Understanding Primary Care Co-Commissioning: Uptake, Development, and Impacts

Executive Summary

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Introduction

The Health and Social Care Act 2012 gave the power and responsibility for commissioning health services and budgets to groups of GP practices called Clinical Commissioning Groups (CCGs). CCGs will commission the great majority of NHS services for their patients but will not be directly responsible for commissioning services that GPs themselves provide. The responsibility for commissioning primary care services (medical, dental, eye health, and pharmacy) was given to a new statutory organisation called NHS England (NHSE), known as the NHS Commissioning Board in statute. This was to ensure a more standardised model and consistency in the management of the four groups.

In May 2014, following Simon Stevens appointment as the Chief Executive of NHS England, CCGs were delegated the responsibilities to commission primary care services. This was to enable better integrated care outside hospitals, ensure that primary, community and mental health are properly resourced, and CCGs having more influence over how funding is invested for local population, which would ensure sustainability of their local NHS. Co-commissioning would also enable the development of new models of care such as multispecialty community providers (MCPs) and primary and acute care systems (PACSs), as set out in the *NHS Five Year Forward View* (NHS England, 2014a).

This report presents the findings from a study following the development of Clinical Commissioning Groups (CCGs) in England. This is the *third phase* of the project, which **aims** to understand the ways in which CCGs are responding to their new primary care co-commissioning responsibilities from April 2015, providing feedback to NHSE supporting CCGs going through the approval process.

The study provides detailed evidence about the experiences of CCGs as they took on delegated responsibility for primary care commissioning. The study took place between May 2015 to June 2017. The strength of this study lies in the bringing together of evidence from senior policy makers as to the overall objectives for the policy with both telephone survey and case study evidence as to how it is playing out in practice. The specific research questions addressed in this report are:

- What is the scope of co-commissioning activity and the process of change?
- What approaches have been taken by CCGs to:
    - Develop governance structure to oversee primary care co-commissioning?
    - Commissioning and contracting?
    - Manage and develop the relationships between CCGs and their membership and between CCGs and external stakeholders?
    - Manage conflicts of interest?
- What are the impacts and outcomes CCGs would expect from taking on delegated responsibility and claims of early successes?
- What factors have affected CCGs' progress and development?

Methods

The timeline of our research is set out in Figure 1. We undertook an exploratory approach, combining evidence from:

- Face-to-face interviews (*n*=6) with senior Department of Health and NHSE staff (June to July 2015) who had played a role in the development of primary care co-commissioning policy to understand the official aspirations underlying the policy.

- In-depth analysis of the main policy documents related to co-commissioning. We explored the uptake of primary care co-commissioning nationally (April to May 2015) by reviewing CCGs' application documents as provided by NHSE with CCGs' agreement. We reviewed 147 applications from 150 CCGs (some CCGs had submitted a joint application with their neighbouring CCGs and one CCG declined to take part).

- Two telephone surveys - the first survey was conducted at one year following the policy announcement (June to August 2015) and the second survey at two years following the policy announcement (August to October 2016). We contacted the same sample of CCGs to ask about the development of co-commissioning locally, to see whether their initial objectives for involvement were the same, whether the CCG had realised any benefits from the new responsibility and if they had made plans to move to a different level of co-commissioning. Job title and roles varied between CCGs but in general, we interviewed: Director/Associate Director/Senior Manager for Primary Care Commissioning, Director for Strategic Commissioning, Chair of Joint Co-Commissioning Committee, Head of Primary Care and CCG Chair/Chief Officer/Accountable Officer.

No of responses from telephone surveys

Levels	Number of CCGs taking over responsibility on Apr 15	Sample CCGs	Total response from the first survey (June-Aug 15)	Total response from the second survey (Aug-Oct 16)
Delegated	64	20	20	12
Joint	87	26	17	8
Greater involvement	58	58	12	1
TOTAL	**209**	**104**	**49**	**21**

- Case studies in four CCGs nationally (3 delegated and 1 joint moving to delegated). Our observations focused mainly on meetings associated with primary care co-commissioning. We attended a total of 74 meetings (approximately 111 hours of observations) and conducted 42 face-to-face interviews with members of the Primary Care Commissioning Committee such as the Lay Chair, Primary Care Manager, Head of Contract, Head of Quality, Head of Estates, Head of Engagement, Local Medical Council representative, Director of Healthwatch and CCGs' Governing Body Chair and Accountable Officer.

The focus of this final report is on findings from case studies. The study looks longitudinally at the development of CCGs hence the evidence we present rests upon a deep understanding of the context. Our case study approach, which combines observational evidence with interviews means that we have not only captured evidence about issues voiced by interviewees, but we have also watched these issues unfold in real time in a variety of meetings. This detailed observational evidence has provided insights which would not have arisen from interviews alone. The ethnographic approach does, however, mean that we were only able to collect data in four case study sites. The generalisability of our findings from these sites rests upon two things: the two

rounds of telephone survey data, which confirmed that the issues arising in our case studies were also issues relevant more widely; and a theoretical generalisation arising from our broader engagement in organisational theory. This report does not focus upon this aspect of the study, but this will be addressed in subsequent publications exploring issues such as accountability and governance.

Results

Our study suggests that CCGs have taken to primary care co-commissioning with varying degrees of enthusiasm, but with a clear sense that the commissioning of primary care services requires local knowledge and involvement of trusted managers with expertise in primary care.

We found no systematic difference between CCGs undertaking delegated and joint arrangements in the initial telephone survey, with those currently undertaking joint commissioning doing 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 were generally expressed in terms of benefits for the CCG and for the practices. The main concern for CCGs at all levels of responsibility was around the resources they need to carry out their new role. Two years following the policy announcement, there were clearer differences between joint and delegated CCGs, in that delegated CCGs claimed that they were able to achieve or were moving to achieve their objectives whereas CCGs undertaking joint commissioning were less positive about this. Delegated CCGs told us that the respective roles of CCGs and NHSE had become clearer over time, with CCGs having a better understanding of what they could do.

For CCGs who took on 'greater involvement', they told us that the reason they opted for this level was due to concern around capacity issues and resource constraints. 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 in the process. Most CCGs in 'greater involvement' we spoke with in 2015 had decided to move to joint or delegated level and therefore we only had one response in the second telephone survey. When asked why they had not opted to do joint or delegated commissioning initially they said that it was not the right time for them as a CCG. However, at the time of the second survey, they had applied to become delegated commissioners as they thought it would help them in their intentions to develop an accountable care system. For detailed analysis of CCGs' experiences of 'greater involvement' and 'actionable messages' to support their development see our interim report.

Our initial engagement with relevant documents and with senior policy makers and managers highlighted two programme theories as to why primary care co-commissioning by CCGs was desirable:

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

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

plans made at CCG level and the strategic plans of individual GP practices as independent businesses; issues associated with conflicts of interest; intrusion of national-level requirements and potential mismatches between national initiatives and local plans; and concern about the lack of visibility of primary care services in local Sustainability and Transformation Plans (STPs).

The concept of a 'place-based' approach to services is one which has gained currency in recent years. Whilst it is not often clearly defined, those involved in the early stages of our study shared a common understanding of 'place-based' as encompassing joined-up commissioning of services for patients in particular geographical areas, with associated shifts of resources between primary, community and hospital services. It was envisaged that CCGs would be able to use their new primary care commissioning powers to facilitate this type of integration and resource-shifting. We did not find significant evidence of this occurring in practice.

In some of our case study sites, new models of care are being developed, and commissioners were keen to invest in community-based alternatives to secondary care services. However, in general we found the funds for these investments were coming from existing primary care sources rather than from disinvestments in other sectors or from pooling of resources across sectors. Even in those sites with developing Vanguards, we found no evidence of an appetite amongst GPs for any change in their base contracts. Thus, investments were occurring via 'add on' contracts funded from existing sources. The pressures currently being felt by primary care providers across the country meant that the focus of all of our sites was on sustaining, developing and supporting primary care, rather than in developing new approaches.

We found some evidence that the need to keep primary care co-commissioning structures and processes separate to the wider work of the CCG in order to minimise conflicts of interest may act to limit opportunities for taking a truly place-based approach. Those GPs with lead roles in the wider CCG were frequently required to leave the room in Primary Care Commissioning Committee meetings, with some telling us that this limited the extent to which they were able to take an overview of all care sectors, as would be required to support a 'place-based' approach to commissioning.

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

- **Issues associated with the speed at which change occurred**, from announcement in May 2014 and when co-commissioning go-live in 2015**.** These issues were generally short-lived, but were significant at the time, requiring considerable work and taking up significant amounts of managerial and clinical time. Some CCGs had to reorganise their governance structures in response to belated guidance
- **Ongoing practical issues** such as: lack of personnel overall to do the work; specific lack of expertise in some areas (e.g. estates, primary care finance) following the downsizing of the NHS managerial workforce following the HSCA12; problems with accessing information; and managing conflicts of interest.
- **Problems generated by the current legislative context.** NHSE retains statutory responsibility for primary care commissioning, with delegated commissioning described by many of our respondents (both policymakers and CCG staff) as a way to 'workaround' the problems that this generates. Ongoing issues associated with the current legislative context include: cumbersome governance arrangement as NHSE retains statutory responsibility hence CCGs are required to keep NHSE informed of any decisions that could involve legal challenges

and/or attract media attention; fragmentation of responsibilities with respect to performance management of GP practices; and lack of clarity over who is responsible for what (e.g., which responsibilities CCGs wish to undertake and which they wish to share with or have the NHSE Regional Team undertake on the CCG's behalf). This latter issue goes somewhat wider than simply primary care commissioning, as the HSCA12 divided commissioning responsibilities in new ways. This has generated lack of clarity around issues of responsibility for areas such as screening. Responsibility for property services, including leases, was an issue in our case study sites.

1. ***Structures and governance***

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

2. ***The practice of co-commissioning***

- The CCGs in our survey and case study sites have focused upon three main areas:
    - The introduction of new practice incentive schemes
    - Rationalisation of PMS/APMS contracts
    - Investment of additional funding in estates and technology
- Strategic plans for investment have been developed through stakeholder engagement, particularly practices, but also, in some cases, patients/the public.
- Many plans focus upon incentivising and supporting practices to work together and provide a broader range of services. There is a clear focus on ensuring the sustainability of general practice. This includes a focus on the development of a broader range of skill mix and improving access, as well as improving the quality and consistency of services. There has been little appetite for local QOF schemes.
- Investment to support these plans comes from a number of sources, including: the existing primary care budget, consolidation of existing Directed and Local Enhanced Services, the wider CCG budget, and other funding streams such as the Estates and Technology Transformation Fund (ETTF).

- Issues arising include the complexity of the schemes, sustainability of various funding streams, and monitoring of the schemes.
- The ETTF has been particularly problematic to administer due to a very short timescale, difficulty in operationalising 'transformation', difficulty in defining strategic need, and a specific lack of capacity and expertise in estates management.

3. Conflicts of interest

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

4. CCG relationships

With member practices

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

With developing GP provider networks/federations

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

With CCG locality groups

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

With other CCGs

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

With Health and Wellbeing Boards and Local Authorities

- CCGs are encouraged to invite HWB members and LA representatives to be non-voting attendees at Primary Care Commissioning Committee meetings. In practice, attendance and engagement by these groups was variable
- Where these relationships work well, they can facilitate collaborative working and integration.
- The pressure on Local Authority budgets was felt to be a significant issue by many.

Patient and Public Involvement

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

Other relationships

- CCGs are engaging with a variety of other organisations and groups with regard to their primary care co-commissioning responsibilities. These include the Local Medical Council, Healthwatch, and Care Quality Commission.

With NHS England

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

- Respondents reported positive experiences of NHSE representation at Primary Care Commissioning Committee meetings, although such representation was not always available.

5. Claims to impact

Respondents reported improved ability to 'join up' the commissioning of primary and secondary/community care, better local decision-making, and improved ability to plan primary care services for the population. Specific claims to success relating to delegated responsibility included:

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

However, some respondents also reported 'increased hassle', with considerable additional workload without additional resources.

6. Legislation

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

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

7. The role of individuals and expertise

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

8. Public vs private meetings

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

9. Primary care estates

Primary care estates is a complex area, with a patchwork of property ownership, including ownership by individuals, ownership by partnerships, standard leasing arrangements and private finance initiative leases. Particular issues were observed in relation to: estates development, issues with finance, misalignment between APMS contract duration and leases on properties, and lack of clarity over who is responsible for holding estate leases.

10. Wider national initiatives

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

For NMC:

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

For STPs:

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

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

11. Experiences of delegation

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

- The process of delegation had been described as rapid and difficult by those CCGs who went early in the process, and there was an early lack of clear information and guidance, requiring CCGs to learn as they went along.
- There remains confusion about some of the legal aspects surrounding delegation, in particular around who has responsibility for different functions (see p.5).
- The fact that NHSE retains statutory responsibility for primary care commissioning means that even those CCGs with delegated responsibility will need to maintain an ongoing close relationship with NHSE.
- CCGs report a lack of managerial capacity both in general (i.e. the number of staff available to manage the workload) and in particular (i.e. lack of specific expertise such as estates or contract management).
- There is an ongoing need to deal with legacy issues arising from NHSE's commissioning of primary care, complicated by lack of audit trails and information about decisions that were made.
- Conflicts of interest are an inevitable feature of primary care co-commissioning by CCGs which are 'membership organisations', and this complicates the relationship between CCGs and their member practices.

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

12. Conclusion and implications for policy

Our study shows that the commissioning of primary care requires detailed local knowledge about services and providers alongside expertise in the unique domain of primary care, and that delegated responsibilities have the potential to provide this more effectively than was the case when NHSE retained full responsibility for primary care commissioning. It is likely that the potential for these benefits to be realised will depend crucially upon the provision of sufficient managerial expertise In addition, primary care co-commissioning by CCGs carries within it the potential for investment that will break down barriers between primary, secondary and community service. However, it is as yet too early for this to have been realised. Furthermore, we found no appetite for fundamental changes to GP core contracts, and it is likely that such investment will take place via 'add on contracts' or incentive schemes. The involvement of GPs in the commissioning of primary care services is regarded as positive, both in terms of engaging local GPs and in ensuring that new services meet local needs. However, conflicts of interest are inherent to this process, and will require ongoing management.

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

- **Statutory responsibility for primary care commissioning remains with NHSE**. This brings with it a number of complications, in particular cumbersome governance structures, with NHSE retaining ultimate responsibility for a number of areas of work and the need for local flexibility in working out where particular responsibilities lie. This limits how far CCGs can collaborate either

with each other or with other organisations. Hence current legislative arrangements may need revisiting.

- **Expertise in and knowledge about primary care** history, contracts, finance, and management, both in CCGs and NHSE, is required alongside adequate managerial resources.
- **Future approaches to commissioning** need to support the setting up of structures and processes that function at the optimum geographical scale. The direction of travel more broadly in NHS policy is towards a regional planning approach, embodied in Sustainability and Transformation Plans (STPs), in which commissioners and providers come together across a sizable geographical footprint to ensure appropriate services for the population. However, our study highlights the benefits of fine-grained local knowledge about primary care services and providers, which is unlikely to be available at this large scale. Furthermore, our respondents reported feeling distanced from the STP process, and voiced concerns that both their local needs and the needs of primary care more generally were not sufficiently visible. There was also a concern that integration between health and social care would erode clinical leadership which is inherent in CCGs.
- Wholesale **contract redesign** is probably less important than approaches which facilitate the negotiation and management of 'add on' contracts and incentives.
- **Conflicts of interest management** is fundamental to the commissioning of primary care by CCGs. It may be useful to distinguish between areas of work in which GP knowledge is fundamental (e.g. designing services to be delivered in the community or strategic issues relating to estates) and those in which it is less important (e.g. decisions about particular practice contracts, day to day decisions about funding for estate development). Whilst transparency will continue to be important, mandating that PCCC meetings take place in public does not necessarily achieve this and could be reconsidered. Robust lay involvement in decision-making is important, although such people may also have conflicts of interest.
- Current primary care commissioning resembles previous initiatives such as Practice-based Commissioning. **Hence recognition of continuities with previous NHS structures** and explicit initiatives to harness that working knowledge and history of working together to learn from what went before may be of value.
- Development of primary care services requires accommodation between local strategic needs, wider regional strategy led by STPs and national priorities. **Greater flexibility in allowing CCGs to spend central funding according to their needs and priorities** may be helpful, alongside guidance in designing appropriate assurance processes to ensure return on investment. It is important that the need for investment in primary care services is championed within STPs.
- **Patient and public involvement and engagement** remains difficult to operationalise. We found very limited routine engagement by the public, with most meetings not attended by any members of the public. Our case study CCGs did not have explicit strategies for encouraging such engagement. The STP process has further highlighted the issues surrounding public engagement; it may be helpful to include issues surrounding primary care services in future initiatives to engage the public with STPs, to avoid duplication.

Figure 1: Timeline of research