow practices more freedom about who to choose to join with. This release from the restrictions of the administrative design of PCTs may improve outcomes. In actuality, there were more restrictions on practices’ freedom to choose constellations of their membership organisations than originally announced and so the potential positive effects of changes in practice membership may be limited. In the empirical analysis, we measure the converse of disruption, the proportion of practices that in a PCT that remained in the same group under CCGs.

The number of local authorities that NHS commissioners need to collaborate with

To calculate the number of Local Authority Districts (LADs) that each CCG had to deal with, we obtained data on administrative geography from the Office for National Statistics on Lower Super Output Areas (LSOAs). Information was provided on the CCG and LAD to which each LSOA belonged at 2015. From these data we calculated the number of different LADs across all of the LSOAs within each CCG area.

The number of local authorities that an NHS commissioner has to deal with may be expected to have direct effects for some outcomes and indirect effects on others. For activities where co-ordination of commissioning activities is required (e.g. public health or care of the elderly), dealing with more local authorities is expected to have a negative direct effect. Being required to deal with more local authorities increases complexity and may also lead to effort diversion from other activities and therefore negative indirect effects on other outcomes.

Outcome indicators

We obtained or derived annual indicators from six sources of data for six financial years, 2010/11 to 2015/16: Hospital Episodes Statistics; the GP Patient Survey; the Quality and Outcomes Framework; GP prescribing presentation-level data; Public Health England; and the CCG Outcome Indicators Framework.

The indicators from the first four sources were measured at practice level. The indicators from the final source were measured at CCG level.
We obtained the following activity counts from Hospital Episode Statistics:
1. Number of emergency admissions for Ambulatory Care Sensitive Conditions (Harrison, Dusheiko et al. 2014)
2. Number of A&E attendances
3. Number of A&E attendances that are self-referred
4. Number of A&E attendances that are referred from a GP
5. Number of outpatient appointments

We also obtained numbers of registered patients at each practice and expressed the above measures as rates per 100 registered patients. We then indexed each rate on a mean value of 100.

The General Practice Patient Survey samples patients from registered lists to collect patient views on their practice. Patients answer each question on a Likert scale, which we dichotomise and then calculated percentages at practice level. The measures obtained from the General Practice Patient Survey were:
1. Percentage of respondents reporting that their overall GP surgery experience was very good or fairly good rather than neither good nor poor, fairly poor or very poor.
2. Percentage of respondents reporting that they saw their preferred GP always or almost always rather than a lot of the time, some of the time, never, almost never or not tried at this GP surgery.
3. Percentage of respondents reporting that their satisfaction with opening hours was very satisfied or fairly satisfied rather than neither satisfied nor dissatisfied, fairly dissatisfied, very dissatisfied, or I’m not sure when my GP surgery is open.
4. Percentage of respondents reporting that they would definitely recommend or probably recommend this practice, as opposed to not sure, would probably not recommend, would definitely not recommend this practice or did not know.
5. Percentage of respondents reporting that the ease of getting through on the phone was very easy or fairly easy rather than not very easy, not at all easy or haven’t tried.
6. Percentage of respondents reporting that their overall experience of making an appointment was very good or fairly good rather than neither good nor poor, fairly poor, or very poor.
7. Percentage of respondents reporting that the receptionist was very helpful or fairly helpful rather than not very helpful, not at all helpful or don’t know.
8. Percentage of respondents reporting that they saw/spoke to GP/nurse on the same day rather than on the next working day, a few days later, a week or more later, or can’t remember.

We obtained the following performance measures from the Quality and Outcomes Framework:
1. Percentage of total points awarded
2. Percentage of clinical points awarded
3. Percentage of hypertensive patients with controlled blood pressure
4. Percentage of eligible patients receiving cervical screening
5. Percentage of cancer patients with a recorded patient review
6. Percentage of dementia patients whose care plan has been reviewed
7. Percentage of depression patients who have been reviewed.

The GP prescribing presentation-level dataset (NHS Digital 2012) records all medicines prescribed by a practice including quantity and dose. These data are available for each month from August 2010 to December 2016. We aggregated the data to calendar years. We inflated the data for August to December 2010 by a factor of 12/5 to approximate the full year values. The prescribing indicators
below are used in reports conducted by the Care Quality Commission (Care Quality Commission 2015) and the National Institute for Health and Care Excellence (NICE 2016). The prescribing performance indicators are:

1. Total antibacterials per STAR PU
2. Broad-spectrum antibiotics as proportion of all antibiotics prescribed
3. Total hypnotics prescribed per STAR PU
4. Ratio of Ibuprofen/Naproxen to NSAIDs
5. Total items prescribed per ASTRO PU
6. Total cost per ASTRO PU
7. Percentage of branded to generic drugs

We indexed each of the prescribing variables to a mean value of 100.

We obtained data at PCT/CCG-level on flu vaccine uptake from Public Health England for all of the years that were available, 2011 to 2014. They cover the winter flu ‘season’, 1st September to 31st January the following year. The data were available at PCT level until 2012 and at CCG level from 2013. We mapped the PCT data to CCG-level using a linking file. These data are available for three sub-populations: people aged 65 years and older; pregnant women; and people aged between 6 months and 65 years defined as ‘at risk’. These data relate to the GP-registered population in England and are gathered from general practices via an online survey which had a very high response rate in each year (e.g. 99.9% in 2014-15). Uptake is measured as the percentage of eligible patients that were vaccinated.

We also obtained nine indicators from the CCG Outcomes Framework for all of the years available. All of these indicators were expressed as directly-standardised rates. These were included because it was claimed that clinically-led commissioning would improve outcomes, and these outcomes were specifically designed to be measures of commissioning effectiveness. We included potential years of life lost from causes considered amenable to healthcare (indicator 1.1). We also included four measures of preventable mortality from specific causes for the populated aged under 75 years: cancer (indicator 1.9), cardiovascular diseases (indicator 1.2), respiratory diseases (indicator 1.6) and liver diseases (indicator 1.7). These indicators are measured in calendar years from 2009 to 2014. We also included rates of four types of emergency admissions: alcohol-related liver disease (indicator 1.8); asthma, diabetes and epilepsy in the population aged under 19 years (indicator 2.7); ambulatory care sensitive chronic conditions (indicator 2.6); and ambulatory care sensitive acute conditions (indicator 3.1). These indicators are measured in financial years from 2010/11 to 2014/15.

Analysis

We analyse the effects of the doses of reform on the outcome measures using Lagged Dependent Variable models (O’Neill, Kreif et al. 2016). We began by considering each of the dose measures separately but, as they are not highly correlated, we present results containing all three of the dose measures simultaneously. We only included the number of Local Authorities in the models for the outcomes that reflected their public health/social care responsibilities.

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5 Specific Therapeutic group Age-Sex Related Prescribing Unit
6 Age, Sex and Temporary Resident Originated Prescribing Unit
7 https://www.gov.uk/government/collections/vaccine-uptake#seasonal-flu-vaccine-uptake:-figures
8 https://indicators.hscic.gov.uk/webview/
The Lagged Dependent Variable model is estimated only on data from the post-reform period \((t > 2\), where \(t=0\) refers to 2010/11). It allows flexibly for differential trends by the level of dose by including historical values of the dependent variable:

\[
y_{it} = \delta_1 x_{i1} + \delta_2 x_{i2} + \delta_3 x_{i3} + \beta_0 y_{i0} + \beta_1 y_{i1} + \beta_2 y_{i2} + \gamma_t + \epsilon_{it} \quad \text{for } t > 2
\]

in which \(y_{it}\) is the outcome for area \(i\) at time \(t\), \(x_i\) are the three measures of the doses of reform to which area \(i\) is exposed, \(y_{i0}\) to \(y_{i2}\) are the historical values of the dependent variable in years \(t=0,1,2\), \(\gamma_t\) are year effects, and \(\epsilon_{it}\) are idiosyncratic error terms. The three parameters \(\delta\) provide estimates of the effect of the reform on the outcome.

Each regression is weighted by the denominator of the dependent variable. The standard errors in the practice level models are clustered by CCG.

6.5.3 Results
The geographical variations in the three measures of the dose of reform are shown in Figures 1 to 3. On average, 56% (SD=10%) of voting governing body members of CCGs have clinical backgrounds, CCGs deal with 2.3 (SD=2.0) Local Authority Districts, and 76% (SD=31%) of practices in the CCG were also in the previous PCT.

The definitions and short labels for all of the practice level outcome variables are provided in Table 9. Descriptive statistics by year for all of the practice-level variables are provided in Table 10 and for the CCG-level variables in Table 11. The panel of practices is unbalanced due to practices opening and closing during the period.

The results of the Lagged Dependent Variable models are contained in Tables 12-18. There are 40 indicators and three measures of dose, though we only included one of the dose measures (the number of Local Authorities) in the models for the outcomes that might plausibly reflect their public health/social care responsibilities. This meant that we estimated 89 coefficients in total. Just 13 (15%) of the 89 estimated coefficients were significantly different from zero at \(p<0.05\).

More clinical contribution to decision-making is significantly associated with 4 of the 40 indicators. These are fewer A&E attendances referred by GPs, lower achievement on the depression QOF, higher levels of potential years of life lost and higher alcohol admissions.

Higher practice stability is significantly associated with 5 of the 40 indicators. These are fewer outpatient attendances, lower clinical QOF points, higher vaccination rates amongst pregnant women, a higher proportion of ibuprofen/Naproxen amongst NSAIDs prescribing, and more alcohol admissions.

Dealing with more Local Authorities is significantly associated with four of the nine public health/social care related indicators. These are lower cervical screening rates, lower achievement on the dementia QOF, and higher ambulatory care sensitive emergency admissions both for acute and chronic conditions.

6.5.4 Discussion
A variety of claims were made in the original policy documents and by our interview respondents about how the introduction of the HSCA was expected to impact on care provision, quality and outcomes. As the Act was introduced across the country, we sought to estimate its impact by developing three measures of the variability in the ‘dose’ of reform across the country. These dose
measures reflected clinical involvement in commissioning, disruption of practice membership in the higher-level organisations, and the number of Local Authorities that CCGs had to co-ordinate commissioning activity with.

We examined whether these dose measures were associated with changes over time in 40 indicators of activity, quality and outcomes. These indicators reflected hospital activity, patient satisfaction with general practice services, general practice prescribing cost and quality, and measures of population health outcomes.

Overall, our analysis indicates little impact of the Act on care provision, quality and health outcomes. Only 13 (15%) of the 89 estimated coefficients were significantly different from zero at p<0.05. The effects also demonstrated no consistent pattern. Clinical involvement in commissioning showed the weakest association with changes in the performance indicators and three of the four statistically significant associations indicated worsened outcomes. There is some suggestion in our findings of poorer public health or social care related outcomes associated with more complex CCG-Local Authority relationships (ie CCGs relating to more than one LA), and this requires further study.

There is a range of reasons why we may not have identified significant impacts of the reform on care provision and population health outcomes. The most likely is that, while the reforms had a substantial impact on some groups of staff, care provision at the front line was largely unaffected. Alternatively, we may not have chosen the right outcome variables to link to the reform, but these are indicators that are widely used to track health system performance including measures that appear explicitly in the outcomes indicator set for CCGs. It is also possible that our measures of the variability in the ‘dose’ of the reform across the country are not sufficiently sensitive to pick out the true effects of the reform. We believe that these three measures reflect key aspects of the reform and, even if they were not particularly sensitive measures, the lack of consistent pattern in their estimated effects across a wide range of indicators suggests they are not missing systematic effects. A final limitation of our analysis is, of course, that we have only been able to measure effects in the short term. We have used up-to-date data and analysed the effects in the three years following the introduction of the Act, but its true impact may take longer than three years to emerge.
<table>
<thead>
<tr>
<th>Variable label</th>
<th>Variable definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital activity</strong></td>
<td></td>
</tr>
<tr>
<td>Acsc</td>
<td>Ambulatory care sensitive emergency admissions per 100 patients</td>
</tr>
<tr>
<td>ae_att</td>
<td>A&amp;E attendances per 100 patients</td>
</tr>
<tr>
<td>ae_att_sr</td>
<td>Self-referred A&amp;E attendances per 100 patients</td>
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<td>GP-referred A&amp;E attendances per 100 patients</td>
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<tr>
<td>Op</td>
<td>Outpatient appointments per 100 patients</td>
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<td><strong>GPPS variables</strong></td>
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<td>Frequency of seeing preferred GP</td>
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<td>Opensat</td>
<td>Satisfaction with opening hours</td>
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<tr>
<td>Recommend</td>
<td>Would you recommend this practice?</td>
</tr>
<tr>
<td>Easephone</td>
<td>Ease of getting through on the phone</td>
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<td>Appexp</td>
<td>Overall experience of making an appointment</td>
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<tr>
<td>Helprecp</td>
<td>Helpfulness of the receptionist</td>
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<td>Sameday</td>
<td>Saw/spoke to GP/nurse on the same day</td>
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<td><strong>Prescribing indicators</strong></td>
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<td>ind1_items</td>
<td>Total antibacterial prescriptions per STAR PU</td>
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<tr>
<td>ind2_items</td>
<td>Percentage of broad to all antibiotics prescribed</td>
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<tr>
<td>ind3_items</td>
<td>Total hypnotics prescribed per STAR PU</td>
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<td>ind4_items</td>
<td>Ratio of Ibuprofen/Naproxen to NSAIDs prescribing</td>
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<td><strong>Quality and Outcomes Framework</strong></td>
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<tr>
<td>hyp006</td>
<td>Percentage of hypertensive patients with controlled blood pressure</td>
</tr>
<tr>
<td>cs002</td>
<td>Percentage of eligible patients receiving cervical screening</td>
</tr>
<tr>
<td>can003</td>
<td>Percentage of cancer patients with a review within 6 months</td>
</tr>
<tr>
<td>dem004</td>
<td>Percentage of dementia patients with reviewed care plan</td>
</tr>
<tr>
<td>dep003</td>
<td>Percentage of depression patients with review</td>
</tr>
<tr>
<td>pc02</td>
<td>Practice holds regular case reviews for palliative care</td>
</tr>
</tbody>
</table>
Table 10 Descriptive statistics for practice-level variables

<table>
<thead>
<tr>
<th></th>
<th>2010/11 Mean (SD)</th>
<th>2011/12 Mean (SD)</th>
<th>2012/13 Mean (SD)</th>
<th>2013/14 Mean (SD)</th>
<th>2014/15 Mean (SD)</th>
<th>2015/16 Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital activity</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>acsc</td>
<td>107.899 (29.552)</td>
<td>104.018 (29.701)</td>
<td>94.971 (28.124)</td>
<td>95.236 (28.066)</td>
<td>98.102 (29.791)</td>
<td>100.868 (29.661)</td>
</tr>
<tr>
<td>ae_att</td>
<td>95.499 (38.258)</td>
<td>99.118 (33.669)</td>
<td>100.726 (32.976)</td>
<td>100.743 (31.356)</td>
<td>100.707 (31.315)</td>
<td>102.827 (32.311)</td>
</tr>
<tr>
<td>ae_att_sr</td>
<td>98.708 (49.441)</td>
<td>101.125 (46.642)</td>
<td>101.654 (47.486)</td>
<td>99.918 (44.431)</td>
<td>98.834 (45.688)</td>
<td>99.551 (46.115)</td>
</tr>
<tr>
<td>ae_att_gp</td>
<td>92.503 (63.821)</td>
<td>95.893 (62.487)</td>
<td>98.735 (63.790)</td>
<td>100.424 (60.142)</td>
<td>104.004 (60.712)</td>
<td>108.063 (61.409)</td>
</tr>
<tr>
<td><strong>Quality and Outcomes Framework</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>qof_total</td>
<td>94.412 (4.466)</td>
<td>95.084 (3.958)</td>
<td>97.540 (3.511)</td>
<td>96.770 (4.811)</td>
<td>93.953 (7.191)</td>
<td>95.219 (6.275)</td>
</tr>
<tr>
<td>clinical_total</td>
<td>96.657 (4.497)</td>
<td>97.274 (4.012)</td>
<td>97.451 (3.719)</td>
<td>95.838 (5.437)</td>
<td>92.704 (8.681)</td>
<td>94.964 (6.709)</td>
</tr>
<tr>
<td>pc02</td>
<td>87.660 (32.892)</td>
<td>89.765 (30.313)</td>
<td>90.880 (28.792)</td>
<td>90.948 (28.695)</td>
<td>95.909 (19.809)</td>
<td>97.222 (16.435)</td>
</tr>
<tr>
<td>hyp006</td>
<td>75.736 (6.414)</td>
<td>76.563 (6.296)</td>
<td>76.962 (6.230)</td>
<td>77.743 (6.102)</td>
<td>79.520 (6.667)</td>
<td>80.488 (5.705)</td>
</tr>
<tr>
<td>cs002</td>
<td>78.114 (6.085)</td>
<td>77.930 (5.892)</td>
<td>77.956 (5.755)</td>
<td>77.493 (5.755)</td>
<td>77.044 (5.966)</td>
<td>76.905 (5.959)</td>
</tr>
<tr>
<td>can003</td>
<td>91.935 (12.888)</td>
<td>92.266 (12.301)</td>
<td>91.820 (13.346)</td>
<td>91.696 (13.200)</td>
<td>78.758 (15.560)</td>
<td>80.608 (13.214)</td>
</tr>
<tr>
<td>dem004</td>
<td>74.996 (14.425)</td>
<td>74.945 (13.989)</td>
<td>74.169 (13.790)</td>
<td>77.759 (12.674)</td>
<td>79.027 (12.906)</td>
<td>77.946 (12.565)</td>
</tr>
<tr>
<td><strong>Prescribing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ind1_items</td>
<td>106.134 (23.410)</td>
<td>99.625 (22.037)</td>
<td>103.678 (22.569)</td>
<td>99.547 (21.842)</td>
<td>98.598 (21.633)</td>
<td>92.636 (20.184)</td>
</tr>
<tr>
<td>ind2_items</td>
<td>125.128 (55.998)</td>
<td>116.218 (51.350)</td>
<td>97.448 (44.120)</td>
<td>92.338 (41.597)</td>
<td>88.372 (39.160)</td>
<td>82.507 (34.179)</td>
</tr>
<tr>
<td>ind3_items</td>
<td>111.884 (57.166)</td>
<td>106.589 (55.585)</td>
<td>101.699 (54.839)</td>
<td>98.044 (53.272)</td>
<td>93.681 (51.394)</td>
<td>88.808 (48.693)</td>
</tr>
<tr>
<td>ind5_items</td>
<td>100.042 (24.186)</td>
<td>96.835 (24.411)</td>
<td>98.682 (25.143)</td>
<td>100.545 (25.973)</td>
<td>101.890 (25.648)</td>
<td>102.150 (25.647)</td>
</tr>
<tr>
<td><strong>Patient survey</strong></td>
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<td></td>
</tr>
<tr>
<td>overallexp</td>
<td>88.750 (6.796)</td>
<td>88.221 (7.556)</td>
<td>86.786 (8.261)</td>
<td>85.888 (8.775)</td>
<td>85.084 (9.408)</td>
<td>85.456 (9.096)</td>
</tr>
<tr>
<td>pref gp</td>
<td>71.319 (66.216)</td>
<td>63.703 (63.016)</td>
<td>61.704 (60.472)</td>
<td>59.256 (59.256)</td>
<td>58.456 (59.256)</td>
<td>57.256 (59.256)</td>
</tr>
<tr>
<td>Variable</td>
<td>Mean 1</td>
<td>Mean 2</td>
<td>Mean 3</td>
<td>Mean 4</td>
<td>Mean 5</td>
<td>Mean 6</td>
</tr>
<tr>
<td>------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
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<tr>
<td>opensat</td>
<td>78.524</td>
<td>81.036</td>
<td>79.891</td>
<td>77.405</td>
<td>75.459</td>
<td>76.329</td>
</tr>
<tr>
<td>recommend</td>
<td>82.386</td>
<td>81.122</td>
<td>79.416</td>
<td>78.278</td>
<td>77.319</td>
<td>77.837</td>
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<tr>
<td>easephone</td>
<td>76.851</td>
<td>80.299</td>
<td>77.681</td>
<td>75.866</td>
<td>73.586</td>
<td>73.011</td>
</tr>
<tr>
<td>helprecp</td>
<td>52.752</td>
<td>89.636</td>
<td>88.672</td>
<td>88.029</td>
<td>87.543</td>
<td>87.758</td>
</tr>
<tr>
<td>sameday</td>
<td>79.958</td>
<td>35.510</td>
<td>35.640</td>
<td>35.886</td>
<td>36.581</td>
<td>37.026</td>
</tr>
<tr>
<td>appexp</td>
<td>n/a</td>
<td>80.544</td>
<td>77.981</td>
<td>76.306</td>
<td>75.032</td>
<td>75.136</td>
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<tr>
<td></td>
<td>(n/a)</td>
<td>(11.017)</td>
<td>(12.100)</td>
<td>(12.728)</td>
<td>(13.421)</td>
<td>(13.089)</td>
</tr>
<tr>
<td>N</td>
<td>5943</td>
<td>6674</td>
<td>6837</td>
<td>6779</td>
<td>6635</td>
<td>6347</td>
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</table>

Notes: Statistics weighted by each variable’s denominator.
### Table 11 Descriptive statistics for CCG-level variables

<table>
<thead>
<tr>
<th></th>
<th>2009 Mean (SD)</th>
<th>2010 Mean (SD)</th>
<th>2011 Mean (SD)</th>
<th>2012 Mean (SD)</th>
<th>2013 Mean (SD)</th>
<th>2014 Mean (SD)</th>
<th>2015 Mean (SD)</th>
<th>2016 Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu vaccination (%)</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>6 months – 65 years</td>
<td>n/a</td>
<td>n/a</td>
<td>51.713</td>
<td>51.406</td>
<td>52.322</td>
<td>50.411</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Over 65 years</td>
<td>n/a</td>
<td>n/a</td>
<td>73.889</td>
<td>73.218</td>
<td>73.082</td>
<td>72.633</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>n/a</td>
<td>n/a</td>
<td>27.944</td>
<td>40.821</td>
<td>40.094</td>
<td>44.619</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACS acute conditions</td>
<td>n/a</td>
<td>1113.719</td>
<td>1125.991</td>
<td>1228.505</td>
<td>1221.173</td>
<td>1312.024</td>
<td>1348.676</td>
<td>1385.810</td>
</tr>
<tr>
<td>ACS chronic conditions</td>
<td>n/a</td>
<td>801.942</td>
<td>788.841</td>
<td>829.374</td>
<td>812.625</td>
<td>828.836</td>
<td>830.938</td>
<td>836.400</td>
</tr>
<tr>
<td>Under 19 years</td>
<td>n/a</td>
<td>345.577</td>
<td>317.436</td>
<td>343.286</td>
<td>315.458</td>
<td>334.635</td>
<td>316.617</td>
<td>308.196</td>
</tr>
<tr>
<td>Alcohol related</td>
<td>n/a</td>
<td>24.925</td>
<td>25.308</td>
<td>26.195</td>
<td>25.320</td>
<td>27.493</td>
<td>29.185</td>
<td>28.628</td>
</tr>
<tr>
<td>Avoidable mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
<td>14.575</td>
<td>15.353</td>
<td>16.079</td>
<td>15.550</td>
<td>15.953</td>
<td>16.312</td>
<td>16.759</td>
<td>n/a</td>
</tr>
<tr>
<td>Respiratory</td>
<td>26.978</td>
<td>27.539</td>
<td>27.738</td>
<td>28.233</td>
<td>29.095</td>
<td>28.787</td>
<td>30.485</td>
<td>n/a</td>
</tr>
<tr>
<td>CVD</td>
<td>72.195</td>
<td>72.013</td>
<td>66.120</td>
<td>66.543</td>
<td>66.667</td>
<td>65.574</td>
<td>65.000</td>
<td>n/a</td>
</tr>
<tr>
<td>Cancer</td>
<td>118.473</td>
<td>119.555</td>
<td>121.020</td>
<td>123.241</td>
<td>123.209</td>
<td>122.762</td>
<td>121.536</td>
<td>n/a</td>
</tr>
<tr>
<td>Potential Life Years Lost</td>
<td>2155.296</td>
<td>2124.834</td>
<td>2087.274</td>
<td>2052.636</td>
<td>2069.628</td>
<td>2105.790</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>N</td>
<td>208</td>
<td>208</td>
<td>208</td>
<td>208</td>
<td>208</td>
<td>208</td>
<td>208</td>
<td>208</td>
</tr>
</tbody>
</table>

Notes: Excludes CCGs in the North East that merged during the period.
Table 12 Lagged Dependent Variable estimation of the impacts of the doses of reform on GP Patient Survey outcomes

<table>
<thead>
<tr>
<th></th>
<th>overallexp</th>
<th>prefgp</th>
<th>opensat</th>
<th>recommend</th>
<th>easephone</th>
<th>helprecp</th>
<th>sameday</th>
<th>appexp</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical decision-making</strong></td>
<td>0.0680</td>
<td>0.635</td>
<td>-0.153</td>
<td>0.481</td>
<td>0.281</td>
<td>-0.589</td>
<td>-0.764</td>
<td>0.706</td>
</tr>
<tr>
<td><strong>Practice membership stability</strong></td>
<td>-0.279</td>
<td>0.192</td>
<td>0.458</td>
<td>-0.246</td>
<td>0.213</td>
<td>-0.190</td>
<td>0.0516</td>
<td>0.00185</td>
</tr>
<tr>
<td></td>
<td>[-0.722,0.163]</td>
<td>[-0.548,0.933]</td>
<td>[-0.0977,1.014]</td>
<td>[-0.778,0.287]</td>
<td>[-0.577,1.004]</td>
<td>[-0.605,0.225]</td>
<td>[-0.715,0.819]</td>
<td>[-0.684,0.688]</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>19276</td>
<td>18292</td>
<td>19276</td>
<td>19276</td>
<td>19277</td>
<td>19277</td>
<td>19266</td>
<td>3951</td>
</tr>
</tbody>
</table>

Notes: 95% confidence intervals in brackets. * p < 0.05, ** p < 0.01, *** p < 0.001. Weighted by denominator of the dependent variable. Standard errors clustered by CCG. Models also include year dummies and historical values of the dependent variable.

Table 13 Lagged Dependent Variable estimation of the impacts of the doses of reform on hospital activity

<table>
<thead>
<tr>
<th></th>
<th>acsc</th>
<th>ae_att</th>
<th>ae_att_sr</th>
<th>ae_att_gp</th>
<th>op</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical decision-making</strong></td>
<td>-0.898</td>
<td>-0.376</td>
<td>5.271</td>
<td>-29.22***</td>
<td>0.571</td>
</tr>
<tr>
<td><strong>Practice membership stability</strong></td>
<td>0.643</td>
<td>-0.405</td>
<td>-2.397</td>
<td>3.325</td>
<td>-6.276**</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>19283</td>
<td>19283</td>
<td>19283</td>
<td>19283</td>
<td>19283</td>
</tr>
</tbody>
</table>

Notes: 95% confidence intervals in brackets. * p < 0.05, ** p < 0.01, *** p < 0.001. Weighted by denominator of the dependent variable. Standard errors clustered by CCG. Models also include year dummies and historical values of the dependent variable.
Table 14 Lagged Dependent Variable estimation of the impacts of the doses of reform on Quality and Outcomes Framework indicators

<table>
<thead>
<tr>
<th></th>
<th>qof_total</th>
<th>clinical_total</th>
<th>pc02</th>
<th>hyp006</th>
<th>cs002</th>
<th>can003</th>
<th>dem004</th>
<th>dep003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical decision-making</td>
<td>0.744</td>
<td>0.543</td>
<td>-1.573</td>
<td>-0.0549</td>
<td>-0.0667</td>
<td>-0.698</td>
<td>-1.885</td>
<td>-3.845*</td>
</tr>
<tr>
<td></td>
<td>[-0.561,2.050]</td>
<td>[-1.145,2.231]</td>
<td>[-3.941,0.796]</td>
<td>[-1.077,0.967]</td>
<td>[-0.815,0.682]</td>
<td>[-3.374,1.978]</td>
<td>[-4.274,0.503]</td>
<td>[-7.197,-0.493]</td>
</tr>
<tr>
<td>Number of Local</td>
<td>Not</td>
<td>Not</td>
<td>Not</td>
<td>-0.0693*</td>
<td>Not</td>
<td>Not</td>
<td>-0.232*</td>
<td>Not</td>
</tr>
<tr>
<td>Authorities</td>
<td>Included</td>
<td>Included</td>
<td></td>
<td></td>
<td>Included</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[-1.198,0.00192]</td>
<td>[-1.323,-0.0378]</td>
<td>[-1.220,0.292]</td>
<td>[-0.575,0.197]</td>
<td>[-0.277,0.225]</td>
<td>[-1.021,1.233]</td>
<td>[-1.105,1.331]</td>
<td>[-2.854,0.116]</td>
</tr>
<tr>
<td>Practice membership</td>
<td>-0.598</td>
<td>-0.680*</td>
<td>-0.464</td>
<td>-0.189</td>
<td>-0.026</td>
<td>0.106</td>
<td>0.113</td>
<td>-1.369</td>
</tr>
<tr>
<td>stability</td>
<td>[-1.198,0.00192]</td>
<td>[-1.323,-0.0378]</td>
<td>[-1.220,0.292]</td>
<td>[-0.575,0.197]</td>
<td>[-0.277,0.225]</td>
<td>[-1.021,1.233]</td>
<td>[-1.105,1.331]</td>
<td>[-2.854,0.116]</td>
</tr>
<tr>
<td>N</td>
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<td>12458</td>
<td>19155</td>
<td>19156</td>
<td>19025</td>
<td>19120</td>
<td>18949</td>
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</table>

Notes: 95% confidence intervals in brackets. * p < 0.05, ** p < 0.01, *** p < 0.001. Weighted by denominator of the dependent variable. Standard errors clustered by CCG. Models also include year dummies and historical values of the dependent variable.

Table 15: Lagged Dependent Variable estimation of the impacts of the doses of reform on prescribing indicators

<table>
<thead>
<tr>
<th></th>
<th>ind1_items</th>
<th>ind2_items</th>
<th>ind3_items</th>
<th>ind4_items</th>
<th>ind5_items</th>
<th>ind6_actcost</th>
<th>ind7_items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical decision-making</td>
<td>2.418</td>
<td>10.48</td>
<td>3.726</td>
<td>-0.656</td>
<td>-0.317</td>
<td>-0.229</td>
<td>0.803</td>
</tr>
<tr>
<td>Practice membership</td>
<td>-0.696</td>
<td>-1.935</td>
<td>-1.557</td>
<td>1.699*</td>
<td>0.259</td>
<td>-0.116</td>
<td>-1.212</td>
</tr>
<tr>
<td>stability</td>
<td>[-1.820,0.428]</td>
<td>[-6.326,2.457]</td>
<td>[-3.340,0.226]</td>
<td>[0.0576,3.341]</td>
<td>[-0.476,0.994]</td>
<td>[-0.918,0.686]</td>
<td>[-3.162,0.739]</td>
</tr>
<tr>
<td>N</td>
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<td>19283</td>
<td>19283</td>
<td>19283</td>
<td>19283</td>
<td>19283</td>
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</tbody>
</table>

Notes: 95% confidence intervals in brackets. * p < 0.05, ** p < 0.01, *** p < 0.001. Weighted by denominator of the dependent variable. Standard errors clustered by CCG. Models also include year dummies and historical values of the dependent variable.
### Table 16 Lagged Dependent Variable estimation of the impacts of the doses of reform on flu vaccination indicators

<table>
<thead>
<tr>
<th></th>
<th>Over 6 months to 64 years</th>
<th>65 years and over</th>
<th>Pregnant women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical decision-making</td>
<td>-0.978</td>
<td>-0.518</td>
<td>-0.352</td>
</tr>
<tr>
<td></td>
<td>[-3.242,1.286]</td>
<td>[-2.293,1.257]</td>
<td>[-5.610,4.907]</td>
</tr>
<tr>
<td>Practice membership</td>
<td>1.198</td>
<td>1.141</td>
<td>10.53*</td>
</tr>
<tr>
<td>stability</td>
<td>[-4.152,6.548]</td>
<td>[-3.058,5.340]</td>
<td>[-0.992,22.05]</td>
</tr>
</tbody>
</table>

\[N = 206\]

Notes: 95% confidence intervals in brackets. * p < 0.05, ** p < 0.01, *** p < 0.001. Weighted by denominator of the dependent variable. Excludes CCGs that did not map from PCTs. Models also include year dummies and historical values of the dependent variable.

### Table 17 Lagged Dependent Variable estimation of the impacts of the doses of reform on mortality indicators

<table>
<thead>
<tr>
<th></th>
<th>Liver disease</th>
<th>Respiratory diseases</th>
<th>Cardiovascular disease</th>
<th>Cancer</th>
<th>Potential years of life lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical decision-making</td>
<td>0.117</td>
<td>2.266</td>
<td>2.912</td>
<td>3.641</td>
<td>172.6**</td>
</tr>
<tr>
<td></td>
<td>[-2.331,2.565]</td>
<td>[-0.464,4.996]</td>
<td>[-1.911,7.734]</td>
<td>[-2.441,9.724]</td>
<td>[18.84,326.3]</td>
</tr>
<tr>
<td>Number of Local</td>
<td>-0.0534</td>
<td>-0.0675</td>
<td>Not</td>
<td>Not</td>
<td>1.784</td>
</tr>
<tr>
<td>Authorities</td>
<td>[-0.190,0.0835]</td>
<td>[-0.217,0.0819]</td>
<td>Included</td>
<td>Included</td>
<td>[-6.228,9.797]</td>
</tr>
<tr>
<td>Practice membership</td>
<td>0.142</td>
<td>-0.479</td>
<td>1.533</td>
<td>-0.515</td>
<td>18.4</td>
</tr>
<tr>
<td>stability</td>
<td>[-0.685,0.968]</td>
<td>[-1.549,0.591]</td>
<td>[-0.362,3.428]</td>
<td>[-2.693,1.664]</td>
<td>[-38.00,74.79]</td>
</tr>
</tbody>
</table>

\[N = 621\]

Notes: 95% confidence intervals in brackets. * p < 0.05, ** p < 0.01, *** p < 0.001. Weighted by denominator of the dependent variable. Models also include year dummies and historical values of the dependent variable.
Table 18 Lagged Dependent Variable estimation of the impacts of the doses of reform on hospital admissions indicators

<table>
<thead>
<tr>
<th></th>
<th>ACS acute</th>
<th>ACS chronic</th>
<th>ACS &lt;19</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical decision-making</td>
<td>40.54</td>
<td>15.79</td>
<td>-13.81</td>
<td>9.779****</td>
</tr>
<tr>
<td></td>
<td>[-78.11,159.2]</td>
<td>[-60.69,92.27]</td>
<td>[-50.29,22.68]</td>
<td>[4.212,15.35]</td>
</tr>
<tr>
<td>Number of Local Authorities</td>
<td>17.93***</td>
<td>12.66***</td>
<td>1.66</td>
<td>-0.00615</td>
</tr>
<tr>
<td></td>
<td>[11.57,24.30]</td>
<td>[8.613,16.71]</td>
<td>[-0.398,3.718]</td>
<td>[-0.322,0.309]</td>
</tr>
<tr>
<td>Practice membership stability</td>
<td>-24.96</td>
<td>-20.42</td>
<td>-4.396</td>
<td>2.472***</td>
</tr>
<tr>
<td></td>
<td>[-62.47,12.55]</td>
<td>[-43.02,2.188]</td>
<td>[-18.74,9.945]</td>
<td>[0.722,4.221]</td>
</tr>
<tr>
<td>N</td>
<td>828</td>
<td>828</td>
<td>828</td>
<td>801</td>
</tr>
</tbody>
</table>

Notes: 95% confidence intervals in brackets. * p < 0.05, ** p < 0.01, *** p < 0.001.
Weighted by denominator of the dependent variable.
Models also include year dummies and historical values of the dependent variable.
Figure 6 Map of variation in the proportion of clinical members of CCG Boards
Figure 7 Map of percentage of practices remaining in same group from PCTs to CCGs
Figure 8: Map of variation in the number of Local Authorities that CCGs deal with.
7  Chapter 7: Discussion

7.1  Summary of findings
This study sought to use sequential qualitative and quantitative methods to explore the impact of the HSCA12 on the NHS commissioning system and the conduct of commissioning. Using a realist approach, we sought to understand the contexts and mechanisms which led to changes in commissioning outcomes. Initial policy analysis identified a number of programme theories underpinning the parts of the HSCA12 relating to commissioning. These can be summarised as follows:

- That increasing clinical involvement in commissioning will lead to more effective commissioning decisions;
- That the creation of a national organisation responsible for overseeing commissioning and for commissioning some services would remove the NHS from political interference and increase consistency in commissioning specialised and primary care services;
- That the creation of commissioning organisations with greater autonomy would support locally-focused commissioning responsive to population need;
- That commissioning for outcomes rather than focusing upon process measures would improve those outcomes;
- That managerial support for commissioning would be more efficient if provided on a contractual basis from a competing market of commissioning support organisations;
- That giving responsibility for public health services to Local Authorities would ensure a more joined up approach to public health improvement which would bring together health services with other services such as housing and transport;
- That the creation of HWBs as statutory partnerships between the NHS and LAs would strengthen those partnerships and lead to greater democratic engagement for the NHS.

The resulting NHS reorganisation was extensive, involving the creation of new organisations at all levels of the Service. It was accompanied by a significant reduction in managerial spending including on commissioning, and an overall reduction in the rate of increase in NHS expenditure. Outcomes from the reorganisation are therefore difficult to attribute to particular changes in the commissioning system, as there have been many different influences at work. However, our realist approach with detailed qualitative data collection has allowed us to explore in depth some of the factors influencing the commissioning of services at local and national levels, and attempt to relate these to trends in outcomes potentially affected by changes in the commissioning system.

Based upon the above analysis of the theories underpinning HSCA12, we addressed three groups of research questions, exploring:
- Commissioning system complexity;
- The conduct of commissioning;
- Quality and outcomes of commissioning.

Addressing each of these in turn, we found that the new system was considerably more complicated than what had gone before. In particular, we found that splitting responsibility for commissioning some types of service between multiple commissioners had led to considerable difficulties in coordination. This was particularly evident in service areas where services for a particular condition ranged from preventive services, through locally commissioned NHS services to more specialised services. Examples include services for HIV, child mental health, and obesity. The new system divided responsibility for commissioning parts of these services between a variety of commissioners, and this has led to problems, with potential gaps in service provision. We also found that the local commissioning landscape had become increasingly complicated, with a proliferation of new local
organisations with which local commissioners were required to engage. Some of these new organisations were created by the HSCA12 (e.g. Health and Wellbeing Boards), whilst others were created in order to compensate for the loss of regional oversight consequent upon the abolition of Strategic Health Authorities. Within this more complex system, respondents described the need for ‘workarounds’ to make the system work coherently, and the importance of longstanding local relationships in this process. More recent moves towards new regional collaborative structures such as STPs suggest recognition by policy makers of these complexities. Our study was completed before any impact of STPs had been felt, but our finding suggest that, without clear statutory roles and authority, the creation of new regional-level organisations will not automatically lead to improvements in commissioning, nor will it solve the problems that we have highlighted associated with fragmentation of commissioning responsibilities. The loss of managerial expertise resulting from the reduction in managerial spending and the creation of CSUs was keenly felt, and the value of managers who had worked in the local area for some time and who knew each other well was frequently highlighted. Whilst it was intended that CCGs would be more autonomous than PCTs, in practice, the fiscal pressures facing the NHS, among other factors, meant that the oversight regime for CCGs was, if anything, more stringent than that for PCTs. Respondents described an initial feeling of freedom, which quickly receded as the CCG assurance process developed.

In terms of the conduct of commissioning, we used ‘tracer’ services to explore commissioning practices in depth. Across all of the tracers, the fragmentation of commissioning identified in initial interviews was an issue, with particular issues affecting sexual health services. The changes embodied in the HSCA12 had acted to both facilitate and impede service developments, depending upon the exact local contextual conditions. Where there were good local collaborative relationships, the reorganisation had caused disruption and delay; where local services were felt to be suboptimal and difficult to change, the reorganisation had provided an impetus for change. Overall, however, the incentives to increased secondary care activity embedded within the payment by results system continued to dominate, driving activity and requiring commissioners to put in place specific approaches to counteract their effects. For example, much of the focus in orthopaedic commissioning was upon measures to reduce secondary care activity.

The greater involvement of clinicians in commissioning did not appear to have led to any clearly identifiable changes to commissioning practice, other than at the margins. Commissioning at national level for specialised and screening services was problematic, with particular issues identified with the move away from commissioning specialised services for particular populations towards an approach focused upon commissioning particular providers. Integration of services became an increasing focus throughout the study, with multiple new initiatives established. In general the fragmentation of commissioning responsibilities was unhelpful in facilitating integration, although local commissioners were working hard across organisational boundaries to overcome these difficulties. Good local relationships between individuals who understand the local health and care landscape were seen as vital in this.

The creation of a market in commissioning management support services intended in the HSCA12 did not occur. We found mixed approaches to the provision of commissioning support, with some CCGs seeking to do this work themselves, whilst others contracted much of it out to their local CSU. In some areas staff from CSUs were seconded to CCGs, creating some confusion over line management.

Commissioning for outcomes proved difficult to operationalise, with the various outcomes frameworks (which changed during the course of the study) not found to be particularly helpful in directing commissioning activity. The role of commissioners in influencing some of the outcomes in the framework was felt to be limited, and in practice the need to remain in financial balance tended
to dominate. Overall, the new system appeared to have made service change more difficult, although as we have indicated in specific local contexts some aspects of the Act were found to have acted to catalyse change.

Focusing upon quality and outcomes that could be attributed to commissioning, interview respondents were asked to identify their perceived successes and the factors underpinning these. Increased clinical involvement in commissioning was felt to have been a positive development, although there were few concrete claims for improvements in outcomes associated with it. In general, claims to success in this area focused upon improvements in relationships between commissioners and their local providers, with clinician to clinician relationships highlighted as proving invaluable in achieving particular service improvements. However, such improvements tended to be driven by the personal interests of the clinicians involved, and only appeared to be successful where there were provider representatives also interested in the same issue. Respondents also highlighted their success in establishing their CCGs as new organisations and maintaining financial balance, and suggested that their relationships with their Local Authority colleagues had improved. Success in taking on new responsibility for primary care commissioning in 2015 and 2016 was also referred to, with respondents highlighting success in supporting quality improvement in general practices.

Prompted by the findings from initial qualitative research, the first analysis using quantitative data examined trends in cervical screening in detail in order to investigate whether the more complex commissioning arrangements for this service following the HSCA12 had had an impact on outcomes. We combined quantitative and qualitative evidence, and showed that the local issues identified by interview respondents relating to lack of clarity over budgets, division of responsibility for commissioning and lack of mechanisms to overcome these issues appeared to have led to a larger than expected decline in screening rates in the areas most affected. This increase in commissioning complexity was, as previously discussed, an unintended consequence of the HSCA12. It arose from a number of unrelated decisions, each of which could, in its own terms, be justified. However, the net result was a system with multiple commissioners each of which was responding to their own set of incentives and drivers, the sum of which had the potential to generate adverse consequences for the system as a whole.

We then expanded this analysis to examine the effects of three different measures of the ‘dose’ of the reform on 40 indicators of a wide range of outcomes likely to be associated to different degrees with the changes in the commissioning system that took place after HSCA12. The three ‘dose’ measures reflected variability in the extent of clinical involvement in commissioning, the disruption of general practice membership of commissioning organisations and the number of LAs that CCGs needed to coordinate commissioning activity with. This analysis showed little evidence of significant impacts of the reform and, where the effects were statistically significant, the patterns were not consistently positive or negative. There is some suggestion in our findings of poorer public health or social care related outcomes associated with more complex CCG-Local Authority relationships (ie CCGs relating to more than one LA), and this requires further study. Most importantly, we found no evidence that more involvement of clinicians in CCG commissioning at board level was associated with greater improvements a range of outcomes, including measures of hospital usage, aspects of primary care quality and measures of patient experience.

We found some differences between the two geographical areas studied. Area 1 was perhaps less affected by the HSCA12, with the new local organisations created by the Act mapping in relatively straightforward fashion to the boundaries of the old organisations. This was found to be particularly helpful in terms of managerial support, with trusted local managers who were well known regarded as especially helpful. In Area 2, by contrast, the new organisations took on quite different
configurations from their predecessor organisations, meaning that GP practices were expected to work together in different ways. There had been some problems associated with CCG formation in this Area, and towards the end of the data collection period some CCG mergers were being discussed. The increased disruption associated with the creation of new organisations had been significant, but respondents in this Area also spoke about the advantages of now working with what they regarded as ‘more likeminded’ peers. In Area 1, there were good pre-reform collaborative arrangements and area-wide forums, which were, to some extent, disrupted by the HSCA12. However, these previous collaborations were also useful in supporting the development of mitigating strategies to offset some of the changes. For example, the area-wide sexual health group in Area 1 was able to negotiate a cross-charging policy for out of area patients, whereas in Area 2 no such system was put in place, with Local Authorities unsure whether they would be able to obtain reimbursement for patients who had obtained services outside their home area. In Area 2, there were fewer pre-existing collaborative forums. In some service areas, the disruption associated with the HSCA12 acted to support the redesign of services which were regarded as having become ‘ossified’ in an unhelpful way. Both areas struggled with funding pressures, with particular issues associated with the pressures on Local Authority funding, which had knock on effects for services commissioned across the NHS/Local Authority boundary, such as dementia services. The reorganisation of NHSE had been experienced as particularly problematic in Area 2, with respondents highlighting a loss of local attention as NHSE refocused its activity at the level of large regions to accommodate the reduction in staff and resources available to NHSE. In Area 1, by contrast, some local NHSE activity remained and was found to be helpful. In both Areas, pre-existing and ongoing relationships between commissioners in different organisations, and between commissioners and providers were particularly helpful in navigating the new complexities; knowing who to call was felt to be important in supporting commissioning activity in a more fragmented system.

The study design allowed exploration of changes over time. In the early phases of data collection (2015), CCGs were relatively new organisations, having been fully established only in 2013. Clinicians had genuine enthusiasm for their new roles, but their initial sense of freedom and increased autonomy became tempered by increasing performance management and financial pressures. By the end of the data collection period (in July 2017) the initial turbulence created by any major reorganisation had dissipated, but rapid policy developments such as the development of new integrated care collaborations under the auspices of the Five Year Forward View (NHS England 2014) meant that commissioners were continuing to have to respond to a rapidly changing environment. We have highlighted the proliferation of new co-ordinating structures and programmes, such as Urgent Care Networks, System Resilience Groups and the Better Care Fund. In early 2016, local CCGs were required to co-operate with local Providers and Local Authorities to establish regionally-based Sustainability and Transformation Plans/Partnerships (STPs) (NHS England, NHS Improvement et al. 2016). STPs cover a large area, with 44 established across England. Many cover as many as ten or more CCGs. STPs were not prominent in interviewees’ accounts of their work, in part because their role and remit was not yet clear, and in part because focus of the study was upon the day-to-day role and activities of CCGs. However, they formed the background context against which our later data collection occurred, with interviewees often highlighting their uncertainties about how the STP plans would affect them.

7.2 Explaining and interpreting the findings

In one sense, it can be argued that the HSCA12 was extremely successful – the new system was implemented rapidly and completely, with the establishment of multiple new organisations within the intended timescale, and respondents were rightly proud of their success in enacting the reforms and setting up new organisations. This was possible, in part, because of the hierarchical nature of
the NHS, and the enactment of the new system in law. PCT staff had no option but to comply, as their organisations were legally disbanded. In addition, it was made a contractual obligation for all GP practices to become members of a CCG. However, it would have been possible for frontline staff to slow or sabotage the implementation, had they refused to engage with the CCG concept. The risk of this occurring was mitigated by the early establishment of a ‘pathfinder’ programme, in which groups of clinicians were encouraged to come forward at an early stage to establish themselves as ‘shadow’ CCGs, with an implied promise that by doing so they would have the opportunity to shape the development of the CCG concept (Checkland, Coleman et al. 2012). This could be described as ‘establishing distributed leadership’, one of Best et al.’s ‘five simple rules’ for successful health care system change (2012), along with establishing feedback loops, attending to history, engaging physicians, and involving patients and families. The process of implementing the HSCA12 established ‘feedback loops’, with shadow CCGs offered opportunities to feedback to the centre about their experiences, shaping, for example, guidance about governance processes and constitutions (Checkland, Coleman et al. 2012). Furthermore, the HSCA12 claimed to take account of history, with the foundational policy White Paper (Department of Health 2010) explicitly referencing the history of clinically led commissioning. Clinician involvement was built into the new system, but patient and public involvement was minimal, with the new architecture of involvement (via local and national Healthwatch) having limited input to the development of the system and facing many challenges (Carter and Martin 2016). Thus, the changes as enacted could be said to meet most of the requirements set out by Best et al for successful change. However, as we have demonstrated, the benefits claimed by the architects of the new system do not appear to have ensued, and the underlying programme theories espoused in policy documents have not been borne out in practice. It could therefore be said that this represents the successful implementation of a major system change which has not delivered the expected benefits. It could also be argued that the overall failure of the changes to affect service performance and population outcomes suggests that wholesale structural change is of limited value in improving service performance (Pollitt 2009).

Whilst the reasons underlying this are complex, the study does appear to point to two significant features of the HSCA12 which have made commissioning more difficult. The first is the abolition of Strategic Health Authorities. In the absence of a regional tier of system management, close enough to local organisations to understand the pressures and tensions that they faced but distant enough to take a strategic overview, a multitude of additional forums and tiers of organisation were created in the immediate aftermath of the HSCA12. These included Urgent Care Networks, System Resilience Groups and, latterly, STPs. The need to reinvent regional oversight and co-ordination would seem to point to this being an important element of a well-functioning system. However, the new bodies and collaborative forums being established have no statutory underpinning or responsibilities; it remains to be seen whether or not these will be required. The second major finding is of the complications introduced by the splitting of commissioning responsibilities for different types of services between different commissioners. The move of the public health function to LAs, for example, has excellent arguments in its favour, but, in practice, it caused significant problems for services such as sexual health and obesity, where services span the full range from prevention to specialised treatments. Similarly, the move of primary care commissioning as a result of HSCA12 away from local level was quickly found to be untenable, with the return of this responsibility to CCGs beginning in 2015/16. However, the fact that this revised distribution of responsibilities is not in legislation has brought with it its own complications, with primary care commissioning requiring a complex and flexible (‘work-around’) relationship between CCGs and NHSE (McDermott, Warwick-Giles et al. in press).

Looking in more detail at the specifics of the changes enacted by the HSCA12, one explicit intention underlying the Act was to decentralise the system and empower local front-line clinicians. England is not alone in oscillating between relative centralisation and decentralisation of the health system
The current study suggests that, whilst the rhetoric underpinning the HSCA12 focused upon decentralisation as the goal, in practice, the strong role of NHSE in performance managing CCGs resulted in a de facto recentralisation within a very short period of time, with CCGs experiencing a diminution of their autonomy over time (Checkland, Dam et al. in press). The creation of STPs suggests a swing back towards a more decentralised but integrated system, but it remains to be seen how this will be enacted, particularly given the existing statutory responsibilities of various organisations, and how much central control will be retained by NHSE over these separate organisations.

Clinician leadership of commissioning was a central intention underlying the HSCA12. As noted above, clinically-led commissioning has a considerable history in the NHS. Study of initiatives going back to the early 1990s suggests that it is possible to engage clinicians in commissioning, and that it can have some benefits, but that these are generally focused upon issues directly under the control of the clinicians involved, focusing upon local services provided in primary care and on prescribing etc. There is little evidence that clinicians are more successful than managers in bringing about larger scale system changes focused upon improving population health (Miller, Peckham et al. 2015). The current study confirms this, with neither qualitative nor quantitative elements of the study finding evidence of significant benefits associated with greater clinical involvement in commissioning. Those benefits which there are appear to be highly context-dependent, arising from particular local circumstances. This is in accord with previous studies of CCGs (McDermott, Checkland et al. 2016). More recent evidence confirms this, with a study of CCG clinical leadership showing that clinical leadership was most successful where clinicians were able to span boundaries and broker understanding with providers, and that most successful service change led by CCG clinicians was seen in areas most relevant to primary care, such as GP, community and urgent care services (Storey, Holti et al. 2018). However, in spite of claims to success in improving primary care services made by our respondents, we did not find any quantitative evidence to back up these claims.

Whilst the HSCA12 radically altered the structures associated with commissioning services, the practicalities of commissioning – incentive structures, contracts, role of competition etc. - largely remained unchanged. The system was still underpinned by a payment system based upon payment for activity, in which most secondary care services were paid for according to a standard tariff payment. The main type of contract between commissioners and providers remains the standard NHS contract (Petsoulas, Allen et al. 2011), with incentives for improved performance governed by the Commissioning for Quality and Innovation Framework (CQUINs), according to which additional payments are available for meeting particular quality targets. Thus, the new system had embedded within it the same incentives and pressures as existed before the Act. Sheaff et al (2013) compared commissioning in Germany and the UK, and concluded that the UK system, which they described as ‘surrogate planning’, relies largely upon incentive payments and cash-limited commissioner budgets to control provider behaviour. This approach, they argue, may limit costs compared with the German system (where all provider activity must be reimbursed), and facilitates an evidence-based approach to treatments, but may reduce consumers’ access to care. This provides a partial explanation for the explosion of the cost of specialised care when the responsibility moved away from a population-focused approach to the national level. Under NHSE commissioning of specialised care, there was no cash-limited budget for a population, rather specialised hospitals were reimbursed for the work that they did, leading to a rapid increase in costs.

More widely, our study suggests that CCG commissioners had the same types of levers available to them to try to control provider behaviour as existed prior to the Act; hence the actual commissioning activity that we observed appeared very similar to that undertaken by PCTs before them (Smith, Shaw et al 2013; Porter, Mays et al 2013; Shaw, Smith et al 2013). However, it had
been intended that the move to a more outcomes-focused performance management regime would begin to shift activity more towards a population-health approach. However, the Commissioning Outcomes Assessment Framework did not appear to be operating in this way, with activity focused as before on maintaining financial balance and meeting those process targets which retained a high profile politically such as the length of waits in emergency departments. There is limited available evidence to support the notion that commissioning for outcomes (rather than processes) improves those outcomes (Bovaird et al 2011). O’Caithan et al (2015) explored the extent to which planned investment by PCT commissioners was successful in improving outcomes, and found limited evidence that this approach worked. In particular, even where commissioners pre-identified the outcomes of interest, both commissioners and providers found it difficult to identify changes in indicators which were clearly related to the work done. More recently, Jones et al (2017) studied a particular outcomes-based commissioning scheme in England in which providers of addiction services were paid according to the outcomes they achieved rather than for the treatments they provided. The evaluation found a small increase in abstinence amongst recipients of the services paid for on the basis of outcomes achieved, but fewer patients entered or completed treatment. Our study suggests that that the HSCL2, despite rhetorical commitment to an outcomes-based approach, has not operationalised this in a meaningful way.

Most recent developments in the NHS in England, including planned moves towards integration and place-based approaches (Ham and Alderwick 2015), have suggested that the balance of activity between commissioners and providers may need to change, with large providers taking over some of the so-called ‘tactical’ aspects of service design and management, with commissioners adopting a more strategic role (NHS Clinical Commissioners 2017). ‘Strategic commissioning’ is defined thus:

*Strategic commissioning is system-wide leadership and service planning across a defined area, involving the development of an understanding of needs and requirements at a population level, monitoring system performance, redesigning the system architecture and repositioning services to better meet local need. This looks to deliver improvements over the longer term and across a wider area.* (NHS Clinical Commissioners 2017 p4)

Our study suggests that these things may be difficult to achieve, and would require commissioners to work together creatively across a variety of ‘footprints’. In particular, the current study illustrates the multiple scales across which different types of services may need to be planned and delivered, and the need for good personal relationships and relevant collaborative forums. International evidence concurs, suggesting that, whilst a strategic approach to purchasing and commissioning services is regarded as desirable across health systems, in practice this is very difficult to achieve (Klasa, Greer et al. 2018).

### 7.3 Strengths and weaknesses

This study has provided a detailed and nuanced analysis of the changes to the commissioning system arising out of the HSCL2. The study explored an extremely complex set of policy changes and initiatives over a two year period. Over this time, the organisations being studied were simultaneously affected severely constrained budgets and a number of initiatives designed to move away from supplier competition towards a system based around collaboration between commissioners and providers. This latter change occurred half way through the data collection period. It is, perhaps, of interest to note that, whilst CCGs in the study areas were involved in a number of these collaborative initiatives, the day-to-day conduct of commissioning continued much as it had done before. This rapidly shifting landscape makes it somewhat difficult to attribute particular issues or achievements to the HSCL2 itself. However, our realist approach allowed us to not only focus upon the specifics of the changes enacted, but also provided us with an understanding of the programme theories underlying the changes made. We were therefore able
specifically to explore the extent to which these were realised in practice. This allowed us to isolate, at least in part, some of the effects of the Act from the more general changes occurring in the system. The realist approach has been criticised, in particular because of the fact that ‘contexts’ and ‘mechanisms’ are not always clearly distinguishable (Porter and Shortall 2009; Marchal, van Belle et al. 2012). Notwithstanding this, we found that these concepts provided a useful analytical framework which allowed us to make sense of complex and rapidly changing situations.

The strength of the qualitative parts of the study lies in the focus on two broad geographical areas, within which we focused not only upon the micro-level of how individual CCGs were tackling their role, but also at the meso level of how organisations were interacting and working together. This is an approach which, as far as we can tell, has not been used previously in the English NHS. It provided a vivid picture of a rapidly developing and complicated landscape, with even those most closely involved sometimes unsure as to who was responsible for what. Respondents appeared to value the opportunity to sit down and reflect on what they had experienced, and we received a strong impression of dedicated managers and professionals working hard to try to make the system function. Our choice of ‘tracer’ service areas proved to be a valuable tool in exploring in more depth some specific aspects of the new system, with screening, sexual health and specialised service commissioning providing particularly valuable insights into the complexities which ensue when responsibility for commissioning different types of services is dispersed between a number of types of organisation. Our dementia tracer was specifically chosen to provide insight into aspects of integration between health and social care. However, in practice, it proved less illuminating than we expected, in part because we found something of a disconnect between health care commissioners – for whom dementia is a clinical condition, with a focus upon diagnosis and referral for treatment – and social care commissioners, who adhere to a social model of health and whose focus is upon care needs rather than the condition underlying those needs. With hindsight it may have been better to investigate integrated commissioning via a focus on the areas covered by the Better Care Fund.

As a mixed-methods study, we sought at all times to integrate our qualitative and quantitative data collection and analysis. This is in contrast to many mixed-methods studies, in which the two approaches either occur more or less in isolation, or in which the qualitative data is seen as primarily valuable in explaining observed quantitative results. In this study emerging qualitative findings were discussed at monthly full team meetings, allowing the quantitative team to design their ‘dose of reform’ measures based on a detailed understanding of the changes as they were experienced by local participants. The focus on cervical screening arose out of this collaborative approach, with the qualitative study findings driving the direction of the quantitative analysis. Guest (2013) suggests that, rather than seeking to characterise mixed methods research in terms of a rigid typology, which may impose an artificial structure on research which is fluid and interactive, mixed methods studies should be characterised in terms of the timing of data integration, and the purpose of that integration. From this perspective, the current study could be described as involving sequential integration, with early qualitative work informing both the design of the quantitative analyses and the choice of outcome indicators. The purpose of integration was therefore to ensure that the quantitative analyses adequately accounted for the complexity of the developing system. In addition, in the cervical screening analysis, sequential data collection was used with the purpose of explicitly testing claims made about the direction of change in expected outcomes for a specific service area. This was intended to provide a rich description which allows causal inference. This complements the realist approach, by explicitly testing claims made about links between contexts and mechanisms.

In terms of the quantitative analysis of outcomes, national administrative data were used. This has the advantages of comprehensive coverage and consistent data collection before and after the reform. However, this is necessarily restricted to outcomes that are measured in the national
datasets. Nonetheless, these are relevant indicators that are included explicitly in the outcome indicator set for CCGs, alongside measures of primary care quality and patient experience. Furthermore, the mixed methods approach allowed us to ask respondents to nominate outcomes which they felt had been improved by their work following the reforms. In practice, many of the claims to success made in interviews proved impossible to operationalise with these routine data, with many respondents focusing upon process issues such as successful establishment of their CCG, and successful transfer of responsibility for primary care commissioning.

The reform was introduced universally at the same point in time making assessment of impact difficult. Rather than relying on interrupted time series, which could be biased by other contemporaneous macro-level changes affecting outcomes, we developed measures of the so called ‘dose’ of reform to the commissioning system and used a continuous difference-in-differences framework to evaluate the impact of differing levels of reform ‘dose’ on a range of relevant outcome indicators. This approach controls for geographical differences in outcomes associated with the ‘dose’ of reform measured before the reform was introduced. Therefore, it controls for the effects of variables such as population deprivation, rurality, distance from services, and local service configuration. However, in the absence of an entirely infeasible randomised trial of the reforms to the commissioning system, this approach relies on the ability of the dose measures to discriminate between areas in how much they are affected by the reform and could always, in theory, be confounded by macro trends that have varying effects that happen to be correlated with the ‘dose’ measures.

Finally, we could only examine impact in the three years following introduction of the Act. It is possible that it takes longer for major reforms like these to start to show improvements in outcomes. For example, study of major changes in public sector organisations suggests that such change takes many years to bed down, with improvement in outcomes unlikely to occur in the short term (Kuipers, Higgs et al. 2014). Furthermore, the extent of subsequent change seen in the NHS, particularly in the form of new initiatives for integrated working, make it increasingly challenging to isolate aspects of the original Act for investigation. As a result, it is not at all clear that the passage of more time will necessarily allow the effects of HSCA12 to be more clearly identified.

7.4 **Recommendations for further research**

This study suggests a number of issues which require further substantive research, as well as providing some methodological avenues to explore:

- The ‘dose of reform’ approach allowed us to explore the impacts of a large scale reform which was implemented simultaneously across a whole country. The value of this mixed method approach is that it allowed us to explicitly examine the programme theories which animated the reforms. Further exploration and testing of this approach in other large scale system changes would be valuable;

- The use of qualitative evidence analysed within a realist framework allowed the explicit testing of claims made about mechanisms of action. This required a flexible approach to the quantitative analysis, with the exact quantitative design and focus in terms of outcomes, not pre-specified. We would recommend this as an approach, alongside more conventional pre-determined quantitative designs;

- The approach that we took, exploring interactions across health economies, provided useful information about the meso-level of inter-organisational collaboration. There are relatively few studies of the NHS which explore this. Cross-UK comparisons between the NHS in
England, Scotland, Wales and Northern Ireland (each of which devolved system has taken a different approach to meso-level co-ordination and collaboration) would be of value;

- Building upon this, we have highlighted the importance of a statutory regional tier of co-ordination of service commissioning. Further study could use historical and international evidence to explore the optimum approach at this level including: responsibilities; accountabilities; and governance;

- We have highlighted the complexity of accountabilities within the commissioning system. Further study is required of how best to operationalise accountabilities, in particular, the balance between local determination of desired outcomes and national/regional requirements;

- Further study is required of integrated approaches to commissioning, in particular, between Local Authority commissioners and CCGs. Our use of the dementia services tracer provided limited insight into this, and further study of how commissioners with different statutory roles and in systems with different funding models (e.g. universal versus means tested services) can work together is required. Our study suggests a possible association of poorer outcomes with more complex CCG-Local Authority relationships and this also requires further study;

- The outcomes that we studied were those available in national administrative data sets. Further study could usefully explore the most relevant outcomes to test approaches to service integration;

- We have confirmed existing evidence which suggests that general practitioner clinical involvement in commissioning requires careful management and is most likely to deliver benefits to the design and management of community-based services. Further research is required to elucidate the best approaches to this sort of clinical involvement, with a particular focus upon how such involvement should be targeted and how outcomes can be optimised at a time when GPs are under significant workload pressures.

### 7.5 Recommendations for policy

#### 7.5.1 Fragmentation of commissioning responsibilities

We have highlighted throughout this report the negative impact of the division of commissioning responsibilities between a range of different organisations. Statutory responsibility for different types of commissioning remains dispersed and, at times, opaque, with our respondents highlighting areas of dispute, such as paying for cervical smears. Commentators are calling for a ‘place-based’ approach to commissioning (Ham and Alderwick 2015). However, evidence from other health systems suggests that this is difficult to achieve (Klasa, Greer et al. 2018). Importantly, current legislation does not support this approach, with our respondents frequently referring to the ‘workarounds’ required to manage these complexities. We therefore recommend that:

- The re-integration of commissioning responsibilities for geographical populations would carry with it significant benefits, with the potential to support approaches more focused upon population health and well-being as well as upon care provision. This would require legislation to adjust statutory responsibilities for commissioning.
7.5.2 Clinical involvement in commissioning
We found no clear evidence of quantitative improvements in outcomes associated with general practitioner involvement in commissioning, and qualitative claims to added value were local and context-dependent (McDermott et al 2016). This is not to say that clinical involvement is not valuable, but it needs to be targeted and specific.

- Our study does not support a policy focus upon involving GPs in commissioning acute care services, but there is some evidence that they may add value in commissioning community and out of hospital services.

7.5.3 Managerial roles in commissioning
Our study suggests that the role of managers with a long term and detailed knowledge of their local area is important in service commissioning. The CSU model (of contracting out managerial functions) has not delivered improved commissioning management, and has contributed to fragmentation as valuable knowledge and skills have been lost at local level.

- CCGs require adequate managerial resources to deliver their commissioning responsibilities, and this requires sufficient locally-based staff able to build relationships across organisational boundaries.

- Managers with long-term experience in a local area should be valued and rewarded. It is important that the new emphasis upon system ‘transformation’ and new approaches to service delivery do not prevent lessons from being learned from past initiatives.

7.5.4 Commissioning for outcomes
Our study suggests that commissioning for outcomes is difficult, and there is no evidence that it has as yet delivered any improvements in outcomes. Evidence from other public services supports this finding (Bovaird 2011).

- If the role of commissioners becomes more strategic, with providers undertaking the service design aspects of the role, the choice of outcomes against which to hold providers to account becomes even more important. The balance between patient experience, activity-based and clinical outcomes needs to be carefully considered.

7.5.5 Commissioning incentives
We found, that the existing ‘Payment by Results’ hospital payment system continues to provide a dominant incentive, with hospital activity rewarded over community-based alternatives.

- As new approaches to commissioning and new forms of contract are developed and used, attention needs to be paid to the embedded incentives at system level.

7.5.6 Regional oversight
We found evidence that the loss of the regional oversight role of the Strategic Health Authority caused significant difficulties following the HSCA12, necessitating the reinvention of a range of regional bodies, none of which currently has a statutory role. The most recent of these – STPs – aims to support and enable collaboration across coherent regional geographies. However, STPs have unclear governance arrangements and accountabilities, and collaboration is voluntary.
• Statutory regional oversight has a role to play in supporting local health economies to work together to deliver coherent services to their population.

7.5.7 The importance of history and evidence
Many of the problems which we have illustrated as arising following the HSCA12 were predictable based upon evidence from the past. In particular: previous rounds of NHS reform in the 1990s required the reinvention of a regional tier of oversight and system management; studies of GP-led commissioning have consistently shown that clinicians are more effective in influencing primary and community-based services rather than large scale service redesign; and commissioning for outcomes has been difficult to achieve in other fields.

• It is important that existing evidence is understood and taken into account. In particular, it is important that current moves towards greater integration takes account of the weight of evidence that integration initiatives, whilst improving patient experience, are unlikely to generate significant savings nor reductions in service activity overall (Nolte and Pitchforth 2014).

7.6 Dissemination of findings
Our dissemination strategy targets four main audiences:

• Department of Health staff responsible for policy relating to commissioning
• Participants
• Commissioners, including NHS England, Local Authority commissioners, and CCGs
• Social policy academics, both UK and international

Table 19 sets out the outputs relevant to each of these audiences:
Table 19 Outputs relevant to different audiences

<table>
<thead>
<tr>
<th>Output</th>
<th>Department of Health</th>
<th>Participants*</th>
<th>Academics</th>
<th>Commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim report</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tracer short reports (WS2)</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Final report</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Academic papers</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Academic conference presentations</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Seminars/meeting presentations*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*Once this final report is agreed with the Department of Health, we will offer participants the opportunity for bespoke feedback in a format which suits them. This might for example, include attendance at Governing Body meetings, or presentations at public meetings in study sites. In addition we have offered to conduct seminars for Department of Health and Social Care policy makers, and are liaising with the Department of Health and Social Care and NHS England about opportunities to discuss our findings informally with relevant staff.

In addition to the project reports, a number of academic papers have been accepted for publication:


One other paper has been submitted to academic journals, with two more in preparation. These address: the concept of ‘care pathways’ as an organising concept for commissioning; our findings relating to cervical screening; and the overall quantitative results from the study.

Scheduled academic conference presentations include:

- Health Policy and Politics Network Spring meeting April 2018
- Organisational Behaviour in Healthcare, Montreal May 2018
- Health Services Research UK July 2018
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8 Appendix 1 Commissioning Fact Sheet
Commissioning fact sheet
for clinical commissioning groups

First published by the NHS Commissioning Board Authority: July 2012
Published by the NHS Commissioning Board: October 2012

This fact sheet sets out the services to be commissioned by clinical commissioning groups (CCGs) from April 2013. It also sets out the complementary services to be commissioned by the NHS Commissioning Board (NHS CB), local authorities and Public Health England (PHE). A number of previous documents have described commissioning responsibilities, but this fact sheet is intended to be a helpful summary, with further clarity on certain aspects. It is not a substitute for legislation or guidance or your own legal advice.

In general, you as CCGs will be responsible for commissioning health services to meet all the reasonable requirements of your patients, with the exception of:

- certain services commissioned directly by the NHS CB;
- health improvement services commissioned by local authorities; and
- health protection and promotion services provided by PHE.

You will play a key role in promoting integrated care and, as a member of your local health and wellbeing board(s), in assessing local needs and strategic priorities. This will mean working collaboratively with local authorities and the NHSCB. You may decide to pool budgets or have collaborative commissioning arrangements.

Your commissioning responsibilities (for the areas set out in part 1) will include:

- planning services, based on assessing the needs of your local population;
- securing services that meet those needs; and
- monitoring the quality of care provided.

In most cases, you will also be responsible for meeting the cost of the services provided. There will be some services that you commission for your geographic area (e.g. A&E services) where the costs for an individual patient may be charged to another CCG (i.e. in an area where the patient is registered or, if unregistered, where they live). There will be guidance on this in due course, which it is expected will follow the current ‘responsible commissioner’ arrangements.

Local authorities will take the lead for improving health and coordinating local efforts to protect the public’s health and wellbeing. They will also provide advice and expertise on how to ensure that the health services you commission best improve population health and reduce health inequalities. For health improvement activities transferring to local authorities, such as smoking cessation, sexual health and drug/alcohol services, you may wish to agree joint commissioning arrangements. You should also consider how best to work with local authorities to ensure that health improvement activities are an integral part of the healthcare services that you commission.1

1 More detail on local authorities’ commissioning responsibilities can be found at:
A new executive agency, PHE, will take the lead for public health at a national level. It will deliver a number of national health services and support the development of the public health workforce. The NHS CB will also commission some public health services nationally as agreed with the Secretary of State.

This fact sheet includes information that is subject to secondary legislation. For example, the list of specialised and highly specialised services that the Board will be required to commission has not been finalised; the final list will be included in regulations, which are expected to be laid before Parliament in the Autumn.
1. **Services to be commissioned by CCGs**

Unless otherwise indicated (such as for urgent and emergency care), your commissioning responsibility will be for your local population. Your local population includes registered patients (some of whom may live in a different area) and unregistered patients usually resident in your area. It does not include members of the armed forces, nor their families if they are registered with Defence Medical Services (DMS) rather than a NHS GP practice, Nor does it include those detained in prison and other custodial settings.

Local authorities will provide public health advice to CCGs on the commissioning of these services.

<table>
<thead>
<tr>
<th>CCG commissioning</th>
<th>Related NHS CB commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency care (including 111, A&amp;E and ambulance services) for anyone present in your geographic area</td>
<td>Urgent care provided under GP contracts</td>
</tr>
<tr>
<td>Out-of-hours primary medical services (for everyone present in your area), except where this responsibility has been retained by practices under the GP contract</td>
<td>Urgent dental care</td>
</tr>
<tr>
<td><strong>Elective hospital care</strong></td>
<td></td>
</tr>
<tr>
<td>Community health services (such as rehabilitation services, speech and language therapy, continence services, wheelchair services, and home oxygen services, but not public health services such as health visiting and family nursing)</td>
<td>Specialised and highly specialised services</td>
</tr>
<tr>
<td>Other community-based services, including (where appropriate) services provided by GP practices that go beyond the scope of the GP contract</td>
<td>Hospital and community dental services</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td></td>
</tr>
<tr>
<td>Maternity and newborn services (excluding neonatal intensive care)</td>
<td>Public health services for children from pregnancy to aged 5 (Healthy Child Programme 0-5) including health visiting and family nursing partnership (commissioned on behalf of Secretary of State)</td>
</tr>
<tr>
<td>Children’s healthcare services (mental and physical health)</td>
<td>Antenatal and newborn screening aspects of maternity services</td>
</tr>
<tr>
<td><strong>Services for people with learning disabilities</strong></td>
<td>Health services (excluding emergency care) and public health services for people in prisons and other custodial settings</td>
</tr>
<tr>
<td>Mental health services (including psychological therapies)</td>
<td>Health services (excluding emergency care services) for members of the armed forces and their families (those registered with DMS)</td>
</tr>
<tr>
<td><strong>NHS continuing healthcare</strong></td>
<td>Mental health interventions provided under GP contract</td>
</tr>
<tr>
<td></td>
<td>Some specialised mental health services</td>
</tr>
<tr>
<td></td>
<td>Secure psychiatric services</td>
</tr>
<tr>
<td></td>
<td>Operation of Independent Review Panels</td>
</tr>
<tr>
<td>CCG commissioning</td>
<td>Related NHS CB commissioning</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>Infertility services</td>
<td>Infertility services for the armed forces and some infertility services for veterans in receipt of compensation under the Armed Forces Compensation Scheme on grounds of infertility</td>
</tr>
</tbody>
</table>

2. **Services to be commissioned by the NHS CB**

<table>
<thead>
<tr>
<th>NHS CB commissioning</th>
<th>Related CCG commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential and additional primary medical services through GP contract and nationally commissioned enhanced services</td>
<td>Out-of-hours primary medical services (where practices have opted out of providing OOH services under the GP contract)</td>
</tr>
<tr>
<td>Out-of-hours primary medical services (where practices have retained the responsibility for providing OOH services)</td>
<td>Community-based services that go beyond scope of GP contract (akin to current Local Enhanced Services)2</td>
</tr>
<tr>
<td>Pharmaceutical services provided by community pharmacy services, dispensing doctors and appliance contractors</td>
<td>Meeting the costs of prescriptions written by member practices (but not the associated dispensing costs)</td>
</tr>
<tr>
<td>Primary ophthalmic services, NHS sight tests and optical vouchers</td>
<td>Any other community-based eye care services and secondary ophthalmic services</td>
</tr>
<tr>
<td>All dental services, including primary, community and hospital services and including urgent and emergency dental care</td>
<td></td>
</tr>
<tr>
<td>Health services (excluding emergency care) and public health services for people in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure children’s homes, secure training centres, immigration removal centres, police custody suites)</td>
<td>Emergency care, including 111, A&amp;E and ambulance services, for prisoners and detainees present in your geographic area</td>
</tr>
<tr>
<td></td>
<td>Health services for adults and young offenders serving community sentences and those on probation</td>
</tr>
<tr>
<td></td>
<td>Health services for initial accommodation for asylum seekers</td>
</tr>
<tr>
<td>Health services for members of the armed forces and their families (those registered with DMS)</td>
<td>Health services for veterans or reservists (when not mobilised), for whom normal commissioning responsibilities apply</td>
</tr>
<tr>
<td>Prosthetics services for veterans</td>
<td>Emergency care, including A&amp;E and ambulance services, for serving armed forces &amp; families registered with DMS practices present in your geographic area</td>
</tr>
<tr>
<td>(Primary care for members of the armed forces will be commissioned by the Ministry of Defence)</td>
<td></td>
</tr>
<tr>
<td>Specialised and highly specialised services</td>
<td>Related services along patient pathways</td>
</tr>
</tbody>
</table>

2 Resources attached to current Local Enhanced Services (LES) (except for public health LES) are proposed to be included in CCG funding.
3. **Public health services to be commissioned by the NHS CB**

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health services for children from pregnancy to age 5 (Healthy Child Programme 0-5), including health visiting, family nurse partnership, responsibility for Child Health Information Systems</td>
</tr>
<tr>
<td>(Responsibility for children's public health 0-5 due to transfer to local authorities in 2015)</td>
</tr>
<tr>
<td>Immunisation programmes</td>
</tr>
<tr>
<td>National screening programmes</td>
</tr>
<tr>
<td>Public health care for people in prison and other places of detention</td>
</tr>
<tr>
<td>Sexual assault referral services</td>
</tr>
</tbody>
</table>

Further detail on the arrangements for commissioning these services will be confirmed in Autumn 2012.
4. Public health services to be provided or commissioned by local authorities

In addition to the functions set out below, local authorities will be responsible for providing population health advice, information and expertise to CCGs to support them in commissioning health services that improve population health and reduce inequalities.

Local authorities will also need to ensure plans are in place to protect the health of their population and will have a supporting role in infectious disease surveillance and control and in emergency preparedness and response.

<table>
<thead>
<tr>
<th></th>
<th>Local authority commissioning</th>
<th>Related CCG commissioning</th>
<th>Related NHS CB commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s public health 5-19</td>
<td>Healthy Child Programme for school-age children, including school nursing</td>
<td>Treatment services for children, including child and adolescent mental health services (CAMHS)</td>
<td>Healthy Child programme (pregnancy to five years old), including health visiting and family nurse partnership Immunisation programmes</td>
</tr>
<tr>
<td>Sexual health</td>
<td>Contraception over and above GP contract</td>
<td>Promotion of opportunistic testing and treatment</td>
<td>Contraceptive services commissioned through GP contract</td>
</tr>
<tr>
<td></td>
<td>Testing and treatment of sexually transmitted infections (excluding HIV treatment)</td>
<td>Termination of pregnancy services (with consultation on longer-term arrangements)</td>
<td>Sexual assault referral centres</td>
</tr>
<tr>
<td></td>
<td>Sexual health advice, prevention and promotion</td>
<td>Sterilisation and vasectomy services</td>
<td>HIV treatment</td>
</tr>
<tr>
<td>Public mental health</td>
<td>Mental health promotion, mental illness prevention and suicide prevention</td>
<td>Treatment for mental ill health</td>
<td>Mental health interventions under GP contract</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Some specialised mental health services</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Local programmes to address inactivity and other interventions to promote physical activity</td>
<td>Advice as part of other healthcare contacts</td>
<td>Brief interventions in primary care</td>
</tr>
<tr>
<td>Obesity programmes</td>
<td>Local programmes to prevent and address obesity, e.g. National Child Measurement Programme and weight management services</td>
<td>Advice as part of other healthcare contacts</td>
<td>Brief interventions in primary care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS treatment of overweight and obese patients</td>
<td>Some specialist morbid obesity services</td>
</tr>
<tr>
<td>Drug misuse</td>
<td>Drug misuse services, prevention and treatment</td>
<td>Advice as part of other healthcare contacts</td>
<td>Brief interventions in primary care</td>
</tr>
<tr>
<td>Local authority commissioning</td>
<td>Related CCG commissioning</td>
<td>Related NHS CB commissioning</td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Alcohol misuse</td>
<td>Alcohol misuse services, prevention and treatment</td>
<td>Alcohol health workers in a variety of healthcare settings</td>
<td>Brief interventions in primary care</td>
</tr>
<tr>
<td>Tobacco control</td>
<td>Local activity, including stop smoking services, prevention activity, enforcement and communications</td>
<td>Brief interventions in secondary care and maternity care</td>
<td>Brief interventions in primary care</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Any locally-led initiatives</td>
<td>Nutrition as part of treatment services, dietary advice in healthcare settings</td>
<td>Brief interventions in primary care</td>
</tr>
<tr>
<td>NHS Health Check Programme</td>
<td>Assessment and lifestyle interventions</td>
<td>NHS treatment following NHS Health Check assessments and ongoing risk management</td>
<td>Support in primary care for people with long term conditions identified through NHS Health Checks</td>
</tr>
<tr>
<td>Reducing and preventing birth defects</td>
<td>Population level interventions to reduce and prevent birth defects (with PHE)</td>
<td>Maternity services</td>
<td>Interventions in primary care such as pre-pregnancy counselling or smoking cessation programmes Some specialist genetic services Antenatal and newborn screening aspects of maternity services</td>
</tr>
<tr>
<td>Health at work</td>
<td>Any local initiatives on workplace health</td>
<td>NHS occupational health services</td>
<td></td>
</tr>
<tr>
<td>Dental public health</td>
<td>Epidemiology, dental screening and oral health improvement, including water fluoridation (subject to consultation)</td>
<td></td>
<td>Oral health as part of dental contracts</td>
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<tr>
<td>Accidental injury prevention</td>
<td>Local initiatives such as falls prevention services</td>
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<tr>
<td>Seasonal mortality</td>
<td>Local initiatives to reduce excess deaths</td>
<td></td>
<td>Flu and pneumococcal vaccination programmes</td>
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Some of the above services will be mandated for local authorities and the commissioning of other services will be discretionary. More information is available at: [www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131901.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131901.pdf)
5. Public health services to be provided or commissioned by PHE – and related NHS CB/CCG commissioning

<table>
<thead>
<tr>
<th>Prevention and early presentation</th>
<th>PHE</th>
<th>Related CCG commissioning</th>
<th>Related NHSCB commissioning</th>
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</thead>
<tbody>
<tr>
<td>Health improvement support for local authorities and NHS CB</td>
<td>Promoting early diagnosis as part of community health services and outpatient services</td>
<td>Promoting early diagnosis as part of primary care</td>
<td></td>
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<tr>
<td>Social marketing and behaviour change campaigns including campaigns to prompt early diagnosis via awareness of symptoms</td>
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<tr>
<th>Infectious disease</th>
<th>Current functions of the Health Protection Agency (HPA) in this area</th>
<th>Treatment of infectious disease</th>
<th>Co-operation with PHE and local authorities on outbreak control and related activity</th>
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<tbody>
<tr>
<td></td>
<td>Public oversight of prevention and control, including coordination of outbreak management (with supporting role for local authorities)</td>
<td>Co-operation with infectious disease services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Co-operation with PHE and local authorities on outbreak control and related activity</td>
<td>Some specialist infectious disease services</td>
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</tbody>
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<tr>
<th>Emergency preparedness and response</th>
<th>Current functions of HPA</th>
<th>Emergency planning and resilience remains part of the core business for the NHS</th>
<th>Mobilising the NHS in the event of an emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency preparedness including pandemic influenza preparedness (supported by local authorities)</td>
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<tr>
<th>Health intelligence and information</th>
<th>Intelligence and information on health improvement and health protection (with local authorities), including many existing functions of Public Health Observatories, Cancer Registries, National Cancer Intelligence Network, HPA and National Treatment Agency for Substance Misuse’s National Drug Treatment Monitoring System</th>
<th>NHS data collection and information reporting systems (for example, Secondary Uses Service)</th>
<th>NHS data collection and information reporting systems</th>
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9 Appendix 2: interview topic guides

Questions for work stream 1: Understanding the new commissioning landscape

CCGs

Individual
What is your current role and job description?

What is your recent job history and have you moved between organisations?

Organisation
Since taking on new organisational form in 2013 how has the work of your organisation changed?

What are the new responsibilities that you undertake?

What would you say are the top priorities of the organisation? What are your top priorities in this role? Can you explain the process by which you arrived at this set of priorities?

What are the greatest challenges facing you and the organisation at present?

How are you able to address these challenges? Can you give examples?

What do you consider to be the most significant achievement(s) of your organisation since 2013?

Accountability
To whom is your organisation accountable? i.e. formal lines of accountability? How does the system of accountability work in practice? Are there other informal lines of accountability?

What degree of autonomy do you think your organisation has?

How does this differ from previous arrangements?

Inter-organisational working
Here in (local area) which organisations does your organisation work with? (NHSE, Area Team, CCGs, LAs, CSUs, HealthWatch, Strategic Clinical Networks, any other)?

How do you work together? E.g. joint committees, formal or informal arrangements? What are the channels of communication?

How would you characterise your inter-organisational working relationships? Which work best?

Which are the most challenging? Why is this the case?

Do you think that there is overlap or duplication of work between organisations (within GM/Birm)?

How do you relate to national level bodies?

Performance management
Is there a system of performance management that is applied between organisations? How does this work? How successful is it? What impact do you think it is having? How does it affect you?

Are there multiple systems of performance management between you and other organisations? Are there areas of duplication or difficulty?

**Commissioning**

We are interested in how commissioning works within [local area] and how you work and co-operate with other organisations. Can you give me some examples of what works well and why it works well and conversely what is problematic and why it is problematic?

Is this different to how it was before 2013 reforms? Can you give examples of how it is different?

Are there any major pieces of work currently being undertaken by your organisation?

We are interested in looking at how commissioning is working in five tracer areas: orthopaedics, dementia care, sexual health services, specialised cardiac services and screening.

What role does your organisation play in commissioning these activities?

Reflecting on your organisation’s role – if you could change one thing what would it be?

**Signpost to other participants**

In the next phase of our research we will be exploring issues concerning the commissioning of these five tracer areas in some depth. Could you suggest individuals within your organisation that we could approach to discuss these commissioning areas in greater depth?
Questions for work stream 1: Local authority commissioners
Understanding the new commissioning landscape

Individual
What is your current role and job description?
What is your recent job history and have you moved between organisations?

Directorate
What impact has the HSCA had on the work that you do? Has your work changed since 2013? Has there been a re-organisation of Directorates in this LA in the last two years? (Ask for details). If so, why has this re-organisation taken place?
What would you say are the top priorities of this Directorate? What are your top priorities in this role? Can you explain the process by which you arrived at this set of priorities?
What are the greatest challenges facing you and the Directorate at present?
How are you able to address these challenges? Can you give examples?
What do you consider to be the most significant achievement(s) of your Directorate since 2013?

Accountability
To whom is your Directorate accountable? i.e. formal lines of accountability? How does the system of accountability work in practice? Are there other informal lines of accountability?
What degree of autonomy do you think your Directorate has?

Inter-organisational working
Which organisations does your organisation work with? (NHSE, Area Team, PHE, CCGs, LAs, CSUs, HealthWatch, Strategic Clinical Networks, Third sector, voluntary orgs, any other)? How do you work together? E.g. joint committees, formal or informal arrangements? What are the channels of communication?
How would you characterise your inter-organisational working relationships? Which work best? Which are the most challenging? Why is this the case?
Do you think that there is overlap or duplication of work between organisations within this geographical area?

Performance management
Is there a system, of what is known in the NHS as performance management, which is applied within LAs? (i.e. sanctions, checks, balances, procedures). Could you explain this? How does this work? How successful is it? What impact do you think it is having? How does it affect you?

Commissioning
We are interested in how commissioning works within this geographical area and how you work and co-operate with other organisations. Can you give me some examples of what works well and why it works well and conversely what is problematic and why it is problematic?
Is this different to how it was before 2013 reforms? Can you give examples of how it is different?
Are there any major pieces of work currently being undertaken by your organisation?
We are interested in looking at how commissioning is working in five tracer areas: orthopaedics, dementia care, sexual health services, specialised cardiac services and screening.
What role does your organisation play in commissioning these activities?

Reflecting on your organisation’s role – if you could change one thing what would it be?

Signpost to other participants
In the next phase of our research we will be exploring issues concerning the commissioning of these five tracer areas in some depth. Could you suggest individuals within your organisation that we could approach to discuss these commissioning areas in greater depth?
Topic guide: WS 4

Preparation: read transcript of first interview (and others from the same organisation)
What were the initial goals/priorities stated or suggested?

[Use these to prompt responses to question about key successes…]

What were the key issues discussed?

[Briefly explore how these issues have developed since earlier interview(s)]

Successes and challenges
What have been your key successes as an organisation (or other entity, e.g. locality)?
What evidence demonstrates these successes most clearly to you?
What features/mechanisms of the system have facilitated this change?
What features/mechanisms of the system have inhibited this change? How have you dealt with these challenges?
Are there any quantitative data that illustrate this chance that we could access? If so, where/how?
What have been the biggest changes since 2012? (Prompt re. policy changes, e.g. STPs, Vanguards)
What have been the biggest challenges since 2012?
What mechanisms are in place to start to measure success locally?

Performance assessment/outcome measures
What outcomes measures are you assessed on that you feel do/do not accurately reflect your performance? (i.e. what outcome measures are within your gift to effectively influence)
What outcome measures do you think your performance should be assessed on (whether they currently exist or not)?
How you think the current approach to commissioning performance assessment could be improved?

Quality / Reductions in health inequalities / Increased system efficiency
Have aspects of the new commissioning arrangements facilitated improvements in...
Quality? Reducing health inequalities? System efficiency? Access to services?
[Explore the details of this… Can they suggest available data to evidence it?]

Overarching project themes
Do these themes resonate with your experience and, if so, in what ways?
• Workarounds
• Importance of relationships
• Fragmented responsibilities
• Lack of levers
• Lack of system arbiter/ring holder
• Perverse incentives
• Public service mentality
Appendix 3: Tracer short reports

Work Stream 2 – tracer short report: Dementia Services

Dr Jon Hammond
Dr Alex Hall
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Introduction

The aim of this project is to understand the development of the commissioning system in England following implementation of the Health and Social Care Act 2012 (hereafter ‘HSCA12’). An initial phase of data collection (March – December 2015) used interviews and observation to develop an overview of the functioning of the new commissioning system. The second phase of the project (November 2015 – March 2017) built upon these findings, focusing in upon five different service area (‘tracers’) in order to explore in more depth the issues arising in different contexts. This report summarises the findings of our exploration of the commissioning of dementia services. This ‘tracer’ was chosen because of its potential to shed light on the development of integrated services between health and social care since the needs of people living with dementia and their informal carers typically span both sectors, and their care requires effective coordination of health and care services.

Dementia is a general term for a number of diseases of the brain that have common symptoms, including problems with thinking, memory, language, and co-ordination. The most common cause is Alzheimer’s disease, accounting for around two-thirds of all cases. Although it is not an inevitable part of ageing, age is a risk factor: dementia affects around one in 14 people over 65, and one in six people over 85. It is progressive, and in the later stages people are highly dependent upon health and social care support as their care needs become increasingly complex. Pharmacological treatments may help lessen some symptoms in the early stages, but there is no effective cure. There is increasing focus upon non-pharmacological intervention (e.g. cognitive therapies; assistive technologies; social support) to help people to live as well as possible for as long as possible. For a detailed overview, see the Alzheimer’s Society dementia guide Invalid source specified.

In the last decade there has been increased global and national policy focus upon dementia, underpinned by widespread acknowledgement that there are dramatically increasing numbers of people with dementia. For the UK, figures commonly cited in recent years have suggested that there are around 800,000 people with dementia, projected to double by 2040, with overall costs to the economy of around £23bn expected to triple within the same timeframe Invalid source specified. 9

The complex and diverse care needs of rising numbers of people with dementia place increasing demand upon health and social care organisations, as well as unpaid carers (usually relatives). The

1 This picture has been challenged by recent work highlighting that such projections have been based on 1980s epidemiological data, and that more recent data suggest prevalence rates (the proportion of the population with dementia) may be stabilising because of overall improvements to people’s health in early and middle life. This alternative position may be difficult to reconcile with the prevailing narrative: “Catastrophic estimates of dementia in future ageing societies serve present political and charity campaigns, and encourage investment into pharmaceutical and health-care industries, maintained by sustained attention of social and general media. Scientific evidence needs to match this excitement to continue to secure research funding and resources” (Wu, et al., 2016).
NHS provides diagnostic services, ongoing assessment, and may fund post-diagnostic social care; otherwise social care is provided by local authorities (LAs) or is self-funded. There is also a key role for the third sector in providing information and additional support services. Increasingly, these organisations are encouraged to work in an integrated manner.

In order to understand the impacts of the HSCA12 upon the commissioning of dementia services, it is necessary to consider the Act as part of a broader array of policy initiatives relating to dementia services and to the integration of health and social care. In the following section, we provide a brief summary of major policy initiatives relating to these two areas. For more detail, see the House of Commons Library briefing papers on dementia policy and health and social care integration respectively.

**Dementia and integrated care: siting the HSCA12 within a broader policy landscape**

Specific focus upon dementia began in earnest in 2006 with the first national clinical guideline on the care and support of people with dementia and their carers. This included emphasis upon integrated working amongst diverse health and social care organisations. In 2007, the Labour government announced its intention to make dementia a national priority via the development of the first ever National Dementia Strategy, which contained three broad aims: (i) to increase awareness and reduce stigma; (ii) to increase diagnosis rates; and (iii) to enhance post-diagnostic services. Following the 2010 general election, the Coalition government demonstrated continuing commitment to these aims through the Prime Minister’s Challenge. With the Alzheimer’s Society, the government also launched the Dementia Friends initiative in 2012, to help develop dementia-friendly communities through mass roll-out of dementia awareness training within workforces of community organisations. Dementia has also informed the remit of Public Health England (PHE), the executive agency of the Department of Health created by the HSCA12 to oversee national health and wellbeing. PHE lent its support to the Dementia Friends initiative and has made dementia risk reduction one of its seven priorities.

These dementia-specific initiatives form part of a broader context of initiatives to support the integration of health and social care, beginning with the Health Act 1999 which enabled the NHS and LAs to pool budgets. The HSCA12 introduced statutory Health and Wellbeing Boards, subcommittees of LAs, to act as key co-ordinating mechanisms or stewards for local health and social care systems. The HSCA12 was introduced in the midst of a number of spending reviews which all announced initiatives to integrate budgets, most notably the £5.3bn Better Care Fund (implemented from 2015/16) to create pooled budgets between LAs and NHS Clinical Commissioning Groups (CCGs), signed off by Health and Wellbeing Boards. The Care Act 2014 created the legislative basis for the Better Care Fund, and pronounced statutory requirements for LAs regarding social care, including an obligation to support carers. There have also been initiatives for organisational integration. The Five Year Forward View (FYFV) included emphasis upon the integration of health and social care services through new care models. These include ‘integrated care pioneers’ primarily aimed at improving user and carer experiences of services, and ‘vanguards’ in 50 local sites testing a number of different models to improve coordination of community and/or hospital services. Implementation of the FYFV is to be supported by Sustainability and Transformation Plans (STPs) covering 44 areas across England. Each STP outlines a vision for integrating health and social care within its footprint from April 2017 to March 2021, with funding to be allocated from a £2.1bn Sustainability and
Transformation Fund. STPs have no statutory basis and require a willingness from multiple stakeholders to cooperate.

This brief exploration of the policy landscape shows that there is no specific, novel programme theory within the HSCA12 that underpins any explicit changes to the commissioning of dementia services. The HSCA12 also did not give much specific attention to the integration of health and social care. Figure 1 below shows a timeline illustrating key relevant initiatives since 2006, highlighting where the HSCA12 sits in relation to other initiatives. It shows that the commissioning of dementia services is influenced by longer-standing initiatives around dementia and integration that span at least a decade. These two strands of policy initiatives contain their own programme theories, which may be summarised at a broad level as:

- The programme theory underpinning dementia-specific initiatives is founded upon the main aims of the National Dementia Strategy, and may be thought of as one of linear logicality: a clear and widespread conception of ‘dementia’ as a discrete condition, and a better understanding of its challenges, will result in more appropriate and effective preventive and supportive interventions because of increased attention, knowledge and information-sharing.
- The programme theory underpinning integration initiatives holds that integrating NHS and local authority services will result in the patient being placed at the heart of care, enhancing clinical outcomes, patient experience and value for money, because of a range of mechanisms to integrate budgets and ways of working.

The relevance of the HSCA12 to dementia services commissioning has been to place primary care clinicians at the heart of commissioning through the creation of CCGs, and to introduce (either directly or indirectly) of a number of mechanisms (such as Health and Wellbeing Boards and the Better Care Fund, which added democratic oversight) to support integration of care.

![Figure 1: Key initiatives relevant to dementia and the integration of health and social care, 2006 - 2017](image)

**Dementia ‘tracer’: approach and findings**

In order to explore the impact of the HSCA12 upon dementia services commissioning, we undertook extensive reading of relevant policy and other documents, and conducted interviews with a range of commissioners and service providers. These comprised the 78 interviews in Work Stream 1 (involving individuals from CCGs, NHSE, and LAs), and subsequent, more detailed Work Stream 2 interviews with nine individuals from LAs, CCGs, and third sector organisations, in two English Areas, which
correspond to NHSE Area Team footprints (as originally conceived). Data analysis was iterative, with the findings from the emerging analysis informing later interviews.

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million and a large city at its core.
- **Area 2** is a highly ethnically and socio-economically diverse metropolitan county with a population of over 1.25 million and a large central city.

This report presents findings organised into two overarching themes: (1) The impact of CCGs upon dementia services, and (2) Mechanisms for integrated working.

**Theme 1: The impact of CCGs upon dementia services**

One joint commissioner of dementia services in an Area 2 locality felt that the creation of CCGs as discrete organisations had led to fragmentation and variability in service provision:

“before where you could talk to one PCT and they would broker arrangements with other PCTs, now you have to speak to each CCG separately... so I’ve had to [develop] business cases by CCGs... it means that it can be a postcode lottery” [16450, CCG, Area 2, Oct 2016]

One senior CCG member in Area 1 reflected that joint working between CCGs and LAs around dementia commissioning was more influenced by a local history of joint working than the creation of CCGs directly, highlighting the absence of specific attention in the Act to integrated working:

“there’s a history of working like that together and I don’t think the Act has particularly catalysed it or impeded it... you could argue that the Act has helped because now we’ve got clinicians driving more of that commissioning... [who] see the unintended consequences of reductions in local government expenditure... but frankly my view is that that’s just a pragmatic response to where we are anyway” [18967, CCG, Area 1, Jan 2017]

Participants offered reflections about opinions of primary care clinicians on national targets for diagnosis rates, and the impact these opinions had on commissioning. Work stream 1 data suggested that in one locality within Area 2, there was reluctance amongst some clinicians to diagnose because of a perceived lack of post-diagnostic social care services [6814, CCG, Area 2, Sept 2015]. However, data from work stream 2 suggested that historic attitudes to dementia amongst clinicians in this CCG appeared to be changing over time:

“you still get people at a strategic level that think what is the point of commissioning services for people with dementia [because there is no cure]... [however] we are building up a generation of newer GPs that are coming on board with it” [16450, CCG, Area 2, Oct 2016]

Similarly, work stream 2 data from an Area 1 CCG revealed that the drive to increase diagnosis was seen as an essential first step in supporting people with dementia:

“we have very high diagnosis rates, and that’s because I think the majority of our clinicians recognise that the only way to start to deal with some of these issues is to
know that they exist... there’s a whole range of different support [services] available” [18967, CCG, Area 1, Jan 2017]

One commissioner in Area 2 expressed frustration with an apparently high level of influence that GPs held within the CCG (“the one thing the CCG will listen to is clinicians”), and feared that this influence was unquestioned by members of an older generation:

“people with dementia and their carers, they’re old people that won’t ask for anything, they’re grateful for whatever they get, so if the GP says there’s no services for you, they will believe the GP” [16450, CCG, Area 2, Oct 2016]

The prominent role for clinicians in shaping the commissioning and awareness of dementia services may have resulted in these services being viewed through the lens of a medical model rather than a social model of care. This was exemplified by one dementia services joint commissioner in Area 2, reflecting on an information event she had arranged for GPs:

“[a family carer speaking at the event] was telling these GPs that how going to a carers’ group for two hours every two weeks kept her going for four years looking after her dad with dementia, and around the room there was this sharp intake of breath... she didn’t want anything else, she just wanted to be able to talk to somebody, but how do you get that across when all they’re interested in is measurables?” [16450, CCG, Area 2, Oct 2016]

This quote suggests that the medical model may hold influence because it is more amenable to discrete measurements required by national CCG Improvement and Assessment Framework indicators. One of these indicators is the proportion of people with dementia whose care plans have received an annual review. One commissioner in Area 2 was sceptical of the appropriateness of this indicator for service improvement, suggesting that it did not capture more holistic aspects of social support:

“the government rate CCGs based on a 12 month annual review that GPs have to do with a care plan... we have these workers that spend all their time with people in the first diagnosis but that’s not included... there’s a lot of tick-box stuff... they’re looking in the wrong place for signs of improvement.” [19314a, CCG & LA, Area 2, Feb 2017]

One CCG participant in Area 2 highlighted how the need to commission dementia support services at a broad social level was felt to be a very different type of commissioning than the traditional commissioning of medical services:

“There’s a massive amount of anxiety [about dementia] but there’s nothing we can do about it. So that’s about organising society at a system level to cope with the impacts of cognitive impairment in old people. How the hell do we support people and carers to deal with that phenomenon in society? That’s a completely different type of commissioning, that’s involving engaging and talking to people, partnership working” [6010, CCG, Area 2, Aug 2015]

There were questions about the amount of resources commissioners would be able to allocate to dementia services in a milieu of competing performance management priorities, although in December 2016 in Area 1 it seemed that there had been improvements in recognition of dementia services:
“the CCG as commissioners have obviously only got a finite amount of money... if you’ve got another condition that they’re really not performing well with, why would they put the money against dementia... that was quite noticeable when there was a review done of [all Area 1] locality plans, albeit it was very early days and I think locality plans have become much more sophisticated now” [18216, Service provider, Area 1, Dec 2016]

The impact of primary care clinicians as influential agents seemed to have been recognised by a prominent third sector organisation, which sought to present its offers of service in ways that might appeal to GPs:

“we’ve worked very much in selling the service to GPs as a treatment, part of your treatment plan, so speaking their language” [17945, Third Sector, Area 2, Dec 2016]

Another third sector participant from Area 1 pointed to some confusion about how far the third sector was seen to be a viable option:

“because of the awareness of dementia there’s much more open door... [but] there’s still a little bit of that ‘we can’t work with the voluntary sector because we’d be recommending your services and we can’t do that”’ [17946, Third Sector, Area 1, Dec 2016]

Reasons why CCGs may show some reluctance to engage with the third sector were unclear, but CCG participants in both Areas highlighted some challenges in working with the sector. Some felt that a prominent national organisation may have lacked flexibility in a financially competitive environment and that its service offers may not have been tailored to local needs:

“[National dementia organisation] are very much stuck in ‘we want to provide you with these two roles... because it’s our national branding’... a lot of CCGs and commissioners just give them money because it’s [name of organisation]... they couldn’t understand why they weren’t winning any of our contracts and it’s because they don’t compete anywhere else” [19314a, CCG & LA, Area 2, Feb 2017]

“let’s take the concept of the dementia support worker but let’s understand is that a concept that has been sold by [national dementia organisation] or does it have viability in a world where we’ve got lots of competing layers of resource?... [we came to] a view that there would be some things that we could do collectively across [Area 1], but that did not include the concept of the dementia support worker” [18967, CCG, Area 1, Jan 2017]

Other challenges included a lack of cross-sector cohesion:

“the voluntary sector needs to better connect together to have a standard offer that it puts to commissioners... that requires a maturity of leadership that often isn’t there in these organisations because they’re run by volunteers a lot of the time, and understandably they’re thinking about their own back garden as opposed to thinking about how can we work with that [other third sector] organisation next door” [18967, CCG, Area 1, Jan 2017]

In Area 2, one participant from a LA highlighted a mechanism to encourage recognition of the third sector through synchronising operating procedures:
“the standard operating procedures [the third sector use] aligns to what the health service would use... because we want to ensure that when we’re referring or encouraging the sector to be used that we are confident what they’re delivering will meet NHS requirements” [19314b, LA, Area 2, Feb 2017]

In summary, this theme highlights a number of issues arising from the creation of CCGs. CCG participants offered mixed reflections about the value of national targets for diagnosis rates. The influence of primary care clinician opinion appeared to lean towards viewing dementia through a more medical model, which was amenable to discrete measurement demanded by performance indicators. There was uncertainty about how far the third sector was integrated into the dementia care system.

**Theme 2: Mechanisms for integrated working**

**Health and Wellbeing Boards** became fully operational in April 2013, but in work stream 1 interviews, around two years after the introduction of the Boards, some participants seemed uncertain about their functionality. One Area 2 CCG member suggested that its Board was “a bit fluffy and overly strategic without real clarity as to how it’s going to achieve what it wants” [6165, CCG, Area 2, Aug 2015], and a member of an Area 1 LA was uncertain how their Board might fulfil a different role from existing LA structures of governance [6167, LA, Area 1, Aug 2015]. However, one participant from a different Area 1 LA identified how they took turns biennially with their CCG in chairing the Health and Wellbeing Board, in order to create a shared endeavour [7033, LA, Area 1, Sep 2015].

There appeared to be established mechanisms for integrated working between CCGs and LAs around dementia services. One CCG member cited a joint “dementia steering group” but highlighted challenges arising from differences in ways of working between the CCG and the LA:

“we talk about the dementia steering group where the local authority is represented... but there’s a lot of distrust between the two organisations from a financial perspective and I think also from a, kind of, understanding of the different ways we commission... even the language is different in terms of what things mean... we’ve had services disinvested from the local authority with short notice... the CCG has picked up the tab a few times... working with colleagues in the CCG, if I say something and they disagree with it, they’ll be quite honest... with the local authority, that doesn’t come through... they’ll have to talk to their boss and their boss will have to talk to their boss... it’s just a very different way of working” [3391, CCG, Area 1, May 2015]

Another CCG member referred to a “fully integrated commissioning team”:

“The team under which dementia is commissioned is a fully integrated commissioning team between the city council and the CCG... managed by a director of integrated commissioning who reports both to me and to the director of adult and child social services in the city council” [18967, CCG, Area 1, Jan 2017]

However, in work stream 1 interviews many participants referred to Section 75 of the NHS Act 2006, which permitted pooled budgets between LAs and the NHS, as a facilitator of integrated working (e.g. 3665, CCG, Area 1, May 2015; 10071, LA, Area 2, Nov 2015). Others reflected that similar arrangements to Health and Wellbeing Boards had been in place prior to the HSCA12 (e.g. 6775, CCG, Area 2, Sept 2015). Therefore, it was unclear how far integrated working regarding dementia services was influenced by the Health and Wellbeing Boards created by the HSCA12.
One CCG member felt that the Better Care Fund was a potent mechanism for integrating care [5732, CCG, Area 2, Aug 2015]. National Audit Office analysis published at the time of writing this tracer report stated that the Better Care Fund has not yet achieved its potential, but has been successful in incentivising local areas to work together invalid source specified. The Fund appeared to result in commissioners parcelling dementia services up within broader social care programmes for older adults, and there were mixed perceptions about whether or not this would help or hinder the availability of dementia services. In Area 2, one joint commissioner suggested that it might help to increase dementia services [16450, CCG, Area 2, Oct 2016], but a third sector participant expressed a preference for dementia services to be commissioned discretely [17753, Third Sector, Area 2, Dec 2016].

Participants from two CCGs in Area 1 highlighted how the Fund seemed to have helped develop relationships between CCGs and LAs, and navigate reciprocal impacts of financial decisions [4785, CCG, Area 1, Jul 2015; 4721a, CCG, Area 1, Jun 2016]. Similarly, a participant from an LA in Area 1 suggested that it helped the LA consider its joint working with the local CCG [8247, LA, Area 1, Nov 2015]. However, one CCG member in Area 1 expressed some uncertainty around governance because the Fund was primarily an LA responsibility that seemed to be “working slightly without the CCG in practice” [3391, CCG, Area 1, May 2015]. Another participant from an Area 2 CCG felt that the Fund had not been able to ease tensions between the CCG and the LA:

“there’s an uneasy relationship between the CCG and some elected members because they politically disagree with the way the government has restructured the NHS... we’ve really committed resource to [the Better Care Fund], so we’ve put £[X] million into [name of locality] alone to directly cross-subsidise adult social care this year... [but] that relationship, despite that, actually still feels uneasy” [6010, CCG, Area 1, Aug 2015]

Work stream 2 interviews suggested that financial disparity inherent to Better Care Fund contributions led to persistent friction which might threaten joint working:

“I feel there’s an increasing divide between the council and the CCG because of the Better Care Fund contributions... traditionally the CCG has put in quite a lot and not seen an awful lot for it and I think the CCG kind of wants that back now... there’s a lot of unpleasantness... I’m not even sure that joint commissioning will continue” [19314a, CCG & LA, Area 2, Feb 2017]

From the outset, one locality in Area 1 had used its Fund allocation as a contribution to a greater pooled budget for elderly care, which was believed to be a rare innovation compared to most of the country [3772, CCG, Area 1, May 2015]. This possibly challenges the status of the Better Care Fund as the principal mechanism for integrating care, as the contribution specific BCF funding had made to this pooled budget was relatively small. Around a year after the introduction of the Fund, a member of another Area 1 CCG reflected that its locality should also have pooled budgets to a greater extent, but also seemed to suggest that the public might find the increased level of risk to be unpalatable:

“I think the Better Care Fund is a bit of a distraction because it was a small amount of money and we spent loads of time on it and actually what we probably need to start really thinking of is, just pool our budgets and that will come with the risks that it comes with, but there’s then a story to the population about how we really allocate and manage our budgets.” [4519, CCG, Area 1, Jun 2016]
Two participants reflected that the Fund was a nebulous concept, describing it as a “cash shunting process” [19313, LA, Area 2, Feb 2017] with some “smoke and mirrors” [18967, CCG, Area 1, Jan 2017] creating a disingenuous image of a completely new resource.

At the time of writing this tracer report, the leading mechanisms identified for integrated working are Sustainability and Transformation Plans (STP). The relationship between STPs and the Better Care Fund was unclear; one participant from an Area 2 CCG expressed strong opinions that a focus on dementia and the Better Care Fund had not been integral to STP development:

“we thought [the STP] was going to be built on the BCF [Better Care Fund] and things like dementia would be in there, but they’ve done all their planning and it’s only in the last couple of weeks that we’ve been saying hang on a minute, you’ve got to include the BCF stuff [16450, CCG, Area 2, Oct 2016]

This lack of focus likely reflects the fact that STPs have been driven by the FYFV and the NHS, whereas the Better Care Fund is a joint venture between LAs and the NHS. This participant also expanded on her frustrations at the perceived primary care clinician influence highlighted earlier, suggesting that “if [name of clinician] gets a role [in the STP] then dementia will be important... if it’s not him, there are no other clinicians in the city that are interested” [16450, CCG, Area 2, Oct 2016]. This highlights the important influence that interested individuals can have on areas of service.

One participant in Area 2 who was employed in a joint post between a coterminous LA and CCG highlighted an inherent tension for STPs comprised of smaller localities that may have incompatible needs:

“the [#] areas of [name of STP footprint] have got different needs... locally the council is very clear about us having its one CCG to work for the [name of town] population... it’s not in the council’s interest to want its commissioners to suddenly only work for [name of STP footprint] and not just in [name of town]” [19314a, CCG & LA, Area 2, Feb 2017]

This extract highlights the lack of involvement of LAs in the development of STPs, which has been highlighted elsewhere invalid source specified. This participant also stated “I’m not employed to work for an STP and I don’t intend to”, foregrounding a potential challenge for STPs arising from their lack of statutory footing compared to LAs and CCGs.

In summary, this theme shows that integrated working around dementia services predated the HSCA12. The relationship between dementia services and Health and Wellbeing Boards was not entirely clear, and the Better Care Fund was generally perceived as a superior mechanism for integration. It was seen to be useful for helping develop relationships between CCGs and LAs, although there could be tensions due to their imbalanced financial contributions. There was some confusion that the name ‘Better Care Fund’ erroneously implied that the Fund was new money. Dementia was not always included within STPs and there could be some tensions for STPs comprised of localities with apparently mutually incompatible needs.

Summary

The HSCA12 was implemented in the midst of a number of initiatives which were focused either specifically upon dementia services or upon integrating health and social care. Across both Areas 1 and 2 there was a broadly similar picture in which:
CCG participants offered mixed reflections about the value of national targets for dementia diagnosis rates, which appeared to relate to understandings about the availability of post-diagnostic support.

The power of primary care clinician interest in determining resource allocation towards dementia was particularly highlighted in one locality of Area 2.

Dementia may still be viewed through more of a medical model than a social model of care, perhaps in part because of the measurements demanded by national performance indicators.

The third sector appears to have a key role to play but the extent to which it is perceived to be a full member of the dementia care system is variable and unclear.

The influence of Health and Wellbeing Boards on integrated working in dementia services was unclear.

The Better Care Fund has generally been perceived as useful for helping develop relationships and joint working between CCGs and LAs. However, CCGs contributed a greater proportion of the money, and this disparity seemed to be foregrounded in situations where there were existing uneasy relationships between the CCG and the LA.

There is some confusion that the name ‘Better Care Fund’ misleadingly implies that it was an entirely additional resource.

In Area 2 there were concerns that dementia was not included within STPs, and some tension for STPs comprised of smaller localities that may have incompatible needs.

### Actionable messages

This tracer report has highlighted that dementia services commissioning is influenced by over a decade of policy initiatives focusing specifically on dementia, and more broadly on integrating health and social care. Specifying the direct impacts of the Health and Social Care Act 2012 from within this broad policy context is difficult. The influence given by the Act to primary care clinicians may result in some tensions between medical and social models of dementia care. There may also be challenges in implementing mechanisms to help join together health and social care. The evidence highlights the need for:

- Simplification and clarification of mechanisms for joint working and commissioning of dementia services between CCGs and Local Authorities
- Further consideration of how to integrate the third sector into the dementia care system as a whole
- Greater focus upon dementia services within STPs, but with recognition of existing work within localities of the STP.

### References

There are no sources in the current document.

### Disclaimer

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### Acknowledgements

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Introduction

The aim of this project is to understand the development of the commissioning system in England following implementation of the Health and Social Care Act 2012 (hereafter ‘HSCA12’). An initial phase of data collection (March – December 2015) used interviews and observation to develop an overview of the functioning of the new commissioning system. The second phase of the project (November 2015 – March 2017) built upon these findings, focusing in upon five different service area (‘tracers’) in order to explore in more depth the issues arising in different contexts. This report summarises the findings of our exploration of the commissioning of orthopaedic services. This ‘tracer’ was chosen because it represents an area likely to be relatively unaffected by the changes introduced in the HSCA12.

Orthopaedics is a specialism focused on the treatment of issues arising with the musculoskeletal system (MSK), which is comprised of bones, joints, ligaments, tendons, muscles and nerves. Orthopaedic services provide treatment for long-term conditions (e.g. osteoarthritis) and traumatic injuries (e.g. fractures). MSK disorders command an NHS budget of around £10bn, the third-highest after mental and cardiac health (Briggs, 2015), and this figure is expected to rise as an ageing population brings increasing demand for orthopaedic care (Murray et al., 2013). Orthopaedic referrals from GPs to secondary care providers are increasing by around 8% per year, and 25% of all surgical interventions are carried out by trauma and orthopaedic surgeons (Briggs, 2015). Orthopaedic service provision therefore represents a substantial portion of NHS activity and expenditure.

In order to explore the impact of HSCA12 upon the commissioning of orthopaedic services, we conducted interviews with a range of commissioners and service providers in two English Areas corresponding to NHS England Area Team footprints (as originally conceived).\(^{12}\)

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million and a large city at its core.
- **Area 2** is a highly ethnically and socio-economically diverse metropolitan county with a population of over 1.25 million and a large central city.

Orthopaedics was discussed in the majority of the 78 Work Stream 1 interviews, which primarily involved individuals from Clinical Commissioning Groups (CCGs) and NHS England (NHSE). On the basis of this data, we found little evidence of pre and post HSCA12 variation, or variation between Areas, in terms of orthopaedic commissioning and provision. Consequently, we conducted three orthopaedic focused Work Stream 2 interviews (a CCG commissioner, and two Providers) in Area 1 only.

Pre-HSCA12

\(^{12}\) Area Teams were absorbed into the four existing regional teams when NHS England was reorganised in April 2015.
Prior to the HSCA12, Primary Care Trusts (PCTs) were responsible for commissioning routine and specialised orthopaedic treatments. Specialised services were those that covered a planning population (catchment area) of more than a million people, and PCTs worked in collaboration with others close by to provide for populations at broader footprints and pool financial risk (National Audit Office, 2016). See ‘Specialised Services’ tracer report for more details.

Most treatments were paid for from PCT funding allocations under the standard NHS tariff, with a small amount paid for by central government.

**Post-HSCA12**

Following the introduction of the HSCA12 and the abolition of PCTs, the commissioning responsibility for routine treatments passed to the newly-created CCGs, with NHSE taking over responsibility for specialised orthopaedic care, including major trauma services.

The HSCA12 introduced a statutory duty for NHSE to conduct an annual assessment of CCGs. This assessment includes use of a framework to ensure that CCGs are meeting certain targets, which for orthopaedic-related activity includes the 18-week referral-to-treatment time established as a patient right in the NHS Constitution.

There was little within the HSCA12 which specifically focused upon orthopaedic services. However, the Act as a whole was underpinned by the programme theory (Weiss, 1998) that GP-led CCGs would be more efficient and effective commissioners than PCTs because of their enhanced clinical leadership, with clinicians assumed to have a greater understanding of population needs (Checkland et al., 2014). The other main change arising from the HSCA12 is the role for NHSE in the commissioning of specialised orthopaedic services. This role is part of changes to the commissioning of specialised services as a whole, which are explored in the ‘Specialised Services’ tracer short report.

To explore the impacts from the HSCA12 upon orthopaedic services commissioning, this report presents findings from interview data organised into two themes: (1) Orthopaedics as “bread and butter” routine commissioning activity; (2) Controlling orthopaedic activity.

**Theme 1: Orthopaedics as “bread and butter” routine commissioning activity**

More so than any other tracer, orthopaedics was perceived by interviewees as largely unaffected by the HSCA12. It is an area of commissioning that has continued “in the old vein...” [2623, Area 1 CCG, Apr 2015] with a relatively straightforward handover of responsibility. From a provider perspective, a surgeon reported: “On the coal face there’s been no change. In fact you can’t see any difference at all” [15845, Area 1, provider, Aug 2016]. In particular, there was no obvious change towards a more clinically-focused approach to commissioning. One interviewee stated that she had observed an increase in bureaucracy in relation to service procurement since the HSCA12 – describing it as a “bureaucrats’ party” – but could not say whether this was a consequence of the HSCA12 or would have developed in this way regardless of it [12580, Area 1, provider, May 2016].

Commissioners tended to describe orthopaedics using terms such as “bread and butter” [2388, Area 1, CCG, Mar 2015] and “transactional” [6010, Area 2, CCG, Aug 2015], a traditional or even stereotypical commissioning activity: “…you do demand and capacity modelling, it’s actually what quite a lot of people think commissioning is about, you know, how many of these, I’ll buy them from there, what’s the price and let’s get it...” [6010, Area 2, CCG, Aug 2015]. However, interviewees identified that there was considerable variation in terms of orthopaedic treatment activity both within their Area and nationally [4095, Area 1, CCG, Jun 2015], and this had not changed post-
Several commissioners commented on the historical tendency for orthopaedics to focus on the surgical procedure as mechanistic and discrete, and how orthopaedic care needed to better take account of the individual and their broader social context for the good of the patient and the health and social care system:

“...say for arguments sake, you have a hip replacement, you can’t get up and down the stairs and you say, I’d like a stair lift, well you can have one in two and a half years, well, say no more and if somebody needs a chair lift to leave them at home, why doesn’t health prescribe them? Why does it have to be social care? Because actually, if we kept them in the home and not in a hospital or somewhere, that’s cheaper. So you may spend £2,000 on a stair lift or you can spend £2,000 a week keeping them in a hospital and all the infrastructure costs and you don’t release to home and you make people more dependent, you’ve lost their health and wellbeing. So we need to think wider about the individual rather than about, well, that’s health money, that’s the problem, the mind set has to change.” [4246, Area 1, CCG, Jun 2015]

“You can continue to give people new knees but if you don’t help them to exercise and live more healthily they’ll just knacker the new knee that’s been put in. If you don’t tell them that they’ve got to do ten minutes exercise at least a day to get the benefit of having a new knee there’s no point in putting a new knee in.” [4519, Area 1, CCG, Jun 2015]

There was no notable difference between Areas 1 and 2 in terms of the dominant issues in orthopaedic commissioning and provision. However, interviewees reported a number of issues and arrangements specific to local CCGs and the providers that they interacted with. For example, two CCGs, one from each Area, noted that their local hospital providers had a lack of capacity for orthopaedic procedures, leading to unsatisfactory waiting times for patients [3271, Area 1, CCG, Apr 2015; 6120, Area 2, CCG, Aug 2015]. In Area 1 there was a footprint, encompassing multiple CCGs, where there had been a pre-existing Clinical Assessment and Treatment Service (CATS) run by a private provider. This was commissioned pre-HSCA12 by the Department of Health. This contract was then transferred to NHSE, and CCGs were committed to funding it for several years before the provider was notified that the contract would not be extended further. An interviewee from one of the relevant CCGs noted that this arrangement had constrained the degree of financial control they enjoyed as commissioners and that all of the CCGs were now able to re-procure these services, which was positive [2623, Area 1, CCG, April 2015].

**Theme 2: Controlling orthopaedic activity**

Commissioner interviewees perceived orthopaedics to be an attractive domain of activity for providers and a strong source of revenue. One stated:

“That’s the most difficult arena because orthopaedics is a burgeoning... it’s lovely if you’re a provider. It’s a huge area of income generation. And the challenge in orthopaedics is, is it effective use of your resources. So there are a lot of procedures that are being done in orthopaedics which are of limited clinical benefit. It’s an area where demand is growing very rapidly. And those that provide those services drive up the demand as well, and there’s a procedure for everything” [4144, Area 1, CCG, Jun 2015].

This extract highlights a key challenge perceived by commissioners: how best to make judgements about the relative value of orthopaedic procedures, and the allocation of funding to those procedures. One commissioner in Area 1 reported that his CCG, which has a large specialist
orthopaedic provider Trust within its footprint, had received a request to fund “some sort of bionic wrist replacement” at a cost of approximately £30,000. The surgeons were keen to secure funding for the procedure in part because “they want to keep pushing themselves to do the next fantastic thing”, but the CCG had to weigh up the cost of this procedure and the potential benefit for the patient with the potential benefit for the CCG population at large from a range of other health care services [4519, Area 1, CCG, Jun 2015].

However, with the majority of orthopaedic contracts being Payment by Results, commissioners do not always have the levers to control the activity of providers and, consequently, the size of the bills that they receive from them. This was an issue in Area 1. An acute hospital, located within the boundaries of a CCG, undertook a significant expansion of its orthopaedic service capacity without consulting the CCG first. The business model for this expansion involved increasing activity from commissioners outside the local area. The hospital did not attract the desired levels of activity and began running ‘education’ events for local GPs (the CCG members) to try and encourage them to refer patients for treatment earlier. This generated more income for the hospital and caused a spike in surgical activity paid for by the CCG. The following year the CCG implemented an MSK pathway based closely on the Department of Health model CATS service (Department of Health, 2006). This reduced the CCG’s spend with the provider significantly, actually lowering it below the level they were paying before the hospital’s expansion, and the CCG and hospital entered into discussions to decide on arrangements that would meet the needs of both organisations without adverse effects.

Commissioner concern about a lack of control over provider activity levels was often coupled with a concern that referrals by GPs were not always appropriate: “I think we’ve struggled to control it and we’re struggling to control the way GPs refer as well” [3391, Area 1, CCG, May 2015]. Increasing control over orthopaedic activity and, therefore, spending was frequently cited by commissioners as a reason for introducing or developing systems that involved triaging and filtering GP referrals and/or screening the procedures carried out by providers to ensure that they were being charged appropriately. There were numerous examples of these systems in place in Area 1 and Area 2 referred to by a range of titles such as “referral gateways” [4095, Area 1, CCG, Jun 2015]. These orthopaedic specific services were often conceived as part of a broader “MSK pathway”, and when interviewees were asked about orthopaedics they often responded by talking specifically about MSK and allied services, which indicates how they were seen as inseparable. MSK pathways frequently involved the provision of rheumatology and pain services, and the relocation of orthopaedic activity from hospital settings into the community. The intention behind these schemes was to reduce the number of handovers between different providers and services (including local authority and third sector), and better co-ordinate linkages between them, to make the experience of accessing care less fragmented for patients and to reduce costs by reducing unnecessary hospital based care. Crucially, the planning and enactment of these was in some cases carried out by PCTs, pre-HSCA12, and the schemes were continued unchanged or developed further by CCGs.

A CCG in Area 1 had a particularly well-established MSK pathway. The CCG commissioned what was referred to by interviewees as both an “integrated provider hub” and a “holistic community based MSK service.” This was orchestrated by a non-profit “honest broker” organisation, staffed by orthopaedic experts. This broad service was primarily provided in community settings where patients could have initial consultations with consultants as well as access a range of other related services. The service was originally commissioned by the PCT but proved successful in controlling orthopaedic spending and so the CCG had extended its contract and expanded the remit of the service. The CCG was very positive about its benefits and had allocated their entire orthopaedic budget for management by the non-profit provider organisation [7412, Area 2, CCG, Oct 2015].

In Area 2, two CCGs each commissioned referral “triage and assessment” services that were primarily community based and involved physiotherapists. Interviewees from both CCGs expressed
dissatisfaction with these services due to duplication and cost, and both were at different stages of tendering for an MSK pathway service [7290, Area 2, CCG, Oct 2015; 7679, Area 2, CCG, Oct 2015]. An interviewee from one of these CCGs stated that the CCG had found itself in a significantly worse financial position than the PCT before it, and the financial pressures upon them had contributed to a less constructive and collaborative relationship with their main local provider of orthopaedic services. His perception was that senior figures from the provider organisation were unhappy that the CCG was tendering for a new MSK service, in the interests of making savings, because they might not win the contract [7679, Area 2, CCG, Oct 2015].

Summary

- Little change in the landscape of orthopaedic commissioning and provision reported as a result of the HSCA12. Commissioning responsibility was passed from PCTs to CCGs, with little obvious change related to greater clinical involvement in CCGs
- Commissioners commonly referred to orthopaedic activities as straightforward, “bread and butter,” and “transactional”
- Some commissioners were concerned about a lack of control over activity, with demand and costs rising, and perceived that some providers were motivated to increase demand because of the profitability of orthopaedic procedures
- The majority of CCGs operated, or were in the process of developing, a musculoskeletal (MSK) pathway with orthopaedics rolled into a suite of linked service including rheumatology and pain management, commonly involving local authority and third sector organisations, with a greater proportion of delivery in community settings
- Whilst it might be thought that CCGs, as ‘membership organisations’, would have a greater ability than PCTs to control the activity of their GP members, in practice we saw no evidence of this. Control of referral activity generally focuses upon “referral gateways” or consultant led triage systems run by an independent, non-profit organisation to act as an “honour broker”. Such mechanisms were, in many cases, instigated by PCTs before the establishment of CCGs.

Actionable messages

The main issues that arose in studying this area of commissioning are familiar ones: the need to control costs whilst maintaining an effective and accessible service. Our interviewees suggested that:
- Strict separation of activity into ‘commissioning’ and ‘provision’ is not necessarily the most effective approach. Those CCGs which had managed to control costs had usually done this by working closely with local providers in order to set up a system which effectively triaged patients to the most appropriate service, and which provided access to lower-level and less costly services such as pain management and physiotherapy
- Incentives built into the payment by results system can be unhelpful.

References


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Introduction

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Understanding screening

Screening programmes are a public health strategy focusing on specific diseases within large-scale, clearly defined populations, with the intention of reducing risk of the disease within that population. For example, there is a screening test for bowel cancer (the specific disease) offered every two years to all adults aged 60-74 (the defined population) [Invalid source specified.]

Though screening provides the opportunity to detect risk of diseases and allows for early intervention to save lives, it can be complex, emotive, and often misunderstood. Public understanding tends to be centred upon the opportunity to save lives through earlier detection of ill health, and in recent years there have been increased calls to widen the scope of existing screening programmes or to develop programmes for diseases not currently screened for. However, understanding screening requires appreciation of two fundamental concepts, sensitivity and specificity, and their related outcomes of false negatives and false positives [Invalid source specified.]:

- Sensitivity refers to the ability of a screening test to detect people who have the disease
- Specificity refers to the ability of a screening test to avoid erroneous detection of people who do not have the disease
- Imperfect sensitivity leads to false negatives, i.e. where a screening test fails to identify people who have signs of the disease. This may lead people to believe that they have been given the all-clear and to ignore future symptoms
- Imperfect specificity leads to false positives, i.e. where a screening test falsely identifies people as showing signs of the disease when they do not have it. This may lead to people unnecessarily undergoing further tests or treatment.

In a perfect world, any screening test offered to the public would be 100% sensitive and 100% specific, but in reality no test is entirely accurate.

It is important to differentiate screening from diagnosis: screening is applied to apparently healthy people who are at risk of developing a specific disease, whereas diagnostic tests are applied to
people already showing symptoms of the disease **Invalid source specified.**. Screening poses **numerous ethical complications**, such as the anxiety for people upon discovering that they may have a health problem. There are also more specific complications regarding particular types of screening; for example, reproductive screening raises the need to make decisions about pregnancy termination and issues relating to societal perceptions of disability **Invalid source specified.**.

There are **internationally-recognised criteria** for appraising screening programmes **Invalid source specified.**, which include considerations of whether:

- the disease presents a significant population-level health problem and its rate of progression is slow enough to allow time to intervene after detection;
- the screening test is simple, valid, and acceptable to patients;
- there is an effective intervention to treat people positively identified through screening;
- there is robust evidence for the clinical effectiveness of the screening programme, for its social and ethical acceptability, that its benefits outweigh harms, and that it is cost-effective;
- there is a clear implementation plan.

Since its inception in 1996, the **UK National Screening Committee** (NSC) has been responsible for recommendations on all aspects of screening policy. The NSC was developed to improve quality in the development and appraisal of screening programmes, guided by the principle that any screening must do more good than harm **Invalid source specified.**. At the time of writing, the NSC database provides appraisal information for screening for over 100 conditions, recommending systematic population screening programmes for **30 Invalid source specified.**

**Screening programmes: public health commissioning pre- and post-HSCA 12**

In order to understand the commissioning of screening programmes in the post-HSCA12 system, it is useful to consider changes in the broader field of public health services commissioning. Prior to the 2010 general election, public health responsibilities lay with NHS Primary Care Trusts (PCTs). Following the election, the Coalition Government set out a new strategy for public health in its ‘Healthy Lives, Healthy People’ White Paper **Invalid source specified.**. This proposed a shift in public health responsibilities from PCTs to local authorities (LAs), arguing that LAs were better placed than PCTs to oversee public health improvement for local populations because of their existing functions relevant to addressing the wider determinants of health. It also announced the creation of a new “**dedicated and professional public health service**” (p.52) called Public Health England (PHE), an executive agency of the Department of Health, which would be a “**uniting force for the wider family of professionals who also spend time on improving people’s lives and tackling inequalities**” (p.27), with a mandate to allocate ring-fenced public health budgets to LAs. The HSCA12 saw the majority of duties to improve the public’s health transferred to LAs, and amended Section 7A of the NHS Act 2006 to allow the Secretary of State for Health to delegate responsibility for public health functions to NHSE, which now has responsibility for commissioning national screening programmes as a consequence. The Act also saw the Secretary of State’s duty to protect health and address inequalities delegated to PHE.

NHSE’s regional teams are responsible for commissioning national screening programmes but PHE employees are ‘embedded’ within their Screening and Immunisation teams “**to provide accountability and leadership for the commissioning of the programmes and to provide system leadership**” (NHS England and Public Health England 2013, p.7). PHE produces national service specifications to direct NHSE in the commissioning of national public health services via an annual ‘public health functions agreement’ between the Secretary of State for Health and NHSE **Invalid source specified.**. These agreements contain a list of ‘Section 7A services’ to be commissioned by NHSE, including screening programmes. The Immunisation and Screening National Delivery
Framework and Local Operating Model (NHS England and Public Health England 2013), published in 2013, set out the roles and responsibilities of NHSE, PHE, the Department of Health, and LAs in relation to screening. At the national level, PHE houses the secretariat of the UK National Screening Committee. One national level interviewee described the dynamic between PHE and ‘the NHS’ thus: “Public Health England writes the knitting pattern and the NHS finishes it” [16350, National level, Oct 2016]. CCGs do not commission national screening programmes, the services that they do commission, or pay for, can however form part of some screening pathways. For instance, in sickle cell and thalassemia screening, prenatal laboratory genetic testing costs are paid by NHSE from the screening and immunisation budget, whereas the costs for specialist counselling are to be split between CCGs and NHSE according to a local agreement, and any terminations are commissioned by CCGs. In the new system, LA public health teams have a responsibility to ensure that adequate screening and immunisation plans are put in place within their area and to challenge NHSE if this is not the case. Diagram 1, below, provides a simplified representation of the key organisations in the post-HSCA12 screening programme system.
The main implication for screening arising from the HSCA12 was the creation of PHE, to bring together a range of public health professionals and specialists from more than 70 organisations into a single public health service **invalid source specified**, and oversee protection and improvement of national health and wellbeing, and the allocation of commissioning responsibility over national programmes to NHSE. **There is no identifiable programme theory invalid source specified.** For these changes to screening programme commissioning, however, it is notable that in contrast to the valorisation of localism associated with the creation of CCGs, screening commissioning (like specialised services commissioning) became more centralised as a consequence of the HSCA12.

To explore the impact of HSCA12 upon the commissioning of screening programmes, we conducted interviews with a range of commissioners and service providers. This comprised the 78 interviews in Work Stream 1 (involving individuals from CCGs, NHSE, and LAs), and subsequent, more detailed, Work Stream 2 interviews with 6 individuals from PHE, and NHSE. Due to the relevance of the national scale to screening programme commissioning, we extended our focus for this tracer beyond the two English Areas (corresponding to NHSE Area Team footprints, as originally conceived) that we have primarily explored in our study. Some interviewees’ work related primarily to the national level whereas others worked in geographical patches that included, or matched closely with, one of our two Areas. There was little difference between Areas in terms of the issues reported. Data analysis was iterative, with the findings from the emerging analysis informing later interviews.

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million and a large city at its core
Area 2 is a highly ethnically and socio-economically diverse metropolitan county with a population of over 1.25 million and a large central city.

In this section we present data according to three emerging themes: 1) Perspectives on screening; 2) Advantages and challenges of the new national screening programme commissioning architecture; 3) Fragmentation of responsibility and ambiguity in accountability.

**Theme 1: Perspectives on screening**

Most CCG interviewees from the first phase of the project (March – December 2015) were positive about the value of screening in general but some had particular reservations. Contrast the two following examples from CCG interviewees:

“I think screening is really important, to me, that’s in the preventative and proactive end of care. I’m a great one for all the screening things that go on, because it makes a difference and it saves money.” [4246, CCG, Area 1, Jun 2015]

“Well there are very few things that have I think clinical and financial utility in screening. I think it causes more upset than it often saves and unless you’ve got a very specific and a very sensitive test I think it is a flawed process and also, as I said to you, financially it’s difficult for us to do because if we do screen people and do pick up stuff and manage them early so they don’t get the complications and so on, that’s a costly process which won’t produce any financial benefit to the organisation until five, ten years or further down the line.” [2627, CCG, Area 1, Apr 2015]

There was considerable variation in the degree to which different CCGs considered a focus on screening to be a priority. For example, some CCGs were financially incentivising their member GP practices to increase uptake of bowel cancer screening and breast screening [4785, CCG, Area 1, Jul 2015], whereas others did not see screening as a feature of their day to day work [6323, CCG, Area 2, Sep 2015].

When asked to comment on screening in general, CCG interviewees frequently mentioned the NHS Health Check programme but some were unsure whether it technically constituted a screening programme. NHS Health Checks are offered to all UK adults aged 40-74, every five years, to ascertain risk of heart disease, diabetes, kidney disease and stroke. National level interviewees, and those from NHSE and PHE, noted that the Health Check programme had not been through the assessment process the NSC used to define a screening programme and was unlikely to fulfil the requisite criteria if it did. The creation of the programme, much like the National Chlamydia Screening Programme and the National Childhood Measurement Programme, was “politically inspired”, i.e. it was a created as a result of the preferences of politicians [16350, National level, Oct 2016].

In summary, interviews with CCG members early in the project revealed variety in terms of perceptions about the value of screening, and relatedly the degree to which screening was considered a focus of CCG activity. There was also some uncertainty from interviewees about what was technically a screening programme. Interviews at the national level revealed that the introduction of a small number of national programmes, including NHS Health Checks, had occurred as a result of the efforts of politicians and had not been subjected to the NSC’s process to designate screening programmes.

**Theme 2: Advantages and challenges of the new national screening programme commissioning architecture**
A national level interviewee felt strongly that the HSCTA12 had conferred a number of advantages to screening. Previously, each of the 152 PCTs had a screening lead with considerable variability between them in terms of their levels of enthusiasm for the role and engagement with the national level, which provided some challenges for the NSC in co-ordinating screening activities. Post-HSCTA12, the NSC deals directly with a significantly smaller number of individuals, each of whom sits within an NHSE regional team, which has facilitated more effective communication and programme organisation between national and local levels:

“So this reorganised system has had its advantages in the sense that in terms of, kind of, orchestrating screening programmes nationally, it’s more straight forward having these, kind of, 10 Public Health England embedded teams within the current NHS England structure.” [16350, National level, Oct 2016]

An NHSE interviewee believed that these changes had resulted in more dedicated commissioning attention being paid to screening than PCTs (as a group) had been able to provide and that commissioning across larger geographic areas was likely to be beneficial in terms of improving screening quality [20012, NHSE, Area 2, Mar 2017]. Additionally, the creation of PHE has meant that a concentration of expertise has taken place at the national level, and having a single employer (with one set of HR policies) has provided a “mechanism” to, for example, unify what were previously organisationally disparate cancer screening teams and their quality assurance teams [16350, National level, Oct 2016; 19974, National level, Mar 2017]. The reforms have also meant that identifying good local practice in screening programme implementation and incorporating this into national guidance has become more straightforward [16350, National level, Oct 2016].

However, the embedding of PHE employees into screening and immunisation teams within NHSE was recognised by both PHE and NHSE interviewees as problematic. The allocation of staff from PCTs to LAs, NHSE, or PHE in the post-HSCTA12 system occurred on the basis of an insensitive formula relating to time spent working on particular tasks. This was highlighted as an issue contributing to a loss of professional expertise and institutional memory:

“It meant when it came to transition the rules which have to be there were if 50 per cent of your job was in one thing, you go to local authorities or you go to NHS England, PHE, wherever you went, which meant that a lot of capacity at the time in 2013 with the screening expertise was actually going into Local Authority and not very much was coming in the transitional process here, and so a lot of expertise and organisational memory stuff was getting lost and is lost, and has been lost within the processes.” [18352, PHE, Area 1, Jan 2017]

One PHE interviewee, embedded in NHSE, noted that members of her screening and immunisations team had left their jobs because they found it too difficult attempting to cover the size of geographical area that corresponded to their NHSE sub-regional ‘patch,’ which was significantly larger than they were used to. There were logistical issues, such as travel times, associated with covering larger patches but also other practical difficulties associated with attempting to influence screening practices at a more local level:

“…say we wanted to sort out cervical screening coverage in GP practices, in [Town G] PCT you’ve got 64 GP practices, […] bottom 20 per cent you could talk to the 12 practices. In my new patch we’ve got 600 practices. So you have to think in a completely different way. So you never have that thing of oh, we’ll just take the bottom ten per cent and […] because that’s just not possible. Couldn’t do that to 70 practices. You don’t have the time…” [17685, PHE, Area 2, Dec 2016]
Challenges associated with working at a broader scale without an increase in resources, also arose from the fact that Directors of Public Health (DPH) and their LAs have a statutory health protection role which involves seeking assurance from NHSE on the suitability and quality of local screening programmes. For an NHSE screening commissioning team, the sheer number of LAs in its patch provided difficulties in terms of meeting requests for data and evidence:

“So we get a lot of pressure, because now there’s so many local authorities and DPHs all asking for reports, asking for all kinds of things because they think they have...well, they do have an assurance role and they want to implement that role. So there’s a balance to strike between providing assurance of what we’re doing and actually doing things.”

[17685, PHE, Area 2, Dec 2016]

Information governance processes were reported as another difficulty. Issues stemmed from the fact that PHE, as an executive agency of the Department of Health, is part of the Civil Service and has different information governance policies and ‘gateways’ than NHSE, an executive non-departmental body of the Department of Health whose staff are not part of the Civil Service. This has necessitated local strategies and workarounds as well as attempts between PHE and NHSE at the national level to address the problems this gives rise to:

“So PHE holds some data, it can’t let NHS England look at it. Because of our embedded nature in the service, we get to see both the PHE data and the NHS England data, and we have to have internal conversations about who you can then let see it and manage it and do it, instead of it all being in one place, and, as I say, that’s been there since April 2013 and it is still not resolved. There are fixes in different places that are being done, and recently there have been some formal MoUs that have been put in place between NHSE and PHE to kind of sort the organisational thing which is then feeding through to us.”

[18352, PHE, Area 1, Jan 2017]

This formal distinction between PHE and NHSE was thrown into relief by the day to day realities of those working within these NHSE regional teams with embedded PHE staff. One screening and immunisation lead, employed by PHE, talked about the pragmatic practices that she and her team members adopted when dealing with those from outside the team:

“So if people talk to us and think that we’re PHE then we’ll respond, we’ll say that’s who we are, because otherwise you end up in a confusing conversation about the difference in responsibilities...If people talk to us as if we’re part of NHSE then we’ll talk to them back as part of NHSE. We’ll kind of go either side, which actually gets the right conversation happening with people around the process.”

[18352, PHE, Area 1, Jan 2017]

This speaks to a blurring of identities for public health professionals in PHE. A PHE interviewee in Area 2 discussed this issue in relation to the variety of opinions that her team members had about their identities within NHSE and whether they thought of themselves as commissioners:

“...If you ask people in my team are they commissioners or are they PHE or are they both you’d get a variety of answers. I’m reasonably comfortable about being a PHE person, but I would also consider myself a commissioner. I don’t know if everyone else would. So there are various models. Some people think the SIL [Screening and Immunisation Lead, PHE employee] around quality and is there to make sure that quality’s implemented by NHS England. Some people think that we’re pure
commissioners, others think we’re a mixture, and the people within the team have different views about that as well.” [17685, PHE, Area 2, Dec 2016]

One positive aspect of the reforms identified by PHE staff embedded in NHSE was **improvement in access to training opportunities** when compared to those available to screening commissioners within Primary Care Trusts [17685, PHE, Area 2, Dec 2016].

In summary, this theme illustrates how the post-HSCA12 national screening programme commissioning architecture was perceived as having some advantages, particularly for those working at the national level, in terms of national-regional co-ordination, disseminating best practice, and increasing access to training opportunities. However, at the NHSE sub-regional level of screening and immunisation teams, which include PHE staff embedded in NHSE, the new architecture was problematic in a number of respects including: a loss and re-allocation of professional and local expertise, practical challenges of working in large geographical ‘patches’ containing numerous organisations, information governance incompatibilities, and identity dissonance and confusion.

**Theme 3: Fragmentation of responsibility and ambiguity in accountability**

A PHE interviewee described her perceptions of the post-HSCA12 screening system as it was taking shape and the resultant distribution of responsibilities between organisations, which made little sense to her:

“…by the time we got through to December ’12 and beginning of ’13, the system that it was clear we were going to be having of a weird process of having public health specialist advice in one organisation called Public Health England, the commissioning responsibility for most but not all of the screening programmes resting in a new body called NHS England, with support coming from different places, it felt to me, and to many of my colleagues, to be very strange at different times, and utter madness.” [18352, PHE, Area 1, Jan 2017]

For CCG and LA commissioners, approximately two years after the implementation, there was ongoing uncertainty about where the boundaries of responsibility for screening lay between organisations, and between national and local programmes:

“… I don’t know the technical answer to who the commissioner is for some of the screening services... literally I don’t know whether it’s Public Health England [or] public health local [authority] who are the Commissioner.” [3271, CCG, Area 1, Apr 2015]

One CCG interviewee in Area 2 was uncertain as to exactly what NHSE’s role in screening was. She described screening as an area that existed in the “fault lines between organisations”:

“...And screening is another one that resonates with me because it’s an area of high confusion between Public Health England, CCGs and NHS England in so much as they commission primary care. So those two areas exist in the fault lines between organisations, so they are issues we’ve had quite a lot of work dealing with like whose job is this anyway?” [6010, CCG, Area 2, Aug 2015]

The uncertainty around divisions of responsibility as a consequence of a “fragmented commissioning framework” [17685, PHE, Area 2, Dec 2016] were also associated with ambiguity over accountability in the system: “…some of those screening things are a bit of a muddle in terms of who’s actually accountable” [7033, LA, Area 1, Sep 2015]. One PHE interviewee noted that this
does not present a significant issue when screening programmes are operating as they should but could become problematic if there was an “incident.”

“...there are some issues around accountability, responsibility, leadership. If something went wrong, if [...] if there was an incident in a screening programme who’s ultimately accountable, responsible, is it shared, is it PHE, is it the SIL [Screening and Immunisation Lead, PHE employee] is it the head of public health commissioning [NHSE employee]. Those are the scenarios where I’m not sure it’s going to be totally clear.” [17685, PHE, Area 2, Dec 2016]

An NHSE interviewee noted that although the National Delivery Framework and Local Operating Model (NHS England and Public Health England 2013) sketched out the roles and responsibilities of NHSE and PHE in terms of screening, this was not sufficiently detailed to be of practical value locally and was now out-dated (the document refers to NHS England Local Area Teams and other organisational entities which no longer exist) [20012, NHSE, Area 2, Mar 2017]. As a consequence, considerable variation has developed locally in terms of the relative roles and relationships between NHSE and PHE employees within the sub-regional screening and immunisation teams in NHSE. When asked whether this dynamic had become clearer over time a PHE interviewee stated:

“It’s become less clear really. What happened was we started with the national framework of how we work together and then local teams basically didn’t follow the framework and there was complete variation across the country, and then the result of the second review was that they said we’ll tolerate the variation, so there is a kind of fudge and there’s variation and there’s various things going on across the country. I don’t think it’s any clearer now than it was two years ago.” [17685, PHE, Area 2, Dec 2016]

Cervical screening provides an illuminating example of the difficulties associated with fragmented responsibilities within the post-HSCA12 system. Primary Care Trusts previously commissioned screening and sexual health services. Officially, cervical screening was provided by GP practices, which received additional funding, linked to levels of activity. In practice, some GPs were less interested in providing these services and patients would be told that they could get their smears done at the local sexual health clinic (even though the latter received no additional funding for this) [8384, LA, Area 1, Nov 2015]. Post-HSCA12, LAs commission sexual health services and NHSE commissions cervical screening. However, due to funding constraints and a recognition that it is not their responsibility, LAs are not including smears as a funded activity in new sexual health service contracts. NHSE and PHE would prefer it if patients could choose to go to a GP or sexual health clinic for their smears, whereas some LAs insist that they will only provide opportunistic smears and that NHSE should commission clinics to provide smears. One NHSE interviewee argued that the public health budget of each LA reflects the levels of cervical screening activity previously taking place in their sexual health clinics but that this is not clear because the funding was not “disaggregated” [4058, NHSE, Area 1, Jun 2015], in other words it is not possible to discern what the sexual health component of the public health budget consisted of previously. A PHE interviewee suggested that NHSE is reluctant to commission for logistical reasons:

“So cervical screening we could go to every sexual health provider and have a separate contract. The difficulty again becomes around commission capacity. So I think we’ve got 14 local authorities, so we have 14 separate contracts all very low value, it’s about 1,000 screens in each, so you’re talking maybe 14 £20,000 contracts or something. So it’s a very bitty way of doing stuff. So we could still do it and we could pay for it, but in terms of the amount of paperwork or the amount of outcomes it becomes potentially unmanageable.” [17685, PHE, Area 2, Dec 2016]
She also noted that national guidance was too vague to help resolve the issues, stating things like: “...‘local authorities and NHS England should work together for a local solution,’ which means nothing” [17685, PHE, Area 2, Dec 2016]. A national level interviewee suggested that the consequences of this ambiguity of responsibility, and the resulting gaps in provision, were likely to be highly variable across the country, reflecting the different trends in GP cervical screening provision, and result in reductions in the number of patients receiving smears [18352, PHE, Area 1, Jan 2017]. Adding to the complexity of the picture is the fact that CCGs are assessed on whether certain levels of patients are receiving smears and, in some local contexts, there is not sufficient capacity to meet these targets without sexual health clinics taking a share of the activity [8384, LA, Area 1, Nov 2015].

Numerous interviewees talked about the importance of inter-personal relationships in overcoming fragmentation and ambiguity within the screening commissioning system in order to get things done:

“How does it work now? It works now on the basis of people and relationships. There are still organisational issues which are unclear around responsibilities and such...” [18352, PHE, Area 1, Jan 2017]

A national level interviewee, interviewed in March 2017, reported that in the new system an effective system leader with the power to compel organisations to follow a particular course of action is lacking. In order to overcome this, it was sometimes necessary to call on established relationships with individuals working in other organisations in order to negotiate responses to issues, allocate responsibility, and present a coherent message to the public:

“...we do use all those personal relationships shamelessly in order to get round the system where you don’t have any...you don’t really have any power to make anybody do anything.” [19974, National level, Mar 2017]

The key messages from Area 1 and Area 2 interviewees regarding screening were largely consistent but a PHE interviewee from Area 1 highlighted how certain characteristics of Area 1, such as pre-existing inter-organisational arrangements and operational forums, were advantageous in facilitating collaborative work that helped to mitigate some of the fragmentation within the system [18352, PHE, Area 1, Jan 2017].

For those operating at the national level there was a perception of a lack of ‘levers’ to employ to engender change at more local levels despite the increased centralisation in screening commissioning as a consequence of the HSCA12. For instance, an attempt to codify the responsibilities of (now LA employed) Directors of Public Health in regard to screening programme responsibility has been derailed by the lack of a mechanism to get such a proposal agreed nationally [16350, National level, Oct 2016]. A more specific concern related to the Chlamydia Screening Programme, which is now a LA sexual health commissioning responsibility. A national level interviewee was concerned that LAs were disinvesting heavily in the programme. This was a particular concern for the NSC because the effectiveness of the programme is predicated on a sufficient level of funding and provision. However, due to the post-HSCA12 division of commissioning responsibilities, the NSC could not identify a means of influencing the level of financial resource LAs allocated to the programme. This problem stems from the fact that, as noted earlier, the Chlamydia Screening Programme is one of four national programmes not subject to the NSC appraisal process for what constitutes a screening programme. The fact that LAs have taken on responsibility for it, as part of their broader sexual health remit, reflects its position as outside the usual commissioning mechanisms for national screening programmes. The significant cuts to LA budgets, and an annually shrinking ring fenced public health budget, are also important contextual factors.
Clear mechanisms for exerting influence over providers were apparently lacking between NHSE, PHE, and CCGs at the local level. In the following example, a CCG commissioner explained that PHE had approached the CCG and requested that it monitor the performance of a local hospital Trust in relation to outcomes of screening services which the CCG was not commissioning:

“...Public Health England have some concerns about how our hospital has been running one of the screening services... but it is very odd, because they’ve then said, well can you include that in your contract meeting with the Trust and we’re like yeah, but our contract meeting is about our contract with them, what are you doing with them. So we have said in the end, you know what, we’ll bloody performance manage it for you through our contract meeting, but it just seems very odd, you know, that they come in and do visits and they do quality assurance and then they send letters having concerns and they copy me in but what real influence do I have because it’s not what I do, you know.” [3262, Area 1, CCG, Apr 2015]

Another comparable incident was raised by a different CCG [7412, Area 1, CCG, Oct 2015].

A PHE interviewee provided a clear example of how a lack of influence over providers was related to the post-HSCA12 fragmentation of responsibilities and funding:

“...one part of the screening programme is the antenatal newborn screening programme. So these are screens done by midwives, and they are paid something called a maternity tariff. So every birth the maternity service is paid a set amount to do all the maternity checks for that birth, and part of that care includes some of the screening antenatally and of the newborn baby. Now, technically NHS England are the commissioners of that, because under 7A we’re the commission of antenatal newborn screening. But all the payment is part of the tariff, and that tariff is paid by CCGs who are the commissioner of maternity services.” [17685, PHE, Area 2, Dec 2016]

Finally, two interviewees highlighted what they perceived as a governance deficiency in the new system in terms of accountability. Both expressed concerns that NHSE was effectively assuring itself for its performance as a commissioner of national screening programmes [16350, National level, Oct 2016; 19974, National level, Mar 2017]. However, an NHSE interviewee did not share this opinion and believed that current assurance mechanisms were sufficient [20012, NHSE, Area 2, Mar 2017].

In summary, the HSCA12 resulted in a system of screening commissioning, and a distribution of responsibilities between organisations, that some public health professionals found confused. Two years after implementation of the Act, local CCG and LA commissioners were still uncertain as to which organisation was responsible and accountable for screening. The relative accountabilities of PHE, embedded in Screening and Immunisation Teams, and NHSE were particularly fuzzy to PHE interviewees, and this was considered an issue that would be tested should a significant ‘incident’ occur. The National Delivery Framework and Local Operating Model (NHS England and Public Health England 2013) was sufficiently vague to allow considerable local variation to develop nationwide in the dynamics between PHE and NHSE, and despite some faltered attempts to impose standardisation from national level discussions, this has only increased over time. Inter-personal relationships have been important in ‘working round’ the consequences of these issues, as well as the lack of an effective organisational arbiter for screening. The fragmentation of commissioning responsibilities, within and beyond screening, had implications for the ability of commissioners to exercise influence over providers due to the distribution of organisational ‘levers.’

**Summary**
• Opinions of CCG commissioners about the value of screening, and the extent to which it was considered a CCG priority, were variable
• Uncertainty among CCG commissioners about whether NHS Health Checks was technically a screening programme reflected the fact that it was created outside of the usual NSC designation process with governmental impetus and commissioned, post-Act, by LAs
• A number of advantages of the new screening commissioning system were highlighted: enhanced national-regional co-ordination (between NSC and NHSE/PHE), more straightforward dissemination of best practice, increased access to training opportunities for PHE employees, and potential improvements in screening quality
• A number of disadvantages were also identified: loss and re-location of professional and local expertise; practical challenges of working in large geographical ‘patches’, without an increase in resources, containing numerous organisations; information governance incompatibilities
• The division of responsibility within the new system was a source of confusion for local commissioners in CCGs and LAs, even two years after the Act’s implementation
• NHSE’s regional teams are responsible for commissioning national screening programmes but PHE employees, ‘embedded’ in NHSE Screening and Immunisation Teams, have a role providing expert advice and leadership. The relative responsibilities and accountabilities of these organisations, in practice, were not clear to interviewees, and a range of varied inter-organisational dynamics have evolved in local contexts
• Inter-personal relationships were identified as crucial in ‘working round’ the ambiguities of the system and the lack of an effective organisational arbiter
• Fragmented commissioning responsibilities, within and beyond screening, had implications for the ability of commissioners to exercise influence over providers due to the distribution of organisational ‘levers’
• Cervical screening illustrates how the fragmentation of screening commissioning responsibilities has disrupted an established but largely tacit arrangement for provision leading to local variation and potential gaps in provision.

Actionable messages

• Respondents highlighted difficulties associated with the fragmentation of responsibility for commissioning and monitoring screening programmes. The NHS in England is currently engaged in creating geographically focused Sustainability and Transformation Plans. There may be utility in creating a designated ‘screening lead’ with statutory oversight of screening programmes in each STP area
• The role, accountabilities and responsibilities of PHE staff embedded in NHSE could usefully be clarified
• The lack of clarity over how the delivery and performance of screening programmes should be locally monitored suggests that consideration could be given to the development of some kind of co-commissioning arrangement, whereby CCGs have a formal role in contract monitoring. This would, however, require the transfer of additional management resource to CCGs
• The status of some screening programmes as outside the scope of the NSC is a source of confusion. Consideration could be given to a process whereby screening programmes outside the purview of the NSC could be brought within its remit

References

There are no sources in the current document.

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Introduction

The aim of this project is to understand the development of the commissioning system in England following implementation of the Health and Social Care Act 2012 (hereafter ‘HSCA12’). An initial phase of data collection (March – December 2015) used interviews and observation to develop an overview of the functioning of the new commissioning system. The second phase of the project (November 2015 – March 2017) built upon these findings, focusing in upon five different service area (‘tracers’) in order to explore in more depth the issues arising in different contexts. This report summarises findings of our exploration of the commissioning of sexual health services. This ‘tracer’ was chosen because it sheds light upon the interaction between Clinical Commissioning Groups (CCGs) and local authority (LA) commissioners responsible for commissioning public health services.

Sexual health services encompass the provision of information and advice, prevention, support and treatment for a broad range of sexual health related issues, including: contraception, sexually transmitted infections (STIs; including HIV), termination of pregnancy, and sexual assault. These services are required by law to be offered on an ‘open access’ basis, i.e. to any member of the population of England wherever they choose, rather than restricted geographically to local residents upon proof of address.

National commissioning arrangements pre- and post-HSCA12

Prior to the HSCA12, sexual health services were commissioned by NHS Primary Care Trusts (PCTs), via ‘enhanced service’ arrangements with general practices and community pharmacies and via services directly commissioned from a range of providers offering contraception and testing and treatment for sexually transmitted infections (Public Health England and Department of Health 2013). The HSCA12 divided and relocated responsibility for commissioning sexual health services to CCGs, NHS England (NHSE), and LAs, with the majority of services going to the latter as part of a more general shift of public health service responsibility in April 2013. Public Health England provides commissioning support at a regional level via its four regions and nine local centres. Table 1 below shows how sexual health commissioning responsibilities have changed as a result of the HSCA12.

<table>
<thead>
<tr>
<th>Pre-HSCA12</th>
<th>Primary Care Trusts (PCTs) commissioned the majority of sexual health services</th>
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<tbody>
<tr>
<td>Post-HSCA12</td>
<td>Local authorities commission... Clinical Commissioning Groups commission... NHS England commissions...</td>
</tr>
<tr>
<td></td>
<td>Contraception over and above GP Promotion of opportunistic testing and Contraception services commissioned through</td>
</tr>
</tbody>
</table>

13 Locally Enhanced Services (LESs) and Direct Enhanced Services (DESs) were schemes commissioned by PCTs through various primary care contracts. LESs were locally specified and designed to reflect needs and priorities; DESs were nationally specified schemes that PCTs were required to establish.
TABLE 1: The division of commissioning responsibilities for sexual health services pre and post Health and Social Care Act 2012

<table>
<thead>
<tr>
<th>Pre-2012</th>
<th>Post-2012</th>
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<tbody>
<tr>
<td>GP contract</td>
<td>HIV treatment</td>
</tr>
<tr>
<td>Sexual assault referral centres</td>
<td></td>
</tr>
<tr>
<td>Termination of pregnancy services (with consultation on longer-term arrangements)</td>
<td>Sterilisation and vasectomy services</td>
</tr>
<tr>
<td>Testing and treatment of sexually transmitted infections (excluding HIV treatment)</td>
<td>Sexual health advice, prevention and promotion</td>
</tr>
</tbody>
</table>

There is no identifiable ‘programme theory’ Invalid source specified. for the specific shift of sexual health commissioning responsibility to LAs, but the explicit policy objective for the more general move of public health commissioning to local government was “[t]o realise administrative cost savings, and achieve greater alignment with local government responsibilities for local health and wellbeing” (Department of Health 2010, p.47). Connected to this objective was a suggestion that LAs responsible for public health, each led by a Director of Public Health overseeing a specialist team, would be more attuned to the needs of their local populations, more able to influence a broader range of factors affecting the health of those populations, and more democratically accountable (Department of Health 2012). The change was accompanied with a promise from government of a ‘ring fenced’ public health budget (Department of Health 2012).

In order to explore the impact of the HSCA12 upon sexual health services commissioning, we undertook extensive reading of relevant policy and other documents, and conducted interviews with a range of commissioners and service providers. This comprised the 78 interviews in Work Stream 1 (involving individuals from CCGs, NHSE, and LAs), and subsequent, more detailed Work Stream 2 interviews with 15 individuals from LAs, and sexual health service providers in two English Areas, which correspond to NHSE Area Team footprints (as originally conceived). Data analysis was iterative, with the findings from the emerging analysis informing later interviews.

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million, more than eight LAs, and a large city at its core
- **Area 2** is a highly ethnically and socio-economically diverse metropolitan county with a population of over 1.25 million, more than five LAs, and a large central city.

In this short report, we first summarise the picture of sexual health services in Area 1 and Area 2 prior to the implementation of HSCA12. We then explore post-HSCA12 sexual health services commissioning within both Areas by considering three prominent themes: (1) Collaboration and boundaries of responsibility; (2) Fragmentation of treatment and prevention; (3) Democracy and politics.

**Pre-Health and Social Care Act 2012**

In the early 2000s, commissioners and service providers in **Area 1** came together to form an Association in order to better deal with a range of problems including long waiting times, high ‘did not attend’ rates, and high STI prevalence. Regular meetings were established where issues could be
discussed and lessons shared. Common service specifications were developed amongst the commissioners’ sub-group and some Area-wide initiatives, such as a central access point for terminations of pregnancy, were instituted. Those involved credit the Association with facilitating significant improvements in service quality, as well as supporting high quality training, across Area 1. Prior to the HSCA12 the PCT commissioners within the Association had begun initial discussions about tendering for an Area-wide sexual health service.

**Area 2** had no comparable forum for inter-organisational collaboration. Prior to the HSCA12 sexual health services were commissioned by multiple PCTs. For example, in one locality of Area 2 there were three major providers: two large hospital Trusts (Trust 1 and Trust 2), and a large third sector organisation which mainly provided services for young people. The hospital Trusts both provided genitourinary services, with Trust 1 responsible for a bigger share of the contracted work (approximately half of all sexual health services). Trust 2 provided a smaller element of health promotion and outreach activities. Contracts for all of these services were renewed annually by the PCTs. The multitude of separate contracts for providers was reported to have led to disjointed service provision. Several interviewees reported that the services, particularly those for targeted health promotion around STIs, had not been closely reviewed for many years and were simply continuing due to systemic inertia. Furthermore, there was a general lack of co-ordination in activities between providers [9742, Area 2, LA, Jan 2016].

**Post-Health and Social Care Act 2012**

**Theme 1: Collaboration and boundaries of responsibility**

Post-HSCA12, the Association in Area 1 pursued its ambition to specify and procure an integrated sexual health service across the Area. This **collaborative commissioning approach** did not seem to represent a change of course from pre-HSCA12 developments. Moreover, one interviewee stated that, rather than facilitating collaboration, the HSCA12 had been disruptive and an obstacle to the progress that the Association had been making:

“...to be honest... all of this stuff is stuff that we would have wanted to do pre-Health and Social Care Act. ... the Health [and] Social Care Act has made it all more difficult. There’s still no bright side to any of that... What’s happened is that three years on we’re managing to regroup and, you know, get back to where we were probably three years ago...” [14456, Area 1, LA, Jul 2016]

One LA interviewee suspected that the impetus for working collaboratively with neighbouring LAs was partially an **outcome of increasing financial pressures** (rather than specifically a result of HSCA12):

“I think this would have happened and evolved regardless of where we sat, especially if money’s being reduced generally, I think we would have to work in this way.” [10944, Area 1, LA, Mar 2016]

In Area 2 the picture was different. Some interviewees stressed that the HSCA12 and the move of public health into LAs provided an **opportunity to ‘reset’ the landscape of sexual health provision**. One group of LAs commissioned a new service from a single provider that managed the sexual health budget and sub-contracted a range of other smaller providers, including pharmacies and third sector organisations, as well as offering an on-line STI testing service. The commissioning intention was to create a more unified, simplified service that catered better to the population at a lower cost, which
included shifting more activity into primary care. One interviewee described how the move had engendered a more collaborative, holistic focus to sexual health:

“...it is taking a much more holistic social view of the people we’re dealing with rather than just seeing it as one particular medical problem to be dealt with and then that’s the end of that. So it was much more clinically focused before and I think now more socially focused.” [11799, Area 2, Provider, Apr 2016]

The open access nature of sexual health services makes it necessary for an individual patient’s local commissioning body to pay for the cost of that patient’s use of services irrespective of where they are accessed. Pre-HSCA12, ‘cross-charging’ reimbursement between PCTs for patients accessing genitourinary (GU) services outside of their local area was seen to be relatively straightforward using a Payment by Results (PbR) mechanism that was standardised across and familiar to all NHS organisations. Post-HSCA12, there was concern that cross-charging would become problematic in Area 2 because it was not clear that LAs would respect the previous tariff arrangements, and there was no authoritative force to arbitrate and enforce payments for services used between LAs (non-NHS organisations) and providers (NHS organisations). This problem seemed to be present three years after the introduction of the Act:

“[Trust 1] will certainly try and bill [name of LA] for 50 whatever, but whether the local authority will pay up remains to be seen, because it’s not clear to me who is holding the ring; whereas in the past there was a clear National Health Service understanding that you would cross-charge in this way; so it actually did happen, but getting these things to work is that, you know, you can send a bill on, it doesn’t mean to say you’ll ever get any money for it, it’s not clear to me who is going to say to [name of LA], you must pay up.” [11799, Area 2, Provider, Apr 2016]

The financial risks associated with cross charging were mitigated in Area 1 because all commissioners and providers had, as one of their first post-HSCA12 tasks, worked together through the area-wide Association to agree to continue with the pre-existing GU recharging arrangements as well as agreeing an additional local tariff for CASH (Contraception And Sexual Health services). The motivation to do this was to make the process of cross charging straightforward and to protect against “…a race to the bottom and people cutting services...” [8384, Area 1, LA, Nov 2015].

Other participants described scenarios which illustrated how the HSCA12 had created confusion over the boundaries of responsibility between organisations. This is clearly exemplified by the provision of cervical screening (smear tests), which present an overlap between sexual health services and screening services:

“[...]in the past when people have got a cervical screening letter they could go to their local GUM or CASH clinic and some areas want to take that off the offer letter... there wasn’t a problem when they were doing them before it’s just the money wasn’t disaggregated. However local authorities have been put under significant pressure in their public health teams to reduce their budgets.” [4058, Area 1, NHSE, Jun 2015]

The overlap between sexual health services and screening appeared to present confusion around financial arrangements whereby the providers of sexual health services that now fall within the LA remit appeared reluctant to carry out cervical screening due to ambiguity about funding. The confusion around funding was particularly problematic in the early post-HSCA12 period but was still somewhat of an issue as recently as January 2016:
“But because the commissioning responsibilities and the funding are so fragmented it doesn’t sit with the CCG who commission GPs as well now I think, it still sits with NHS England because it comes under screening. Or is it NHS England? Is it Public Health England and it’s embedded in NHS England? It’s so complicated even I can’t explain it? Certainly had to meet with two different people when we went to discuss it.” [9742, Area 2, LA, Jan 2016].

Theme 2: Fragmentation of HIV treatment and prevention services

Interviewees noted that they perceived that the commissioning and provision of HIV treatment and prevention services had become fragmented as a consequence of the HSCA12. Post-HSCA12, LAs commission HIV prevention while NHSE commissions treatment for patients with HIV. This differs from other STI service provision, for which LAs commission both prevention and treatment (see Table 1). However, in practice, the HIV treatment commissioned by NHSE is frequently delivered by the same genitourinary (GU) consultants commissioned by LAs to deliver other STI treatments. An Area 1 interviewee explained:

“Commissioning of HIV prevention is with public health. And the commissioning of HIV treatment is with NHS England specialist commissioning. Which is completely insane because almost all of our HIV treatment is done in our GU clinics by our GU consultants... The people that we're commissioning to provide our STI services are simultaneously providing HIV services. And they're not running separate clinics to do HIV... They have to get their HIV money separately.” [8384, Area 1, LA, Nov 2015]

This separation of responsibilities for the commissioning of HIV prevention and treatment appeared to be less of a problem in Area 2. One major sexual health service provider reported that the sexual health services and HIV treatment services they provide were separated from each other over 10 years ago and based in different locations, which meant that the changes the HSCA12 introduced had little impact on them [11799, Area 2, Provider, Apr 2016].

The disconnection between budgets for HIV prevention and treatment appeared particularly prominent in debates regarding PrEP (Pre-Exposure Prophylaxis), a pharmacological treatment to be taken prior to sexual activity as a pre-emptive measure to protect against contracting HIV. PrEP has been shown to have high efficacy if used as directed and was recommended by the WHO in September 2015. The fragmentation of treatment and prevention seemed to fuel disagreements about whether PrEP was classed as a preventative measure, meaning that funding responsibility would lie with LAs (as argued by NHSE), or as a treatment, meaning that NHSE would be responsible for funding (as argued by LAs). In November 2016, the Court of Appeal ruled that PrEP was a treatment and thus any funding would be the responsibility of NHSE.

At the time of writing, the NHS does not prescribe PrEP, but generic versions are available online and may be purchased legally in the UK. PrEP does not prevent other STIs and there were concerns from one LA interviewee that its use could discourage condom use and thus create a rise in other STIs, which would increase costs for LAs since they are responsible for the treatment of all other STIs:

“NHS England could say, well, actually we want it given, we'll pay for the drugs, we want it given, because it'll save them money. But we'll pick up all the treatment costs of the people going for having the extra STIs and stuff. We'll also pick up the treatment costs of people having to go to the clinics for extra screening... they might pick up some savings in HIV prevention, but... most of the cost is going to fall on us.” [8384, Area 1, LA, Nov 2015]
The fragmentation of prevention and treatment of HIV arising from the HSCA12 thus fostered an environment in which stakeholders made arguments about organisational responsibility for funding particular drugs. It also contributed to concerns that decisions or actions taken by one stakeholder may have unintended negative consequences for another stakeholder.

**Theme 3: Democracy and politics**

The programme theory associated with the HSCA12 for shifting public health responsibility to local government was that it would make public health more democratically accountable. One public health consultant was very positive about a change in organisational culture and a perceived increase in democratic accountability afforded from being part of the LA rather than the NHS. This included opportunities for increased user involvement in service design, which was felt to have made greater changes to services than would have been possible within the NHS:

“[...]it’s got a democratic mandate attached to that, so you can truly decide collectively how you go about things with involving other people who you serve. You don’t get that in the NHS... we would never have done what we did in sexual health in terms of having a panel of [#] young people to consider the plans for redesigning the whole sexual health system.” [10248, Area 2, LA, Feb 2016]

There was also the feeling that the LA was a more influential partner, able to drive change rather than simply respond to NHS-led initiatives:

“We can lead and help influence our partners in the NHS through our position on boards, our connectivity and clout in terms of reach to other services and other areas. You can actually become more of a system leader for change as opposed to a passenger within the fragmented system.” [10248, Area 2, LA, Feb 2016]

However, some other Directors of Public Health and public health consultants found that the high levels of decision-making authority they had been afforded in PCTs were curtailed in LAs. One interviewee suggested that Directors of Public Health and other members of the public health team now had less autonomy as LA employees because decisions had to go through local government governance processes:

“[...we all have to come back to the ranch, we all have to come back to our local authorities[...] we can’t make decisions. So it’s really difficult then, for that [Association] to actually make decisions. And they don’t recognise the fact that they come from a local authority, and they can’t.” [10944, Area 1, LA, Mar 2016]

Furthermore, some individuals in public health teams found themselves in less senior positions in LAs than they had occupied in PCTs:

“And most public health consultants have been put into the local authorities but not at a sufficiently senior level, because there already were people in those senior levels... we don’t have the seniority in the local authority that we had in the NHS... a lot of our position power has gone, both from the NHS and from the local authority.” [8384, Area 1, LA, Nov 2015]

Another LA commissioner had concerns that in the post-HSCA12 system certain sexual health services (e.g. preventative outreach work at premises frequented for sexual activity) could now potentially be more vulnerable due to politicisation by local councillors who believe such services...
should not be provided [12649, Area 2, LA, Apr 2016]. She said that public health had to be prepared to argue and fight such proposals if they appeared.

Other interviewees expressed concerns about the **bleak-looking funding landscape** of public health. Public health funding allocations to LAs are ring-fenced until March 2018, but they are being reduced year-on-year. Multiple interviewees expressed concerns that public health funding would be appropriated for purposes that stretch the interpretation of traditional public health activities because of the severity of strain on LA budgets. One public health commissioner remarked:

“...when we moved in, we joked that we'd be ending up spending our money on gritting roads as a falls prevention activity. And I think there are now public health teams who have money taken away from them to provide gritting to roads.” [8384, Area 1, LA, Nov 2016]

Another concern expressed by interviewees was that, due to the fact that they are now funded through local government, sexual health services were more vulnerable than they were prior to the HSCA12:

“... although we are delivering...NHS organisation delivering services for the NHS, we could potentially be cut back in a way that the rest of the NHS will not be. And I think that’s an unintended consequence of the way the money is coming down to us through the local authorities.” [11799, Area 2, Provider, Apr 2016]

This extract highlights implications for services from changes to funding sources, whereby NHS funding and the services it pays for are more secure than LA funded services.

**Summary**

- In Area 1, the HSCA12 disrupted pre-existing inter-organisational commissioning practices, leading to complaints of arrested development. The existence of these practices (and the Area-wide Association which underpinned them) was felt to have mitigated some of the effects of the Act.
- In Area 2, the HSCA12 was seen by some commissioners as creating an opportunity to ‘reset’ the landscape of provision by allowing the termination of annually renewed separate contracts with multiple providers and the procurement of a new framework contract operated by a single provider. This new service was perceived as offering a more holistic approach to sexual health that extended beyond a purely medical model.
- However, the HSCA12 appeared to have fragmented sexual health service commissioning and created confusion over the boundaries of responsibility between organisations. This was particularly problematic in the early post-HSCA12 period but was an on-going issue.
- ‘Cross charging’ between budget holders (either the LA or delegated provider) is difficult when there is no formal arbitrator to settle disputes. This represents a source of financial uncertainty for budget holders because they cannot guarantee they will be reimbursed when patients from a different locality use their services. In Area 1, all LAs agreed to a common tariff and specification for services to make this more straightforward and avoid a ‘race to the bottom’ in service offering between localities. This was facilitated by pre-existing joint working.
- Sexual health overlaps with other service areas e.g. screening. There are financial implications e.g. regarding smear tests. Thus, prior to the HSCA12 women were able to seek smear tests from sexual health services as well as from their GP. LAs are not paid for providing these services, and there is some confusion as to whether sexual health services will continue to offer them...
• The split in commissioning responsibilities for HIV treatment (NHSE) and prevention (LAs) creates perverse incentives, disagreements over responsibility, and potential difficulties for holistic services presenting unified messages, as seen with the funding of PrEP drugs
• Some interviewees argued that relocating sexual health services to LAs had a positive potential to increase democracy (e.g. public involvement in service design), allow for a more holistic focus on sexual health, increase the ability of LAs to influence the NHS on a more equal footing, and realise sexual health services through the more rigorous commissioning practices of local government
• However, there were concerns that certain sexual health services might be vulnerable as a result of ‘politicisation’ with potential for councilors to raise moral concerns in line with the perceived opinions of their constituents
• The LA funding picture is bleak. Public health funding is ring-fenced (until March 2018) but being cut year-on-year. Interviewees were anxious that sexual health services are already being disinvested in and that public health funding is being utilised for tenuously-related services.

**Actionable messages**

The transfer of responsibility for public health service commissioning and provision to LAs, whilst underpinned by strong arguments around democracy and the opportunity to act upon the social determinants of health, has thrown into sharp relief the areas of ambiguity around the commissioning and provision of sexual health services. In particular, it has highlighted the artificiality of distinctions between prevention and treatment, the need for close collaboration across organisational and professional boundaries and the overlaps between prevention and screening. In Area 2, the disruption associated with the HSCA12 acted to ‘unfreeze’ a somewhat dysfunctional system, allowing innovation and renewal. In Area 1, by contrast, a functioning system of area-wide collaboration was disrupted. Together, this evidence highlights the need for:

• Close collaboration between all commissioners and providers of sexual health-related services
• Area-wide forums within which disputes over issues relating to payment, charging and areas of responsibility can be managed and resolved
• Contracting arrangements which share risks and benefits to prevent inappropriate cost-shifting as budgets come under increasing pressure.

**References**


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Work Stream 2 – tracer short report: Specialised Services

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Introduction

The aim of this project is to understand the development of the commissioning system in England following implementation of the Health and Social Care Act 2012 (hereafter ‘HSCA12’). An initial phase of data collection (March – December 2015) used interviews and observation to develop an overview of the functioning of the new commissioning system. The second phase of the project (November 2015 – March 2017) built upon these findings, focusing in upon five different service area (‘tracers’) in order to explore in more depth the issues arising in different contexts. This report summarises the findings of our exploration of the commissioning of specialised services. This ‘tracer’ was chosen because of its potential to shed light upon the interaction between NHS England (NHSE) and Clinical Commissioning Groups (CCGs), and because it allows examination of the interplay between local and national commissioning.

Specialised services commissioning seeks to ensure that the needs of people with relatively rare conditions (e.g. specialist kidney conditions, cystic fibrosis, rare cancers) are met. The equipment and skills for providing specialised services are often only available in certain regional or national centres, and the costs of providing such services are often high. In 2015-16, specialised services cost around £14bn, approximately 14% of the NHSE budget, and are set to increase to around £19bn, approximately 16% of the NHSE budget, by 2020-21 (National Audit Office, 2016).

Pre-HSCA12

Prior to the HSCA12, a service was considered specialised if it covered a “planning population (catchment area) of more than a million people” (NHS Specialised Services, 2013). Primary Care Trusts (PCTs) held responsibility for commissioning these services for their patient populations, and each worked in collaboration with others to provide for populations over broader footprints and to pool financial risk (National Audit Office, 2016). Due to perceived deficiencies in these collaborative processes, primarily a lack of robust and consistent commissioning arrangements throughout the country, the Carter Review of specialised services commissioning was initiated by the Department of Health (2006). This review made a number of recommendations, including: the creation of a National Specialised Commissioning Group to orchestrate commissioning activity; the creation of 10 Specialised Commissioning Groups (SCGs; coterminous with the 10 Strategic Health Authorities) operating with budgets pooled from their constituent PCTs; and a review of the Specialised Services National Definition Set, which contains a list of all services that are designated ‘specialised’. These recommendations were enacted in 2007. In March 2010, the House of Commons Health Select Committee (2010) published a report on commissioning, expressing concerns that there remained significant local variation in specialist service provision, that the review of the National Definition Set had been unsatisfactory, and that the positioning of specialised services commissioning as a pooled responsibility between PCTs left it lacking regulation and accountability. Immediately following publication of this report, the May 2010 General Election saw a change in government, and the new Coalition Government’s response (HM Government, 2010b) to the Health Select Committee report highlighted the proposals in the ‘Equity and Excellence’ White Paper (HM Government, 2010a) would address these concerns.

Post-HSCA12
The HSCA12 altered the basis for deciding what constitutes a specialised service; rather than reflecting planning populations of over one million, the designation is now based on an assessment of four ‘factors’ (NHS England, 2014, p.8):

5. The number of individuals who require the provision of the service or facility;
6. The cost of providing the service or facility;
7. The number of persons able to provide the service or facility;
8. The financial implications for Clinical Commissioning Groups (CCGs) if they were required to arrange for the provision of the service or facility.

A process of re-assessing the classification of specialised services using these four factors was undertaken by the Department of Health’s Clinical Advisory Group for Prescribed Services (comprised of health professionals, patient representatives, and commissioners including GPs). This group took advice from the 60 Clinical Reference Groups, each of which is focused on a particular specialised commissioning area. It recommended that virtually all of the pre-existing specialised services should retain their classification, and also recommended the reinstatement of a number of services removed in a previous iteration of the Specialised Services National Definition Set.

In April 2013, NHSE assumed responsibility for setting the specialised commissioning budget and for commissioning specialised services. Between 2013-2015, 10 (of the 27) NHSE Area Teams commissioned specialised services. In April 2015, NHSE underwent a structural reorganisation, aimed at reducing costs and simplifying organisational operation, in which Area Teams were abolished. specialised services commissioning became the responsibility of four NHSE regional teams, with commissioning activities carried out through 10 ‘hubs.’ Crucially, these hubs no longer cover a geographical population. Whereas PCTs commissioned services for their local patient populations, NHSE commissions for England as a whole. This new approach represents a fundamental change, with the commissioning hubs set up to commission services from specific providers, contracting with them for all the services they provide, including for patients from outside their local catchment area.

Analysis of relevant documents suggests that the programme theory (Weiss, 1998) underlying the changes to specialised services commissioning was that a centralised commissioning approach orchestrated by NHSE would enhance equity for patients through increased standardisation of care and reduced geographical variability in service provision. NHSE’s Operating Model for Specialist Services Commissioning (NHS Commissioning Board, 2012) explicitly differentiated between commissioning (establishing priorities and strategy), which was to be done at a national level, and contracting (relationship management), which was to be done at a local level (initially through the Area Teams; now through the NHSE regional teams and hubs). The Operating Model thus aimed to facilitate a standardised and equitable approach to specialised services commissioning through centralised oversight, whilst retaining sensitivity to local contexts.

In order to explore the impact of HSCA12 upon specialised services commissioning, we undertook extensive reading of relevant policy and other documents, and conducted interviews with a range of commissioners and service providers in two English Areas:

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million and a large city at its core
- **Area 2** is a highly ethnically and socio-economically diverse metropolitan county, with a population of over 1.25 million and a large central city.

Specialised service commissioning was addressed within the 78 interviews in Work Stream 1, which primarily involved individuals from CCGs and NHSE. Subsequent, more detailed interviews were conducted with seven individuals from CCGs, NHSE and specialised service providers in Areas 1 and
2. Data analysis was iterative, with the findings from the emerging analysis informing later interviews.

This short report highlights three prominent and interacting themes from the project thus far: (1) Scale of commissioning; (2) Governance and accountability; (3) Finance and contracting.

**Theme 1: Scale of commissioning**

Interviewees understood the logic in the programme theory underpinning the changes to specialised services commissioning, citing the desirability of reducing inequity in access to specialised services, concentrating expertise to make services safer, simplifying the commissioning process by reducing the number of conversations between providers and commissioners, and giving the commissioner (NHSE) more power to influence providers. However, interviewees reported a variety of challenges associated with the changes, which primarily manifested themselves as tensions in commissioning between national and local scales.

There were examples of how the shift to commissioning of specialised services on a national scale had fractured pathways of care, in which initiatives around prevention and early intervention for particular conditions that might be commissioned by CCGs had become divorced from the specialised end of the pathway which was commissioned by NHSE. This fracturing of pathways also had the ability to increase pressure on local services that had to support an influx of patients from outside the locality at the specialised end of the pathway. An interviewee from a CCG in Area 2 described a scenario within Child and Adolescent Mental Health Services in which non-specialised tier 1-3 services (community and outpatient) are commissioned locally by CCGs to meet the needs of the local population, but specialised tier 4 services (inpatient) are commissioned at a national level by NHSE. This separation of local and national commissioning meant that tier 4 services in Area 2 are available for patients from anywhere in the country, which reduced capacity for the local population [7160, Area 2, CCG, Oct 2015].

Following NHSE’s internal reorganisation in April 2015, members of the specialised services commissioning teams who had been working on an Area Team footprint were asked to cover a much greater footprint. Interviewees noted that as a consequence of the change, the relationships and local knowledge that they had established were less relevant and they felt that they now had less autonomy due to having to report directly to managers at the regional level [5931, Area 2, CCG, Aug 2015]. Over a year after this reorganisation, an interviewee from an NHS Trust explained that NHSE commissioners had to seek decisions from a national team. This was intended to allow NHSE to control spending; however, local commissioners felt that it stymied local decision-making and innovation:

“It's made it more difficult, like I say, to get business cases and developments through because I think the local commissioners, you know, as in our regional team that we liaise with, so our day-to-day supplier managers, have got very little control or decision making ability. They have to pass almost every decision up to the national team. The national team don't sort of have the time or inclination to comment on what's happening in [Area 2], unless it's part of a national decision that they're making everywhere.” [14376, Area 2, Provider, Jul 2016]

In April 2015, NHSE formally launched ‘Collaborative Commissioning’, a policy initiative intended to overcome the tensions created by trying to commission both nationally and locally (NHS England Specialised Commissioning National Support Centre, 2015). This initiative involved CCGs and NHSE working together in Specialised Collaborative Commissioning Oversight Groups in order to design
and develop commissioning pathways to mitigate issues of fragmentation. Interviewees recognised
the logic in attempting to create pathways rather than commissioning services in isolation, but
raised questions about how far collaborative commissioning was actually being realised in
practice. Around six months after the launch of the initiative, a CCG member suggested that
different statutory responsibilities (i.e. towards local populations for CCGs; towards the national
population) might be acting as a barrier to genuinely collaborative commissioning. This interviewee
identified a number of related issues, including: lack of pooled budgets; powerful incentives for NHSE
and CCGs to protect their own budgets; and little capacity for CCGs to engage with collaborative
processes around specialised services that might offer only marginal benefits to their local
population [7160, Area 2, CCG, Oct 2015].

Around a year after the introduction of the initiative, questions remained about the extent to which
Specialised Collaborative Commissioning Oversight Groups were able to exert influence. The
initiative was perceived as being overtaken by forthcoming Sustainability and Transformation
Plans (STPs) and their emphasis upon place-based commissioning:

“...[Area 2 Specialised Collaborative Commissioning Oversight Group] can make
suggestions to the National Oversight Group but it can't actually change anything
without agreement from the National Oversight Group because the statutory
responsibility for specialised commissioning is identified against specific services and it
would require a legislative change in order to change that... So I think it will stay in
parallel until STPs either prove themselves or don’t. If they don’t, it would have a
stronger role, I guess, but if they do prove themselves we may see, I guess, the
dismantling of that over time and those responsibilities allocated to STPs.” [10648, Area
2, CCG, Mar 2016]

Interviewees thus appeared to understand the rationale for changes to specialised commissioning,
but felt that in practice, the changes had led to fragmentation of pathways, and unresolved tensions
between commissioning responsibilities at national and local scales.

**Theme 2: Governance and accountability**

Interviewees suggested that the changes to specialised services commissioning had created
confusion around governance and accountability. One CCG interviewee felt that the basis on which
decisions were reached about classifications of specialised conditions was unclear. She also felt that
NHSE was largely unaccountable, and that the various changes instituted by NHSE since taking on
specialised commissioning had made it hard to keep track of where responsibilities were allocated in
the system:

“The world of specialised commissioning is really remote, extremely unaccountable, I
don't know where accountability sits... services are managed nationally and I
understand that some of the point in some of the areas but in others in order to get
service improvements you need local pathways and those local pathways aren’t in place
or can’t be in place because the local relationships aren’t there. So specialised
commissioning appears to go through a reorganisation every ten minutes so you never
really know who’s responsible for what.” [3393, Area 1, CCG, May 2015]

This sense of confusion appeared to be exacerbated by the April 2015 restructuring of NHSE and the
development of Collaborative Commissioning, which had moved some of the responsibility for
commissioning specialised services back to the smaller footprints of CCGs and regions. The feeling of
continuous reorganisation of specialised services commissioning was articulated by a former NHSE
specialised services commissioner who had moved to work in a CCG. She highlighted it as a challenging factor shaping local service delivery:

“So it always is feeling like this flux, which is difficult to do strategic planning and local planning on operational plans on that footprint because it’s feeling like there’s that constant evolution of where services may or may not land going forward.” [5931, Area 2, CCG, Aug 2015]

There were perceptions that the commissioning system was now lacking an effective mediator holding a comprehensive strategic overview. There was an expectation from some providers that NHSE should fulfil this role, but that it was failing to do so, and this failure was acting as a barrier to decision-making and innovation. Post-HSCA12, and particularly following the internal re-organisation of NHSE, decision-making appears to have become centralised, more remote, and lacking a strategic overview. An interviewee from an NHS Trust suggested that NHSE was initially underprepared to act in a commissioning role, and that its internal reorganisation in April 2015 had caused delays which stifled innovation and resulted in a loss of knowledge about specialised services:

“the disorganisation since the Health and Social Care Act, and the fact that NHS England’s taken quite a while to stop being a rabbit in the headlights and actually start commissioning things, they've spent a long time looking at their own organisation and their own structure, and they actually lost an awful lot of knowledge of the services they commissioned... It’s been really hard to get decisions made.” [14736, Area 2, Provider, Jul 2016]

This perception of lost knowledge was echoed by a former NHSE specialised commissioner, who cited challenges from the demarcating of commissioning team staff into contract managers and service specialists:

“we’ve carved up the commissioning functions and the operational versus strategic... there is a danger that we’ve lost organisational memory, we’ve lost some of the skill set. So, for example, the specialised commissioning team, there was a decision that the structure would work that you would either be a contract manager or you would be a service specialist. That’s not how we commission. We commission on the commissioning cycle, and there’s a danger that we’ve deskill staff over time or potential that we will deskill them going forward.” [5931, Area 2, CCG, Aug 2015]

Interviewees thus painted a picture in which specialised services commissioning was perceived to undergo frequent confusing reorganisation, coupled with a lack of strategic oversight by NHSE, which led to delays in decision-making at local levels and the potential de-skilling of commissioning team members who were now asked to work on specific aspects of commissioning, rather than more holistically.

**Theme 3: Finance and contracting**

There were perceptions that the move of specialised services commissioning from the pre-HSCA12 Specialised Commissioning Groups into the post-HSCA12 NHSE had been much more complex than anticipated, with NHSE struggling to perform the administration of commissioning specialised services from providers on a standardised, national scale:

“...when it came into NHS England, you can imagine the number of different arrangements and policies and ways in which it was organised and commissioned, varied up and down the country... a lot of the first part of the work was developing
those national policies... NHS England, they under-estimated... I think they naively thought, oh that’s fine, just bring ten teams together, and it’ll all be wonderful. And I think they got the shock of their lives to be honest, the level of complexity of this.” [5930, NHSE Area 2, Aug 2015]

Post-HSCA12, providers of specialised services reported an increase in administrative workload, but attributed this to a number of factors, none of which are direct consequences of the Act itself: NHSE’s April 2015 reorganisation and the move to more central control over commissioning processes following the abolition of Area Teams; the Department of Health re-writing their contract templates to be more detailed, alongside commissioners preferring to regulate through contractual mechanisms with providers; and the NHS regulator (then Monitor; now NHS Improvement) seeking greater detail in reporting from providers.

A provider in Area 1 highlighted challenges for financial administration and oversight around referrals within the specialised services system, arising from a lack of cohesion between GPs, NHS Trusts, and NHSE:

“I audited three months of referrals of [local] GPs into [Area 1 hospital Trust] for MSK [musculoskeletal services] and about half of them were for what we call normal variance, so for problems which are perfectly capable of being managed by our community team here... and yet there’s no incentive on GPs or health visitors to do the right referral, they just do the referral and the problem is solved. There is an incentive at [Area 1 hospital Trust] to flood themselves, because they get the specialist tariff for every patient they see and there isn’t the same incentive on the CCG to manage it, because the budget is paid by NHS England who don’t know what’s going on.” [12580, Area 1, provider, May 2016]

This interviewee highlighted how Trusts have an economic incentive for providing specialised rather than non-specialised services, since NHSE pays Trusts on a specialised tariff based on the referral practices of GPs who are disconnected from the economic consequences of the type of referral that they make. The picture in the post-HSCA12 landscape therefore seems to be disjointed; there is no incentive for GPs to choose non-specialised referrals, an economic benefit for providers to deliver services on a more lucrative specialised tariff, and no levers by which NHSE can control this activity.

Summary

- The HSCA12 changes to the specialised commissioning system have seen care pathways become fragmented, with unresolved tensions between commissioning responsibilities at national and local scales
- Specialised Commissioning Collaborative Oversight Groups were created with the intention of addressing this problem. However, CCGs have limited capacity and few incentives to prioritise this activity, and uncertainty surrounding their status in the context of STP development is a problem
- There was a lack of clarity over governance and accountability, with a particular tension between the need to control spending and the need to support local innovation
- Specialised services commissioning appears to have undergone frequent confusing reorganisation, coupled with a lack of strategic oversight by NHSE, which seems to have led to delays in decision-making at local levels and the potential de-skilling of commissioning team members
There also appears to be perverse incentives built into the new system, with no incentive for GPs to choose non-specialised referrals, an economic benefit for providers to deliver services on a more lucrative specialised tariff, and no levers by which NHSE can control this activity.

**Actionable messages**

Specialised services commissioning seeks to ensure that the needs of people with relatively rare conditions are met. Prior to HSCA12, specialised services were commissioned by PCTs for catchment areas of more than one million people. Post-HSCA12, they are commissioned by NHSE for the country as a whole. The rationale for this change was to increase standardisation of services and reduce geographical variation in access.

Interviewees accepted the rationale for the changes. However, some problems were identified which highlight the need for:

- NHSE could usefully clarify their intentions regarding Specialised Commissioning Collaborative Oversight Groups, and consider how best to incentivise CCG participation
- The development of STP plans and ‘place-based’ commissioning structures offers an opportunity to consider a return to commissioning for (larger scale) geographical populations. However, this would require the creation of a regional tier of organisations with statutory responsibility for a defined budget
- It is important that future disruption to NHSE’s specialised commissioning teams is kept to a minimum, and retaining and developing skilled staff is made a priority
- Perverse incentives need to be addressed urgently in any future development of NHS tariffs and contract models.

**References**


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11 Appendix 4: Advisory group

Advisory group membership:

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angela Young</td>
<td>PPI rep</td>
<td>Public scrutiny of health services, including membership of a Community Health Council and of Local Healthwatch</td>
</tr>
<tr>
<td>Jan Giles</td>
<td>Huddersfield CCG</td>
<td>CCG manager</td>
</tr>
<tr>
<td>Huw Charles-Jones</td>
<td>W Cheshire CCG</td>
<td>GP and CCG senior leader</td>
</tr>
<tr>
<td>Vicci Owen-Smith</td>
<td>PHE</td>
<td>Public health leadership, and commissioner</td>
</tr>
<tr>
<td>Steve Harrison</td>
<td>Academic</td>
<td>Extensive experience on social policy research</td>
</tr>
<tr>
<td>Ged Devereux</td>
<td>GM HWB</td>
<td>Public health expertise, and member of a Health and Wellbeing Board</td>
</tr>
<tr>
<td>Judith Smith</td>
<td>Nuffield Trust/university of Birmingham</td>
<td>Experienced researcher of commissioning and health service organisation</td>
</tr>
<tr>
<td>Virginie Perotin</td>
<td>Academic, Leeds</td>
<td>Economist with expertise in quantitative methods</td>
</tr>
<tr>
<td>Andrew Jackson</td>
<td>NHSE</td>
<td>Senior Analyst with quantitative expertise and experience of CCG development</td>
</tr>
<tr>
<td>Ivan Ellul</td>
<td>NHSE</td>
<td>Senior NHSE manager with a commissioning role</td>
</tr>
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Remit:
- To provide an external voice to support the project, providing advice based upon position, experience and current role
- To receive reports about the conduct of the project, and approve any significant changes to methods or timings
- To provide a critical audience for our emerging findings
- To support the project team in formulating reports and other outputs, and to provide advice on dissemination

Process:
The group will meet:
- early on in the course of the project
- in the middle of year 2
- in the middle of year 3

In addition we may communicate with the group by email during the course of the project if significant issues arise.