PRUComm

POLICY RESEARCH UNIT IN COMMISSIONING AND THE HEALTHCARE SYSTEM

Understanding primary care co-commissioning: Uptake, scope of activity and process of change

Interim report

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1 PRUComm work programme

The Policy Research Unit in Commissioning and the Health Care System (PRUComm) was commissioned by the Department of Health to study the development of Clinical Commissioning Groups (CCGs). We have been following CCGs' development since their initial establishment as 'Pathfinders' (the programme was announced in October 2010 and the first Pathfinders were established in January 2011).

In the *first phase* of the project (January 2011 to September 2012), we followed the development of CCGs (initially known as GP Commissioning Consortia) from birth to authorisation i.e. from when they were involved in the 'pathfinder' programme and were officially sub-committees of their local PCT Cluster until their authorisation in April 2013. We conducted an intensive investigation working with eight case study sites alongside two national web-based surveys of CCGs. We explored issues that arose and were important as the CCGs developed and factors affecting their progress and development, as such we detailed the experiences of emerging CCGs being part of the 'pathfinder' programme (Department of Health, 2010a) and explored issues, which were drawn thematically from the evidence we found. This included the different approaches to being a membership organisation, how the emerging CCGs were developing their external relationships (for example with the Health and Wellbeing Board, other CCGs, etc.), and what approaches were being taken to commissioning and contracting (for full report see Checkland et al., 2012).

One of the issues highlighted by our participants in the first phase of the study was the perception of GP 'added value'. Participants from many of our case study sites told us that they felt that the involvement of GPs had 'added value' in both commissioning and contracting. We followed up those claims in the *second phase* of our study (April 2013 to March 2015). For this phase, we started by interviewing both clinicians and managers in 7 case study sites to explore in more detail their understanding of the value of clinical input in commissioning (with concrete examples where possible). The findings from these interviews have been published (see Checkland et al., 2014; Perkins et al., 2014). The results from these interviews were used to focus on the next phase of data collection, in which the claims made were followed up in observations of the work of four of our existing case study sites (for full report see McDermott et al., 2015).

The focus of this report is on the *third phase* of the project (April 2015 to December 2017), which aims to explore the significant changes to the work of CCGs as they began to take over varying levels of new responsibility for commissioning primary care services from April 2015. The scope of activities includes general practice commissioning, local incentives scheme, general practice budget management, complaints management, and contractual general practice performance management (NHS England, 2014c).

2 Policy background

The Health and Social Care Act 2012 gave responsibility for commissioning primary care services to NHS England (NHSE). Part of the rationale for CCGs not having primary care commissioning responsibilities was to move towards a more standardised model of primary care commissioning:

> *The principle of rewarding quality will also apply in primary care. In general, practice the Department will seek over time to establish a single contractual and funding model to promote quality improvement, deliver fairness for all practices, support free patient choice, and remove unnecessary barriers to new provision. Our principle is that funding should follow the registered patient, on a weighted capitation model, adjusted for quality. We will incentivise ways of improving access to primary care in disadvantaged areas* (Equity and Excellence, 2010 para 3.21)

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

Primary care co-commissioning was first mooted in the *Call to Action* phase 1 report published in March 2014 (NHS England, 2014b) where "joint commissioning" was identified as one of national level supports to improve general practice. Simon Stevens reiterated this, in his first appearance before the House of Commons Health Select Committee as the new Chief Executive of NHSE on 29th April 2014. The announcement was made official during the Annual Conference of NHS Clinical Commissioners on 1st May 2014. He announced that CCGs would get 'new powers' under a new commissioning initiative and asked CCGs to consider the additional powers and responsibilities they would like to assume. CCGs was asked to submit an expression of interest by 20th June 2014, the same date that CCGs completed their initial five-year 'Forward Views' for local NHS services. The following week, on 9th May 2014, NHSE issued a letter to all CCGs setting out details on how to submit the expressions of interest (Roughton & Hakin, 2014). The following were included in CCG's expressions of interest: whether it was an individual or group of CCGs proposing the arrangements; how the proposal fitted with their five-year strategic plans; the scope of activities; the nature of co-commissioning; proposed timescale; proposed governance arrangements; how CCGs were engaging with members and local stakeholders; and how CCGs were planning to monitor and evaluate the impact and effectiveness of the proposed arrangements.

In the following month (June 2014), NHSE started to set out details on how CCGs could submit expressions of interest to develop new arrangements for co-commissioning of primary care services. The letter issued to CCGs (Hakin, 2014) suggested that the scope of activities could include:

- working with patients and the public, and with Health and Wellbeing Boards to assess needs and decide strategic priorities,
- designing and negotiating local contracts (e.g. PMS, APMS, any enhanced services commissioned by NHSE),
- approving 'discretionary' payments, e.g. for premises reimbursement,
- managing financial resources and ensuring that expenditure does not exceed the resources available,
- monitoring contractual performance,
- applying any contractual sanctions,

- deciding in what circumstances to bring in new providers and managing associated procurements,
- making decisions on practice mergers.

In July 2014, NHSE (at their Board meeting) (NHS England, 2014g) revealed the number of expressions of interest submitted for each category:

- **Level 1** (greater involvement) – 19 expressions of interest. CCGs would have 'influence' but not take the lead in shaping primary care locally. This was considered good practice but has no formal process.
- **Level 2** (joint commissioning) – 110 expressions of interest. CCGs would set up joint committees with NHSE Area Teams (ATs) (from April 2015, the 27 ATs were integrated into four existing regional teams: London, Midlands and East, North, and South) to share primary care commissioning responsibility, potentially supported by pooled funding arrangements. NHSE and CCG(s) were to set up a joint committee and funding would remain with NHSE finance so they remain party to all decision making.
- **Level 3** (delegated authority) – 74 expressions of interest. CCGs would take on delegated authority of some aspect of primary care commissioning. They would take over budgets from ATs and take the lead on primary care commissioning. CCGs would carry out defined functions on behalf of NHSE and ATs would hold CCGs to account for how effectively they carried out these functions. Final approval and granting of delegated authority rested with the CCG Assurance & Development Committee. According to the report, the vast majority of CCGs were ready to take on delegated authority (20 were ready, 45 were ready soon, and only 9 were not ready).

Following on from the submission of expressions of interest, the joint CCG and NHSE primary care co-commissioning Programme Oversight Group (POG) published a *Next steps towards primary care co-commissioning* document (NHS England, 2014c) which aimed to provide "clarity & transparency around co-commissioning options" (Doyle, Dodge, Ellul, & Simon, 2014). In order for commissioning arrangement to 'go live' from April 2015, CCGs had to submit their applications by January 2015.

This change in policy brings with it a number of important issues. In particular, the status of CCGs as membership organisations means that GPs will essentially be commissioning themselves to provide services. Issues of conflicts of interest, the role of alternative providers of primary care services, and the management of poor performance would need to be addressed as the policy develops. Taking on responsibility for commissioning primary care may affect the relationship between a CCG and its members (practices), and would require changes to governance arrangements and structures, with new committees established. It would also affect the relationship between the CCG and NHSE, and there would be significant issues raised by the phased approach that has been adopted. This has significant implications for NHSE, whose managers will potentially be managing a situation in which they are fully responsible for primary care commissioning for some CCGs whilst setting up 'joint commissioning committees' with others and having minimal responsibility for those who have taken over delegated responsibility.

Initially there was no clear expectation that CCGs would move from 'greater involvement' or 'joint commissioning' in primary care commissioning to taking on full responsibility over time, although some of the expressions of interest submitted explicitly proposed such a movement highlighting 'phases' by which the CCG would take on more responsibility over time. However, one year on, the pressure on resources has started to manifest. In October 2015, NHS England issued a letter to CCGs encouraging those operating under 'joint commissioning' or 'greater involvement' to consider applying for full delegation by November

2015 (Dodge & Doyle, 2015). The letter stated that early benefits and opportunities of delegated commissioning and concluded by highlighting a shift towards a 'place-based' commissioning and the possibility of CCGs taking more responsibility of co-commissioning of other primary care areas. There is a clear parallel here with the 1998 White Paper (Department of Health, 1998), in which it was proposed that new Primary Care Groups would progressively take on greater responsibility for commissioning services, overseen by the then Health Authority. In practice, it proved expedient for the timetable to be drastically shortened, with the progressive handing over of responsibility apparently impossible to achieve. Questions therefore arise as to how NHSE will manage the process, how resources will be transferred to CCGs, and how the handover of responsibilities would work in practice.

The overarching aim of our study is to understand the scope of co-commissioning activity, its uptake, and the process of change. There are three stages in the study:

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

This report concerns Stages 1a, 1b and 2a as described above. Our research questions are:

1. What are the CCG's objectives for their involvement in co-commissioning, and how do they intend to achieve these?
2. Which areas of activity and service are the CCGs focusing upon? What plans do they have to make changes to services?
3. What internal governance and other arrangements have been put in place to manage their new responsibilities? How did the CCG decide which arrangements to adopt? Who was involved in the decision-making? What factors affected their decision?
4. How has NHSE managed the process, and what has been the impact on the work of NHSE ATs?

3 Methods

We started by exploring the uptake of primary care co-commissioning nationally (April to May 2015). Using CCGs' application submissions (as provided by NHSE with CCGs' agreement), we created a database of CCGs listing their levels of co-commissioning arrangements, contact details of a named person responsible within each CCG, and detailed information on what was stated or included in their application. Although CCGs were required to submit their application using a standardised form, the amount of details written in each application varied widely with some CCGs simply replicating what was in the official documents.

From the database, we generated a representative sample of CCGs to target for a telephone survey (June to August 2015). Our sampling criteria includes; level of co-commissioning responsibility, regional team the CCG belong to, size of CCG, urban vs rural CCG, those undertaking collaborative commissioning with neighbouring CCG or having submitted a joint application, and those adopting other new models of care (for e.g. GP Federation, Vanguard, etc.). The telephone survey addressed the research questions above and the results were tabulated into a database for analysis.

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

4 Programme theories

This section sets out the rationale underlying the policy and expected outcomes. We conducted an in-depth analysis of policy documents related to primary care co-commissioning and interviews with senior NHSE and Department of Health staff who played a role in the development of the policy. Essentially, we encountered two arguments. *Firstly*, that engaging CCGs with commissioning primary care would solve a number of problems, which entered the system following the Health and Social Care Act (HSCA) 2012. *Secondly*, that demographic and financial challenges required a move towards a more 'place-based' approach, in which budgets were shared and commissioning focused upon an entire population, removing 'artificial' barriers between primary, secondary, community and social care.

4.1 Co-commissioning as the "sticky plaster" or solution to a problem

In our analysis of policy documents and interviews with senior policy makers, we found that co-commissioning was often described as a 'solution' to the problems identified. If co-commissioning was the 'solution', what were the 'problems' it was trying to solve?

It will be useful to start with how and when primary care co-commissioning was introduced. Primary care co-commissioning was firstly referred to in the *Call to Action* phase 1 report (NHS England, 2014b). It (referred to in the document as "joint commissioning") was described as one of national level support to improve general practice. The report argued that general practice needed to change for the following reasons: (1) demographics (to meet changing needs and expectations of populations); (2) outcomes (to improve outcomes & tackle inequalities); (3) financial constraints (to maximise limited resources); and (4) workforce (to secure a sustainable service). The need to address the workforce crisis and sustainability issues in primary care was also emphasised by Simon Stevens in his first appearance as the new Chief Executive of NHSE at the Health Select Committee. He argued that co-commissioning would enable CCGs to have more impact over decisions about spending not only in GP services but also in primary care services, and thus would provide a means of addressing some of these issues.

The need to invest more in primary care was emphasised in the *NHS Five Year Forward View* (5YFV), which was published in October 2014 (NHS England, 2014a). The 5YFV argued for the need to have a 'new deal' for GPs over the next five years. It further stated that:

> *GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.* (NHS England, 2014a p.4)

Following the publication of 5YFV, NHSE published the N*ext steps towards primary care co-commissioning* in November 2014. The purpose of the document was to provide "clarity and transparency" around co-commissioning options. It stated that:

> *The introduction of co-commissioning is an essential step towards expanding and strengthening primary medical care. Co-commissioning is recognition that clinical commissioning groups (CCGs): are harnessing clinical insight and energy to drive changes in their local health systems that have not been achievable before now; but are hindered from taking an holistic and integrated approach to improving healthcare for their local populations, due to their lack of say over both primary care and some specialised services; and are unable to unlock the full potential of their statutory duty to help improve the quality of general practice for patients. That's why NHS England is giving CCGs the opportunity to assume greater power and influence over the commissioning of primary medical care from April 2015* (NHS England, 2014c p.4)

The quote above implies that the rationale for giving CCGs greater power and influence over the commissioning of primary medical care was that the current system prevented CCGs from taking an integrated approach due to their lack of influence in primary and specialised services and this generates an inability to "unlock the full potential of their [CCGs'] statutory duty". It seems that the argument made in the HSCA 2012 for having primary care commissioning outside CCGs - i.e. to move towards a more standardised model of primary care commissioning - has shifted to an argument based upon the need to take into account different local contexts.

The document further stated that:

> *Although we are confident that co-commissioning – or delegation to CCGs – is in the best interests of patients, the offer (emphasis original) from NHS England is just that: it is for each and every CCG to consider carefully, and make up its own mind as to how it will respond. We know that the imposition of a single national solution just won't work, and will fail to take into account different local contexts.* (NHS England, 2014c p.4)

By emphasising that co-commissioning was an "offer", it implied that the uptake was meant to be voluntary.

Our interviews with senior policy makers elucidated the 'problems' felt to exist with existing arrangements further. It was argued that the HSCA 2012 had generated a disconnect between primary, secondary and community care, and that co-commissioning was the means by which this could be remedied:

> *Actually, I think co-commissioning was, if you like, almost like a sticky plaster to start trying to build that together and starting to replace some of what has been lost…..the historic divide between primary care and secondary care is artificial, from a patient point of view and from a care point of view. And increasingly, if we're going to be able to deliver an efficient service within health, and particularly an efficient service in alignment with the local authority social care, we need to get rid of some of those barriers and make it far easier for services to be commissioned jointly from a primary care or community care kind of setting, and a specialist or a secondary care setting….I mean, I guess I think the view of many - maybe not all - but I think the view of many is that the Health and Social Care Act did drive an artificial distinction into how commissioning was being delivered. Not artificial, maybe that's the wrong word, but it certainly became a factor in terms of it fragmenting the commissioning of services, which meant that there was a step back from being able to develop a greater sense of, I suppose, local ownership and, indeed, a strategic overview of what, from a clinical perspective and from a local perspective, we wanted to achieve.* [Policy maker ID1]

Moreover, there was an early understanding that NHSE was struggling with primary care commissioning. ATs had significantly less management resource than PCTs, and as a result found it difficult to move beyond a transactional approach for commissioning these services, which focused upon payments and contract management:

> *I think what happened, very early on, both in the year or so leading up to the formal change on 1st April 2013, and increasingly after April 2013, once CCGs were doing this for real, people started to say, this isn't really working, we get the theory of how CCGs could work alongside NHS England, but partly because NHS England has a much reduced primary care commissioning function, it feels rather remote from local communities, it's a very transactional form of commissioning, it's not really the strategic form of commissioning which CCGs are interested in* [Policy maker ID5]

In part, this was inevitable, as NHSE were constrained to act in a common way across the country, moving towards a standard model. This required a significant amount of effort, limiting any opportunities to look more strategically at services:

> *And then because NHSE is a national body... clearly, legally, they have to be operating absolutely fairly with everybody, with all contractors. So trying to establish single operating models, …but it's difficult and lots of people don't really like it, because they'd rather do it their own way or they'd rather have their own relationship. And examples of things like that, just to give you a sense of it is, PCTs, some of them did occupational health services, for GPs in some of them, didn't. And some PCTs did all the call and recall letters for the flu vaccine. And some PCTs didn't.* [Policy maker ID3]

However, whilst recognising this inevitability, there was some regret expressed at the loss of the expertise, which had been built up in PCTs:

> *But the thing I was most interested in was that 'world class commissioning' agenda for primary care …. really encouraging PCTs to come together and work out what it meant to commission services in a meaningful way. And … there was a step back from that, not necessarily because people thought it had been the wrong thing to do, but just because there was a brutal realism about how much NHS England, as a new commissioning organisation with significantly reduced running costs, could do in that space.* [Policy maker ID5]

Hence, within these accounts, co-commissioning was framed as an opportunity to bring the commissioning of different services back together and to take a more strategic approach.

4.2 Co-commissioning as an opportunity to develop 'place-based' commissioning

In the *Next Steps* document (NHS England, 2014c), the vision and aims of co-commissioning was described in relation to the wider agenda set out in the *NHS Five Year Forward View* (5YFV) (NHS England, 2014a):

> *Co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. The Forward View emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will drive the development of new integrated out-of-hospital models of care, such as multispecialty community providers and primary and acute care systems…… Primary care co-commissioning is the beginning of a longer journey towards place based commissioning.* (NHS England, 2014a p.11)

Co-commissioning was seen as a mechanism to support the development of new models of care. The document further stated the benefits of co-commissioning, with more certainty for CCGs rather than patients and the public:

> *Co-commissioning will give CCGs the option of having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained. Co-commissioning could potentially lead to a range of benefits for the public and patients, including:*
>
> - *Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;*
> - *High quality out-of-hospitals care;*
> - *Improved health outcomes, equity of access, reduced inequalities; and*
> - *A better patient experience through more joined up services.*
>
> *Co-commissioning could also lead to greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services. Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.* (NHS England, 2014a p.11).

Similarly, the senior policy makers we interviewed linked the vision for primary care co-commissioning to the 5YFV, new models of care, and place-based commissioning. The focus was on commissioning that could be local, aligned across different care sectors, and focussed, leading to whole system change and a locally sensitive NHS. Thus, it was argued, bringing primary care commissioning together with secondary and community care would facilitate population-based approaches:

> *And increasingly what we'd been saying and not us a lot of people in the system have been saying is what we need if we're going to act as effective agents for the public in local areas we need place based commissioning. So as far as possible let's try and mesh the money, what they call in Manchester the Manchester pound and let's try and link not just the various bits of the health service together but other parts of the public sector so that we can commission services in an integrated way and have trade-offs between different bits of the system.* [Policy maker ID2]

Co-commissioning, it was argued, would enable planned investment into primary care and general re-structuring of secondary care, allowing patients to be treated earlier in the community, with greater investment in prevention, creating opportunities for savings overall. There is an underlying assumption at work here that, in future, there may be greater variation than there has been in the past, with less emphasis on a national contract and greater local variability, However, it is not yet entirely clear how this will work in practice, given that national negotiation of the GMS contract remains.

Our informants also told us that they anticipated that the new system would enable opportunities for CCGs to act creatively to develop a broader primary care workforce. This might, for example, involve the employment of pharmacists or other professionals to support general practice, which would, in turn, alleviate the current pressures:

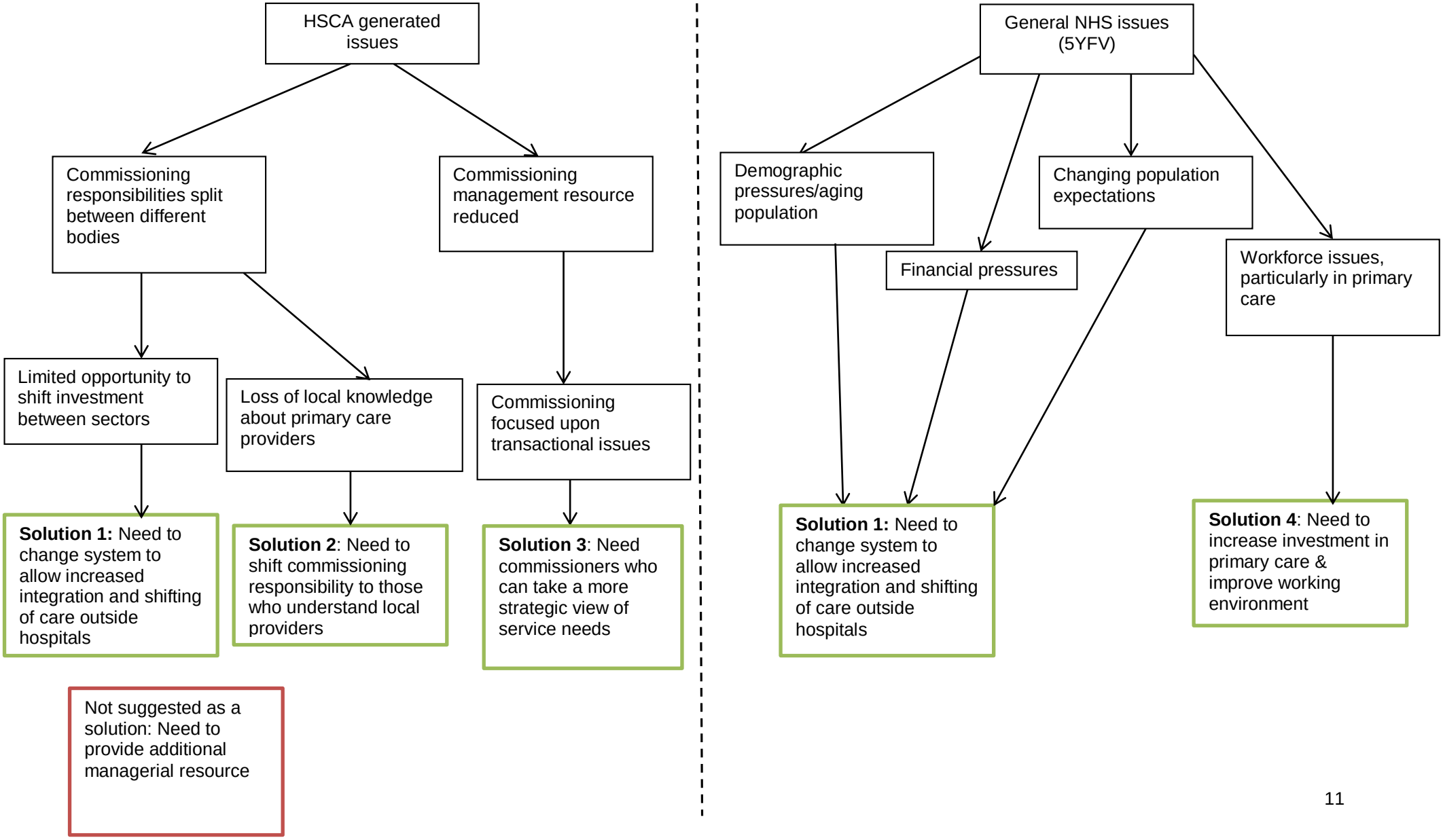
> *So from the other side of all of this, is creating a world of general practice, that by virtue of sitting at the centre of this more cohesive set of services, and a more intelligently organised set of services, we'll attract some of our brightest and best medical graduates who will want to embrace general practice careers.* [Policy maker ID2]

Finally, our respondents discussed the potential issues surrounding perceived conflicts of interest. However, it was argued that robust governance processes and transparency in decision-making would alleviate this risk, and the potential benefits outweighed the risks.

4.3 Summary

Figure 1 summarises the issues identified in both our interviews and the published documents as underpinning the need to move primary care commissioning from NHSE to CCGs

Figure 1: Problems identified in documents and interviews – and suggested solutions



Hence, the two programme theories underpinning the solutions suggested are:

1. Integration of budgets and commissioning responsibility with a single commissioner for commissioning primary, community and secondary care for a geographical population. This will allow the shifting of resources between sectors, facilitate the development of a more integrated approach to service provision, and provide an environment, which supports the development of integrated organisations delivering new models of care as envisaged in the 5YFV. This will then deliver more care outside hospitals and care, which from the patient's perspective is more integrated and will be more efficient, effective, and cheaper.

2. CCGs understand primary care and local needs. Allowing CCGs to commission primary care will support the development and implementation of local strategies for service improvement, support innovation in primary care, and allow investment in primary care (by allowing resource shifting as above). This will improve quality of care, make primary care a more attractive place to work, and facilitate recruitment and retention.

In the rest of this study, we will explore the extent to which these programme theories hold good as primary care co-commissioning is taken up by CCGs. One thing that stands out from these accounts are the lack of managerial resource to support primary care commissioning by NHSE, which was highlighted by many of our senior interviewees. The transfer of responsibilities to CCGs does not carry with it any transfer of managerial resource; it will therefore be important to explore how CCGs taking on co-commissioning responsibility cope within their existing resources.

5 CCGs application documents

In exploring the uptake of primary care co-commissioning nationally, we reviewed the application documents from 150 CCGs (out of a total of 151 CCGs taking on co-commissioning responsibilities) to create a database of CCGs. NHSE assisted in obtaining the CCGs' permission to share their contact details and their submission proforma for our research team to review. The purpose of reviewing the application documents was to identify a random sample of CCGs to target for the telephone survey and to review the CCGs' co-commissioning objectives to inform the questions for the survey. In the database we listed CCGs' level of co-commissioning, core objectives, contact details of a person responsible within each CCG, and detailed information on what was stated or included in their application.

For joint commissioning, the proforma required CCGs to "describe the objectives and intended benefits of the joint commissioning arrangements, particularly the benefit for patients" (NHS England, 2014d). CCGs also had to submit governance documentation such as the terms of reference incorporating a scheme of delegation and any proposed constitutional amendment. The deadline for the application was 30th January 2015.

For delegated commissioning, CCGs were required to "review and revise its conflicts of interest management policy in light of forthcoming new statutory guidance; describe the intended benefits of co-commissioning arrangements; and detail the finance arrangements of the delegated budget" (NHS England, 2014e). CCGs also had to submit their governance structures and any proposed constitutional amendment. The AT would need to confirm that CCGs met the required thresholds for assurance, conflicts of interest management, financial control, and all statutory and business planning requirements. The deadline for the application was 9th January 2015.

We found that different CCGs interpreted what was required as part of their submission differently. Some CCGs provided standard aspirational "answers" (with some replication from official documents) while others provided a very detailed application with additional documents such as the risk and impact assessment, consultation documents, and letter of support. Following a review of CCGs' application documents, we chose a random sample of CCGs to target for the telephone survey.

6 Telephone survey

This section presents the findings from the telephone survey. This was a sample survey in which representatives of CCGs across England who opted for 'delegated authority' (Level 3) and 'joint commissioning' (Level 2) were invited to take part. Sampling criteria were dependent upon the findings of an initial examination of the applications for co-commissioning responsibility submitted by CCGs (see Method section). We also surveyed all CCGs who opted for 'greater involvement' (Level 1).

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

Table 1 summarises our sample. We spoke to 20 CCGs taking on delegated responsibilities, 17 CCGs setting up joint arrangements and 12 CCGs who had chosen greater involvement across the country.

Table 1: Number of responses according to levels of co-commissioning responsibility and regions

Levels	Regions	No of CCGs	Sample chosen	Total response
Delegated (L3)	North	24	7	7
	Midlands & East	26	8	8
	London	6 (2 joint applications)	2	2
	South	8	3	3
Total (L3)		64	20	**20**
Joint (L2)	North	31	10	6
	Midlands & East	16	6	3
	London	20 (3 joint applications)	3	1
	South	20	7	7
Total (L2)		87	26	**17**
TOTAL (L2+L3)		**151 (147 applications)**	**46**	**37 (20 from L2 + 17 from L3)**
Greater involvement (L1)	North	12		2
	Midlands & East	16		5
	London	6		1
	South	24		4
Total (L1)		58		**12**
TOTAL (L1+L2+L3)		**209**		**49 (20 from L3 + 17 from L2 + 12 from L1)**

6.1 Findings from CCGs opting for 'joint' and 'delegated' arrangements

We asked CCGs undertaking 'joint commissioning' and 'delegated authority' to describe the following; main objectives for involvement, factors affecting their decisions, benefits and risks for CCGs doing primary care co-commissioning, success in 3 years' time, areas of activity and service, structure and governance arrangements, management of conflicts of interest, and experience of the process. Generally, we found no systematic difference between CCGs who opted for delegated and joint commissioning. The reason for this was that CCGs who opted for joint commissioning did so to 'test the water' before moving to the delegated level. In some CCGs who opted for joint arrangements, they were already operating at the delegated level in shadow form.

6.1.1 CCGs main objectives and factors affecting their involvement

We asked these CCGs opting for 'joint' or 'delegated' levels to describe their main objectives for involvement, the factors affecting their decisions, and who was involved or consulted in the decision-making.

All CCGs (both joint and delegated) had discussed their options with their members. Some CCGs held a vote or sent out a survey, while others had discussions with practices. Two CCGs claimed that their decision to hold a vote whether or not to take on the responsibility was due to the need to make amendments to their constitution. Discussions that took place

with member practices were around the benefits and risks of the different levels of responsibility. Discussions also took place at various groups such as the governing body, primary care steering group, council of members, locality groups, Health and Wellbeing Boards, Health Watch, Local Medical Councils, and/or Local Authorities. Some CCGs held engagement events with general practice and other stakeholder group to get their views.

The majority of CCGs we spoke to claimed that their main objective for involvement was to "put commissioning back together" i.e. co-commissioning enables commissioning primary care alongside the commissioning of other services, an important gap identified in the pathway introduced by the HSCA. They also looked forward to the opportunity for local decision-making and flexibility. They claimed that co-commissioning gives them greater influence and ability to develop primary care services, and gives them the opportunity to look at the whole of general practice. Some CCGs claimed that co-commissioning is part of their wider transformation and integration agenda.

Some CCGs also claimed that they wanted to commission primary care because it is the most efficient way and it also gives them more control to develop pathways from a patient perspective (3 CCGs) and because co-commissioning gives CCGs more power and opportunity to deliver high quality services (3 CCGs). Two CCGs saw co-commissioning as a way to break down the operational service barriers between primary and secondary care i.e. breaking down the contractual arrangement and having more control over primary care contracts. Another CCG argued that they could not effectively improve primary care services without full control of both contracting and commissioning.

Some CCGs claimed that co-commissioning would give them the ability to manage or develop the practices in their membership. Two CCGs claimed that co-commissioning would enable them to get closer to members to support the redesign of primary care and develop a degree of confidence of the member practices. Only one CCG said that their main objective was to take on the role of monitoring and performance management of GP providers.

In our survey, when asked about their main reasons for taking on co-commissioning responsibility, there was little mention of new models of care, place-based or outcome-based commissioning. The concept of bringing together commissioning of all health and care services was strong in policy documents and interviews with senior policy makers. However, there was only one CCG who explicitly claimed that co-commissioning would enable them to move forward with the new models of care that were being developed and one CCG who specifically referred to place-based commissioning.

Two CCGs claimed that they had 'no choice' but to take on co-commissioning responsibility for primary care, as this seemed to be the direction of travel i.e. either they do it now or they would be pushed in the future. One of these CCGs said that the 'sub-text' that they discerned in official communications was that it would be better to get involved now than to be handed something on a plate later on.

Our survey also asked how CCGs were planning to achieve their main objectives. Quite a number of CCGs at both joint and delegated levels claimed that their main objectives could be achieved through the development and implementation of a primary care strategy, which covers integrated working, care closer to home, and developing new roles and new models of care in general practice (5 CCGs). Three other CCGs planned to explore how primary care sat within the whole system looking at GP Federations, super-partnerships, alliances, or an Accountable Care Organisation. Two CCGs claimed that they could achieve their main objectives by working collaboratively with other CCGs.

Some CCGs focus on contractual mechanisms. Three CCGs planned to have a local contract by pulling in monies currently committed to Directed Enhanced Services and tailoring these to meet their objectives more effectively. One CCG planned to move to a GMS Plus contract, which would provide opportunities for practices to offer a wider range of services under their GMS contract, and another CCG planned to move from 'silo contracting' across the sector towards commissioning for outcomes. Only one CCG mentioned that their main objective would be achievable because they will have greater budget flexibility, bringing in estates and IT and allowing them to move money between budget areas.

The majority of CCGs undertaking joint and delegated commissioning identified conflicts of interest, governance, risk and benefit, and wanting better control over primary care as factors affected their involvement. When we asked those CCGs who opted for joint arrangement to elaborate further what other factors affected their involvement, they told us that they were concerned about the uncertainty around what is involved in delegated with the added unknown financial risks. For CCGs who opted for the delegated arrangement, they told us that they saw no point of doing joint commissioning, as it was seen as a halfway position. They argued that co-commissioning is a clear direction of travel and the choice they faced was to do it now, with the opportunity to help develop how it would work, or wait and run the risk of being dictated to later on.

6.1.2 Benefits for patients and the public, practices, and CCGs as a whole and risks for CCGs

The benefits described by our survey participants were generally couched in terms of benefits for practices and CCGs rather than for patients and the public. The benefits of co-commissioning for patients and the public often overlapped with the benefits and risks for practices and/or CCGs as a whole.

The benefits of co-commissioning for patients were generally described in terms of improving outcomes and quality of care for patients. Participants told us that co-commissioning would enable patients to receive more joined up, proactive, and patient-centred care. One of the CCGs gave us an example, explaining that patients would complain about waiting times in general practice, and they would have to spend time explaining to them that it is not the CCG's role to manage practice contracts. They argued that co-commissioning was a way of bringing all that together and "reinventing the PCT with more clinical input".

In terms of benefits for practices, a majority of our survey participants told us that they felt that NHSE staff were over-stretched and did not always have a good understanding of local issues. They told us that as CCGs are more attuned to local context, co-commissioning would enable CCGs to add local flavour in terms of having local ownership of the problem, local flexibility and local decision making (9 CCGs). Co-commissioning would also allow general practice to have more say in some of the services they were delivering, as one CCG put it "this is all about practices having their own destiny and being in control of what happens to them". Moreover, due to CCGs' relationship with their member practices, co-commissioning would allow CCGs to work more collaboratively with member practices to re-design models of care (2 CCGs). Only one CCG described the benefit for practices in terms of performance managing practices that are performing poorly. Another benefit identified was sustainability in terms of workforce. As practices would have a stronger voice in the system, they would be able to attract and recruit more staff and the CCG would be able to manage that collaboratively (2 CCGs); improve balance between pressure of work and resource available by enabling practices to work together in a new way (1 CCG); and assurance for practices in their income streams (1 CCG).

Being “masters of their own destiny” was described as a benefit for the CCGs overall. Our survey participants told us that co-commissioning would enable CCGs to have better control of the budget and wider resources hence having the flexibility to move resources around (6 CCGs). It would also allow them to have more capability for primary care transformation (although this would not have been seen yet) (3 CCGs), coherent commissioning plans across the whole system (4 CCGs), and sustainable primary care and health and social care (2 CCGs). Additionally, we were also told that co-commissioning would enable CCGs to; become a more GP responsive organisation (1 CCG), improve their relationship with practices as they can respond to the needs of their practices (2 CCGs), have better oversight and knowledge of what is happening in practices (2 CCG) hence enabling CCG to make a more pragmatic local decision. Some CCGs viewed co-commissioning as part of integration/ joined up/ transformation approach (6 CCGs). Only one CCG described the benefit for CCGs as having a “one-place commissioner” and one CCG who told us that they did not see any benefit and that co-commissioning is more challenging due to conflicts of interest. Table 2 summarises the benefits for taking on primary care co-commissioning.

Table 2: Benefits for practices and CCGs for taking on primary care co-commissioning.

Benefits	**For practices (no. of CCGs)**	**For CCGs (no. of CCGs)**
Having local ownership of the problem, local flexibility and local decision making	9	
Masters of own destiny	2	6
Sustainability of the workforce	2	
Improve balance between pressure of work and resource available by enabling practices to work together in a new way	1	
Assurance for practices in their income streams.	1	
Performance management of practices	1	
Being part of integration/ joined up/ transformational approach		6
Coherent commissioning plans across the whole system		4
Capability for primary care transformation		3
Sustainability of primary care and health and social care		2
Improving CCG relationship with practices as they can respond to the needs of their practices better		2
Having better oversight and knowledge of practices to enable a more pragmatic local decision		2
Enabling CCGs to become a more GP responsive organisation		1
Having a “one-place commissioning”		1
No benefit		1

We asked our survey participants to identify three main risks for CCGs in taking on primary care co-commissioning. A majority of our participants undertaking joint and delegated commissioning identified resources as one of the main risks, in terms of workforce capacity and capability and running costs (20 CCGs) They told us that the reduction in running costs, the loss of expertise previously present in PCTs and their inability to employ their own staff may risk CCGs being unable to deliver NHSE expectations. The second main risk is a relational risk between the CCG and their members, with a tension between engaging and contractually managing them (5 CCGs) and the risk that the current close relationship might change if CCGs were to adopt a transactional rather than transformational approach

(5 CCGs). Lastly, reputational risk with both external partners (being seen as favouring primary care over other providers (2 CCGs) and with internal members for e.g. CCGs may not do what is right for patient because of both internal and external fear over perceived conflicts of interest (4 CCGs). However, one CCG claimed that they do not see conflicts of interest as a risk because there is an official guidance for this. For delegated, there was an additional financial risk i.e. whether or not there will be enough money to deliver the services (5 CCGs) and huge management risk (1 CCG). Table 3 summarises these main risks.

Table 3: Main risks for CCGs taking on primary care co-commissioning.

Main risks	**For CCGs (no. of CCGs)**
Resources in terms of workforce capacity and capability and running costs	20
Relational risk between the CCG and their members, with a tension between engaging and contractually managing them	5
Change in current close relationship if CCGs were to adopt transactional rather than transformational approach	5
Financial risk for those taking on delegated commissioning	5
Reputational risk with internal members due to fear of perceived conflicts of interest	4
Reputational risk with external partners	2
Management risk for those taking on delegated responsibility	1

6.1.3 Success in 3 years' time

Most CCGs undertaking joint and delegated commissioning claimed success in terms of having a sustainable primary care. Sustainability was described in terms of CCGs having a sustainable workforce (5 CCGs), being a financially stable CCG (3 CCGs), having general practice that feels more confident about themselves (1 CCG), and up scaling of primary care (7 CCGs). For example, having bigger practices and reduction in single handers, seeing GP Federation /partnership/ alliance coming together, and practices working together at scale.

Some CCGs described success in terms of patient outcomes e.g. having seamless pathways for patients and increased patient access (9 CCGs) or reduced requirement for hospital services (2 CCGs). Others described it in terms of having more integrated services (7 CCGs), having contractual change (5 CCGs), and having a functional co-commissioning committee whereby issues discussed were strategic and the ability of that committee to deliver the strategy and achieve the outcomes expected (4 CCGs). Three CCGs suggested success would be seen as a move towards new models of care based on population or outcomes. One CCG claimed they do not even know what success would be in three months' time, and two CCGs claimed that success for co-commissioning should be seen as part of the wider plan (2 CCGs). Table 4 summarises these claims of success.

Table 4: Success in 3 years' time.

Success	No of CCGs
Having seamless pathways for patients and increase access	9
Up scaling of primary care	7
Having more integrated services	7
Having a sustainable workforce	5
Having contractual change	5
Having a functional co-commissioning committee	4
Being a financially stable CCG	3
Moving towards new models of care based on population or outcome	3
Reducing requirement for hospital services	2
Success for co-commissioning should be seen in the context of the wider plan	2
Growing primary care investment	1
Having conflicts of interest mapped out	1
Successfully transforming general practice	1
Practices having higher than average level of income	1
Improvement in the quality in primary care	1
Having general practice that is more confident about themselves	1
Not sure as they do not even know what success would be in 3 months' time	1

6.1.4 Areas of activity and service

In the survey, we asked which areas of activity and services CCGs were focusing upon within their co-commissioning work and asked them to explain why those areas had been chosen. We also asked if CCG members and/or the public had been consulted.

The majority of CCGs who opted for joint and delegated responsibilities involved their members in developing their work programme, discussing risks and opportunities for each level. However, there were a handful of CCGs who did not consult openly and the CCG took a corporate view. When members were consulted, they held either a referendum, email ballot, or vote. Most CCGs did not carry out public consultation but some CCGs discussed it with their local Health Watch, through the Health and Wellbeing Board and with patient participation/reference groups. The reasons given for not consulting the public included not appropriate as public consultation is for provision of services and not for contracting issues which is what co-commissioning is about; could not meaningfully engage with the public due to limited timeframe; and the decision lay within the clinical membership.

Most of the CCGs we spoke to talked about areas of focus for co-commissioning within the wider agenda. These areas of focus vary widely between CCGs. Table 5 summarises these various areas.

Table 5: Main areas of activity and service CCGs were focusing upon within their co-commissioning work.

Areas of activity and service	No of CCGs
Primary care quality	8
Directed Enhanced Services (DES)	6
Personal Medical Services (PMS) and/or Alternative Provider Medical Services (APMS) review	5
Workforce	5
Primary care strategy	2
Primary care offer	2
Primary care estates	1
General Medical Services (GMS) Plus contrast	1
Primary Medical Services (PMS) Premium	1
Performance management of practices	1
Organisational development	1
Governance	1
Being considered and negotiated	1

When asked why CCGs had focussed on these areas, the majority of CCGs told us that it was part of the whole host of work programmes (5 CCGs). Some claimed that it was part of their primary care strategy (3 CCGs), overall commissioning plan (1 CCG), 5-year plan (1 CCG), was locally driven (1 CCG), or clinical service review (1 CCG).

We also asked if CCGs had plans for the Quality and Outcomes Framework (QOF), Directed Enhanced Services (DES), Personal Medical Services (PMS) contracts, and/or Alternative Provider Medical Services (APMS) contracts. The majority of CCGs we surveyed have no major plans and did not want to do anything immediately but were reviewing the strategy. Some had plans for DES, which was mostly around unplanned admissions, dementia, learning disabilities, access, and integration with community services. All CCGs we surveyed were involved in the national PMS review, although they were at different stages of the review. For some CCGs, it had been completed while in others they were still early in the process. Some CCGs were involved in APMS re-procurement and were quite concerned about having difficult conversations with member practices.

6.1.5 Governance

For delegated commissioning, CCGs we surveyed had set up a Primary Care Co-Commissioning Committee (PCCC). In CCGs where they collaborate with two or more CCGs, they had set up a 'committee-in-common' or an advisory committee with representatives from CCGs involved. Some CCGs had set up various other groups that sit underneath the PCCC such as primary care operational group, primary care directorate, primary care steering group, primary care quality working group, and internal reference group. The functions of these groups included making recommendations for the PCCC, supporting the PCCC, or setting the agenda. Members of these groups range from quality and finance to commissioning and contracting, and may include front line general practice representatives or clinicians. One CCG told us that they decided not to set up a PCCC but were using the CCG Governing Body with robust conflicts of interest policies in place whereby GPs are excluded entirely from the appropriate meeting section. For joint commissioning, CCGs we surveyed had set up a Joint PCCC (or Joint Primary Care Programme Board) with NHSE. Some CCGs have also set up a 'committee-in-common' with other CCGs.

The lead responsibility for co-commissioning varied from the Head/Director of Primary Care/Commissioning to the CCG Accountable Officer, Chief Operating Officer, or the Medical Director. Five CCGs had decided to recruit additional people including lay member, an out of area GP who could vote, and some operational staff.

Some CCGs in delegated level told us that they encountered problems when setting up their governance. The first was the difficulty in agreeing the Terms of Reference (ToR) for their governance arrangements. The model ToR for delegated commissioning stipulates that:

> *Statutory Framework.*
> *9. The Committee is established as a committee of the **[Governing Body]** of each named CCG **[Individual agreements should include appropriate provisions consistent with overriding governance arrangements]** in accordance with Schedule 1A of the "NHS Act".*
> *10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.*
> ***Role of the Committee***
> *11. The Committee has been established in accordance with the above statutory provisions to enable the members to **[for example]** make collective decisions on the review, planning and procurement of primary care services in **[insert name of area]**, under delegated authority from NHS England. (Emphasis in original)* (NHS England, 2014f para 9-11)

Some CCGs had interpreted the above as a possibility of PCCC having an equal power to the Governing Body hence refusing to sign the ToR.

The second was an issue with 'double delegation' for delegated co-commissioning. A number of CCGs we spoke to told us that they have initially planned to form joint committees with neighbouring CCGs. In one of the CCGs, their application was signed off by NHSE before their own legal team advised them that it was a double delegation, which was not permitted. The CCGs we spoke to have set up an individual PCCC and a 'committee-in-common' which functions as an oversight committee with representations from all CCGs involved. However, the set-up of these committees varies depending on individual CCG arrangements.

We explored further the guidance relating to joint committees. In March 2014, the Department of Health laid the draft Legislative Reform Order (LRO) that would allow two or more CCGs to form joint *decision-making* committees. The LRO is an unusual form of delegated legislation, which is used to "amend or repeal a provision in primary legislation which is considered to impose a burden on business or others" (Department of Health, 2014a). There were two proposals in the draft Order (Department of Health, 2014b):

1. Proposal A: Section 14Z3 of the Act allows two or more CCGs to exercise their commissioning functions jointly but there is no express provision within the Act to enable CCG to form joint committees. Hence, CCGs are unable to create *a joint decision-making body*. Some CCGs are forming 'committees in common' where they delegate the exercise of their functions to their members or employees who then attend a committee in common with other CCGs. However, before the committee can agree any decisions, it has to be ratified by each CCG or its Governing Body. The LRO would enable CCG to form joint committees as in the PCT where each PCT would typically nominate a representative to attend that committee and it was open for the ToR of the committee to provide for majority decision making.

2. Proposal B: Section 13Z of the Act enables NHSE to exercise its own functions jointly with a CCG and form a joint committee when doing so. However, there is no similar provision to jointly exercise a CCG function. The LRO would enable CCGs and NHSE to jointly exercise a CCG function or to create joint committees when doing so.

The draft LRO further argued that the approach of establishing committees in common is not only an "administrative inconvenience, but an obstacle to efficiency, productivity and value for money, and hence a burden for the purposed of the 2006 Act" (Department of Health, 2014 p.7) and that the Order would reduce that burden. The LRO was passed through Parliament in September 2014 and came into effect from 1 October 2014. If CCGs decided to form a joint committee, they would need to review their constitution and if necessary make an application for a constitutional amendment to NHSE. The wording for constitutions can be tailored to individual circumstances.

For joint commissioning arrangements, a joint committee is the recommended governance structure (NHS England, 2014c p.19). NHSE clarified further the governance arrangement relating to joint committee by publishing a policy note in March 2015 (NHS England, 2015e). The policy note stated that to enable a group of CCGs to work together, NHSE and each CCG would need to form a joint committee first and these joint committees could then meet as 'committees-in-common'. This approach enables CCGs to "make decisions in a joined up way" although the final decision would need to be taken at an individual CCG joint committee level.

However, for delegated commissioning, although CCGs receiving delegated functions from NHSE are able to collaborate with other CCGs through the formation of joint committee, this committee will *not* be a decision making body as NHSE can only delegate its function once and only to a single CCG (NHS England, 2014h). CCGs could collaborate through agreement. The CCGs we surveyed decided to meet through committees-in-common.

Hence, it seems that the problems in setting up governance arrangements as identified by the CCGs we surveyed showed that there was confusion over the term "joint committee". A *joint committee* is a governance arrangement for joint commissioning between a CCG and NHSE. This is a decision-making body. CCGs opting for joint committee could decide to implement a *joint committees-in-common* approach whereby an individual CCG would form a joint committee with NHS England and these joint committees could meet as *committees-in-common*. However, *committees-in-common* is not a decision making body and the final decision would be taken at an individual CCG *joint committee* level. CCGs opting for delegated responsibility could also use the *committees-in-common* approach to enable collaboration between two or more CCGs or could collaborate through agreement.

6.1.6 Managing conflicts of interest

We asked CCGs to define and describe their main concerns in the area of conflicts of interest for example, whether it is financial, personal, loyalty, or something else. Most CCGs defined conflicts in terms of when an individual may have an involvement (relationship or financial) in an environment where CCG is commissioning services for e.g. GP involvement when taking about contract or GPs involved in decision affecting their income. One CCG described conflicts of interest in terms of managing poorly performing GPs in relation to whether or not they should be party to some of these conversations. One CCG claimed that there had been no concerns with conflicts of interest as they declared everything and had been as transparent as they could. They thought that the issue of conflicts of interest had been escalated.

The CCGs we surveyed also described how they had or planned to manage conflicts of interest. Generally, conflicts were seen as something that have always existed and would continue to do so. Hence, it was seen as something that cannot be avoided and needed to be managed. It was also about the *perception* rather than reality of the conflicts. The most commonly cited way to manage conflicts was by declaring any conflict at the beginning of the meeting or being upfront in procurement about who was involved and what their involvement was. One CCG claimed that they decided not to only declare interest at the beginning of the meeting but also for each individual item in meetings. Some CCGs decided not to allow GPs to vote while others decided not to allow people (including GPs) who had possible conflicts to participate in meetings. One CCG argued that they believed it was important to have GPs in the room and they tried to reduce conflicts of interest by having GPs with a different contractual arrangement sitting in that meeting. Another CCG decided to employ an independent GP from an outside area to sit on the PCCC. One CCG talked about managing out conflicts in other committees by putting decisions to PCCC if that committee could not reach a decision due to conflicts of interest.

6.1.7 Experience of the process

We asked our survey participants to describe their experience of the process of taking over co-commissioning responsibility. The majority described the transfer as chaotic and problematic due to the speed of the implementation and lack of information and clarity. We were told by one CCG that the AT seemed to be as bemused as the CCG. Hence, it seemed that although there was a clear national direction, this was not sensitive to local variations. There was also frustration with long delays in agreeing the ToR that could be signed off by all parties and difficulty in appointing staff due to delay in Human Resource (HR) guidance.

The CCGs we surveyed told us that support from NHSE, which they found most helpful were the regular meetings they had with the AT, networks, national workshops, and staffing support. Additional support wanted included; understanding of resources NHSE can release (7 CCGs), staffing (5 CCGs), capacity (4 CCGs), additional flexibility in running cost allowance/ management cost (3 CCGs), transfer of skills & knowledge from NHSE (2 CCGs), clearer and timely information/guidance (2 CCGs), and timely advice on learning coming out (1 CCG). One CCG asked to be given the funding for them to share with other CCGs and one CCG claimed that they do not need any additional support for co-commissioning. Another CCG told us that there needed to be a balance between having a national direction (top down) and a local (bottom up) solution. During the process, it was felt that CCG had no authority. For example, they have no recourse to reverse the delegated authority decision they took but NHSE could take it away anytime.

We also asked CCGs about what could have been done differently in terms of the whole process. Timescale was the biggest issue. CCGs felt that the process was too rushed; there was limited time to plan and/or to have good engagement with practices. They felt that process for future waves needs to be done at a better pace. There was also an issue about the timing of the guidance. One CCG argued that HR guidance should have been published at the same time or before the handover to enable them to plan earlier. The timing of the guidance had caused this CCG difficulty in appointing staff to do the work. Another CCG have set up a committee before the guidance was published and following publication, they needed to change their governance arrangement.

6.2 Findings from CCGs opting for 'greater involvement'

In addition to surveying the CCGs who opted for joint and delegated arrangements, we also surveyed some of those who opted for 'greater involvement'. We explored the reasons why they opted for this level and factors that would affect their decision to change status in future.

One of the reasons was around finance. One of the CCGs we spoke to had been put under special measures and had to withdraw their application. Another CCG was initially accredited for delegated arrangements but had to withdraw due to a 'financial blip'. After the issue was resolved, there was nothing in place for them to go for joint commissioning. In another CCG who also had some financial problem, their members voted for joint commissioning but was rejected by NHSE as it was seen as a distraction from regaining financial stability, would add burden to the structure, and also because NHSE could not resource it.

Two CCGs claimed that they could do whatever they wanted to do in general practice without having to take on co-commissioning. One of the CCGs told us that they wanted to incentivise patients to come to them so they could commission differently. They argued that they could do so without having to fight with primary care money and without having to manage primary care.

Two CCGs were worried about how co-commissioning would change the CCG's relationship with members in terms of the CCG being a membership organisation. Additionally, members were unclear about the benefits and risks around conflicts of interest.

In one of the CCGs we spoke to, the Local Medical Council (LMC) had expressed strong opposition because they felt it was the first step in beginning to unbundle the GP contract. The strong LMC opposition had more prominence in the South than other regions. In another CCG, they argued that co-commissioning was not the right issue for them to focus on. They emphasised the need to focus on commissioning within a health system and that with the new model of care they had chosen, they needed to focus on providers.

CCGs' decision to go for 'greater involvement' was supported by their members. Member practices were consulted before the decision was made about which level of co-commissioning to adopt, although some CCGs found that their members did not seem interested to engage in the discussion. Some CCGs had a voting system while others include discussion with wider external partners such as the Local Medical Council, Health and Wellbeing Board, other CCGs, and patient reference groups.

We asked CCGs if they intend to move to another level in the future and what would be the factors affecting their decision-making. The majority of CCGs we spoke to intended to move to delegated arrangements in the next year. One of the CCGs had set up the Primary Care Co-Commissioning Committee in shadow form. Some CCGs argued that there is no choice about this and that this seems to be the direction of travel. Only one CCG who said they did not intend to take on co-commissioning in the next 12 months. They argued that their focus was on their Vanguard and a new model of care but keeping an open mind about the possibility of taking on co-commissioning later. They added that co-commissioning was more about contractual issues rather than bringing about change.

Factors affecting their decision to change status in future included the feeling that there is no option and wanting to be "masters of own destiny" rather than being pushed later on in the process. Those CCGs who were unsure about opting for delegated arrangement argued that their main concerns were capacity issues and resource constraints. The CCGs we surveyed also told us that learning and taking advice from other CCGs that did take part in co-

commissioning made them feel more prepared about moving to the next level. Other factors included the risks of taking on co-commissioning such as being responsible for seeing practice issues, financial risks (primary care underfunding), reputational risk (losing contact with practices), capacity (difficult to get GPs involved because they don't have the time), and the potential to lose what limited support they have from NHSE if they do not engage with co-commissioning. The CCGs we surveyed also told us that that additional support required include staffing, funding, and clearer governance.

The majority of the CCGs we surveyed in this category (8 CCGs) told us that they felt the pressure to take on more responsibility, albeit a gentle pressure, with most seeing this as the direction of travel. One CCG told us that it was indicated to them that if they do not move to a higher level it would adversely affect their assurance rating with NHSE and they will be seen to be poor leaders. Four CCGs claimed that there was no pressure for them to move on to the next level. One of the CCGs said that if their members voted no, they could not actually do anything about it.

7 Discussion and actionable messages

This report provides an overview of the uptake and scope of primary care co-commissioning nationally. The picture shows organisations that are at different levels in assuming their new responsibility. Some have a clear organisational and governance structures, while others were at an early stage of development.

We identified two programme theories underpinning the need to move primary care commissioning from NHSE to CCGs from our analysis of policy documents and interviews with policy makers. *Theory 1* suggested co-commissioning is a "sticking plaster" i.e. a 'solution' to the split in commissioning responsibilities between the different bodies and a reduction in commissioning management responsibilities, which entered the system following the HSCA 2012. Bringing together primary and secondary care commissioning will allow the development of a more efficient 'place-based' approach, which will facilitate integration. *Theory 2* suggested co-commissioning would allow local GPs to bring to bear their local knowledge and expertise, supporting primary care development and allowing investment to improve quality.

The findings from our telephone survey indicate that *Theory 2* provides a better description of how CCGs currently see the process. The CCGs we surveyed told us that their main objectives for taking on co-commissioning responsibility were to enable them to commission primary care alongside the commissioning of other services, which, was seen as an important gap caused by the HSCA 2012. This will give them an opportunity for local decision-making and local flexibility, and allow them to improve investment in primary care and so increase quality. There was little mention of place-based commissioning, new models of care, or outcome-based approach, despite these being much discussed in policy documents and interviews with senior policy makers. In our survey, there were only 2 CCGs who specifically referred to place-based commissioning or having a one place commissioner, although three CCGs stated that 'success' in three years' time would be judged by their success in setting up new models of integrated care. This suggests that immediate concerns of CCGs revolve around the need to ensure sustainable high quality primary care services, but that some are aware of the longer-term potential to start to think creatively about how services are provided across a local geography.

It is clear that, although the picture is somewhat mixed, there is genuine enthusiasm for co-commissioning, with many CCGs eager to take the opportunity to improve both the quality and the sustainability of primary care services. Our study found no systematic difference between CCGs undertaking delegated and joint arrangements, with those currently undertaking joint commissioning did so to 'test the water' before moving to the delegated level. Some CCGs who opted for joint arrangements were already operating at the delegated level in shadow form. The potential benefits of joint and delegated commissioning were generally expressed in terms of benefits for the CCG and for the practices, with many CCGs expressing their wish to be 'masters of their own destiny'.

The main concern for CCGs at all levels of responsibility was around the resources they need to carry out their new role. This encompasses both human resource and the financial resources to support their staff. The limited resources available brings with it risks to their wider commissioning responsibilities, as there is a danger that commissioning staff will be over-stretched. This is an area that will be of particular importance for CCGs currently at Level 1 who are planning to move to delegated level. A secondary area of concern is the potential risk to the relationship with their member practices should they be required to performance manage those practices to any significant degree. To date, the main problem encountered by CCGs undertaking joint and delegated arrangements have been the speed of the change, and the difficulty in obtaining the guidance that they needed in a timely manner, particularly about the legal issues surrounding delegation. This was particularly an issue for those wishing to work collaboratively with their neighbours. CCGs at both joint and delegated levels claimed that conflicts of interest were not a significant cause for concern, with most CCGs we surveyed confident that they can manage these without difficulty. Conflicts of interest were seen as a longstanding and inevitable consequence of GP involvement in commissioning, which will be managed by a combination of transparency and careful management of committee membership.

The new voluntary GP contract was first announced in October 2015, after the survey has been undertaken and it was therefore not discussed with our participants. However, a number of CCGs told us that some of their earliest work would focus upon reviewing PMS and APMS contracts, and a small number were planning to look at contractual change such as 'GMS plus' in which the structure of incentive payments would be reviewed. Their approach to GMS and other contracts will be one of the issues followed up in later rounds of the telephone survey.

With CCGs encouraged to apply for full delegation (Dodge & Doyle, 2015) and 52 more CCGs (in addition to the existing 64 CCGs) authorised in December 2015 to take on the delegated responsibility from April 2016 (NHS England, 2015c) our research suggests a number of areas on which ongoing support and guidance could usefully focus:

1. Our telephone survey respondents who opted for joint and delegated responsibilities highlighted some concerns around the statutory framework underpinning primary care co-commissioning. This is especially important for CCGs currently at Level 1, those in the process of moving to delegated level, and smaller CCGs wishing to work collaboratively with neighbouring CCGs. Clear guidance as to what can and cannot be done would be useful, and this needs to be regularly updated as CCGs start to take on their new responsibilities. Quick access to relevant legal and procedural advice would also be useful.

2. The process so far has been rapid. CCGs' new responsibilities are extensive, and their management resources limited, it is important that assessments of progress of CCGs at all levels of responsibility take this into account, and that they are given time to develop new ways of working.

3. The greatest risk to the process of the transfer of responsibility highlighted by CCGs undertaking joint and delegated responsibilities was the lack of managerial and financial resources. This is a very important issue for CCGs moving to full delegation, and especially for CCGs currently at Level 1 who opted that level due to special measures being applied to them. The lack of resources could have implications on CCGs' ability to deliver NHSE expectations. CCGs at all levels of responsibility will need considerable support from NHSE as they develop their capabilities.

4. When asked what additional support they would like, alongside a desire for more financial resources many of our respondents also highlighted the need for local managerial support from their NHSE colleagues. This has been made somewhat more difficult by the development of a more regional structure for NHSE recently. Those responsible for this agenda within the new four NHSE regions could usefully support the development of longer-term relationships between NHSE managers with knowledge of local areas and their respective CCGs. Having a known manager to call upon for support was valued.

5. Place-based commissioning figured strongly in the interviews with policy-makers, but less so amongst CCGs. This is perhaps inevitable, as CCGs initially focus upon setting themselves up and developing new ways of working with their practices. There may be a role for NHSE and for NHS Clinical Commissioners in developing a longer-term support and development programme for CCGs, which focuses upon supporting them in thinking about the longer-term strategic issues associated with primary, secondary and community services, with a view to supporting them in considering new ways of working across traditional boundaries.

6. If it is intended that all CCGs be encouraged to take on co-commissioning responsibility, reassurance will be required about managerial and other resources. CCGs will continue to require NHSE managerial support even after they have taken on delegated responsibility.

8 Ongoing research

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

Building on from the findings we have so far, we outline below the areas of work that we intend to focus in the next stage of the project:

- Structures and governance – We will track the ongoing development of structures and governance mechanisms. For CCGs taking on delegated responsibility, they will also need to develop a local workforce model with NHSE (NHS England, 2015b, 2015f) and undergoing additional assurances (NHS England, 2015a). We will explore how this actually works in practice and how this would affect CCG's relationship with NHSE and neighbouring CCGs.

- Approaches to managing conflicts of interest – Our survey participants showed a general awareness that conflicts of interest are something that have always been there and will continue to be there and it is about managing them and being "open and transparent". Our survey findings also concur the King's Fund early findings (Holder et al., 2015) that any concern CCGs expressed were centred on the *perception* rather than actual conflict and that CCGs were generally confident that they have an adequate system in place to manage these. We will explore how the system being developed by CCGs to manage conflicts of interest actually works in practice.

- Internal relationships and approaches to contracts - With more pressure for CCGs to apply for full delegation (Dodge & Doyle, 2015), how will this affect CCG's relationship with their members? The performance management of practices remains complicated. Official guidance suggests that CCGs will be responsible for liaising with CQC about issues relating to *practice* performance, but will not be responsible for issues relating to *individual GP performance,* responsibility for which remains with NHSE (NHS England, 2015d). In practice, these two things may not be easy to separate, as, for example, CQC inspections may flag up problems with individual GPs.

- External relationships – We will explore the development of external relationships, including with neighbouring CCGs, Health and Wellbeing Boards, Local Authorities, Local Medical Councils, and providers.

- Areas of activity and service– As the transfer of responsibilities to CCGs does not carry with it any transfer of managerial resource; what approaches are taken by CCGs to cope with their existing resources, what impacts these will have on local primary care services, and what factors facilitated or inhibited the development of these services or improvement in existing services.

- Wider commissioning responsibility – Our interviews with senior policy makers and analysis of policy documents showed the official aspiration is for primary care co-commissioning to be a mechanism to achieve place-based commissioning as envisioned in the 5YFV. However, there was little mention of new models of care, place-based or outcome-based commissioning by our survey respondents. It will be important to explore how CCGs would manage taking on more commissioning responsibility with the already stretched capacity and resources.

The letter from NHSE encouraging CCGs to apply for full delegation emphasised the benefits of delegated commissioning and claimed that in the first six months delegated commissioning has:

- *Increased the local appetite and energy to develop primary care services and new models of care.*
- *Enabled the development of a clearer, more joined up vision for primary care, which is aligned to CCGs' wider system priorities.*
- *Increased clinical leadership and public involvement in primary care commissioning, enabling more local decision-making.*
- *Improved CCGs' relationships with a wide range of local stakeholders, including member practices, as more conversations are now happening locally about primary care development and practice sustainability.* (Dodge & Doyle, 2015)

It remains to be seen how far these benefits are realised in practice. Some of the CCGs we surveyed have only started setting up their primary care co-commissioning committee. In the next stage of the project, we will be observing and analysing the issues identified here in more detail to provide a more comprehensive and detailed evidence of how CCGs are taking on their co-commissioning responsibility, factors facilitated or inhibited their development, and the impact co-commissioning has on CCGs' work.

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