

Debate & Analysis

Primary care co-commissioning:

challenges faced by clinical commissioning groups in England

INTRODUCTION

The English Health and Social Care Act 2012 gave GP-led clinical commissioning groups (CCGs) responsibility for commissioning the majority of healthcare services for their registered population. However, responsibility for commissioning primary care services was given to a new national body, NHS England (NHSE),¹ to avoid conflicts of interest¹ and because of a perceived need for a standardised and consistent approach to commissioning.² It soon became apparent that NHSE was struggling to move beyond a transactional approach to commissioning, focused on payments and contract management. When Simon Stevens took over as the Chief Executive of NHSE (April 2014), he advocated transferring responsibility for commissioning primary care services from NHSE to CCGs. Two years on, how have CCGs responded to their new responsibilities and what challenges do they face?

WHAT IS PRIMARY CARE CO-COMMISSIONING?

Co-commissioning is intended to support the development of integrated out-of-hospital services based around local needs. The scope of co-commissioning in 2015–2016 covers only general practice services, including: managing practice contracts; commissioning enhanced services and local incentives; establishing new GP practices; and approving practice mergers. It excludes individual GP performance management.

There are three possible levels of responsibility: greater involvement — CCGs have 'influence' in shaping primary care; joint commissioning — CCGs share responsibility with NHSE regional teams; and delegated authority — CCGs lead primary care co-commissioning. The policy intention is for all CCGs to ultimately take on delegated responsibility. However, in April 2015 a large proportion (87 of 209 CCGs) opted for joint commissioning, due to uncertainty over what co-commissioning would involve. One year on (April 2016), 115 of 209 CCGs (55%) have delegated responsibility, 68 (32.5%) joint commissioning, and 26 (12%) greater involvement.

Under delegated responsibility, CCGs must set up a Primary Care

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Commissioning Committee (PCCC) as a sub-committee of their governing body (GB). Unlike other sub-committees, which make recommendations to the GB,³ PCCCs have decision-making authority. To ensure transparency and avoid conflicts of interest (Cols), PCCCs are chaired by a lay member and have a lay/executive majority.⁴

WHAT DOES IT INTEND TO ACHIEVE?

The NHS *Five Year Forward View* (FYFV) called for 'new care models' (NCMs) that envisage local commissioners and providers working together to break down the boundaries between primary, community, and secondary care.⁵ Co-commissioning is seen as a 'key enabler' to drive the development of NCMs. It is intended that CCGs will take a more integrated approach to commissioning,⁴ which will enable a shift of resources between sectors and facilitate the development of integrated organisations delivering NCMs. This is seen as a step towards 'place-based commissioning',⁶ which in turn will support planning by place for local populations. This will allow the local development of Sustainability and Transformation Partnerships (STPs).

STPs were first introduced in the 2016–2017 NHS planning guidance,⁷ being likened to a 'route map' representing different ways of working, bringing together health and care commissioners and providers. Although the 44 STP 'footprints', with leaders agreed by NHSE, are not statutory bodies and do not replace existing local bodies or change accountabilities, the importance of STPs as a vehicle for change is reflected in this year's operational guidance,⁸ in which they form a key element. The criteria and

requirements for CCG mergers have also been updated to include the need to align CCG 'footprints' to support STP delivery.⁹ In practice, STPs have been criticised for their lack of GP involvement.

DISCUSSION

What are the challenges associated with primary care co-commissioning in the context of these changes? One of the biggest concerns underpinning the original decision to give responsibility for primary care commissioning to NHSE was Cols.¹ However, in practice the need for policy 'workarounds' to solve the fragmentation introduced into the system by the Health and Social Care Act 2012 outweighed this concern. When primary care co-commissioning was introduced, it was argued that robust governance processes and decision-making transparency would alleviate Cols.⁴ Two years on, concern over Cols remains.¹⁰ There is little publicly available information on CCGs' arrangement to manage conflicts, and NHSE has little data about how effectively they are doing this, relying on an exception-based assurance process and on Monitor as the system regulator.¹¹ This raises questions about both transparency and local accountability. There is considerable variability in the processes used by CCGs to manage Cols, ranging from minute taking and updating declarations of interest to no clearly defined process to manage breaches.¹² However, with most CCGs claiming that their concerns centre on the perception rather than actual conflicts,⁶ having guidance that attempts to cover every eventuality risks making the process a tickboxing exercise.

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Second, guidance suggests that CCGs will be responsible for liaising with the Care Quality Commission (CQC) about issues relating to practice performance, but will not be responsible for issues relating to individual GP performance, which remains with NHSE. In practice, these two things may not be easy to separate. For example, CQC inspections may flag up problems with individual GPs. CCGs are constituted as ‘membership organisations’, with every practice required to be a member. Performance managing their own members is challenging for CCGs, who have tried to make this more palatable by shifting the discourse away from ‘performance management’ to ‘peer-learning’ or ‘peer support’.

Third, as GP federations and super-partnerships become more common it would make sense for GPs who have an appetite for lead roles to focus their efforts as providers of services rather than as commissioners. This may have significant implications for the sustainability of CCGs as clinically-led commissioning organisations, as they may struggle to fill GB places. Clinical leadership is already somewhat eroded by the fact that GP members do not form a majority on decision-making PCCCs. This means that significant decisions affecting local practices may be made that GBs cannot overturn.

Last, with no additional financial resource and a loss of managerial expertise since PCTs were abolished, CCGs are grappling with difficult organisational and structural issues around commissioning primary care.⁶ The previous transactional approach taken by NHSE left CCGs having to deal with considerable legacy issues such as getting hold of and understanding existing contracts.

CONCLUSION

The policy intention underlying the transfer of responsibility for primary care commissioning to CCGs was to allow more integrated commissioning, with the ability to shift resources around the system. CCGs are clearly enthusiastic about the

opportunities this affords them, but it is as yet too early to tell how far this will be achieved.⁶ In terms of supporting the development of new ways to deliver care, our ongoing research suggests that the ability to vary local contracts for enhanced primary care provision has supported the incentivisation of practices to work together ‘at scale’. The hope is that practices will eventually move towards different organisational forms that could take on new contracts arising out of the FYFV, such as multispecialty community providers (MCP). STPs may require changes to the way general practice is delivered, and buy-in will be difficult to achieve if GPs have not been included in the discussions.

As these changes unfold, CCGs as membership organisations need to ensure that they bring their membership with them to maintain the clinical voice and local understanding.

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organisations at a time of considerable turmoil and change. We are also grateful to Dr Lynsey Warwick-Giles, Dr Donna Bramwell, and Dr Valerie Moran, who are involved with the project.

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