

**Ipsos MORI**  
Social Research Institute

**NHS Clinical  
Commissioners**

The independent collective voice  
of clinical commissioning groups

# Ways of Working Survey

**For NHS Clinical Commissioners**

29 November 2013

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# Foreword by NHS Clinical Commissioners

This survey has happened at an important moment in time as we begin to see how the new commissioning system is settling in and how leaders in CCGs view their relationship with NHS England. Working together NHS Clinical Commissioners and our CCG members co-produced with NHS England *Ways of Working* to describe the behaviours we all expected to see exhibited in the emerging relationships between the different parts of the commissioning system. This survey enables us to review these relationships at a relatively early stage with the findings available to be used to identify best practice and potential improvements in how CCGs and NHS England work together

There is much in the report which is positive and in particular the signs that, through the assurance process, staff in ATs have been supporting CCGs to be the best they can be. CCGs were closely involved in developing the assurance process and it may be no surprise that it is that which CCGs felt was the best-developed role undertaken by NHS England.

What the findings also demonstrate is that this is a system which is still young. In several areas considerable numbers of respondents neither agreed nor disagreed to particular questions. It is not we surmise that they did not know (another possible category) rather they do not yet feel they are in a position to know whether things are working well or not.

There is a possible risk here which local commissioners and NHS England need to be mindful of. In some questions one in three respondents were undecided about whether things are working or not. Given this there is as much potential for CCG leaders to fall into a poor perception of relationships as there is for things to improve. NHS England and CCGs need to look as closely at these areas as they do at areas where matters are already of concern to ensure that things improve.

While the survey has found areas where CCGs do believe things are developing in the right direction, it is clear that particularly in relation to NHS England's role as a direct commissioner this is not currently the case. The survey seems to indicate disconnects across the commissioning system and CCGs have responded poorly to the current situation with regard to commissioning of both primary care and Specialist Services.

The survey findings show discontent about how NHS England and CCGs work together around co-commissioning. For primary care commissioning, CCG leads questioned the current structure and a number thought that such commissioning would sit better with CCGs.

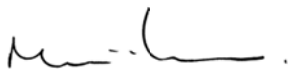
The other part of NHS England's commissioning responsibilities, specialised commissioning, has been a challenging area for CCGs and NHS England to work together on. CCG leads talked about the risk that specialised commissioning poses to the system. Many CCG leads did not seem to have much interaction with specialised commissioning teams and they rarely reported a shared vision or collaborative approach. More joint working was requested in order to tie the various commissioning strands together, with a shared vision that is aligned to local needs and takes into account the impact of specialised commissioning on CCGs.

This is something we strongly endorse. Commissioning of any services should not be happening in isolation from the other parts of a care pathway and NHS England and CCGs need to be working together, ensuring information is shared, so as to be able to ensure the best possible services for patients

The Ways of Working Survey was commissioned to help NHS Clinical Commissioners understand how well NHS England is modelling the ways of working across the system. Importantly, by reviewing working relationships at this relatively early stage, the survey findings can be used to identify best practice and potential improvements in how CCGs and NHS England work together. Results from the survey will be shared with NHS England, who will use them in their Organisational Development plans for 2014/15.

This report creates a baseline from which to build. We strongly recommend that CCGs and Area Teams use the findings for their area as a basis for ongoing discussions and that they engage with positive intent to enhance local relationships.

NHS Clinical Commissioners will be seeking to repeat the survey in 2014 to track progress from this early stage. We look forward to seeing how well the *Ways of Working* have become embedded as the way to do business throughout NHS England and across the commissioning system.



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# 1. Executive summary and key themes

Ipsos MORI were commissioned by NHS Clinical Commissioners to undertake an independent survey of CCG leads in England, in order to understand how the ways of working designed to frame relationships between NHS England and CCGs are being modelled. Clearly, as new organisations developing new relationships, implementing the ways of working within six months is challenging. The survey is therefore intended to provide a baseline, serving to stimulate conversations between CCGs and NHS England about how relationships can develop further. NHS Clinical Commissioners will be seeking to repeat the survey in 2014 to track progress from this early stage.

This report is based on the findings of 273 surveys of managerial, clinical and financial leads from CCGs across England. The surveys were completed via an online survey and Computer Assisted Telephone Interviewing (CATI) between 9<sup>th</sup> October and 11<sup>th</sup> November 2013. The response rate to the survey was 48% (273 of the 569 leads invited to participate), with responses received from 177 of the 211 CCGs in England.

This executive summary outlines the key findings that emerged from the survey.

## Overall relationships with NHS England

CCG leads were positive about how effectively the area teams work with them to enable them to do a great job. On the whole, they described close relationships with their area teams, relationships that both CCGs and NHS England had been working hard to develop. However, opinion was more divided regarding how effectively the regional and national teams work with CCGs and area teams to enable them to do a great job. This was partly due to a feeling that these teams are more distant, as would be expected given that CCGs work more closely with area teams. For some, a more distant relationship did not have any particular impact on them, but others thought that regional and national teams were more directive in their approach to CCGs. Other CCG leads questioned the decision-making capacity of area teams, or whether they were more communication conduits for the regional teams.

Overall, CCG leads were very positive about NHS England's assurance role, while working relationships around the provision of support and development were also largely thought to be working well. However, NHS England was seen to work less effectively with CCGs when co-commissioning, both for primary care and specialised services.

## Support and development

CCG leads' assessments of NHS England's support and development role suggested that the good relationships and the positive intentions of area teams are limited by NHS England's ability to deliver a service that truly meets their needs. Whereas a large majority of leads said that they were able to highlight their needs as part of the assurance process, just one in three CCG believed that NHS England offers the support and development needed to

enable their CCG to be the best it can be. Some leads commented that they thought local area teams were under-resourced to be able to deliver this role and, as such, organised their own support and development.

Encouragingly, around half of CCG leads considered that NHS England works with them as a partner, agreeing that the organisation strikes a good balance between autonomy and support, and providing their CCG with the space and freedom to innovate. Perceptions of NHS England's cultural approach to support and development were also broadly positive, citing strong relationships with, and positive engagement from, their area teams. For a smaller number of others, however, there was a sense that the organisation is operating in 'top down' mode.

Finally, there was also some feeling from CCG leads that NHS England's support and development offering can be constrictively narrow, and that interventions can be too prescriptive or 'off-the-shelf' to fully meet local needs. As a consequence of this, some leads felt that area teams were limited by NHS England's national offerings in what they were able to offer CCGs.

## Assurance

Overall, assurance was viewed as the role on which NHS England worked most effectively with CCGs. When asking about specific aspects of assurance, there were mixed views. Most CCG leads believed that NHS England recognises and respects the different roles and responsibilities each party has with regard to commissioning, and that NHS England teams understand when intervention is needed. Reflecting their positive working relationships, the vast majority considered that the recent assurance process was conducted in an open, honest and respectful manner.

Some CCG leads felt that it was simply too soon to tell how effective the process has been, citing the developing relationships between CCGs and area teams, and also the need for greater clarity on roles and responsibilities.

CCG leads generally thought that NHS England supports them to make the best use of public money for the benefit of patients and that the assurance process added value to what can be achieved for patients, although around three in ten were undecided. Some CCG leads suggested that the balanced scorecard places too much emphasis on hard outcome measures, to the detriment of local intelligence and a greater focus on patients.

The concept of mutual accountability was widely discussed with reference to the assurance role. In particular, many CCGs queried the extent to which the assurance process can represent a partnership of equals when only one organisation seemed to be accountable, particularly around NHS England's commissioning role. It is noticeable, however, that there were signs that mutual accountability is starting to develop in some relationships. Furthermore, there was also a sense of optimism and a willingness to strengthen collaborative working as systems embed and evolve.

## Primary care commissioning

CCG leads showed some concern about primary care commissioning arrangements. Although many felt that they share responsibility with NHS England for securing the best outcomes for patients, they often did not feel like there was a shared vision for primary care. Furthermore, CCG leads often expressed an opinion that NHS England lacks the resource and experience to deliver this role. It was felt by some leads that area teams sometimes passed on responsibility for elements of primary care commissioning. Therefore, while NHS England's approach was generally thought to be collaborative, leads were less confident in their understanding of the respective roles and responsibilities.

Concerns about the resource available to area teams to deliver primary care commissioning were mirrored by a belief that CCGs, with more local knowledge, may be better placed to commission these services. These combined to cause some CCG leads to express a belief that primary care commissioning should be the remit of CCGs. It was recognised that this would require significant safeguards to be developed within the system, for example to avoid a conflict of interest. Even if such a change is not possible, the findings suggest that greater clarity of roles and responsibilities and more communication between CCGs and NHS England would strengthen how the ways of working are implemented around primary care.

## Specialised commissioning

The ways of working generally appeared to be more difficult to implement with respect to co-commissioning specialised services, with more distant relationships between CCGs and specialised commissioning teams. Relationships appeared less collaborative than for other roles, with CCG leads suggesting that more information could be shared and more could be done to listen to their views and understand the impact of decisions on CCGs.

CCGs sometimes ascribed this sense of remoteness to working with a separate area team with whom they do not have established relationships. This had been affected by discussions about budget allocations, which CCGs flagged as a risk for the system. Some leads also argued that the shared responsibilities across the commissioning system means that it can be difficult to co-ordinate commissioning plans for all levels of the service, and that much more collaboration was needed.

## Regional differences

Some differences by region emerged in the survey findings. In the Midlands and East, relationships between the CCGs and area teams seemed particularly strong, while views of relationships around primary care co-commissioning were also particularly positive in comparison with other regions. In addition, CCG leads in the Midlands and East were more positive than others about some aspects of assurance and the assurance process.

CCG leads based in London tended to be more negative than others about many aspects of the ways of working. The exception was around specialised co-commissioning, where views were more in line with the average.



CCG leads in the North of England tended to be a little more negative or undecided about specialised co-commissioning. They were also more undecided about some other aspects of the ways of working, particularly around support and development.

In the South of England, CCG leads were more positive than in other regions about some aspects of the ways of working, but more negative about other aspects. Views of support and development, assurance and primary care co-commissioning were particularly mixed, although views of specialised co-commissioning were often more positive than in other regions.

## Key themes

Although CCG leads were not asked specifically for their thoughts on the ways of working, developed by NHS Clinical Commissioners with NHS England, when commenting on relationships with NHS England, the ways of working seemed to be viewed as a positive approach. Some CCG leads used ‘old SHA behaviours’ as a negative contrast to the ways of working and how relationships should be developing.

Overall, local relationships between CCGs and area teams were seen as good and developing well. Some CCG leads had built up good personal relationships with those working within NHS England’s area teams. However, the survey clearly shows that this is not a consistent picture; while some CCGs pointed to strong relationships along the ways of working, a smaller number were still thought to be operating in an older, more ‘top down’ manner. Indeed, there were differences at times between staff working within the same area team, suggesting that relationships are very much driven by individual connections between the organisations.

The regional and area team analysis demonstrated that there are real differences across teams. In addition, even within the same area team, some CCGs seem to have significantly better relationships with NHS England than others. Both CCGs and NHS England teams may therefore wish to reflect on the survey findings in order to improve relationships.

CCG leads often felt that assurance was the best-developed role undertaken by NHS England, and were particularly positive about the open, honest and respectful conversations that took place in the most recent assurance process. However, some argued that assurance took priority over support and development and commissioning roles. Some CCG leads pointed to a perceived conflict of interest between the different roles that NHS England plays, and that it therefore cannot perform well across all of those roles.

One key theme emerging from the survey is the need for greater clarity about roles and responsibilities. For example, some CCG leads wanted greater clarity about the roles of the regional and national teams. At times, CCG leads thought that the extent to which the area team were able to display the ways of working was inhibited by the actions of the more distant regional and national teams. This sometimes led to CCG leads seeing area teams as communication channels, influencers or ‘middle men’ rather than as decision makers. Greater clarity about the respective roles of the different parts of NHS England may therefore address some of these impressions.

The survey findings clearly show discontent about how NHS England and CCGs work together around co-commissioning. For primary care commissioning, CCG leads questioned the current arrangements and a number thought that such commissioning would sit better with CCGs. This was sometimes linked to the belief that CCGs were already having to take a lead on primary care commissioning and that CCGs were being passed responsibilities by NHS England, which they didn't think had the capacity to fulfil its role. This raises a number of different issues, but aside from the structural question and need for more resources – which it may not be possible to change – greater clarity about roles and responsibilities would aid relationships here.

This discussion around primary care also highlights another key theme that emerged consistently; a belief that NHS England is not adequately resourced to consistently fulfil its roles. CCG leads thought this had an impact on support and development and co-commissioning. For support and development in particular, this led to a sense that NHS England was unable to deliver on development needs, with some CCGs sourcing their own support instead.

The survey highlighted that specialised commissioning has been a challenging area for CCGs and NHS England to work together on, particularly in terms of finance and budget allocations. CCG leads talked about the risk that specialised commissioning poses to the system and relationships within the system. However, many CCG leads did not seem to have much interaction with specialised commissioning teams and they rarely reported a shared vision or collaborative approach. This was sometimes linked to beliefs about inadequate resourcing. However, the survey findings around area teams suggested that when relationships are formed such challenges can be better navigated; at present, with weaker relationships, specialised commissioning was flagged as an area of concern by many CCG leads. More joint working was suggested in order to tie the various commissioning strands together, with a shared vision that is aligned to local needs and takes into account the impact of specialised commissioning on CCGs.

Linked to this, another key theme that emerged from the survey was a desire for a more mutual relationship. This particularly applied to the assurance process, which CCG leads often felt was one-way, with no requirement for NHS England to account for its activities with respect to commissioning primary care and specialised services. This led to a feeling that CCGs do not have an equal relationship with NHS England. Leads were generally positive about the most recent assurance process; this may again be linked to good personal relationships that can develop once representatives of the two organisations are meeting face-to-face.

Another theme that emerged from assurance was a desire for more local flexibility. In terms of the assurance process, some leads felt that the balanced scorecard was too prescriptive or did not reflect actual progress. In addition, some noted that they were assured on pathways commissioned by NHS England (rather than the CCG) as specialised services. More local flexibility also applied to primary care commissioning, which some CCG leads felt could better reflect local needs. Regardless of how local flexibility could be better incorporated into the system, much more collaborative commissioning arrangements were

seen by many to be crucial. At times, the single operating model was felt to reduce the ability of the system to work locally and some saw this as a disadvantage to the system.

Throughout the different roles that NHS England and CCGs work together on, a significant minority neither disagreed nor disagreed with a number of questions. Further analysis suggests that there were a number of reasons underlying these neutral responses. At times, CCG leads thought it was simply too soon to be able to comment. For others, it seemed that there were some aspects of the statement that they agreed with and thought was working well, but other aspects where improvements could be made. For example, on support and development, some CCG leads thought that the positive intentions and ability to identify support needs was there, but that NHS England had not followed through and delivered on these needs. The analysis suggests that there is therefore an opportunity to move these 'undecided' CCG leads into the 'agree' category, but also a risk of them falling into the 'disagree' category.

The ways of working are structured around three pillars: building from common purpose; local leadership and accountability; and honesty and transparency. The survey findings show that relationships are better developed around some of these pillars than others. For example, honesty and transparency seemed to be embedded in many relationships. There was certainly a sense that CCGs were working hard, alongside NHS England, to engage with positive intent – although around specialised commissioning there were more distant relationships. For the most part, there was a focus on what was right for patients, although NHS England was not always thought to achieve the best outcomes. The vast majority thought that the recent assurance discussions had been open and honest.

In building from common purpose, CCGs felt that they share responsibility with NHS England for securing the best outcomes for patients and communities. However, the mutual aspect of this relationship emerged as an area for development; many CCG leads did not think that NHS England accounted to CCGs, particularly with respect to its commissioning activity, with assurance a more one-way process.

Finally, local leadership and accountability is also an area that could be developed further. While a sense of mutual respect and understanding was reported among many CCGs (although it is important to note that there were exceptions), the roles and responsibilities within the commissioning system were less clear to CCGs. With co-commissioning a key area of risk raised by CCGs, but with many opportunities available to genuinely improve services for patients, greater clarity here would strengthen the ways of working.

As already noted, these key themes did not apply uniformly across England. The survey findings provide an opportunity for CCGs and NHS England to reflect on relationships and improve how the ways of working are implemented, ultimately to achieve better outcomes for patients. The survey serves as a baseline from which this progress can be tracked in a follow-up survey in 2014, once more time – and reflection on these findings – will hopefully lead to stronger and more collaborative relationships.

## 2. Introduction

This report contains the findings of the Ways of Working Survey, an independent survey carried out by Ipsos MORI on behalf of NHS Clinical Commissioners.

### 2.1 Background

April 1<sup>st</sup> 2013 brought much change to the NHS, with new organisations (including Clinical Commissioning Groups (CCGs) and NHS England), new roles for individuals, and most importantly new ways of doing things.

NHS England has multi-faceted roles in relation to the new commissioning sector with prime importance being assurance, support and development of, and co-commissioning with CCGs. In order to achieve the best outcomes for patients in England it is clear that relationships and the ways of working exhibited between the key partners will be crucial.

NHS England and NHS Clinical Commissioners, as the independent collective voice of CCGs and its representative body, therefore co-produced a set of model ways of working to support these relationships. The ways of working fit alongside NHS England's values and purpose, and are integral to the way NHS England and CCGs work together. They were designed to shape behaviours displayed by both NHS England and CCGs, and to work across all NHS England's roles.

The ways of working (illustrated below) are built around three pillars:

- Building from common purpose
- Local leadership and accountability
- Honesty and transparency



**Ways of working that support CCGs and NHS England to secure high quality care for all, now and for future generations**



The Ways of Working Survey was commissioned to help NHS Clinical Commissioners understand how well NHS England is modelling these ways of working in practice, in all its relations with CCGs, across all its roles. Importantly, by reviewing working relationships at this relatively early stage, the survey findings can be used to identify best practice and potential improvements in how CCGs and NHS England work together. Results from the survey will be shared with NHS England, who will use them in their Organisational Development plans for 2014/15. Clearly, as new organisations developing new relationships, implementing the ways of working within six months is challenging. By undertaking the survey at this early stage, it is intended to stimulate conversations between CCGs and NHS England about how relationships can be strengthened and developed further. The survey therefore serves as a baseline and NHS Clinical Commissioners will be seeking to repeat the survey in 2014 to track progress.

## 2.2 Objectives

This research therefore aims to understand CCGs' perceptions of their relationships with NHS England. More specifically, the survey aims to understand relationships in light of the ways of working. NHS England has multi-faceted roles and these varied roles may mean that different parts of NHS England will form different relationships with CCGs. As a consequence, it was important that the Ways of Working Survey could identify how the ways of working are being implemented by NHS England across each of its roles.

Specifically, this survey looks to understand how the ways of working are being modelled by (NHS England) role; by region and between different levels of NHS England; as experienced by different CCG personnel.

The survey offers a snapshot of views of CCGs at the time the research took place. NHS Clinical Commissioners also needed the survey to identify areas of best practice and provide learning and messages for NHS England around how they can better model the ways of working and thereby improve relationships with CCGs.

## 2.3 Methodology

NHS Clinical Commissioners independently commissioned Ipsos MORI to undertake the research on their behalf. The survey questionnaire was developed by Ipsos MORI alongside a working group convened by NHS Clinical Commissioners. This working group consisted of representatives of NHS Clinical Commissioners, NHS England and CCGs<sup>1</sup>. Gaining input from these parties at the questionnaire development phase helped ensure that the questions identified working practices that best exemplified the ways of working, and that the survey questionnaire resonated with CCGs and allowed them to provide relevant and honest feedback. The questionnaire included closed questions asked on a scale, as well as free text questions that allowed respondents to provide more detail on their answers in their own words. While all respondents were required to answer the closed questions, they were able to skip the free text questions if they did not wish to provide further detail.

Three contacts were selected to take part per CCG: these three contacts represented the clinical lead, financial lead and managerial lead of every CCG in England<sup>2</sup>. Those leads who work for more than one CCG were asked to provide a response for all/ each of the CCGs<sup>3</sup>. Contact and email data was supplied by NHS England with the agreement that use of this was for the purpose of the survey only. In total, 569 contacts at the 211 CCGs in England were invited to take part in the survey. Reminder emails were sent, including an additional targeted reminder for financial leads when the response rate among this group was lower than for clinical and managerial leads. The online survey was supplemented with telephone calls to each contact to remind CCG leads about the survey, resend survey links where needed and also to offer them the option of completing the survey by telephone if it was more convenient for them.

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<sup>1</sup> Further details about the working group are included in Appendix B.

<sup>2</sup> Organisational structures differ by CCG and in some CCGs the Accountable Officer (Managerial lead) is also the clinical lead. Where this was the case, the next most senior managerial CCG member was selected as managerial lead. All financial leads were CFOs of their respective CCG. In the email invitation, each respondent was asked to respond as 'a clinical lead', 'a managerial lead' or 'a financial lead'. Where the report talks about 'managerial leads', for example, this refers to all respondents who were invited to take part in the survey as managerial leads. In reality this may also include some clinicians.

<sup>3</sup> At the beginning of the survey questionnaire, those CCG leads who work across multiple CCGs were asked whether they wished to provide a single response covering all of their CCGs, or a separate response for each CCG they work for. This allowed leads to decide whether they felt that their relationship with NHS England differs depending on which CCG they act on behalf of, or whether it is consistent across their roles.



Fieldwork for the Ways of Working Survey took place between 9<sup>th</sup> October and 11<sup>th</sup> November 2013. During fieldwork, a number of CCGs said that they would like to participate in the survey, but would struggle to do so in the allocated timeframe. In light of this, and to ensure that as many people participated as possible, the fieldwork end date was extended from Sunday 3<sup>rd</sup> November to Monday 11<sup>th</sup> November. By the close of fieldwork, 272 CCG leads had participated in the survey, providing 273 responses (as one lead responded twice for two different CCGs). This represents 177 of the 211 CCGs, and only 16% of CCGs did not provide a single response. The number of responses provided per CCG is broken down in the following table:

| Number of responses | Number of CCGs | Percentage  |
|---------------------|----------------|-------------|
| 0 responses         | 34             | 16%         |
| 1 response          | 77             | 36%         |
| 2 responses         | 77             | 36%         |
| 3 responses         | 23             | 11%         |
| <b>TOTAL</b>        | <b>211</b>     | <b>100%</b> |

The overall response rate achieved for the survey was 48%.

|                   | Number of responses | Response rate |
|-------------------|---------------------|---------------|
| <b>TOTAL</b>      | 272                 | 48%           |
| <b>Region</b>     |                     |               |
| London            | 28                  | 35%           |
| Midlands and East | 85                  | 49%           |
| North             | 96                  | 51%           |
| South             | 63                  | 48%           |
| <b>Role</b>       |                     |               |
| Financial lead    | 71                  | 42%           |
| Clinical lead     | 94                  | 44%           |
| Managerial lead   | 107                 | 58%           |

## 2.4 Interpretation of the data

The survey data is based on a sample, rather than the entire population of CCG leads. Therefore, results are subject to sampling tolerances. This report only identifies statistically significant differences. A guide to statistical reliability can be found in Appendix A.

Findings in this report are based on all (273) responses. While 272 individuals participated in the survey, one respondent who worked for two CCGs elected to provide a separate response on behalf of each of the CCGs.

Some questions were not asked of all individuals. Where analysis has been conducted on a subset of respondents, this has been indicated.

Where percentages do not sum to 100 per cent, this may be due to computer rounding, or when questions allow multiple answers. An asterisk (\*) denotes any value less than half of one per cent but greater than zero. For some questions, we refer to ‘net’ figures. These represent the balance of opinion on a particular statement, e.g. the proportion agreeing minus the proportion disagreeing.

This report looks at differences in the data between different groups. In particular, findings are analysed by the role of the respondent (clinical, financial or managerial) and region. Given the low number of total responses, the majority of this analysis looks at groups containing fewer than 100 responses. These findings should be treated with caution. Some groups contain fewer than 30 responses. These findings should be treated as indicative only. Where these have been analysed, findings have been reported as numbers only (rather than percentages), and a footnote has been included to note that findings should be treated as indicative only.

The table below provides the numbers of responses received by the different key groups. A single asterisk identifies those subgroups with low numbers of responses, while two asterisks show very small subgroups, whose results should be treated as indicative only.

| Subgroup          | Number of responses |
|-------------------|---------------------|
| <b>Region</b>     |                     |
| London            | 28**                |
| Midlands and East | 85*                 |
| North             | 96*                 |
| South             | 63*                 |
| <b>Role</b>       |                     |
| Financial lead    | 71*                 |
| Clinical lead     | 94*                 |
| Managerial lead   | 107                 |

## 2.5 Structure of the report

This report has been designed to offer a clear summary of how the ways of working are being implemented by NHS England across their roles. Additional chapters provide a summary at regional and area team levels.

The report is structured as follows:

- Chapter 1: Executive summary – summarising the key findings from the research
- Chapter 2: Introduction – providing an overview of the background to the research and how it was conducted
- Chapter 3: Overview of relationships – provides an overview of relationships between CCGs and NHS England, across the area, regional and national teams; explores how NHS England works with CCGs at an overall level across the four different roles



- Chapter 4: Support and development – focuses on NHS England's role around supporting and developing CCGs
- Chapter 5: Assurance – explores the ways of working in relation to NHS England's assurance role, including looking specifically at the most recent assurance process
- Chapter 6: Co-commissioning primary care – explores how the ways of working are being implemented by NHS England when co-commissioning primary care
- Chapter 7: Co-commissioning specialised services – explores relationships between NHS England and CCGs around the co-commissioning of specialised services
- Chapter 8: Discharge of conditions – focuses on CCGs that have conditions remaining on authorisation, exploring how supported CCGs feel in discharging these conditions
- Chapter 9: Regional findings – offers a short region-focused commentary around differences to the national findings, to allow the reader to build up a picture of the ways of working for each region
- Chapter 10: Area level findings – provides area-level commentary to allow the reader to build up a picture of the ways of working for each area.

Please note that additional data at area team level is provided as a separate volume to this report so that area teams can see the detail of the responses from all the CCG leads who responded within their area.

## 2.6 Acknowledgements

Ipsos MORI would like to thank the 272 CCG leads who took part in the survey. We would also like to thank the members of the working group for their contributions to the survey, including NHS Clinical Commissioners, CCG members of NHS Clinical Commissioners and NHS England. A list of the members of the working group can be found in Appendix B.

### 3. Overview of relationships

This chapter provides an overview of relationships between CCGs and NHS England, across the area, regional and national teams. It also explores how NHS England works with CCGs at an overall level across the four different roles: support and development; assurance; primary care co-commissioning and specialised care co-commissioning.

CCG leads were particularly positive about how effectively the area teams work with them, but opinion was more divided regarding how effectively the regional and national teams work with CCGs and area teams to enable them to do a great job. This was partly simply because CCGs work more closely with area teams, and CCGs commented on the good relationships they have with area teams. However, some CCG leads referenced weaker and less productive relationships with regional teams, and felt that communication from the national team could have greater clarity.

Looking at each of NHS England's roles with regard to CCGs, there was widespread positivity regarding how effectively NHS England works with CCGs in its assurance role, while working relationships around the provision of support and development were also largely thought to be working well. However, NHS England was felt to work less effectively with CCGs when co-commissioning, both for primary care and specialised services.

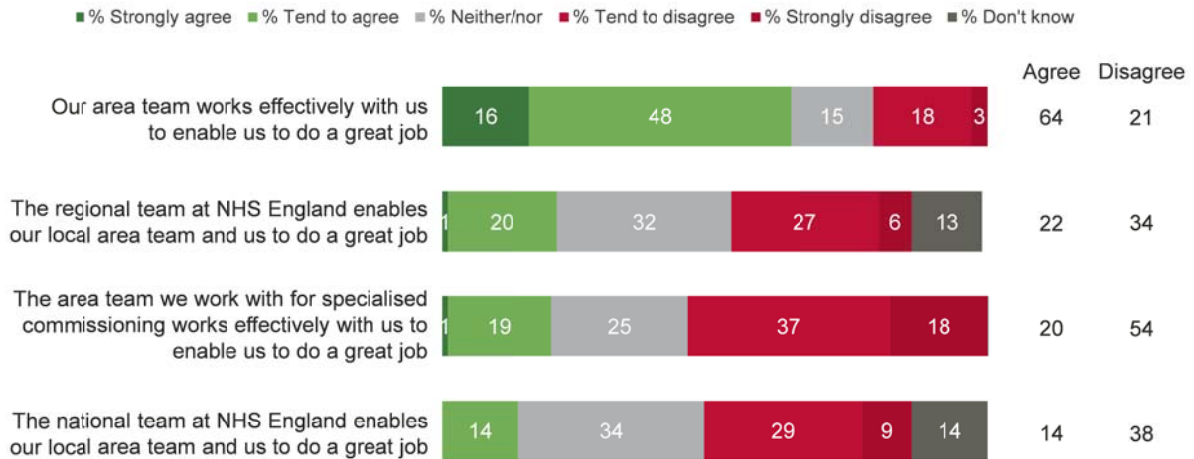
To begin the questionnaire, CCG leads were asked for their overall views on how effectively the area, regional and national teams work with them to enable them to do a great job.

CCG leads were generally very positive about their area teams, with almost two in three agreeing that their area team works effectively with them to enable them to do a great job (64%). However, there was greater room for improvement in working relationships with the area teams that CCGs work with for specialised commissioning. More than half of CCG leads said these teams did *not* work effectively with them to enable them to do a great job (54%).

Opinion was much more divided regarding the regional and national teams, with no clear consensus emerging from CCG leads. While 34% and 38% disagreed that the respective teams enable local area teams and CCGs to do a great job, a significant minority were also neutral (32% and 34% respectively).

## Overall relationship with NHS England

**Please now think about the relationship between NHS England and CCG. Overall, to what extent do you agree or disagree with each of the following statements...**



Base: All responses (273); 9th October – 11th November 2013

Source: Ipsos MORI

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CCG leads from the Midlands and East region were particularly positive about the effectiveness of their area teams; three in four leads from this region thought their area team works effectively with them to enable them to do a great job (74%, compared with 64% overall).

Leads in the North were less positive about their regional team than those from other regions. Around one in eight (13%) agreed their regional team is effective in enabling them and their area team to do a great job, as opposed to 22% overall.

When providing additional commentary on their relationship with NHS England, much of the positivity towards area teams centred around their ability to cater for the individual needs of CCGs. For example, area teams were praised by some CCGs for cultivating equal and effective relationships with CCGs.

*Our local area team is closely aligned [with us] and adopts a partnership approach. We have a 'grown up' conversation of equals. Regional and national teams tend to be distant.*

Clinical lead

Many CCG leads emphasised that they have far greater contact with their area teams, which will to some extent explain the greater divisions with regard to the effectiveness of the regional and national teams. Some leads saw this as an inevitable consequence of the closer working relationships CCGs have with their area teams.

This closeness helps to explain why CCGs are more likely to feel that they have a good relationship with their area team (26%).

*The local senior team have been extremely helpful and positive, probably meaning the regional and national teams have less input.*

Clinical lead

A further 14% of CCG leads said that their area team is supportive.

*Local relationships are good, constructive, challenging when relevant and supportive. Region fairly invisible, and lack of clarity and policy at a national level is a problem.*

Financial lead

However, 10% also said their working relationship with their area team was poor. There was a feeling, however, that area teams lack resource (seven per cent), and that their good intent is limited by capacity constraints. In turn, this leads to concerns that additional risk is being introduced into the system.

*Individuals in the AT are working hard and this is not a personal criticism of them – more the top down culture which is at odds with the way the system was described. Specialised commissioning is a huge risk and our AT is doing its best with something that is under-resourced and operating at a pace that cannot be sustained if we are to avoid unintended local consequences.*

Managerial lead

In contrast to their relationships with area teams, some CCG leads commented on poor communications or a remote working relationship with the region (16%). Given that the relationship with NHS England is intended to work mainly through area teams, this may not be a concern, but some leads suggested that relationships with the regional and national teams could affect local relationships.

*Our AT is trying very hard to establish good relationships with us. This is not always helped by regional and national actions, e.g. recent conversations re specialised commissioning, previous changes to the CCG assurance process.*

Managerial lead

At times, where there was communication with the regional teams, there were concerns among some that their approach was 'top down' (five per cent) and focused on performance management.

*Regional team is too remote and no meaningful relationship has been established.*

Managerial lead

*The regional team appear to be using old SHA ways of working and have a tendency to dictate.*

Managerial lead

*Regional team has a performance management focus rather than focussing on enabling us.*

Managerial lead

Leads also raised concerns regarding relations being 'distant' with the national team. Some felt that communications from the national team could have greater clarity (eight per cent).

*Lack of clarity and policy at a national level is a problem.*

Financial lead

*It appears that aspects of national thinking from NHS England contradicts and conflicts with other thinking; this means that we often have conflicting advice and guidance, or none at all, which makes life difficult.*

Clinical lead

There were also reports of confusion around the roles of different teams in commissioning and worries about the new system being disjointed and lacking consistency (13%).

*There appears to be some confusion between the roles of the regional team and the local area team.*

Managerial lead

Overall, one in three CCG leads neither agreed nor disagreed that their regional team (32%) and national team (34%) enables their area team and them to do a great job. When asked to provide more information, these leads were more likely to say that the regional and national teams are remote, and don't have a significant impact on their day-to-day work. Instead, they emphasised positive relationships with their area team.

*Area Team very facilitative and supportive, difficult to understand Regional Team and whether new world order works at that level.*

Managerial lead

Furthermore, 13% and 14% respectively answered 'don't know' when asked to what extent the regional and national teams enable their CCG and their area team to do a great job. It is noticeable that those CCG leads who feel they have a worse relationship with their area team were more likely to say that they didn't know whether the regional and national teams were working effectively. When asked to discuss their relationships more, these leads were more likely to feel that they have a distant or difficult relationship with their area team.

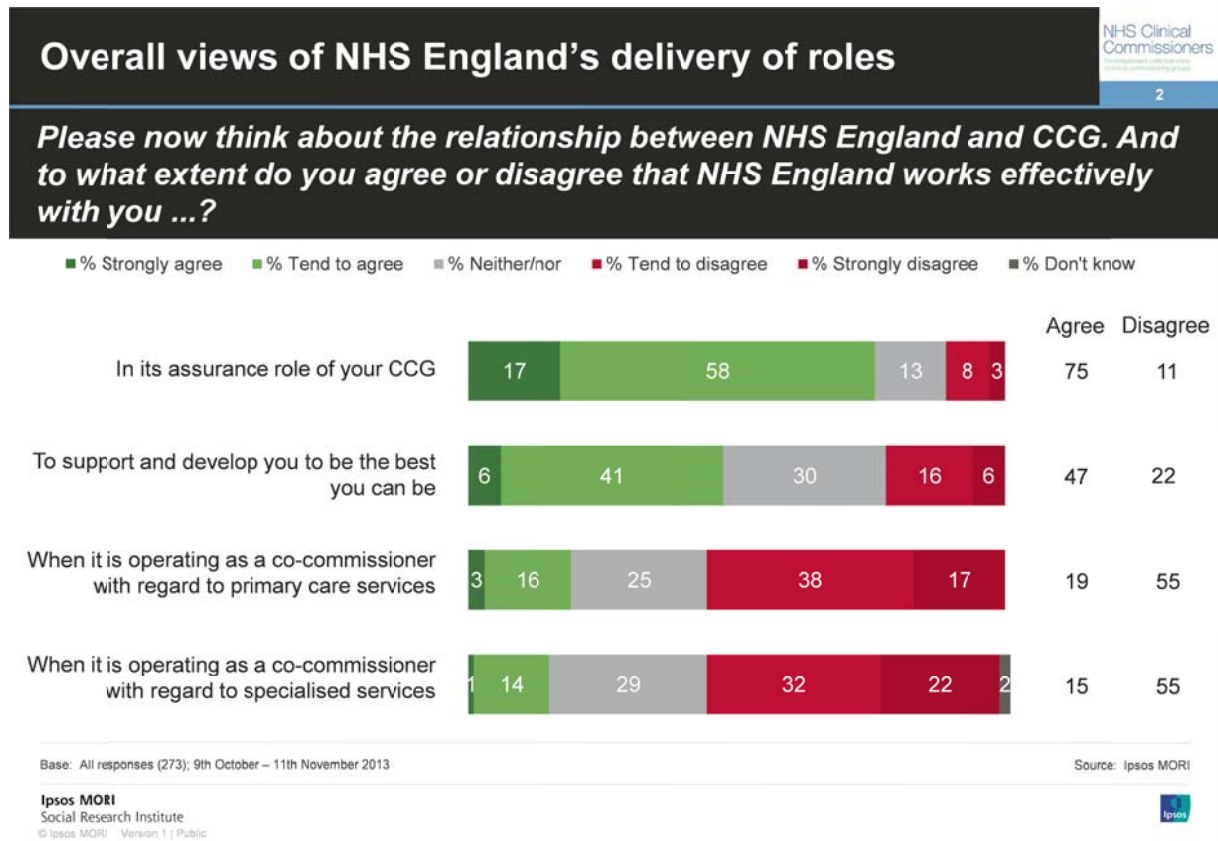
*The relationship with the Area Team is very one-sided. We receive very little information about their commissioning, or the quality, safety, or performance of the services they commission. We find it difficult to get any information in writing.*

Managerial lead

CCG leads were also asked for their overall opinions regarding how effectively NHS England works with them in each of its roles (assurance, support and development, and co-commissioning – both primary care and specialised services).

Leads were very positive regarding NHS England’s assurance role, with three in four agreeing it works effectively with them in this role (75%). They were also broadly positive about how NHS England works with them to support and develop them to be the best they can. Approaching half agreed they are effective in this (47%), with one in five disagreeing (22%).

However, it seems that improvements could be made in working relationships around co-commissioning. Just over half disagreed that NHS England works effectively with their CCG as co-commissioners of primary care services and specialised services (both 55%).



There were some interesting differences across lead types and regions regarding relations with NHS England:

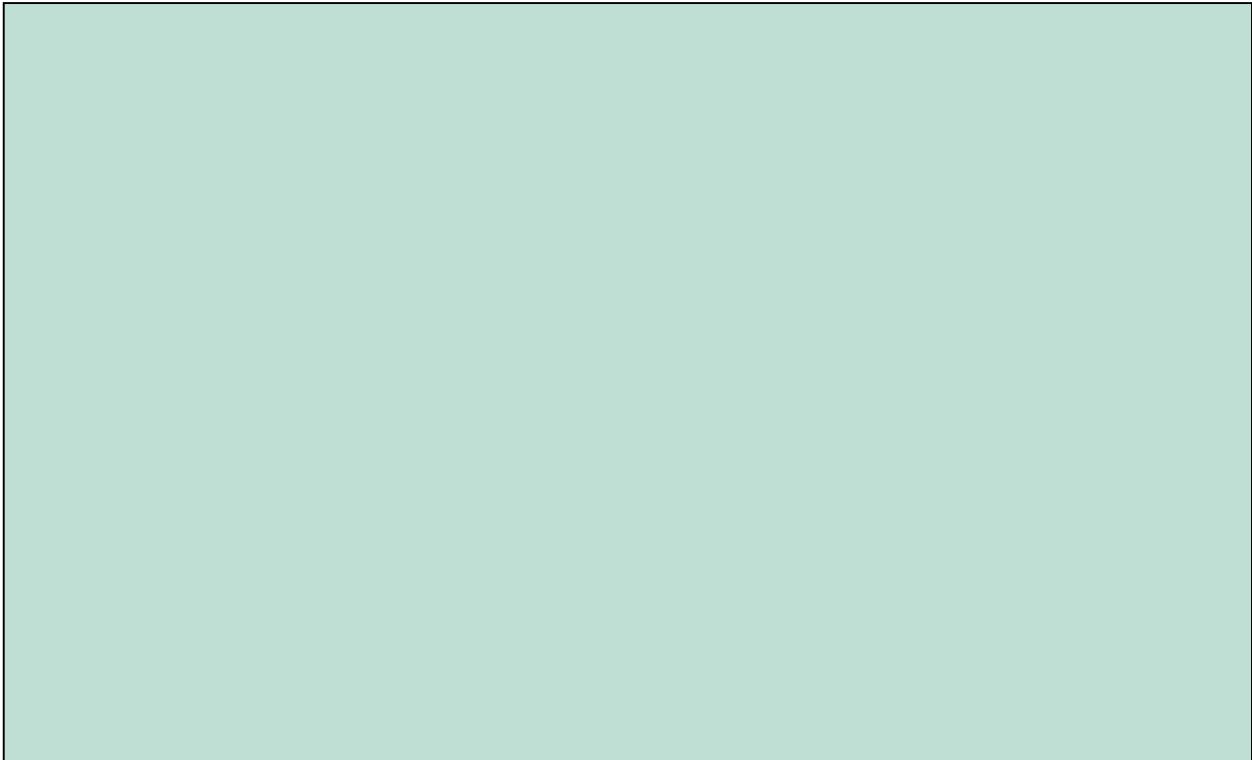
- Clinical leads were less likely than other leads to feel NHS England works effectively with them to support and develop the CCG to be the best it can (36% felt supported, compared with 47% overall). However, they were more positive about NHS England’s role in co-commissioning specialised services, with 22% agreeing that it works effectively with them in this regard (compared with 15% overall).

- Financial leads in particular were less positive about how effectively NHS England works with them when co-commissioning primary care; only 11% agreed they are effective, compared with 19% overall.
- Leads from the Midlands and East region were more positive regarding co-commissioning of primary care services than those from other regions, with one in three agreeing NHS England works effectively with them on this (34%, compared with 19% overall).

The following chapters of the report go on to discuss each of these four roles in more detail.

## 4. Support and development

This chapter of the report focuses on NHS England's role around supporting and developing CCGs.



### 4.1 Overall provision of support & development

Focusing first on NHS England's role in supporting and developing CCGs, CCG leads were asked for their opinions on a number of different statements around the support and development they receive from NHS England.

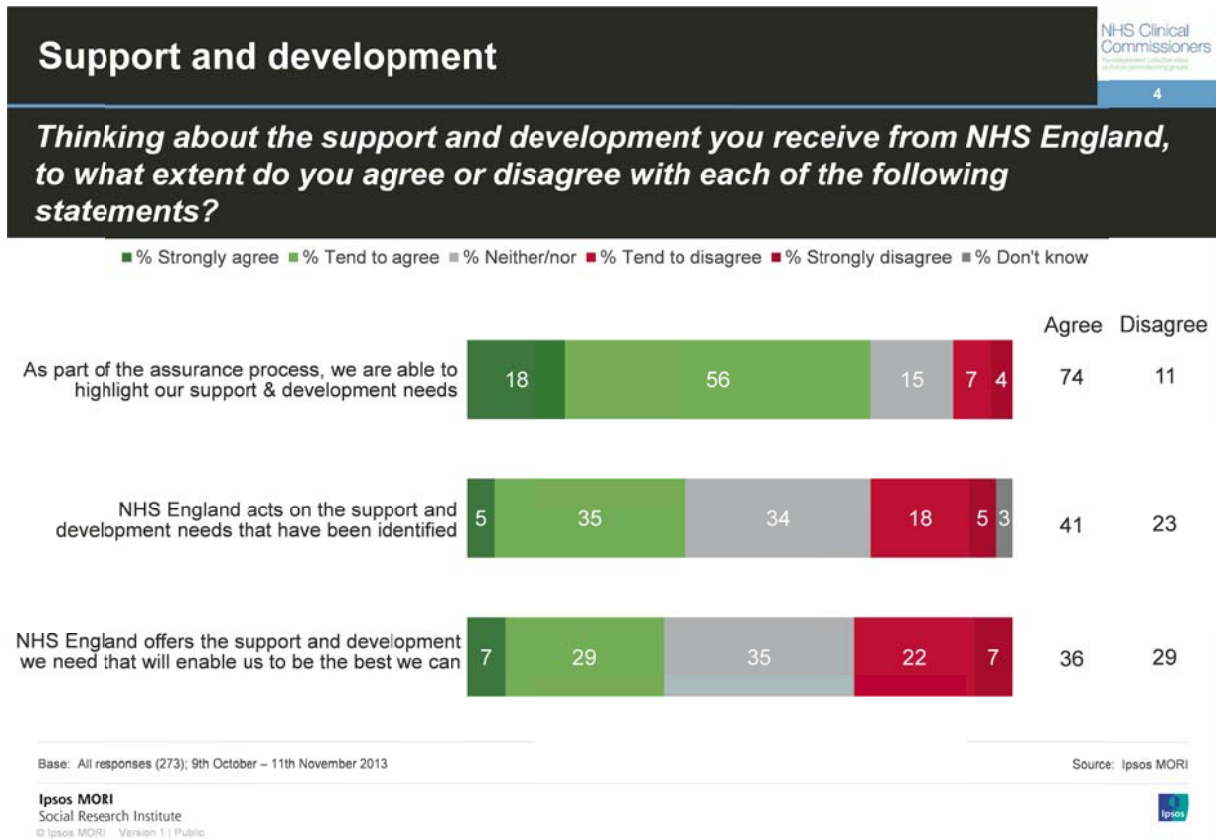
Around one in three CCG leads agreed that NHS England offers the support and development needed to enable their CCG to be the best it can be (36%), while a large minority thought that NHS England is not delivering in this respect (29% disagreed). It is also notable that one in three CCG leads were neutral regarding the support and development they receive (35%). Responses were fairly consistent between leads taking different roles within the CCG, and regionally.

When considering specific aspects of NHS England's approach to providing support and development to CCGs, views were fairly mixed. Encouragingly, three in four CCG leads agreed their CCG is able to highlight its support and development needs as part of the assurance process (74%), suggesting that this a useful and well-established process for identifying needs.

However, far fewer considered that NHS England goes on to act on the support and development needs that have been identified (41%). Here, one in three remained ambivalent



(34%), perhaps reflecting the view expressed in some of the free text comments that ‘it is simply too soon to tell’.



The most prevalent opinion expressed in the free text question was that CCG support and development needs are generally not being met by the respective local area teams and NHS England teams. Many seemed to think this was a function of under-resourcing/ under-staffing within the organisation as a whole (12%) and area teams (9%), rather than an inability to deliver *per se*. Related to this, those CCG leads who neither agreed nor disagreed that NHS England offers support and acts on development needs identified were typically more likely to express a view that their area team did offer support and development, but that it was not appropriate for them. This tended to be because they felt that they had more resources available in-house to address their developmental needs.

*When we have needed external input we have received it but on the whole it feels like because the Area Team is over stretched we just get on with it and we ensure we keep the Area Team informed as to what we are doing and they will say if we have 'got it wrong'.*

Financial lead

*Our impression is that NHS England/AT is working above capacity, helps where you can, but does not have the capacity to help us develop. Having said that you are not hindering our development. We are just getting on and organising it ourselves.*

Clinical lead

Others saw the offering as too prescriptive and would prefer for more tailored support to also be available, with some describing NHS England's offering as weak (11%).

*NHS England has been well-intentioned in offering support to CCGs. However, these have been limited by a prescribed menu. You may want ice-cream but if NHS IQ only have vanilla, tough luck. By all means create some generic offers, but give us the resources and allow us to buy the support we need.*

Managerial lead

*Support partners have off the shelf approaches rather than the bespoke help that is required ... has little to do with reality of implementation.*

Clinical lead

Another often expressed view in this context was that many CCGs have already independently accessed their own arrangements, and in some cases prefer this approach.

*Although we have discussed the support and development required we have yet to receive it. The CCG sets its own development plan and sources support itself both for OD, Board and for individuals.*

Managerial lead

## 4.2 Working in partnership

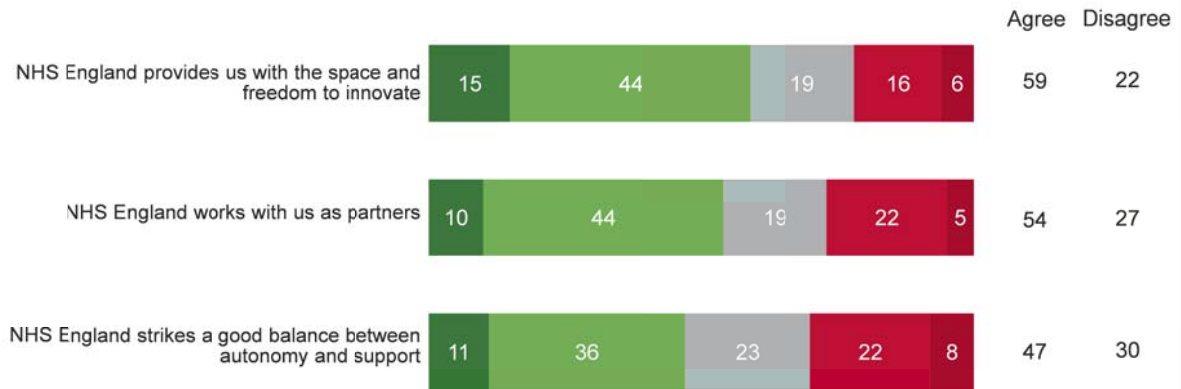
Some of the statements around support and development focused on how the CCG and NHS England work as partners on support and development. More than half of CCG leads considered that NHS England works with their CCG as a partner (54%), although more than one in four did not think the relationship operates in this way (27%).

Reflecting to some extent this overall view of the relationship as a partnership, just under half (47%) thought NHS England strikes a good balance between offering CCGs autonomy and support, although three in ten disagreed (30%). More positively, around three in five believed that NHS England provides their CCG with the space and freedom to innovate (59%), while one in five disagreed (22%).

## Support and development

**Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?**

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (273); 9th October – 11th November 2013

Source: Ipsos MORI

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Broadly speaking, CCG leads in managerial roles tended to be most positive about the way in which NHS England works in partnership with their CCG. For example, over half thought NHS England strikes a good balance between autonomy and support (54%, compared with 47% overall).

There also appeared to be a regional split in opinion, with more CCG leads in London<sup>4</sup> expressing on balance negative rather than positive views. For example, 12 of the 28 leads disagreed that NHS England works with them as partners and only eight agreed. The balance of opinion is consistently positive in the other regions.

When given the opportunity to provide more detail about their answers, a number of CCG leads reflected that for them the relationship between CCGs and NHS England is not yet a true partnership of equals. Despite this, relationships between area teams and CCGs are seen to be good in this area (16%). In some cases, it was felt that there had been a concerted effort to offer support from NHS England generally (20%), and the area team specifically (15%), while others referenced a more ‘top down’ or performance management approach.

*There are many people in new NHS England roles who have just about got to grips with the new world order. We acknowledge it has been a difficult time and we are new as CCGs but we do have a lot of experience of the NHS, which I don't think is recognised always. The tensions between national and local area*

<sup>4</sup> Caution – very low base size – results are indicative only

*team roles needs to be improved in the future to allow all the talents we have in the system to flourish.*

Managerial lead

*We work quite well with the area team but there is still an attempt at top down control which is disappointing. Some AT directors get it but not the majority.*

Clinical lead

*We have had to work hard to move away from a relationship where performance management has been the main focus with limited receipt of support, with some very robust discussion. This has involved a lot of time & energy which frankly distracts from getting delivery done!*

Managerial lead

Few CCG leads referred directly to their perceived freedom to innovate, but as in other respects, experiences were mixed, dependent it seems on the individual relationships involved.

*In terms of autonomy and freedom to innovate, this can be constricted by over-focus on operational issues (e.g. 4 hour waits) at the expense of really improving health outcomes for the population.*

Managerial lead

*We have a strong reputation for competence and capability, which seems to ensure we are left alone rather than supported more fully to further push our innovations.*

Managerial lead

*There is a genuine sense that the Area Team would like us to be autonomous, however, there is often inappropriate and unsolicited interference with providers which confuses governance arrangements and undermines CCGs and NHS England.*

Managerial lead

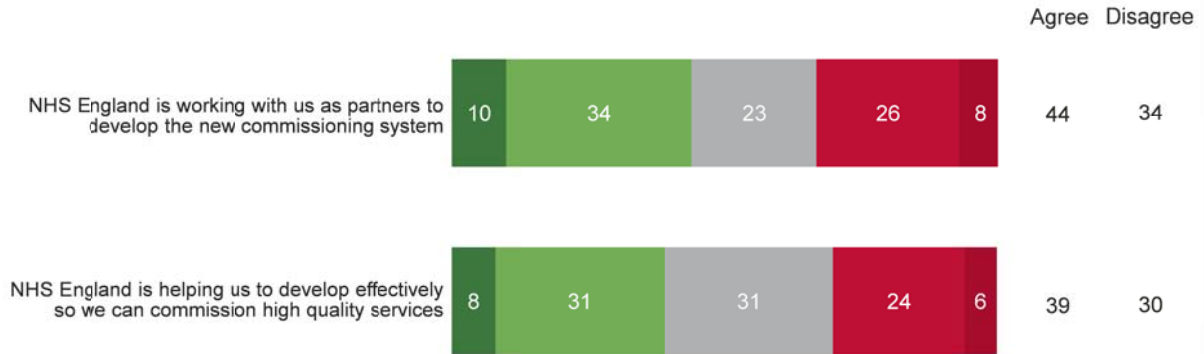
### 4.3 Approach to commissioning

Support and development is in place to enable high quality commissioning by CCGs, and around two in five CCG leads provided positive feedback about NHS England's support in enabling CCGs to develop effective approaches to commissioning. This included seeing NHS England as working in partnership with their CCG to develop the new commissioning system (44%) and helping them to develop effectively so they can commission high quality services (39%). However, although more positive than negative, still significant minorities disagreed (34% and 30% respectively), suggesting that there is some room for improvement here.

## Support and development

**Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?**

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



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There was again a regional split in opinion, with more CCG leads in London<sup>5</sup> on balance expressing negative rather than positive views here. In other regions, the balance of opinion is consistently positive.

The role of NHS England in joint commissioning of services was mentioned by several CCG leads when providing additional comments. One area in particular that CCG leads felt could be improved was to have more of a two-way system through which the area team could also be held accountable by a CCG for its commissioning decisions. At times this was mentioned specifically in respect of co-commissioning.

*The lack of transparency of AT commissioning and performance does not create a foundation of trust.*

Managerial lead

*This does not feel like an equal partnership in terms of commissioning, NHS England hold the CCG to account for commissioning but there does not appear to be an expectation of being accountable to other commissioners in the system.*

Financial lead

*The role of NHS England as joint commissioners is least well developed and if anything causes most tension. On the primary care side there is a view that NHS England assumes that CCGs do everything that involves GPs – clarity over who does what is essential. I am sure NHS England colleagues feel they can't possibly*

<sup>5</sup> Caution – very low base size – results are indicative only

*manage that many relationships and we are better placed but sometimes we feel 'dumped upon'. The reality is probably somewhere in the middle!*

Managerial lead

*We have worked together over an area of specialist commissioning where there have been issues of quality and patient safety. Whilst progress has been made it has been slower than we would have liked and there are still issues ... that remain.*

Clinical lead

#### 4.4 CCG support and development needs

CCG leads were asked to highlight their key support and development needs. One in five CCG leads (20%) said they need to develop management and leaderships skills within the CCG, both of the existing management, but also succession planning. Some CCGs specifically mentioned the development of boards and board members (16%).

*We need to develop the concept of a member organisation. We need to develop our board. We need to recruit and retain really good clinical leaders.*

Managerial lead

In particular, organisational development was seen as key for CCGs, which are still relatively new organisations.

*We are still working through a local OD programme, any support to help with succession planning for clinical leaders would be helpful...*

Managerial lead

A similar proportion of CCG leads (17%) mentioned that they would like greater support in developing commissioning, in particular with a clearer understanding of roles.

*Maintain an understanding of mutual responsibility and accountability with support and development around new joint commissioning arrangements. Also support to the CCG around co-commissioning of primary care.*

Clinical lead

CCG leads also said that they would benefit from greater sharing of best practice to help them optimise working practices for the benefit of patients (17%).

*Sharing good practice, successes and failures and what are the key factors that led to both outcomes, procurement challenges and finally and most importantly, has anyone really cracked the issue of transformational change?*

Managerial lead

On one side, networking was seen as a means to achieve this sharing of best practice, but it was also seen as a way of gauging the extent to which issues occur at a national level which can then be highlighted to NHS England.



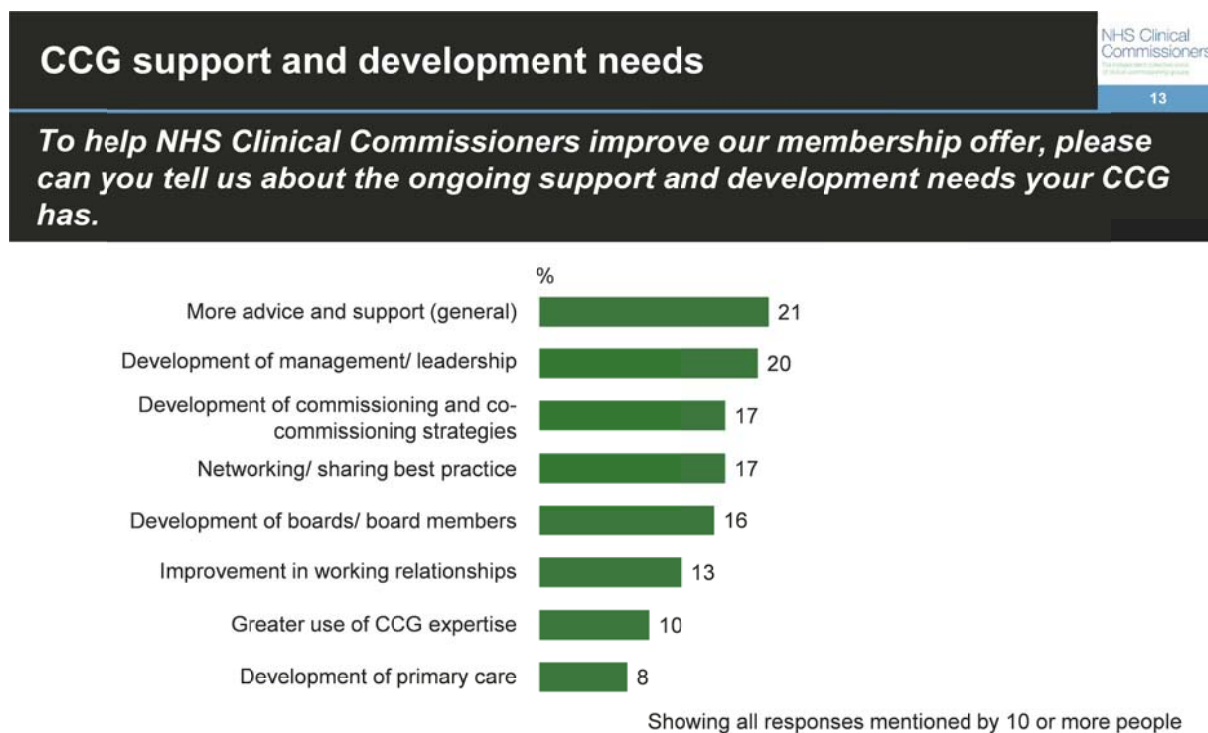
*What is clear from speaking to colleagues around the country is that the vast majority of challenges we are facing as CCGs are common to us all. Networking with colleagues at meetings does allow us to get a feel for how others have met some of these. A way of sharing experience and learning from what has worked for others would be valuable...*

Clinical lead

Reflecting CCG leads' perceptions that they need to play an increasing role in primary care, this was also highlighted as an area where they need to recruit and develop skilled staff (eight per cent).

*Primary care (our member practices) needs support and development urgently. As services move into the community we need skilled staff to do the work.*

Financial lead



Base: All responses (133); 9th October – 11th November 2013

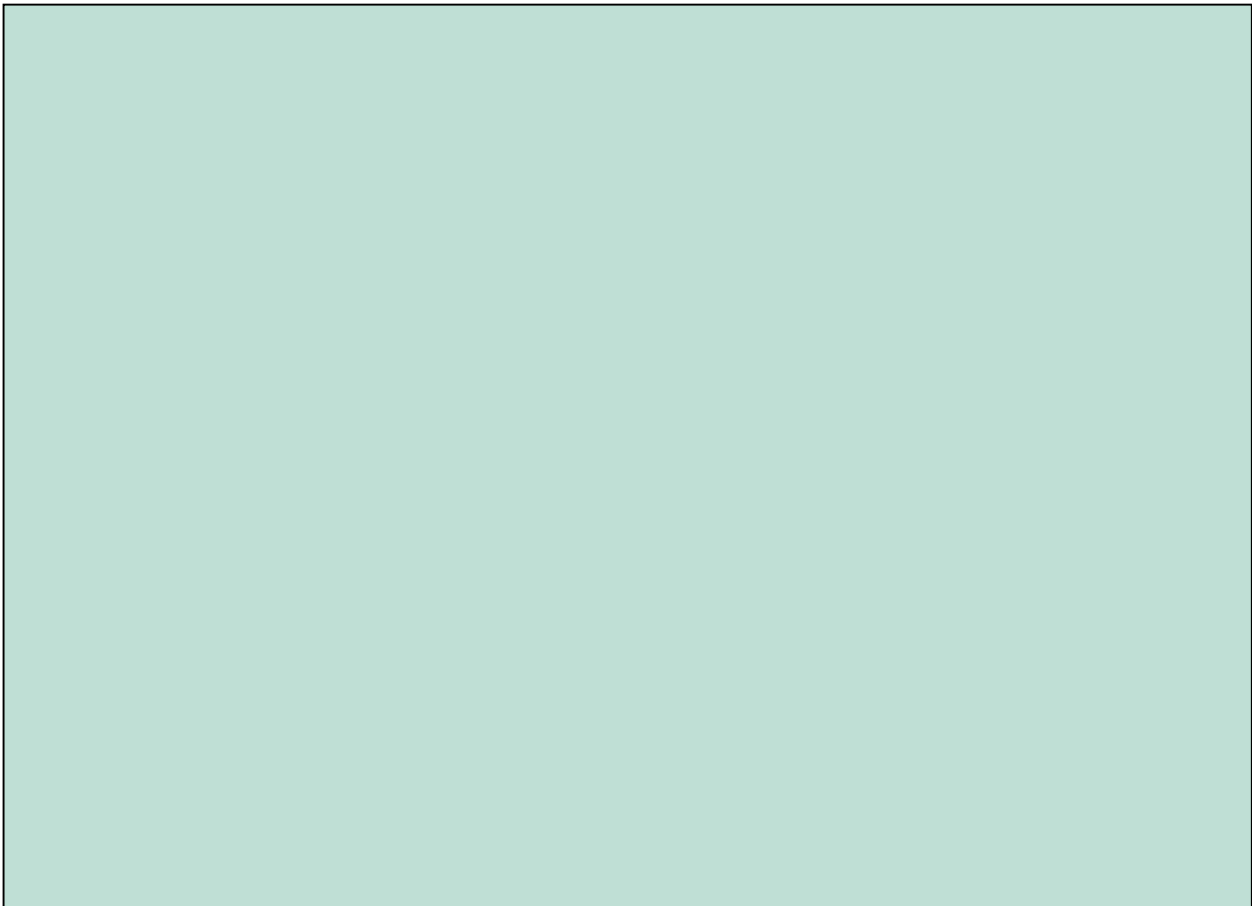
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## 5. Assurance

This chapter explores the ways of working in relation to NHS England's assurance role.



CCG leads were asked about two aspects of assurance, firstly their general relationship with NHS England and how CCGs and NHS England hold each other to account, and then more specifically the most recent assurance process.

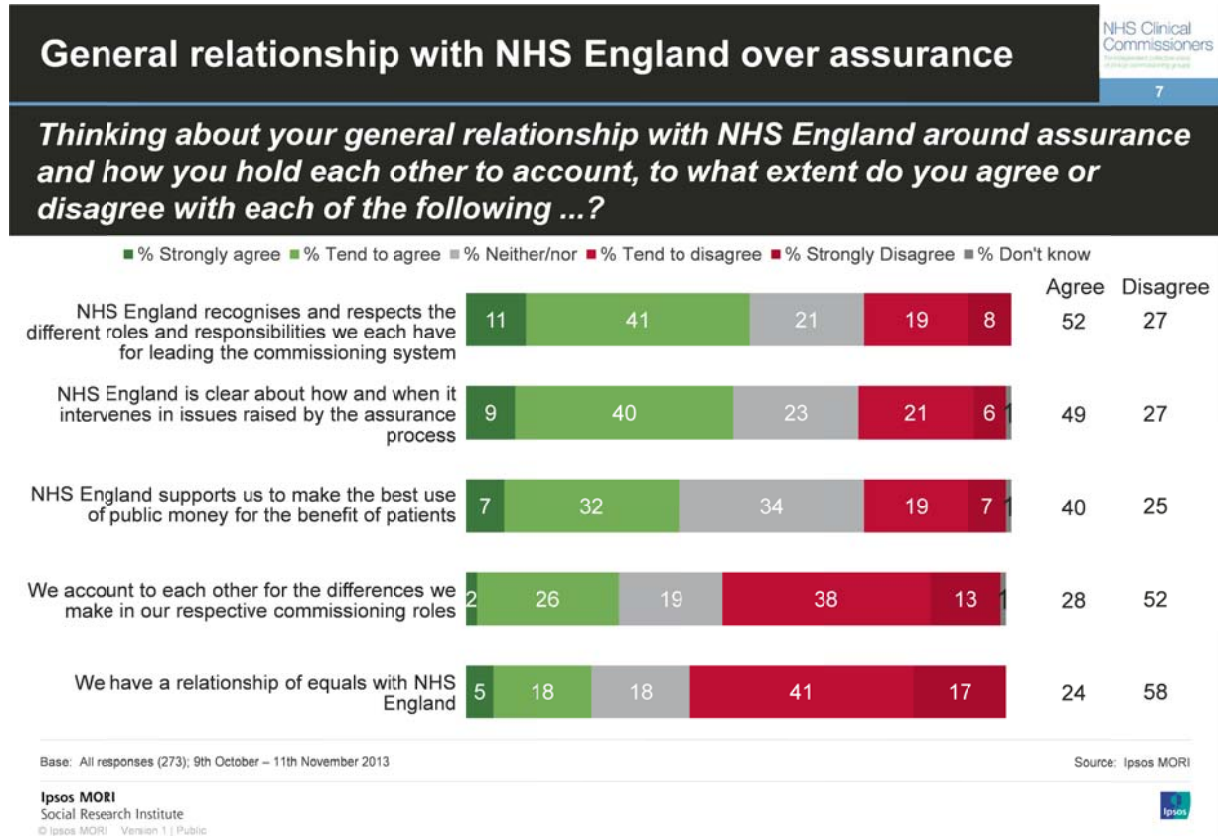
### 5.1 General relationship concerning assurance and accountability

Views were mixed when focused on the CCG's general relationship with NHS England around assurance and shared accountability. On balance, CCG leads seemed to think that NHS England understood the respective roles and responsibilities of the two organisations and the rules for intervening. Around half agreed that NHS England recognises and respects the different roles and responsibilities each party has in terms of leading the commissioning system (52%) and that NHS England is clear about how and when it intervenes in issues raised by the assurance process (49%).

When asked whether they thought NHS England supports CCGs to make the best use of public money for the benefit of patients, the largest proportion is again positive (40%), although one in three remained neutral (34%) and one in four CCG leads disagreed (25%).



However, when turning to the two-way relationship around holding each other to account, CCG leads were consistently less positive. This suggests that when working together on assurance the ways of working can be more difficult to implement. For instance, approaching three in five did not consider that they have a relationship of equals with NHS England (58%) and just over half did not feel that both parties account to each other for the differences they make in their respective commissioning roles (52%).



There were few significant differences by region concerning the general relationship between CCGs and NHS England around assurance, although views in London tended to appear less positive when compared with the views of CCGs elsewhere.

In terms of respondents' roles within the CCG, the views of clinical and managerial leads were broadly similar, while financial leads tended to be more positive. In particular, financial leads were significantly more positive than their counterparts that NHS England supports CCGs to make the best use of public money for the benefit of patients (49%, compared with 40% overall). In contrast, managerial leads were particularly likely to disagree (32% disagreed, compared with 25% overall).

When asked to provide further comments on their general relationship with NHS England around assurance and how both parties hold each other to account, many comments provided positive feedback on the quality of the underlying relationship(s). These comments tended to reflect on a good working relationship with the area team (13%), with several indicating a joint commitment to strengthen collaborative working as systems are developed.

*We have worked hard at developing a collaborative relationship with AT colleagues – and believe they have reciprocated this.*

Managerial lead

*At times it does feel old style! Still work to do around aligning our accountability. Strong commitment to get it right. Clear about roles and responsibilities which is extremely helpful in transition. I have no issues seeking advice and support from the leadership team.*

Managerial lead

Despite this acknowledgement of positive intent on behalf of the area team, some CCG leads commented that the assurance process was not working well (15%). A number of areas for improvement were flagged. In line with the quantitative data, these often reflected on the two-way relationship. For example, similar proportions noted that they did not think NHS England treats the CCG as equal partners (22%) and that accountability is 'one-sided' (21%). This one-way accountability seemed to be weakening perceptions that CCGs have a relationship of equals with NHS England. Those leads who disagreed that they have a relationship of equals with NHS England were particularly likely to cite concerns over one-sided relationships.

*Assurance framework robust but tends to be one way i.e. AT holding CCG to account, we would ask that the AT understand their role as commissioners and are accountable to us too.*

Clinical lead

*There is very little joint assurance happening in reality. For the CCG, trying to gain any form of traction or accountability from NHS England for directly commissioned primary care and other services is very limited currently. We raise issues about NHS England areas of responsibility with the local team at assurance meetings, but rarely get a timely or helpful response. There is very little connectivity between the NHS England role for primary care contracting and CCG quality improvement responsibilities.*

Managerial lead

In addition to the perceived one-sided nature of the assurance process, some CCG leads felt that boundaries or responsibilities were blurred or unclear (21%). In part, this was attributed to capacity issues on NHS England's part requiring CCGs to play a greater role. However, there is also a need for greater clarity of roles and greater understanding of how CCGs work. As a consequence of these factors.

*One way assurance process with little understanding of our roles and responsibilities. Little or no understanding of a membership organisation or that we are elected leaders. Could harness the power of elected leadership to better effect.*

Clinical lead

*There are some difficulties that we experience when the AT assumes that we have responsibility for e.g. communications to GPs on emergency planning or other 'provider' issues – where they say they don't have the capacity to do this, and neither do we! ... As relationships are generally good and we want the system to work we manage to sort these things out amicably on the whole.*

Managerial lead

*To be fair, NHS England colleagues appear not to have been adequately resourced for the tasks they are required to undertake – in staffing capacity and non-pay resources. There are numerous examples where the CCG is requested/ expected to operate beyond our responsibilities to pick up local commissioning issues that formally sit with NHS England. The way forward has to be by strengthening collaborative commissioning arrangements between the CCG and NHS England – and work is in progress to achieve this.*

Managerial lead

## 5.2 Perceptions of the recent assurance process

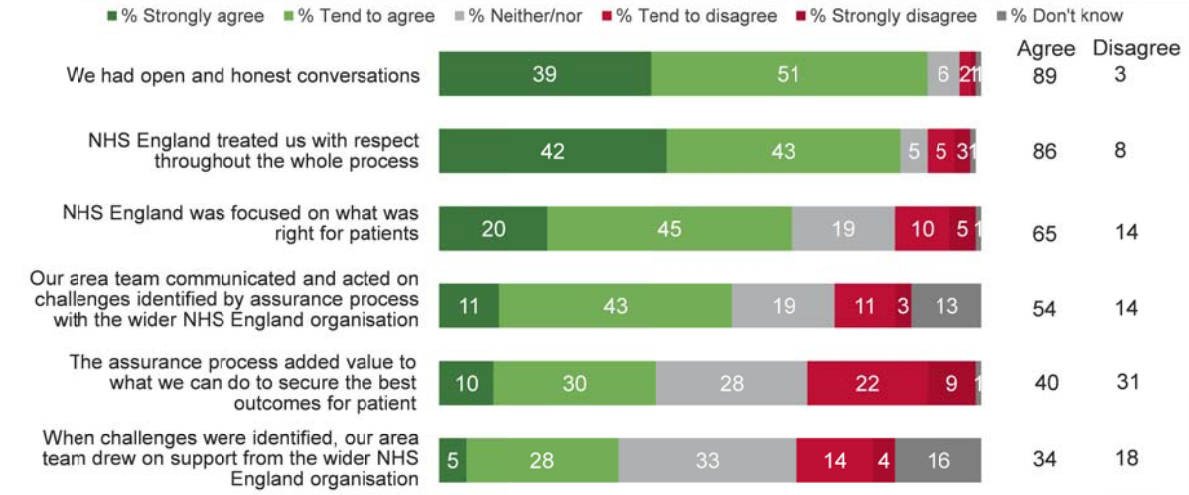
Turning more specifically to the recent assurance process, CCG leads tended to be more positive than they were about assurance and holding each other to account more generally. The vast majority believed that the conversations that took place were open and honest (89%) and said that NHS England treated them with respect throughout the whole process (86%).

While CCG leads tended to agree that NHS England was focused on what was right for patients (65%), opinion was more divided concerning the extent to which the assurance process then added value to the CCG's ability to secure the best outcomes for patients. Here, two in five agreed it added value (40%), while three in ten disagreed (31%) and a similar proportion remained ambivalent (28%).

Considering the links between area teams and the wider NHS England organisation around assurance, just over half of CCG leads agreed that their area team communicated and acted on challenges identified by the assurance process with the wider NHS England organisation (54%). Fewer agreed that their area team drew on support from the wider NHS England organisation where challenges were identified (34%), although nearly half either did not express an opinion either way or gave a 'don't know' response (48%), suggesting that they may not know when this happens.

## Views of the most recent assurance process

**Thinking now about NHS England's most recent assurance process with your CCG, to what extent do you agree or disagree with each of the following statements?**



Base: All responses (273); 9th October – 11th November 2013

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There were few significant differences by region concerning NHS England’s most recent assurance process with the CCG. Views in London again appeared less positive on balance when compared with the views of CCGs elsewhere, although this reflected generally larger minorities of CCG leads in London expressing no opinion either way, as opposed to overtly disagreeing. For instance, when asked whether they believed that NHS England was focused on what was right for patients during the recent assurance process, two in five leads in London<sup>6</sup> gave no opinion either way, compared to just one in five overall (12 out of 28 leads in London, compared with 19% overall).

In terms of respondents’ roles within the CCG, views were very much aligned in respect of NHS England’s most recent assurance process with the CCG. Most noticeably, however, one in five clinical leads did not believe that NHS England was focused on what was right for patients during the recent assurance process (21%, compared with 14% overall).

Reflecting on the recent assurance review process, many comments provided positive feedback on the quality of the underlying relationship(s) (20% of comments mentioned a good working relationship with NHS England in this area, while 10% mentioned the area team specifically) and the general openness of discussions with their area team – albeit then often going on to identify areas for improvement.

*The conversation was open and honest and in fact felt as though it was of a peer relationship. ... The conversation was clinically focussed because of our GPs presence, but the AT had little clinical response to it. The challenges are*

<sup>6</sup> Caution – very low base size – results are indicative only

*that the balanced scorecard fails to accurately reflect progress it has strange thresholds which create red indicators despite good absolute performance.*

Managerial lead

*The assurance process was handled professionally and sensitively at all times. However, where there were specific issues with finance and clear examples of CCGs being treated inequitably, this was not addressed or responded to.*

Managerial lead

*In area team-CCG specific meetings, the conversations felt very open and honest and the feedback at the end was fair. The process could be improved by building in CCG to area team feedback and a sense of mutual accountability.*

Managerial lead

Free text comments on how the CCG and NHS England worked together during the recent assurance process were mixed, however, perhaps reflecting the early stage of this process. Whereas 14% of those commenting mentioned that the assurance review process works well, 16% said that it does not. Clinical leads were less likely to offer a positive assessment of the review process.

*My CCG developed massively and rapidly as a result of the assurance process. This was supported by NHS England locally but was achieved largely through internal CCG response to the process. In the process of removing the conditions, the area team worked well with us and used links increasingly with other CCGs to share lessons. This aspect is improving.*

Managerial lead

Many highlighted where the CCG had experienced challenges with the current system. Importantly, a number of respondents felt that the scorecard approach over emphasises financial and other 'hard' metrics or targets at the expense of focusing on what is best for patients (10%). At times, this affected the ways of working, as CCG leads did not always feel the interests of patients were put first or that the assurance process allowed them to focus on the differences they could make to patients. Furthermore, some CCG leads expressed dissatisfaction with the limitations of the scorecard approach, and did not always think it allowed them to demonstrate the differences they had made.

*The Area Team have demonstrated that they understand the challenges we face and that these cannot be overcome in a short timeframe, considering the position we have inherited and the health challenges of a deprived and diverse population. They have supported us in doing the difficult things. However overall we are disappointed with the balanced scorecard pass/fail approach as it does not recognise improvement and direction of travel. We know the Area Team understand our priorities and the progress we are making but this is not followed through in the scorecard.*

Managerial lead

*The assurance process did not allow for any exploration of the co-commissioning areas of specialised commissioning or primary care and this meant that the meeting felt one way but also missed a number of key areas.*

Managerial lead

Specific suggestions for improvement were also made by some reflecting the challenges identified above. In particular these tended to mention a need to allow CCGs sufficient time to prepare for assurance meetings (12% mentioned that they felt communication from NHS England was poor in this area), greater emphasis to be given to 'soft' outcomes, and similarly more weight to be given to local intelligence in the final scorecard report.

*It went smoothly but a reasonable idea around what would be asked would have helped us prepare more and have the data and information at our fingertips.*

Clinical lead

*Very little about the outcomes for patients ... What would help? Review the targets and make them more meaningful in term soft outcomes rather than outputs. Have better trajectories for the longer period – not the 6-12mths. Localise measures – not all areas need to concentrate on the same things, and targets lead to perverse actions and incentives that miss the point.*

Clinical lead

## 6. Co-commissioning primary care

This chapter of the report explores how the ways of working are being implemented by NHS England when co-commissioning primary care.

CCG leads offered mixed views of primary care commissioning. Although many felt that they share responsibility with NHS England for securing the best outcomes for patients, they did not feel like there was a shared vision for primary care. NHS England's approach was generally thought to be collaborative but leads were less confident in their understanding of respective roles and responsibilities.

This seemed to be tied to concerns about the design of the system, allied to perceptions that CCGs, with their improved local knowledge, may be better placed to commission these services. Some CCG leads also expressed a belief that NHS England does not have sufficient resource for primary care commissioning, strengthening their view that it should be the remit of CCGs. Even if such a change in the system is not possible, the findings suggest that greater clarity and more communication between CCGs and NHS England would strengthen how the ways of working are implemented around primary care.

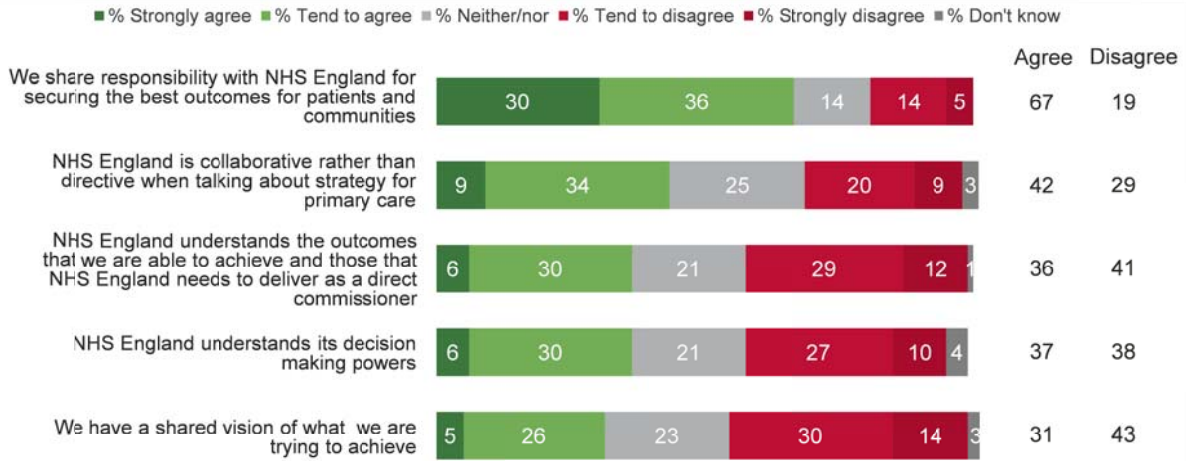
CCG leads had some concerns around primary care co-commissioning and this appeared to be an area where the ways of working were at times coming under pressure. CCG leads were very clear that they are jointly responsible with NHS England for securing the best outcomes through primary care commissioning; two in three agreed that they share responsibility with NHS England for this (67%). Despite this shared responsibility, however, CCG leads did not feel there was a shared vision with NHS England of what they were trying to achieve (43% disagreed that there is a shared vision and only 31% agreed). This suggests some misalignment of primary care commissioning expectations among NHS England and CCGs.

Similarly, CCG leads seemed less confident in the respective roles and responsibilities of NHS England and CCGs around primary care, with opinions relatively divided. For example, similar proportions agreed (36%) and disagreed (41%) that NHS England understands the outcomes that CCGs are able to achieve and those that NHS England needs to deliver as a direct commissioner. In addition, equal proportions agreed (37%) as disagreed (38%) that NHS England understands its decision making powers. CCG leads were a little more positive about the approach NHS England takes to talking about primary care strategy, with two in five agreeing that NHS England is collaborative rather than directive (42%) – although still three in ten leads disagreed (29%).



# Primary Care Commissioning

**Please now think about the relationship between NHS England and CCG. Thinking now about the commissioning of primary care, to what extent do you agree or disagree with each of the following statements?**



Base: All responses (273); 9th October – 11th November 2013

Source: Ipsos MORI

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There were noticeable differences in views across the regions. Whereas CCG leads in the Midlands and East region tended to be more positive about their relationship with NHS England in primary commissioning, those in London were less confident. Typically, differences emerged when discussing collaboration between CCGs and NHS England, suggesting that the quality and closeness of relationships varies by region. For example, leads from the Midlands and East were most likely to agree that they share responsibility with NHS England for securing the best outcomes for patients and communities and have a shared vision of what they are trying to achieve, that NHS England understands its decision making powers and that it understands the relative outcomes each organisation is able to achieve. CCG leads in London<sup>4</sup> were least likely to agree with each of these statements.

Views of primary care commissioning were generally consistent between different functions. Two key points of differences emerge, however. Managerial leads were more likely to have a positive view of NHS England’s approach towards forming strategy; approaching three in five agreed that NHS England is collaborative rather than directive when talking about strategy for primary care (57%), compared with only one in three clinical leads (33%) and financial leads (33%). In contrast, clinical leads were more likely to disagree with this statement (37%, compared with 26% of financial and 23% of managerial leads). Financial leads, meanwhile, were also more likely than their counterparts to think that NHS England understands its decision making powers (49% vs. 35% of clinical leads and 30% of managerial leads).

Leads responding on behalf of CCGs with conditions were more likely to agree that they share responsibility with NHS England for securing the best outcomes for patients and



communities (70% agreed, compared with 55% of those without conditions). This may reflect their closer relationships with their area teams while working to discharge their conditions.

When asked to provide more comments on co-commissioning primary care, CCG leads emphasised the structure of primary care commissioning as a significant challenge that needs to be overcome. There was a feeling among CCG leads that roles, responsibilities and accountabilities are not always clear at present. Some CCG leads said that CCGs are currently driving forward primary care rather than NHS England, and that commissioning should in the future sit with CCGs (15%).

*Area Teams are not good at commissioning primary care and have no idea how to develop it as a cost effective future provider. CCGs need to be able to develop primary care as providers and place them in a position where they can compete on a level playing field in the market.*

Clinical lead

*The regional team is actively supporting the strategy work but nothing has been forthcoming from the LAT team which is where I think it would be better placed. Have had some good joint working with the LAT team around trying to unpick some of the estate issues. Again the biggest issue for the LAT team in primary care is their capacity. So think there needs to be a rethink on the model.*

Managerial lead

Overall, one in four of those providing comments (25%) referred to a need for greater financial support and/or more resources within the commissioning system. In particular, there was a feeling that area teams are struggling to act as a primary care commissioner, as opposed to a contractor of primary care, and that responsibilities are deflected to CCGs. This further drove the perception that CCGs should play a greater role here.

*There are significant local concerns regarding the capacity and capability of NHS England to truly fill its co commissioner role with the CCGs. The relationships that NHS England has with GP Practices are poor and cause significant frustration at Practice level.*

Managerial lead

*This is a more complicated area. The primary care team is too small, GPs don't understand the difference between the CCG role and the AT role (something we are both working on addressing) and there is a complete lack of clarity around primary care quality. We are working with AT colleagues to agree how to address these areas.*

Managerial lead

Related to this, 15% of CCG leads expressed concerns about budget issues, saying that financial arrangements need to be improved, asserting that the onus of meeting any shortfalls is currently being placed on CCGs.

*Strategy is not clear for primary care, nor the impact of funding changes. It's hard to engage with anyone who can answer sensibly or honestly. Primary care*

*finance is awful. GPs can't get answers to outstanding issues, finance give incorrect answers and blame the CCG, we have to point out what the guidance says and limit the damage done with GPs. This is the norm.*

Financial lead

Despite concerns about their resourcing, CCG leads said that regional and area teams do offer support to CCGs and that CCGs have good working relationships with area teams (11%). This is tempered, however, by a perception that while relationships are generally positive, NHS England generally (12%) and area teams specifically (10%) do not have the resources to manage primary care commissioning.

Perhaps as a consequence of these concerns about area teams' resourcing, there is also a belief that primary care strategy is weak (17%). This casts light on the earlier finding that while CCGs feel they have shared *responsibility* for primary care commissioning, they do not have a shared *vision*.

*We have a shared understanding of the responsibility and challenge of commissioning effective and responsive primary care but the practicalities of making it work locally are slow to develop.*

Financial lead

In particular, CCG leads highlighted the importance of the local agenda with regard to primary care commissioning – something they felt was occasionally absent from NHS England's approach.

*NHS England is not resourced to work as closely with Primary Care as PCTs were. Therefore, there is no localism in their approach. We have resourced up to compensate for this & liaise with them as & when necessary. The risk is that national strategy will push primary care in the opposite direction to how we need it to go & may disengage practices.*

Financial lead

*I think NHS England are struggling with this. However, that is not surprising as they have been given what feels like an impossible task. Commissioning primary care requires good local knowledge about local transformation programmes, patterns of primary care provision in the area etc, as well as the relationships to underpin implementation.*

Managerial lead

This can be compounded by perceived poor communication (15%) and a lack of collaboration, and some CCG leads expressed a belief that NHS England takes an approach that is too directive.

*When talking about direct commissioning NHS England may sound collaborative, but the tone and the detail is usually directive and on a 'Parent-Child' relationship basis. NHS England does not have the capacity or capability to adequately manage primary care commissioning, It has no resources*

*delegated to it and consequently is increasingly regarded as irrelevant by primary care and CCGs.*

Managerial lead

In order to build a sense of collaboration, NHS England will need to ensure that it provides a clearer message to CCGs around roles and responsibilities: those leads who neither agreed nor disagreed that NHS England is collaborative rather than directive typically felt that responsibilities need to be more carefully delineated.

*Recently we have had much more positive talks about how we can commission primary care jointly. Up to now there appears to have been a disconnect between the elements of direct commissioning done by the AT and the elements e.g. LES and other primary care development that we have been engaged in.*

Clinical lead

## 7. Co-commissioning specialised services

This chapter of the report explores relationships between NHS England and CCGs around the co-commissioning of specialised services.

The ways of working appear to be difficult to implement with respect to co-commissioning specialised services. Relationships appeared less collaborative than for other roles, with CCG leads suggesting that more information could be shared and more could be done to listen to their views.

CCGs sometimes ascribed this sense of remoteness to working with a separate area team with whom they do not have established relationships. They also express concerns about how local considerations are incorporated into specialised commissioning plans.

More so than for co-commissioning primary care services, the survey findings suggest that the ways of working are put under particular pressure for co-commissioning specialised services. More leads disagreed than agreed with each of the statements relating to specialised commissioning.

As for primary care commissioning, CCG leads did not feel that they share a vision with NHS England of what each are trying to achieve for the local community. While just over half disagreed that there was a shared vision (54%), only around one in five agreed (18%).

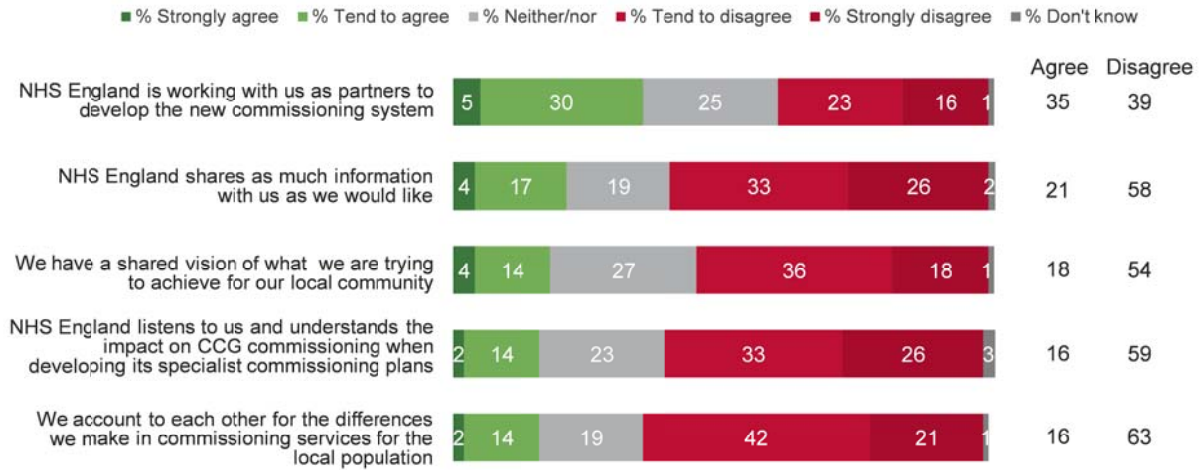
The relationship around co-commissioning specialised services did not seem as collaborative as relationships around other roles. Although more than one in three agreed (35%) that NHS England is working with them as partners to develop the new commissioning system, a similar proportion disagreed (39%). The majority of CCG leads also felt that NHS England should share more information with them, with three in five CCG leads disagreeing that NHS England shares as much information with them as they would like (58%).

Similarly, CCG leads also believed that NHS England could do more to listen to them. Three in five CCG leads (59%) disagreed that NHS England listens to them and understands the impact on CCG commissioning when developing its specialist commissioning plans.

Reflecting apparent lower levels of collaboration, CCG leads tended not to think the CCG and NHS England account to each other for the differences they make in commissioning services for the local population. While around two in three said the two organisations do not account to each other (63%), only 16% agreed that they do. This suggests that greater collaboration on specialised commissioning could enhance outcomes for local populations.

## Specialised Commissioning

**Please now think about the relationship between NHS England and CCG. Thinking now about how the area team has worked with you on specialised commissioning arrangements, to what extent do you agree or disagree with each of the following ...?**



Base: All responses (273); 9th October – 11th November 2013

Source: Ipsos MORI

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Leads representing CCGs in London<sup>7</sup> (19 of 28 leads) were more likely to feel that they don't have a shared vision with NHS England of what they are trying to achieve for their local community than CCG leads in the North (49%) and South (48%). Views were polarised in the Midlands and East region, with leads in this area marginally more likely to disagree (59%), and more likely to agree (24%) than those in the South and North.

Some differences also emerged between CCG functions. Clinical leads were typically more positive than financial and managerial leads when discussing issues around communication and mutual accountability with NHS England (although still negative overall). While they still disagreed with the statement overall, clinical leads were more likely than managerial leads to agree that 'NHS England listens to us and understands the impact on CCG commissioning when developing its specialist commissioning plans', and that 'We have a shared vision of what we are trying to achieve for our local community'. Similarly, clinical leads were less likely to disagree that 'We account to each other for the differences we make in commissioning services for the local population'.

Analysis of the additional comments CCG leads provided supports the idea that relationships between CCGs and specialised commissioning team are more remote.

*We are working well with our Area Team on the services they directly commission and they also work well with our Local Authority. ... However we have no direct contact between the CCG and Specialist Commissioning – which*

<sup>7</sup> Caution – very low base size – results are indicative only

*does not sit in our Area Team's remit. The specialist commissioners are very remote and we have had very little contact.*

Managerial lead

In part, this was because they felt communications around specialised commissioning are weak (29%), saying that they do not have the same amount of one-to-one contact with these teams (although they recognised that resource limitations restrict how effectively specialised commissioning teams can work with each CCG).

*It has been more difficult to hold meaningful discussions with specialised commissioners. They tend to want to talk to a group of CCGs covering a wide area. This does create local opportunities. Some actions have been taken unilaterally between provider and specialised commissioning without CCG input e.g. temporary closure of services. However, team is willing to accept feedback and learn from mistakes and problems.*

Managerial lead

*There is a complete disconnect with the AT responsible for SCG. They do not have the capacity to work with individual CCG localities effectively. They focus on cost shifting (e.g. high cost MH patients) and do not share information.*

Financial lead

Others pointed to systemic challenges, in particular offering a view that NHS England makes decisions remotely (16%).

*Specialist Commissioning has been a nightmare generally through the transition – not helped by the difference in application of the rules by providers and the fact that area teams commission specialist services on value/ volume as well as service, so what is specialist in one provider may not be (and therefore a CCG commissioned service) in another provider... The area team determines what they are going to commission and CCGs left with the rest - no consultation.*

Financial lead

By contrast, those CCGs with more positive relationships emphasised efforts made by specialised commissioning teams to understand local requirements.

*We have a good working relationship with the NHSE team that leads on Specialised Commissioning locally. There needs to be more coproduction as there has initially been more NHSE led development than with CCG – there are now workshops to garner these views.*

Managerial lead

As a consequence of this, one in four CCG leads (24%) felt that their working relationship with NHS England is poor in this respect.

CCG leads also expressed concerns around budgetary and financial issues and how risk is shared between CCGs and NHS England (28%).

*Specialised commissioning does not communicate with us and is just a drain on our budgets as we carry their risk at present it seems.*

Clinical lead

*The process for the transfer of resources from CCGs to SCT was poor. It has left CCGs with huge financial pressures. SCT were unable to explain how the resources had moved and where they had gone. Future improvements need more open and transparent conversations to ensure we all understand how resources are moving to support changes in SCT Commissioning.*


Financial lead

Financial challenges in this area of commissioning seemed to represent a greater challenge for relationships between CCGs and NHS England because there is the same strength of relationships have not developed yet. Accordingly, some CCG leads talked about the breakdown of relationships with specialised commissioning teams.

### Working with partners

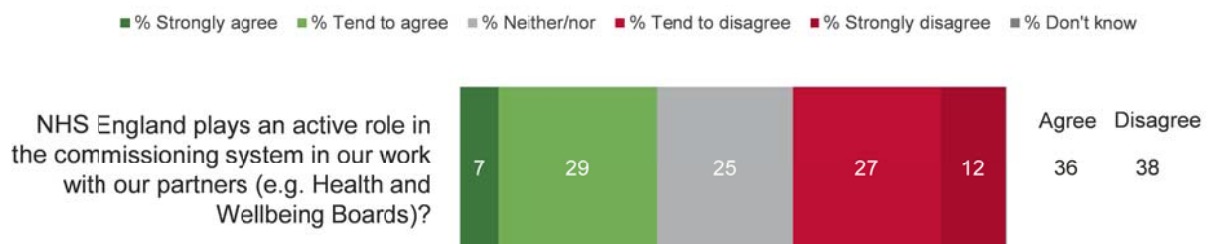
CCG leads were divided over the extent to which they think NHS England works well with their partners. An equal proportion of leads agreed (36%) as disagreed (38%) that NHS England plays an active role in the commissioning system in their work with their partners (e.g. Health and Wellbeing Boards).

## Working with Partners


11

*Please now think about the relationship between NHS England and CCG. To what extent do you agree or disagree with the following statement ...?*

*NHS England plays an active role in the commissioning system in our work with our partners (e.g. Health and Wellbeing Boards)?*



Base: All responses (273); 9th October – 11th November 2013

Source: Ipsos MORI

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Views of NHS England’s wider relationships differed by role and region. Clinical leads were more likely to disagree that NHS England plays an active role (47%, compared with 36% of

managerial leads and 31% of financial leads). Geographically, the strongest agreement with this statement was in the Midlands and East region (51%), while CCG leads in the South (49%) and London<sup>8</sup> (20 of 28 CCG leads) were most likely to disagree. This suggests that the level of engagement NHS England has with the wider healthcare system is not consistent across the country.

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<sup>8</sup> Caution – very low base size – results are indicative only



## 8. Discharge of conditions

This chapter focuses on CCGs that have conditions remaining on authorisation, exploring how supported CCGs feel in discharging these conditions. Due to the limited number of answers we received from CCGs with conditions (58 leads answered on behalf of CCGs with conditions), analysis of differences across region and lead type has not been possible in this section.

The ways of working seemed to be modelled well around the relationship between NHS England and CCGs with conditions, and work to discharge those conditions.

Discussions were thought to be honest and open, with NHS England committed to helping the CCG discharge the conditions and challenging and supporting them to do so.

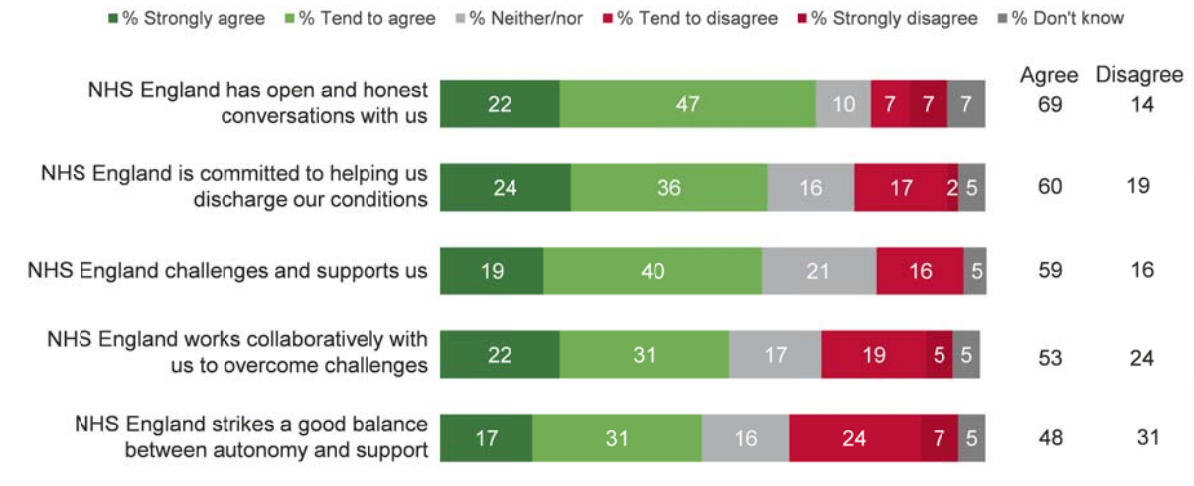
Overall, CCG leads from CCGs that were authorised with conditions were positive about how the ways of working have been modelled when working together to discharge conditions. Leads were particularly positive about honesty and openness – seven in ten leads (69%) agree that NHS England has open and honest conversations with them.

There is more of a split regarding whether NHS England strikes a good balance between autonomy and support, although this remains positive. Just under half agree that they strike a good balance (48%), while 31% disagreed.

Relationships appeared to be collaborative, with just over half of leads in CCGs with conditions thinking NHS England works collaboratively with them to overcome challenges (53%). In addition, three in five agreed that NHS England is committed to helping them discharge their conditions (60%) and that NHS England challenges and supports them (59%).

## Working with NHS England to discharge conditions

**As a CCG with formal conditions and thinking about what NHS England does to support you to discharge your conditions, to what extent do you agree or disagree with the following statements?**



Base: All responses from CCGs with conditions (58); 9th October – 11th November 2013

Source: Ipsos MORI

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When providing additional comments, many were positive about the efforts of their area teams to understand and engage with CCGs seeking to discharge conditions (27%).

*The Area team have helped us remove our planning conditions by undertaking an in depth review of our programme management. They understand our organisation, have challenged but have been very supportive.*

Financial lead

However, one or two remarked on the wider context within which they work and felt that differences between the financial challenges in different CCGs were not taken into account.

*Authorisation was supposed to be a fair process and yet the conditions that relate to the financial challenge are not predicated on a level playing field*

Clinical lead.

## 9. Regional findings

This chapter of the report provides a summary of findings for each region. It focuses on where there were differences between each region and the national findings, to enable readers to build an overall picture of where there may be different practice and relationships across the regions. Please note that the number of responses within each region is fairly low (always under 100 responses), so findings should be treated with caution. Differences are only commented on where they are significant for the North, Midlands and the East, and the South. Please also note that not all CCG leads provided free text comments; those who did so may hold stronger opinions than those who chose not to add further detail.

### 9.1 London

Please note that the number of responses in London is very low (28, of a total of 80) and so the findings must be treated with particular caution. The results for London are therefore presented as more of a qualitative analysis, although all differences to the national picture commented on are significant.

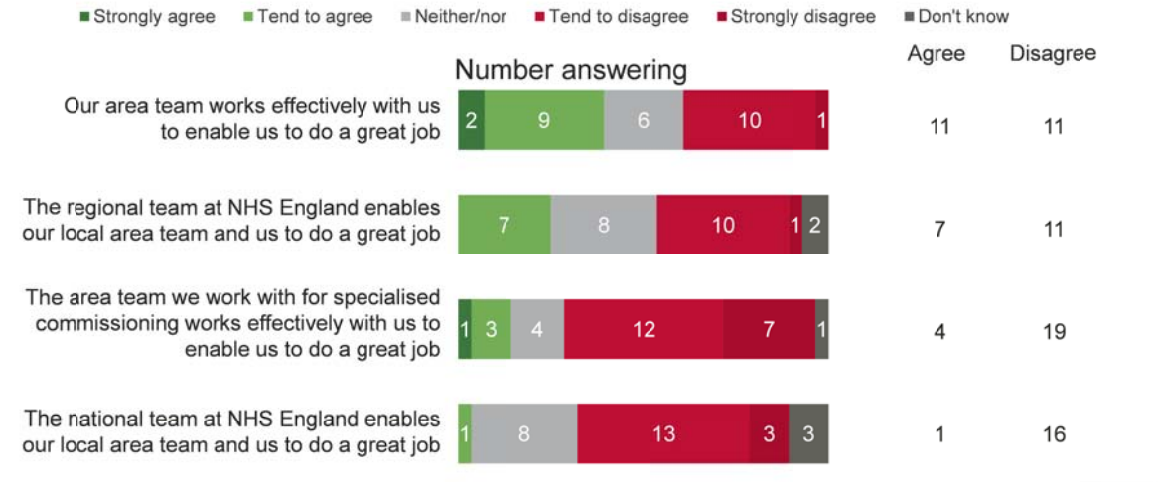
|   |     |
|---|-----|
| Number of CCGs in the region            | 32  |
| Number of CCGs represented in responses | 21  |
| Number of potential respondents         | 80  |
| Number of actual respondents            | 28  |
| Response rate                           | 35% |

CCG leads in London were consistently less positive than CCGs in the other regions. Local relationships seemed to be working less well than elsewhere in England. Only 11 of the 28 agreed that their NHS England team works effectively with them to enable them to do a great job, while the same number disagreed. On the national team, 16 of the 28 CCG leads in London disagreed that they enable their NHS England team and the CCG to do a great job.

## London: Overall relationship with NHS England



**Please now think about the relationship between NHS England and CCG. Overall, to what extent do you agree or disagree with each of the following statements...**



Base: All responses (28); 9th October – 11th November 2013

Source: Ipsos MORI

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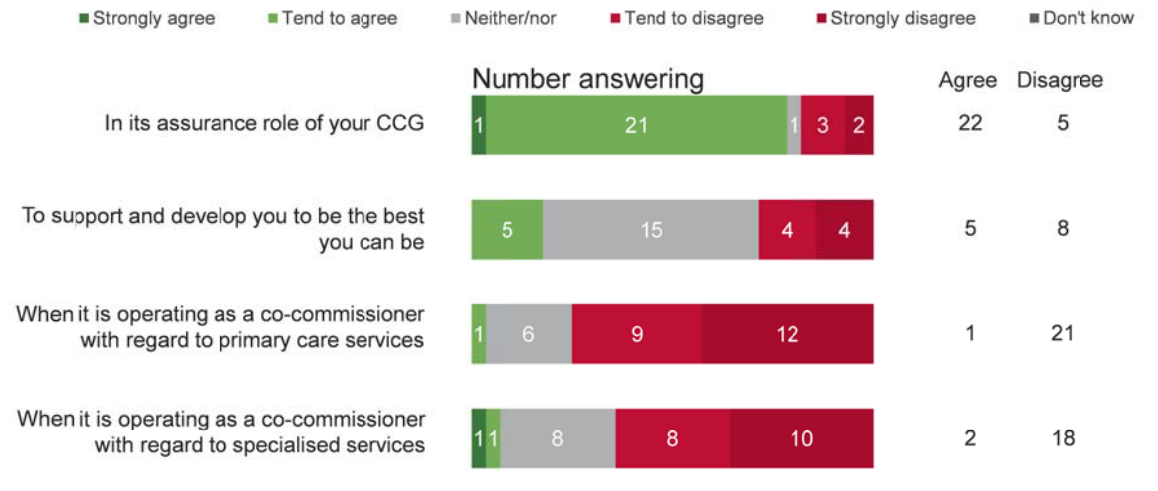
In the free text comments, the themes that emerged were around a lack of clarity, either in roles or in specific policies. As in other regions, co-commissioning was mentioned as a specific area of concern.

*It has been very difficult to engage with specialised commissioning and understand what is being commissioned from our local acute provider – a major teaching hospital – and our contract negotiations and management have been hampered by this. Our local team are not helped by NHS England and often seem disempowered and unable to make decisions in the absence of guidance.*

*The reason for the answer is that the interaction is variable and there is still some uncertainty from NHS England about the functions they should be performing and trying to pass some of those into the CCG without the resource.*

## London: Overall views of NHS England’s delivery of roles

*Please now think about the relationship between NHS England and CCG. And to what extent do you agree or disagree that NHS England works effectively with you ...?*



Base: All responses (28); 9th October – 11th November 2013

Source: Ipsos MORI

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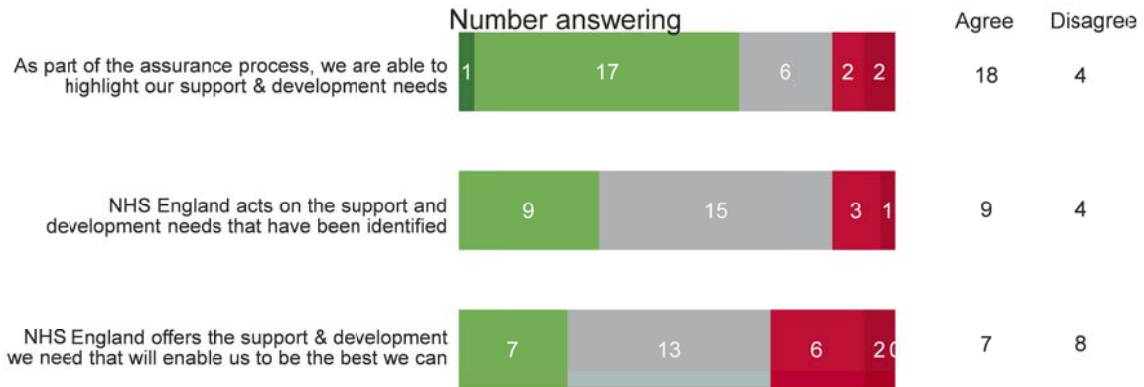


Turning to each of NHS England’s roles in more detail, CCG leads in London tended to be less positive about support and development. In particular, only five of the 28 agreed that NHS England works effectively to support and develop them to be the best they can, while 15 neither agreed nor disagreed. Views were divided on having the space and freedom to innovate, with eight agreeing that NHS England provides them with this and nine disagreeing; 11 neither agreed nor disagreed. Similarly, only eight of the 28 agreed that NHS England works with them as partners and six that it strikes a good balance between autonomy and support. The free text comments tended to reflect those made at a national level.

## London: Support and development (1)

Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?

Strongly agree Tend to agree Neither/nor Tend to disagree Strongly disagree Don't know



Base: All responses (28); 9th October – 11th November 2013

Source: Ipsos MORI

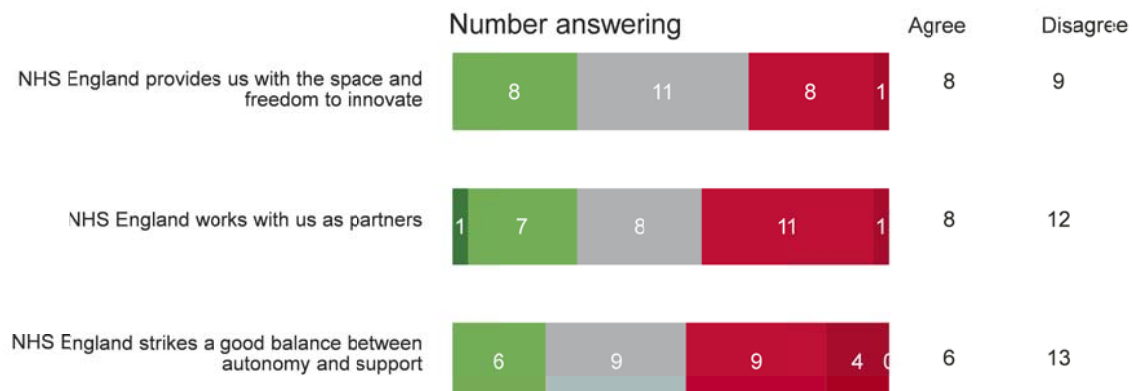
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## London: Support and development (2)

Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?

Strongly agree Tend to agree Neither/nor Tend to disagree Strongly disagree Don't know



Base: All responses (28); 9th October – 11th November 2013

Source: Ipsos MORI

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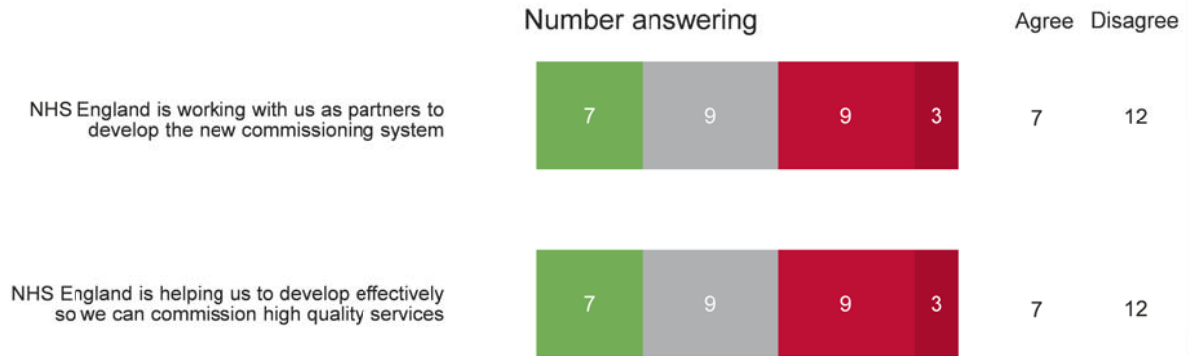




## London: Support and development (3)

*Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?*

■ Strongly agree ■ Tend to agree ■ Neither/nor ■ Tend to disagree ■ Strongly disagree ■ Don't know



Base: All responses (28); 9th October – 11th November 2013

Source: Ipsos MORI

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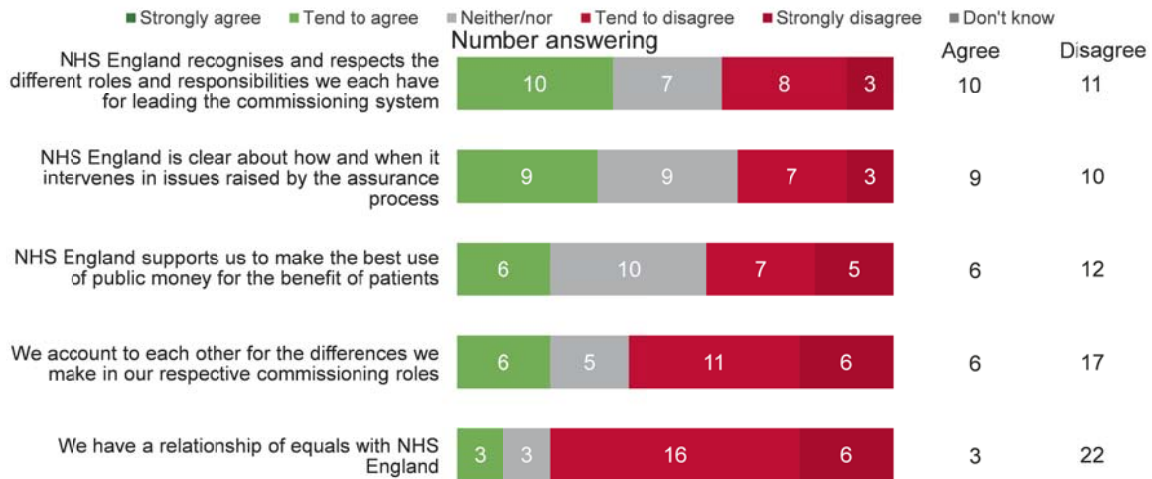
On assurance, CCG leads in London tended to be less positive. For example, 22 of the 28 disagreed that they have a relationship of equals with NHS England. They were also more likely to say that NHS England does not support them to make the best use of public money for the benefit of patients (12 disagreed), while they were more undecided about whether or not NHS England focused on what is right for patients in the most recent assurance process (12 neither agreed nor disagreed). Perhaps reflecting seemingly poorer relationships with the national team, more so than in other regions CCG leads questioned how their NHS England teams interact with the wider NHS England organisation. While 11 disagreed that their team drew on support from the wider NHS England organisation when challenges were identified, nine disagreed that their team communicated and acted on challenges identified by the assurance process with the wider NHS England organisation.



## London: General relationship with NHS England over assurance

NHS Clinical Commissioners  
7

*Thinking about your general relationship with NHS England around assurance and how you hold each other to account, to what extent do you agree or disagree with each of the following ...?*



Base: All responses (28); 9th October – 11th November 2013

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## London: Views of the most recent assurance process

NHS Clinical Commissioners  
8

*Thinking now about NHS England's most recent assurance process with your CCG, to what extent do you agree or disagree with each of the following statements?*



Base: All responses (28); 9th October – 11th November 2013

Source: Ipsos MORI

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As nationally, in the free text comments, CCG leads talked about a lack of two-way accountability, although examples were given of where mutual assurance has been implemented or relationships are improving in this area.

*Area team has reverted to SHA behaviour and is acting as performance manager NOT co-commissioner. This might be, in part, due to their lack of clinical leadership.*

*There is not much of a relationship, on the whole we just get on with things, there are still a lot of muddles about budgets.*

*CCG works well with the assurance team but the accountability tends to be one-way. Primary Care commissioning clearly have capacity problems so limited engagement. Specialised Commissioning absent. CCG looking to work with NHS England assurance team to create a more equal dialogue.*

One or two CCG leads mentioned a lack of clinical involvement in the process, and a concern that data requirements around A&E are not aiding improvements.

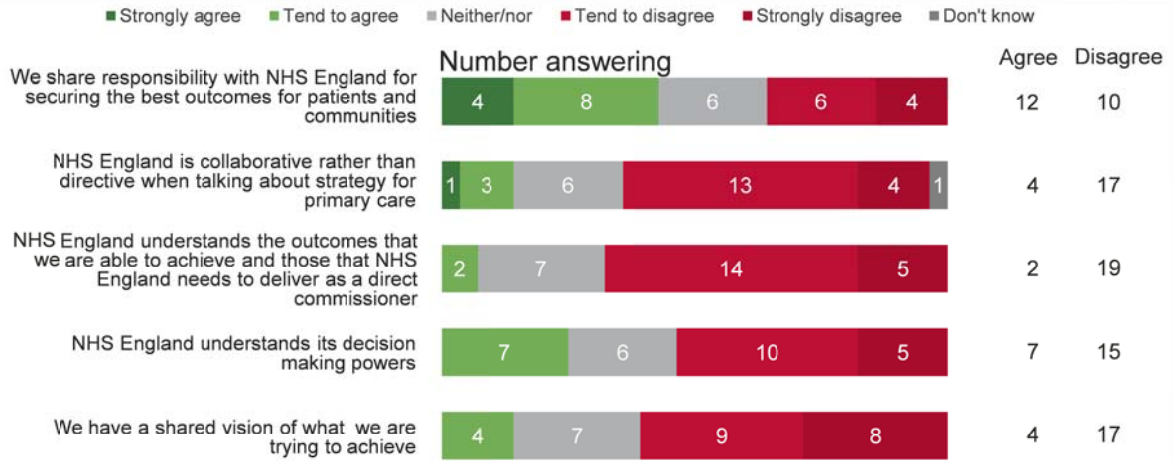
*It was pleasant but muddled around who was responsible for some of the performance issues identified sometimes NHS England doesn't seem to recognise we aren't the successor to the PCT nor are we commissioners of practices as providers under the core contract no focus on outcomes – too much on traditional performance stuff. Very little interest in clinical quality. Only one clinician fielded by NHS England.*

*One area where the usual ways of working have been cut across is around urgent care A&E and four hour waits – the level of intervention reporting etc. has increased to a point of impacting on the system delivery. We believe this to be centrally driven but the monitoring taking place will not support improvement of the issues it just increases workloads.*

On many areas of primary care co-commissioning, CCG leads based in London were more negative about working relationships with NHS England; 21 of the 28 disagreed that it works effectively with them around primary care commissioning. Other specific areas in which relationships seemed less strong than in other regions included NHS England understanding the outcomes that the CCG is able to achieve and those that NHS England needs to deliver as a direct commissioner (19 disagreed), having a shared vision (17 disagreed) or a collaborative rather than directive approach (17 disagreed).

## London: Primary care co-commissioning

**Please now think about the relationship between NHS England and CCG. Thinking now about the commissioning of primary care, to what extent do you agree or disagree with each of the following statements?**



Base: All responses (28); 9th October – 11th November 2013

Source: Ipsos MORI

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Free text comments suggested a lack of strategy and/or joint working (albeit not universally), along with limited capacity within NHS England. Some also mentioned funding as an area of concern.

*We have yet to have a discussion about primary care strategy.*

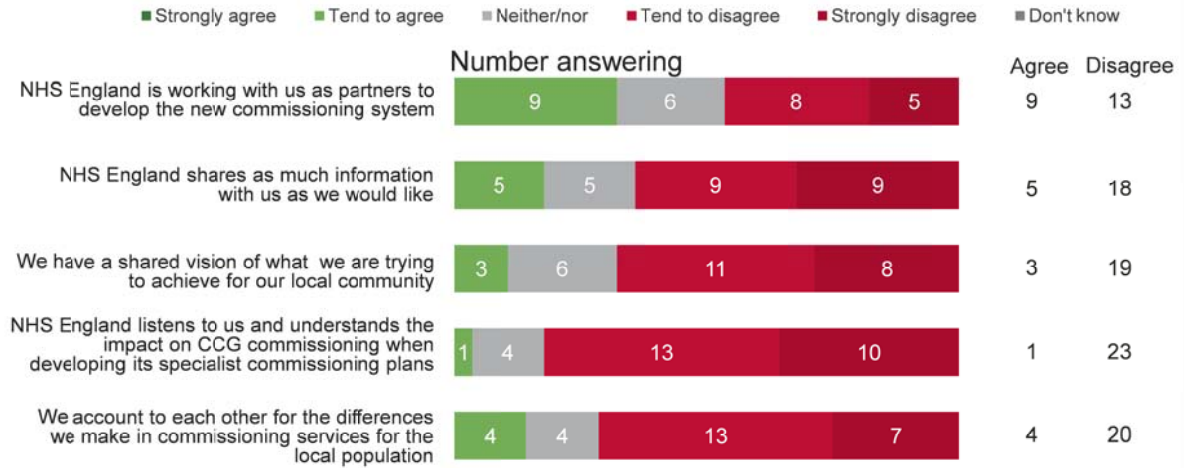
*The regional team is actively supporting the strategy work but nothing has been forthcoming from the LAT team which is where I think it would be better placed. Have had some good joint working with the LAT team around trying to unpick some of the estate issues. Again the biggest issue for the LAT team in primary care is their capacity. So think there needs to be a rethink on the model.*

*Joint working on developing primary care and review of enhanced services. Problems re funding of primary care and future of funding primary care estates have not helped.*

Views on specialised co-commissioning in London tended to be more in line with the national picture, although 23 of the 28 CCG leads in London disagreed that NHS England listens to them and understands the impact on CCG commissioning when developing its plans. Free text comments here reflected the national findings.

## London: Specialised co-commissioning

Please now think about the relationship between NHS England and CCG. Thinking now about how the area team has worked with you on specialised commissioning arrangements, to what extent do you agree or disagree with each of the following ...?



Base: All responses (28); 9th October – 11th November 2013

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Finally, 20 of the 28 CCG leads in London did not think that NHS England has an active role in the commissioning system in the CCGs' work with their partners.

## London: Working with partners

Please now think about the relationship between NHS England and CCG. To what extent do you agree or disagree with the following statement ...?

NHS England plays an active role in the commissioning system in our work with our partners (e.g. Health and Wellbeing Boards)?



Base: All responses (28); 9th October – 11th November 2013

Source: Ipsos MORI

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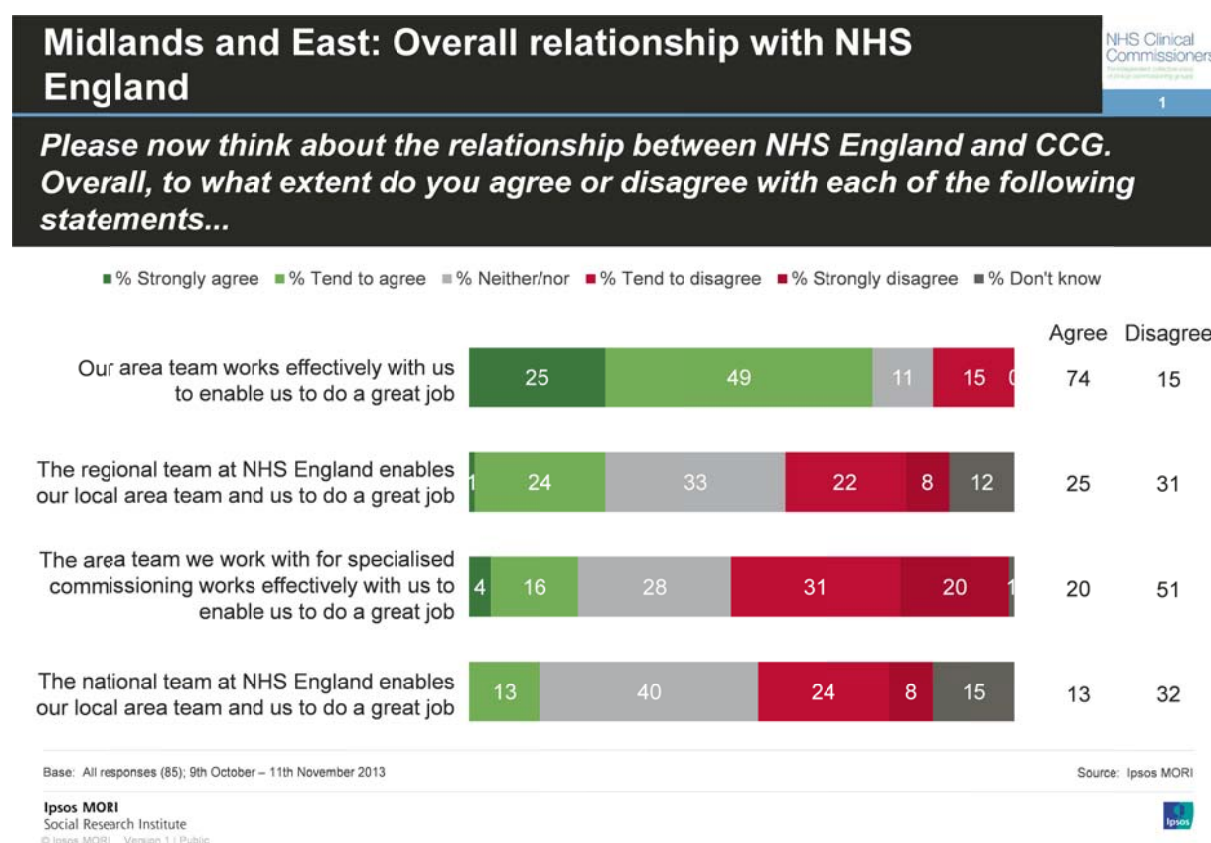


## 9.2 Midlands and East of England

|   |     |
|---|-----|
| Number of CCGs in the region            | 61  |
| Number of CCGs represented in responses | 52  |
| Number of potential respondents         | 172 |
| Number of actual respondents            | 85  |
| Response rate                           | 49% |

For CCG leads within the Midlands and East region of NHS England who responded to the survey (85 of 172), the findings were generally in line with those across England as a whole. Differences did emerge in some areas, and these are highlighted within this section of the report.

Working relationships between CCGs and area teams within Midlands and East seemed to be particularly strong. Three in four agreed that their area team works effectively with them to enable them to do a great job (74%, compared with 64% nationally). This included one in four who *strongly agree* (25%, compared with 16% nationally).



When looking at the free text comments, two in five of those who provided comments to explain their answers reiterated their good relationship with the area team (39%, compared with 26% nationally).



*As a CCG we've worked closely with our local area team and this has been beneficial for both organisations.*

However, there was also a sense – including among those who thought the relationship was good – that the area team were ‘middle men’ or lacked authority to make decisions (14%, compared with eight per cent nationally).

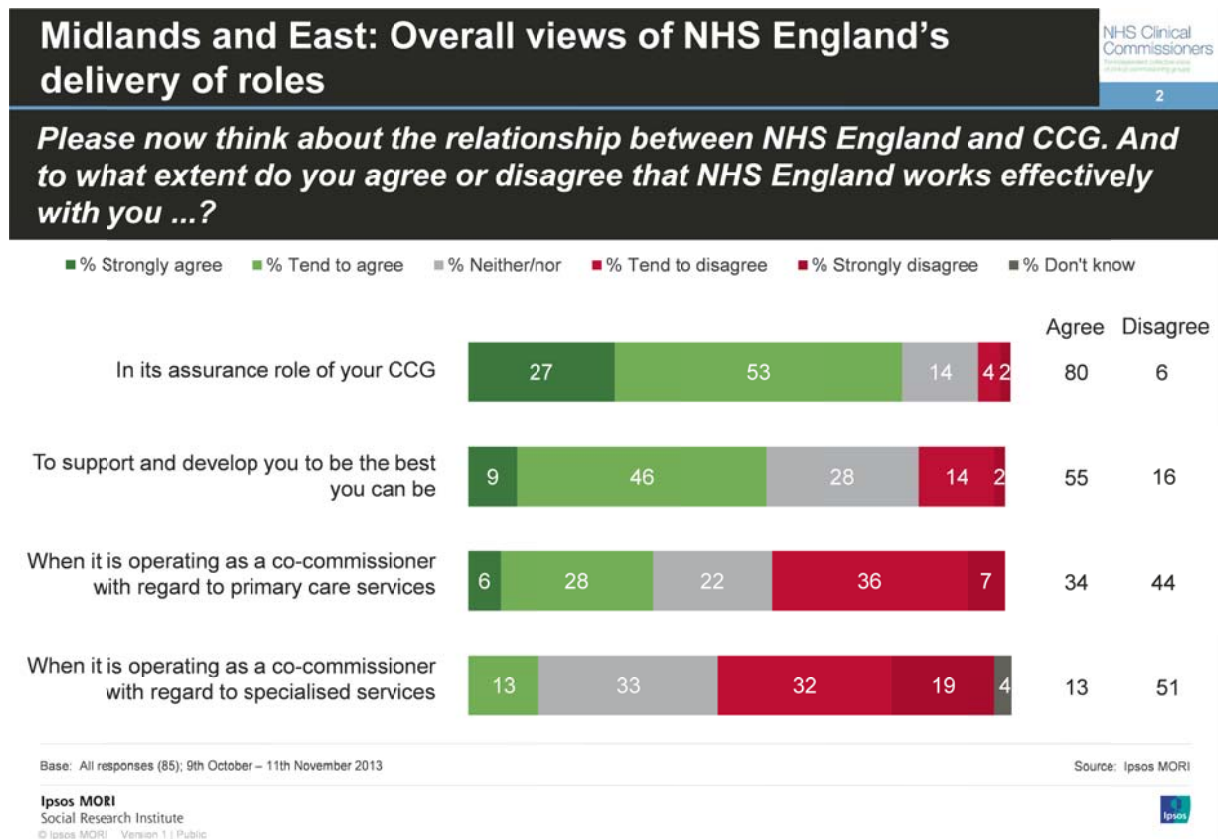
*Decision making about things which affect us seems too remote with area teams limited to influencing decisions as opposed to making them.*

*Really helpful supportive people at LAT, but the system is dominated by regional top down performance requests. Too many last minute requests for information.*

*It feels like Area Team recommendations are sometimes ignored.*

*We have had a good relation with the local team, they have been very responsive. The regional team are more conditional and have an old fashioned management style. There is not enough time for requests of information to be sent. NHS England team feel quite remote. We have to go through the regional team to get to them.*

Turning to each of NHS England’s roles, CCG leads’ views were broadly in line with the national average for both support and development and specialised co-commissioning.



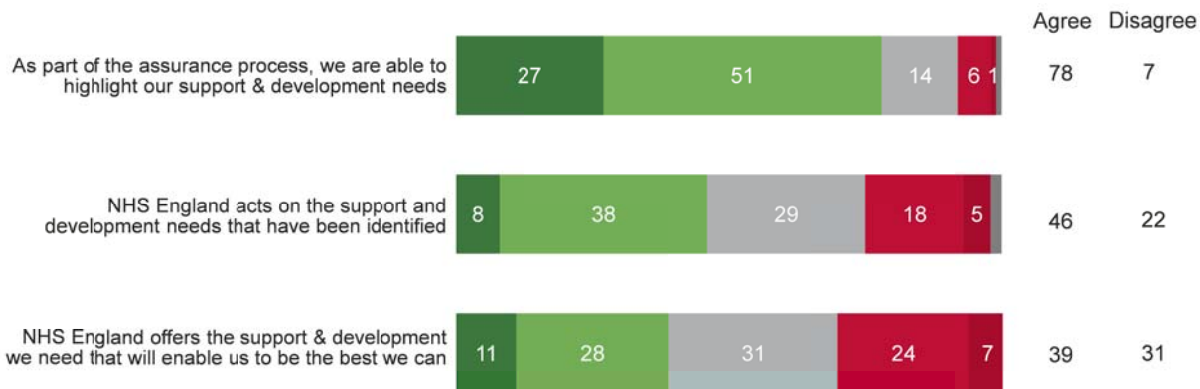
## Midlands and East: Support and development (1)

NHS Clinical Commissioners

4

Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (85); 9th October – 11th November 2013

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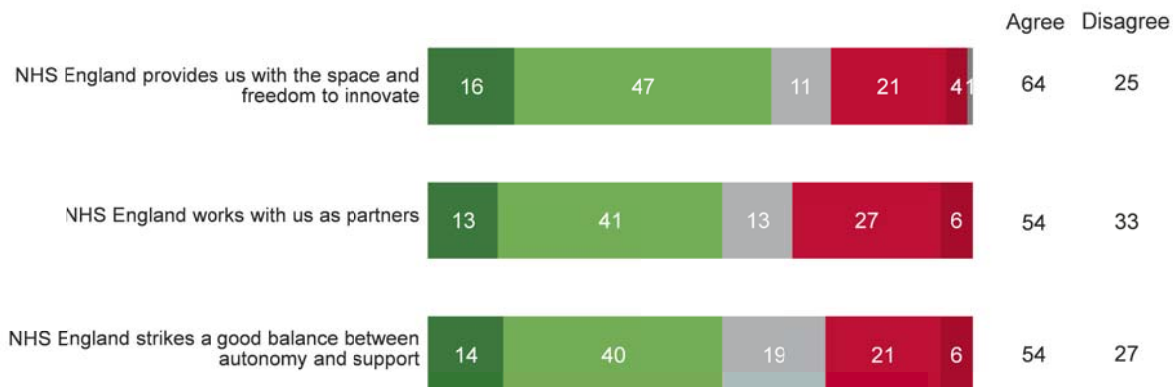
## Midlands and East: Support and development (2)

NHS Clinical Commissioners

5

Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (85); 9th October – 11th November 2013

Source: Ipsos MORI

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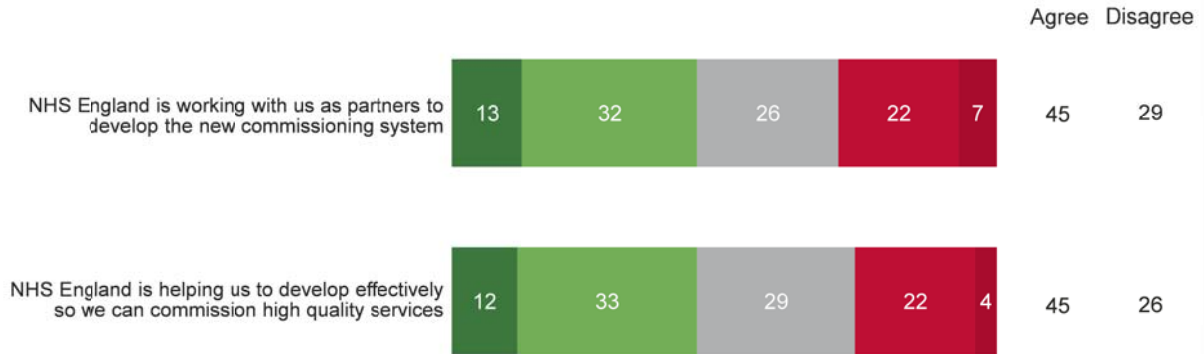




## Midlands and East: Support and development (3)

**Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?**

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (85); 9th October – 11th November 2013

Source: Ipsos MORI

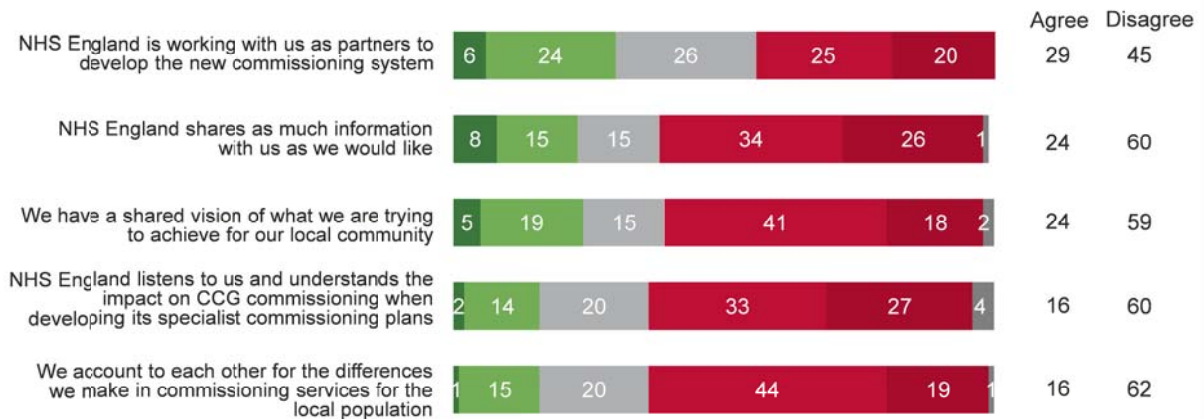
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## Midlands and East: Specialised co-commissioning

**Please now think about the relationship between NHS England and CCG. Thinking now about how the area team has worked with you on specialised commissioning arrangements, to what extent do you agree or disagree with each of the following ...?**

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (85); 9th October – 11th November 2013

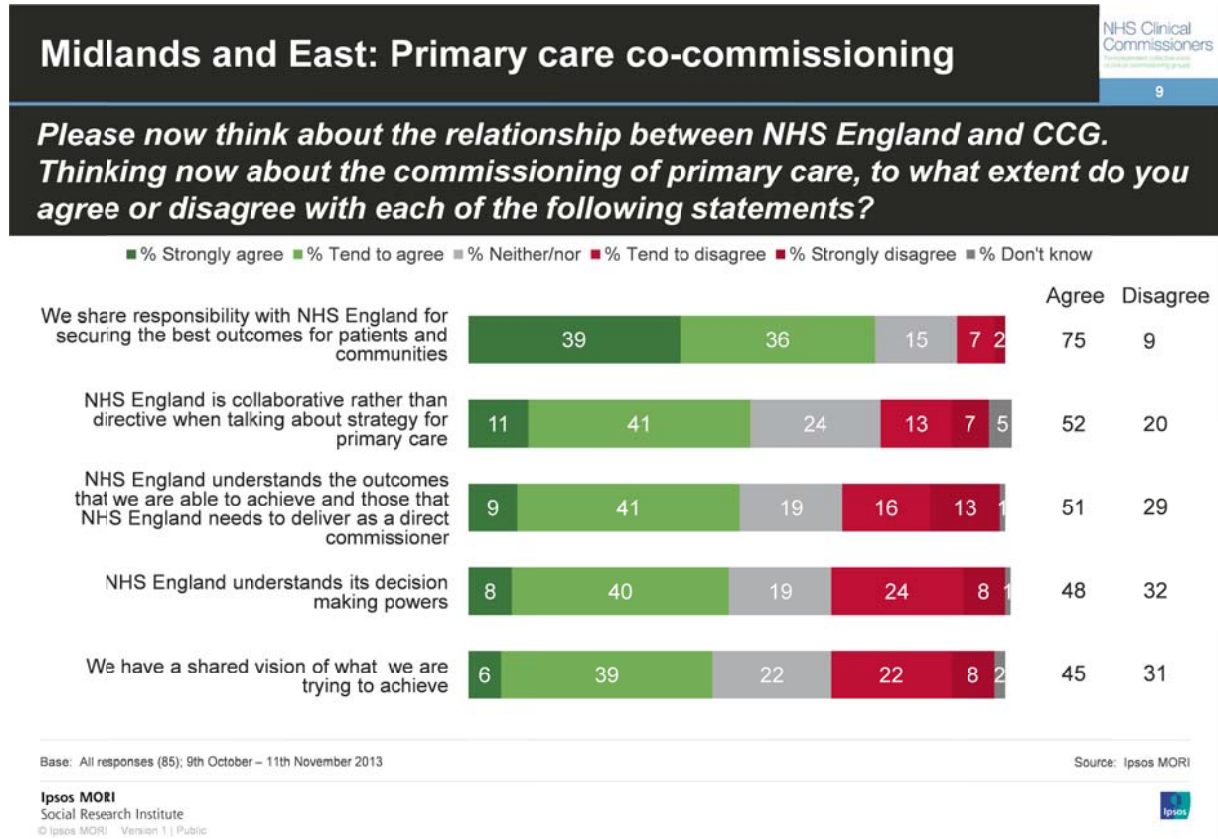
Source: Ipsos MORI

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In comparison with the other regions, relationships between NHS England and CCGs seemed to be particularly strong around co-commissioning primary care in the Midlands and

East region. Overall, one in three leads agreed that NHS England works effectively with their CCG when operating as a co-commissioner with regard to primary care services (34%, compared with 19% nationally). For each specific area of primary care commissioning asked about, CCG leads in the Midlands and East were significantly more positive than the national picture.



The free text comments provided point to good working relationships between NHS England and CCGs (34% of those providing a comment, compared with 26% nationally).

*The development of the primary care strategy is an example of partnership working and co-production. The primary care strategy development has been inclusive and the CCGs' views, visions and strategies have been taken into account. The difference with this piece of work as compared to some other areas is that this is partnership approach rather than a parent child approach.*

*To date, AT have adopted facilitative approach to emerging primary care models and have shown excellent support.*

However, many of the free text comments also suggested that there is further room for improvement and raised issues similar to those raised nationally, for example that primary care commissioning should sit with CCGs (13%, compared with 15% nationally). In particular, those in the Midlands and East who provided a free text response were more likely than in other regions to comment on a perceived lack of consistency and joined-up working with NHS England (17%, compared with 11% nationally).

*Joint working could clearly be improved in this area and needs to be given the important role that primary care has to play in transformation. AT capacity is an issue. More co-ordinated approach required in terms of vision and strategy.*

*NHS England are inviting us to engage in the formulation of their Primary Care strategies. Things which could be improved include the read across between our (separate) plans or perhaps the more formal need for a joined up plan.*

For some elements of the assurance process, the ways of working also seemed to be implemented well in the Midlands and East compared with other regions. In particular:

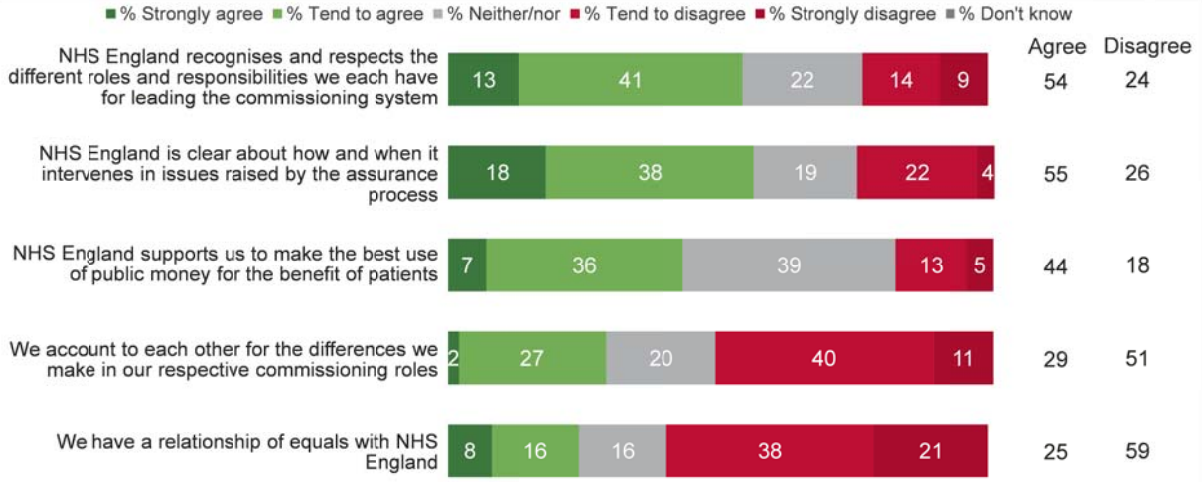
- There was stronger agreement that NHS England works effectively with them in its assurance role of the CCG (27% *strongly* agreed, compared with 17% nationally), while fewer disagreed it was working effectively with them here (six per cent, compared with 11% nationally).
- CCG leads in the Midlands and East were more likely to *strongly* agree they can highlight S&D needs as part of the assurance process (27%, compared with 18% nationally).
- They were also more likely to *strongly* agree that NHS England is clear about how and when it intervenes in issues raised by the assurance process (18%, compared with nine per cent nationally).
- In the most recent assurance process, around half strongly agreed that NHS England treated them with respect throughout the whole process (52%, compared with 42% nationally).
- The assurance process within Midlands and the East also seemed to be more patient-focused. While three in four agreed that NHS England focused on what was right for patients (75%, compared with 65% nationally), over half also agreed that the assurance process added value to what can be done to secure the best outcomes for patients (54%, compared with 40% nationally).

## Midlands and East: General relationship with NHS England over assurance

NHS Clinical Commissioners  
Improving the way we commission and assure

7

**Thinking about your general relationship with NHS England around assurance and how you hold each other to account, to what extent do you agree or disagree with each of the following ...?**



Base: All responses (85); 9th October – 11th November 2013

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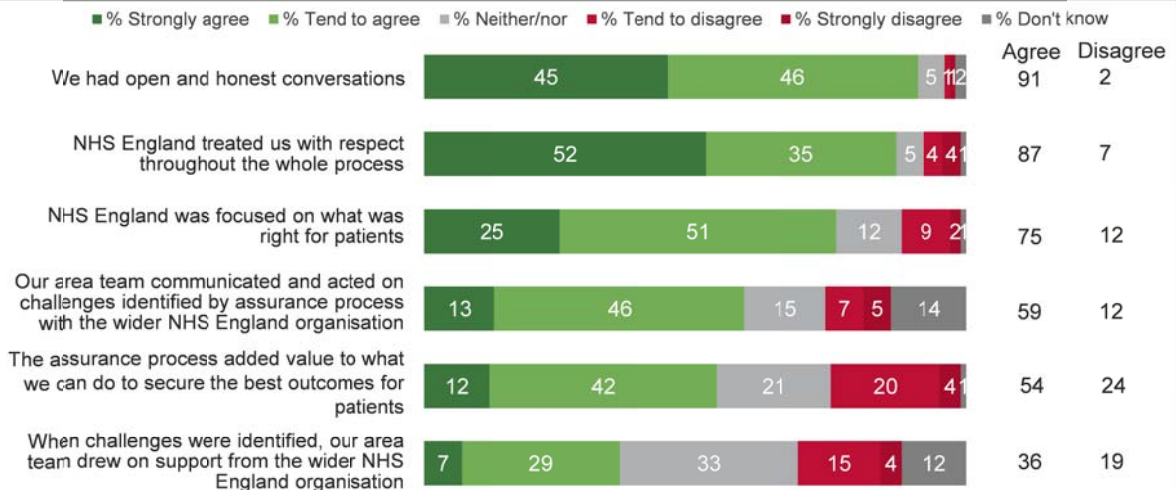


## Midlands and East: Views of the most recent assurance process

NHS Clinical Commissioners  
Improving the way we commission and assure

8

**Thinking now about NHS England's most recent assurance process with your CCG, to what extent do you agree or disagree with each of the following statements?**



Base: All responses (85); 9th October – 11th November 2013

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Again, this seems to be linked to good relationships with the area team. CCG leads providing further detail were more likely than in other regions to comment that NHS England is

supportive (20%, compared with 11% nationally), that working relationships with the area team are good (16%, compared with 10% nationally) and that the review process works well (11%, compared with five per cent nationally). It is also important to note, however, that although more positive about some aspects of assurance than in other regions, these comments were often caveated with similar concerns as were raised elsewhere, suggesting that CCGs think there is still room for improvement in the process.

*We had strategic discussions in the main and it was an opportunity to share information that was helpful to both parties. We also appreciated the external perspective and intelligence that the AT brought to the discussions.*

*Worked well in ensuring shared understanding of problem, which are complex, and agreeing best ways for these to be tackled.*

*The assurance process has been conducted locally in a respectful way. The monthly process could be improved. However we have not fed this back as it is gradually improving.*

*I think there is very good cooperation about the system and challenges we face. I believe there is a narrow view about financial problems, they seem very hide bound by old processes and assumptions. They are less willing to be more flexible.*

Finally, NHS England seemed to be more involved with the wider health sector in the Midlands and East than elsewhere in England, with half agreeing NHS England plays an active role in the commissioning system in their work with partners (51%, compared with 36% nationally).



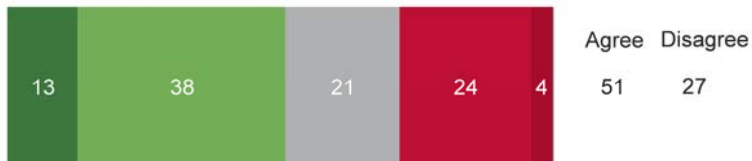
## Midlands and East: Working with partners

Please now think about the relationship between NHS England and CCG. To what extent do you agree or disagree with the following statement ...?

NHS England plays an active role in the commissioning system in our work with our partners (e.g. Health and Wellbeing Boards)?

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know

NHS England plays an active role in the commissioning system in our work with our partners (e.g. Health and Wellbeing Boards)?



Base: All responses (85); 9th October – 11th November 2013

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### 9.3 North of England

|   |     |
|---|-----|
| Number of CCGs in the region            | 68  |
| Number of CCGs represented in responses | 59  |
| Number of potential respondents         | 187 |
| Number of actual respondents            | 96  |
| Response rate                           | 51% |

Overall, the relationships in the North of England reflected the national picture described in this report. However, there were a small number of points of difference.

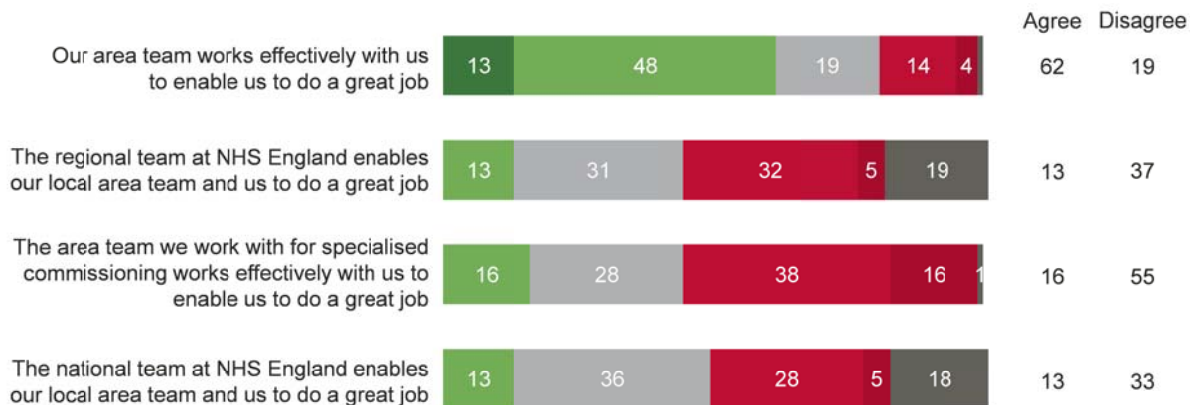
## North: Overall relationship with NHS England

NHS Clinical Commissioners

1

**Please now think about the relationship between NHS England and CCG. Overall, to what extent do you agree or disagree with each of the following statements...**

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (97); 9th October – 11th November 2013

Source: Ipsos MORI

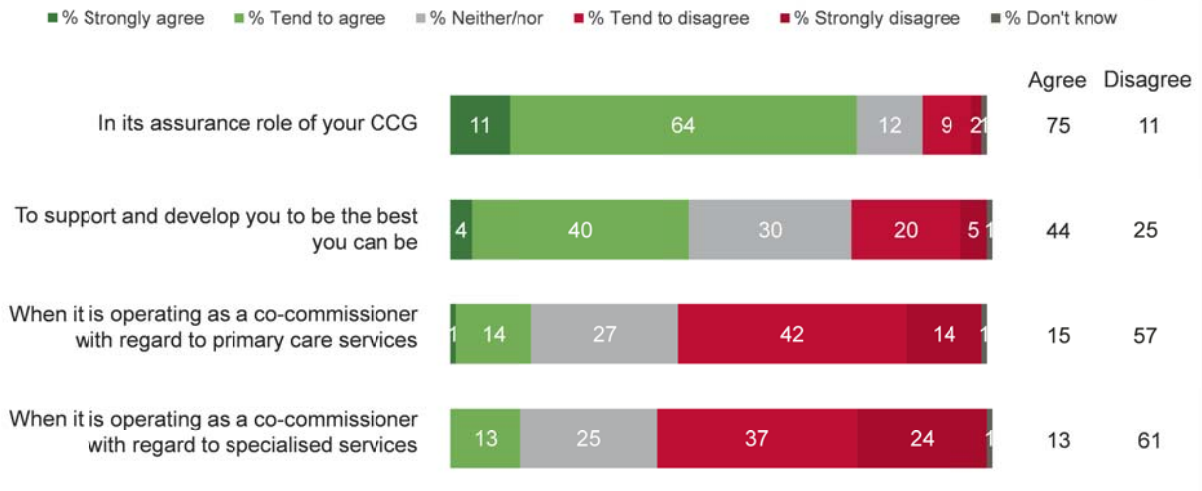
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When asked about specialised commissioning overall, three in five disagreed that NHS England works effectively with them when it is operating as a co-commissioner with regard to specialised services (61%, compared with 55% nationally).

## North: Overall views of NHS England’s delivery of roles

**Please now think about the relationship between NHS England and CCG. And to what extent do you agree or disagree that NHS England works effectively with you ...?**



Base: All responses (97); 9th October – 11th November 2013

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Although there were few differences in views compared to the national picture at the later specific questions about specialised commissioning, in the related free text questions, mentions of budget and finance issues were particularly prevalent among those in the North providing additional comments (22%, compared with 16% nationally).

*The system still appears to be working out how to do this, especially in relation to division of funding. The area team responsible feels slightly distant.*

*Specialised commissioning does not communicate with us and is just a drain on our budgets as we carry their risk at present it seems.*

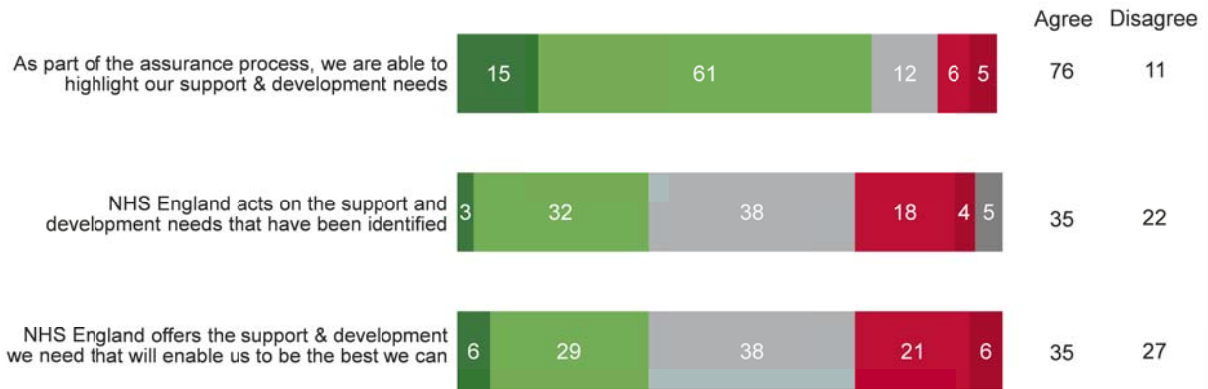
At times, CCG leads within the North were less likely to give an opinion on specific questions, instead being more likely to neither agree nor disagree or say they didn't know. This was particularly the case for support and development. For example, around two in five neither agreed nor disagreed or didn't know if NHS England gave them the space and freedom to innovate (26%, compared with 19% nationally). Similarly, around one in four neither agreed nor disagreed that NHS England works with them as partners on support and development (24%, compared with 19% nationally) or strikes a good balance between support and autonomy (30%, compared with 23% nationally).



## North: Support and development (1)

Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (97); 9th October – 11th November 2013

Source: Ipsos MORI

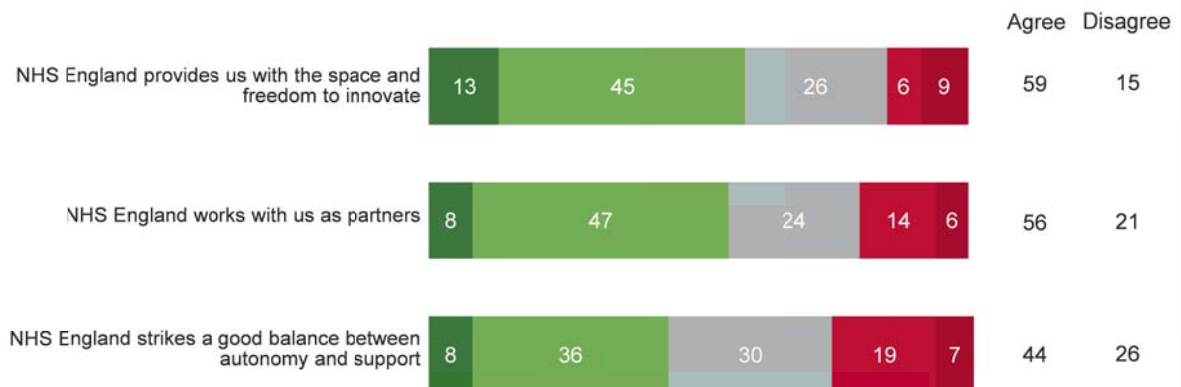
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## North: Support and development (2)

Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (97); 9th October – 11th November 2013

Source: Ipsos MORI

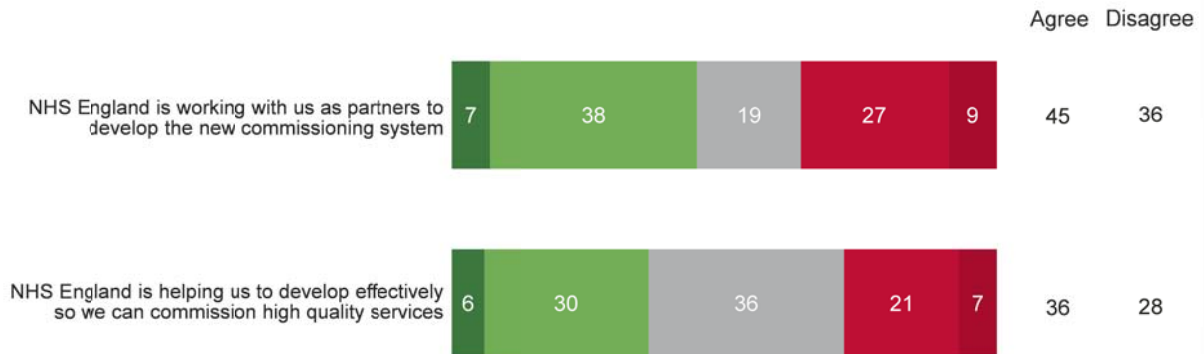
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## North: Support and development (3)

**Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?**

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (97); 9th October – 11th November 2013

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Looking at the free text comments, similar themes emerged as was the case nationally. It was not possible to identify clear themes about why CCG leads in the North would be more undecided. At times it was linked to being too early to tell, while at other times leads seemed neutral about the offer, sometimes referencing positive intentions but a lack of capability or capacity to deliver on them. Leads in the North were more likely to point to a lack of resourcing or understaffing (sometimes specifically mentioning primary care commissioning).

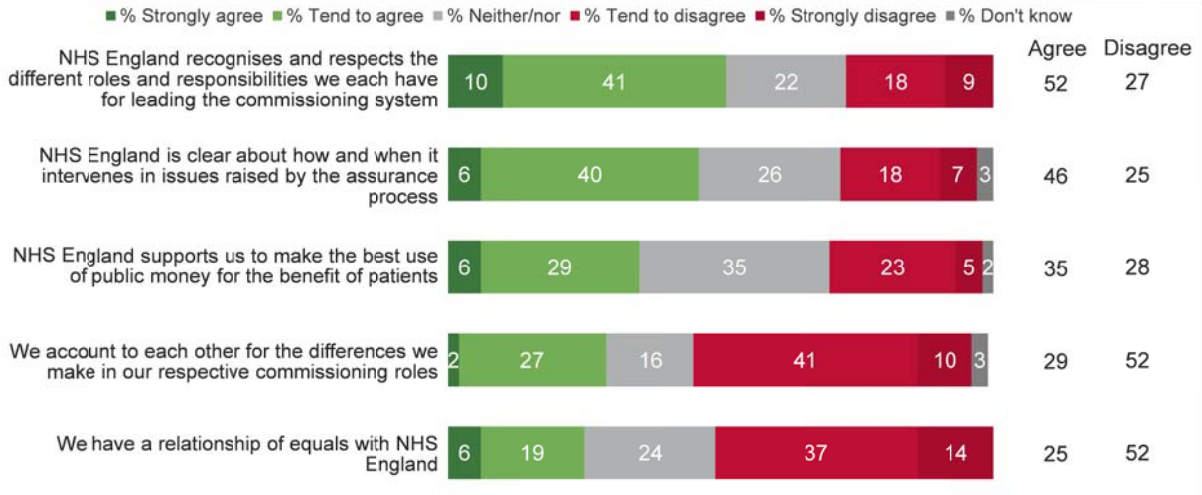
*Personal relationships developing well, sense of lack of capacity and too much emphasis on assurance.*

*I am not sure if there is the resource available to give the support needed. I think NHS England are trying hard to work in partnership but still have top down directives and struggle in the new culture.*

There were few other points of difference, although when considering the most recent assurance process, more *strongly* disagreed that it added value to securing the best outcomes for patient (13%, compared with nine per cent nationally).

## North: General relationship with NHS England over assurance

*Thinking about your general relationship with NHS England around assurance and how you hold each other to account, to what extent do you agree or disagree with each of the following ...?*



Base: All responses (97); 9th October – 11th November 2013

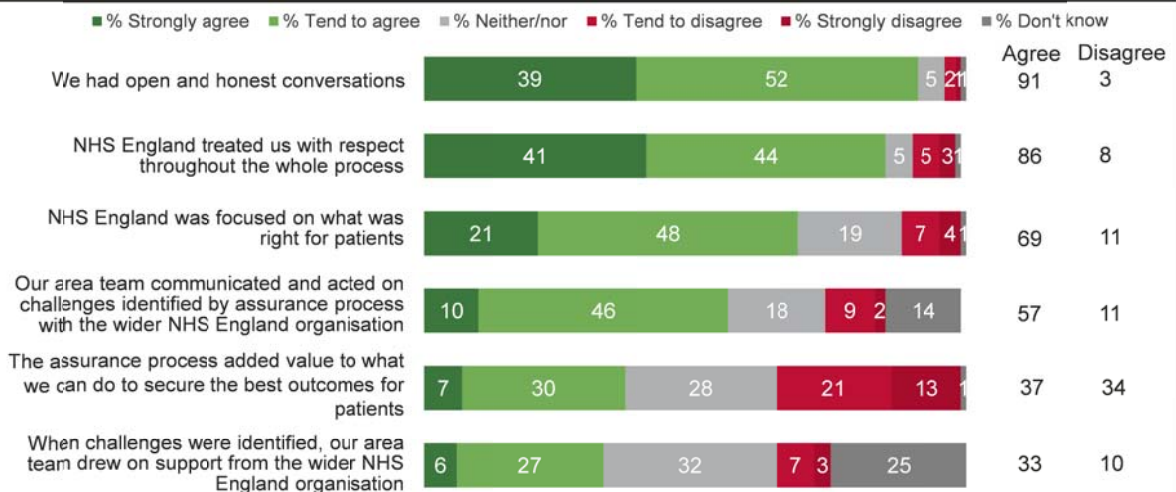
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## North: Views of the most recent assurance process

*Thinking now about NHS England's most recent assurance process with your CCG, to what extent do you agree or disagree with each of the following statements?*



Base: All responses (97); 9th October – 11th November 2013

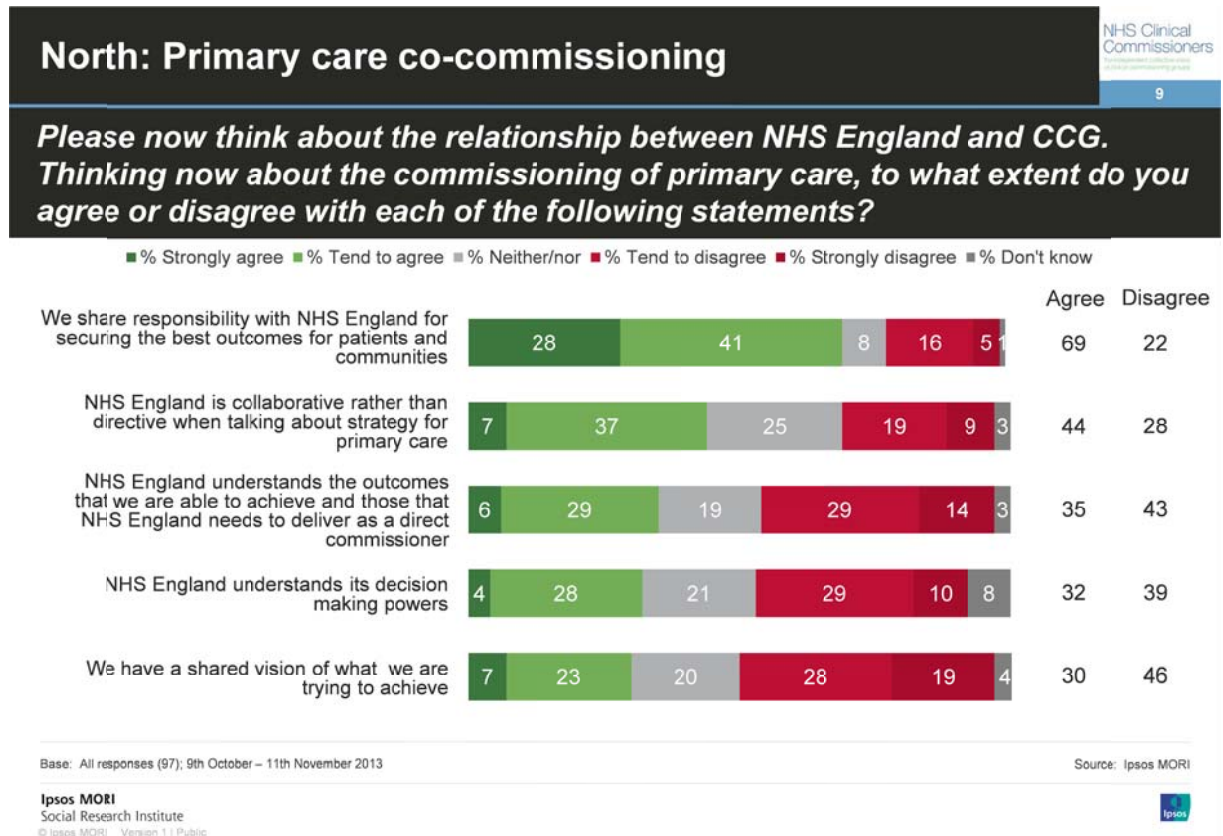
Source: Ipsos MORI

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In addition, on co-commissioning, CCG leads in the North were more divided about the extent to which the CCG and NHS England share a vision. For primary care commissioning,

around one in five *strongly* disagreed that there is a shared vision (19%, compared with 14% nationally).



Looking at the free text comments provided, for those strongly disagreeing there is a shared vision for primary care commissioning, this seemed to be linked largely to a lack of strategy or a feeling that the process is not two-way.

*The Area Team don't have a vision for primary care, constantly say they are not clear re GP IT and premises, and have not developed strategic relationships or capacity to help transform primary care.*

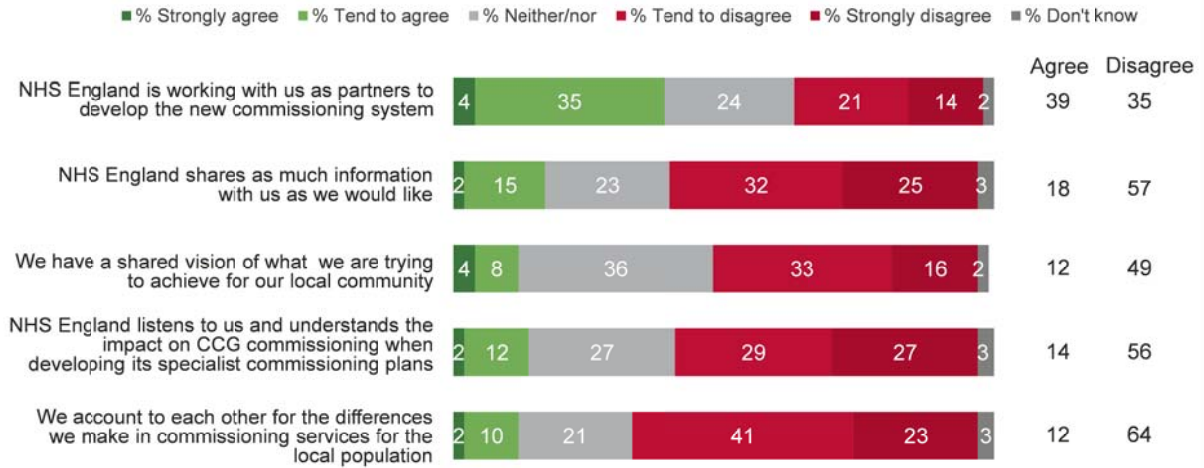
*The AT is struggling to articulate its role and ours in developing a primary care strategy and has not helped to clearly delineate the responsibilities around improving quality of primary care. Their role is currently limited to basic contracting processes and even this may be compromised given the planned budget changes.*

CCG leads were more undecided for specialised commissioning, with more than one in three neither agreeing nor disagreeing that there is a shared vision (36%, compared with 27% nationally).



## North: Specialised co-commissioning

*Please now think about the relationship between NHS England and CCG. Thinking now about how the area team has worked with you on specialised commissioning arrangements, to what extent do you agree or disagree with each of the following ...?*



Base: All responses (97); 9th October – 11th November 2013

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There seemed to be various reasons for this, including that relationships were beginning to move in the right direction, or that there were still thought to be issues to address.

*We are starting to develop plans with the AT responsible for spec comm (see previous answers) – but we haven't got the provider performance issues sorted yet – spec comm 'breeches' show for our trusts whether or not they are our patients, and the discussions re addressing performance are not yet tied together across commissioners. But this relationship feels as though it is going in the right direction overall.*

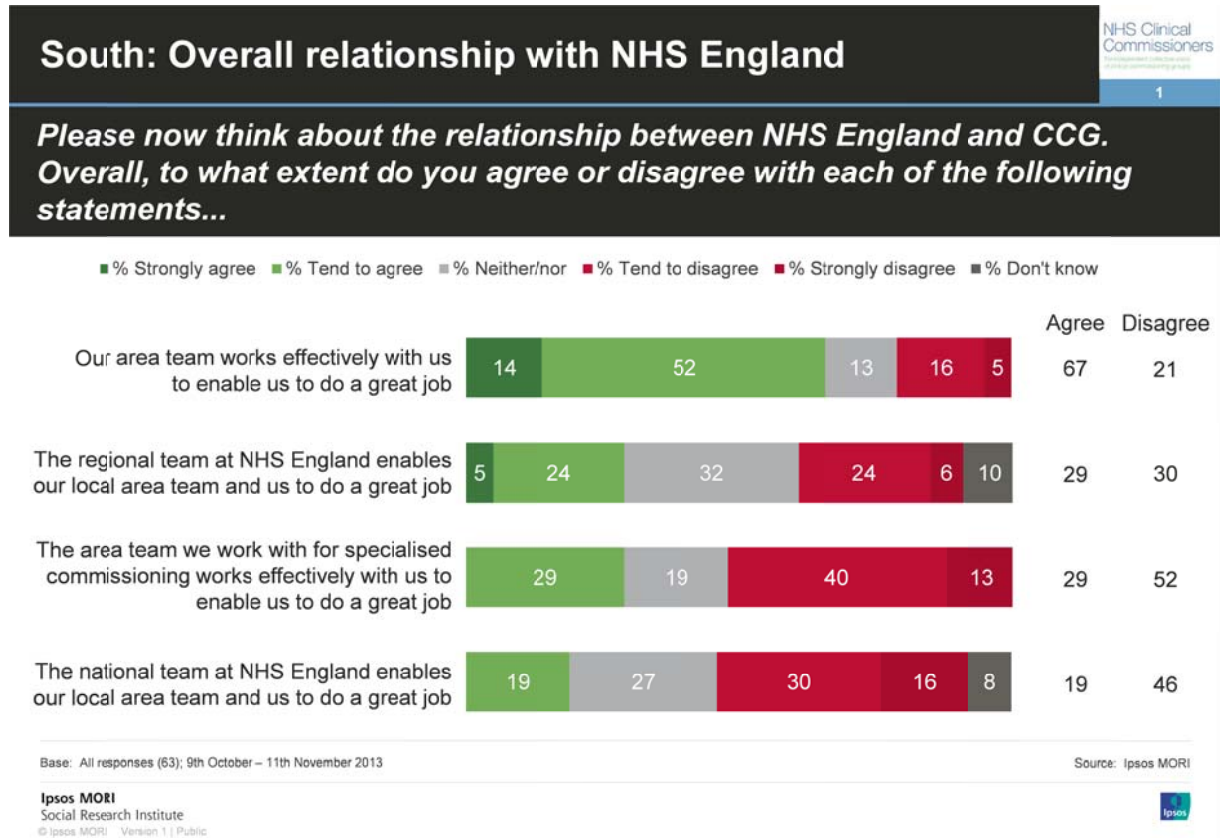
*All of my answers here are in the 'neither agree nor disagree' category because, as with a previous answer, the focus of the area team's conversations has been the money.*

### 9.4 South of England

|   |     |
|---|-----|
| Number of CCGs in the region            | 50  |
| Number of CCGs represented in responses | 45  |
| Number of potential respondents         | 130 |
| Number of actual respondents            | 63  |
| Response rate                           | 48% |

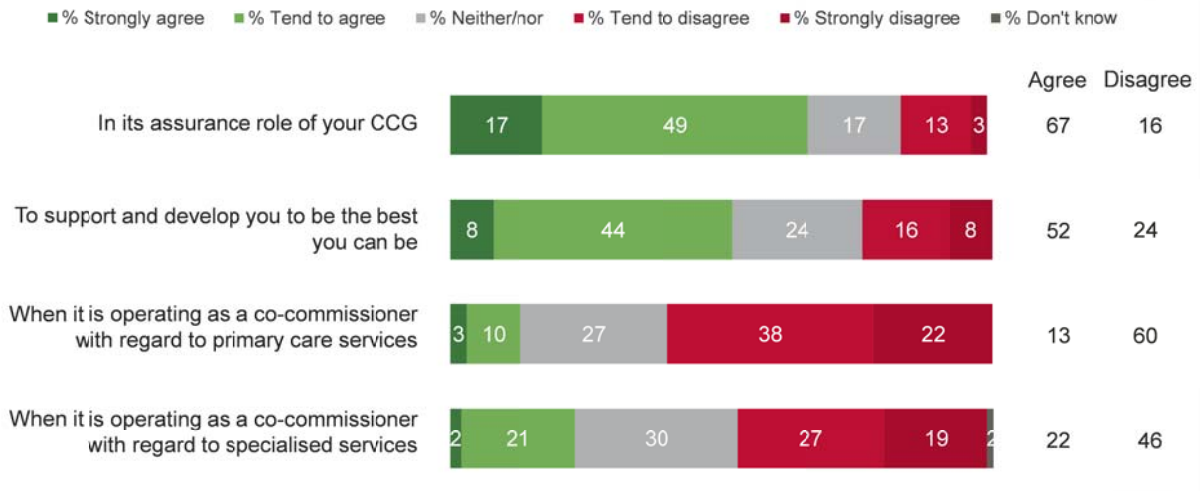
A consistent picture did not emerge from the South of England when compared with other regions; while in some areas CCG leads were more positive, in other areas they were more negative about relationships with NHS England.

Views differed to other regions on working relationships with the regional and national teams of NHS England. CCG leads in the South were more positive about how the regional team works with them to enable their local area team and them to do a great job (29% agreed, compared with 22% nationally). However, almost half disagreed that the national team enables their local area team and them to do a great job (46%, compared with 38% nationally).



## South: Overall views of NHS England’s delivery of roles

**Please now think about the relationship between NHS England and CCG. And to what extent do you agree or disagree that NHS England works effectively with you ...?**



Base: All responses (63); 9th October – 11th November 2013

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Looking at the free text comments provided, CCG leads in the South were particularly likely to say that their area team is supportive (23% of those commenting, compared with 14% nationally). However, they also more frequently mentioned a view that specialised commissioning is badly handled (13%, compared with eight per cent nationally), or generally mentioning budgets or finance issues (12%, compared with seven per cent nationally). This may be linked to a more widespread view about a ‘top down’ culture or centralised approach from NHS England (17%, compared with eight per cent nationally).

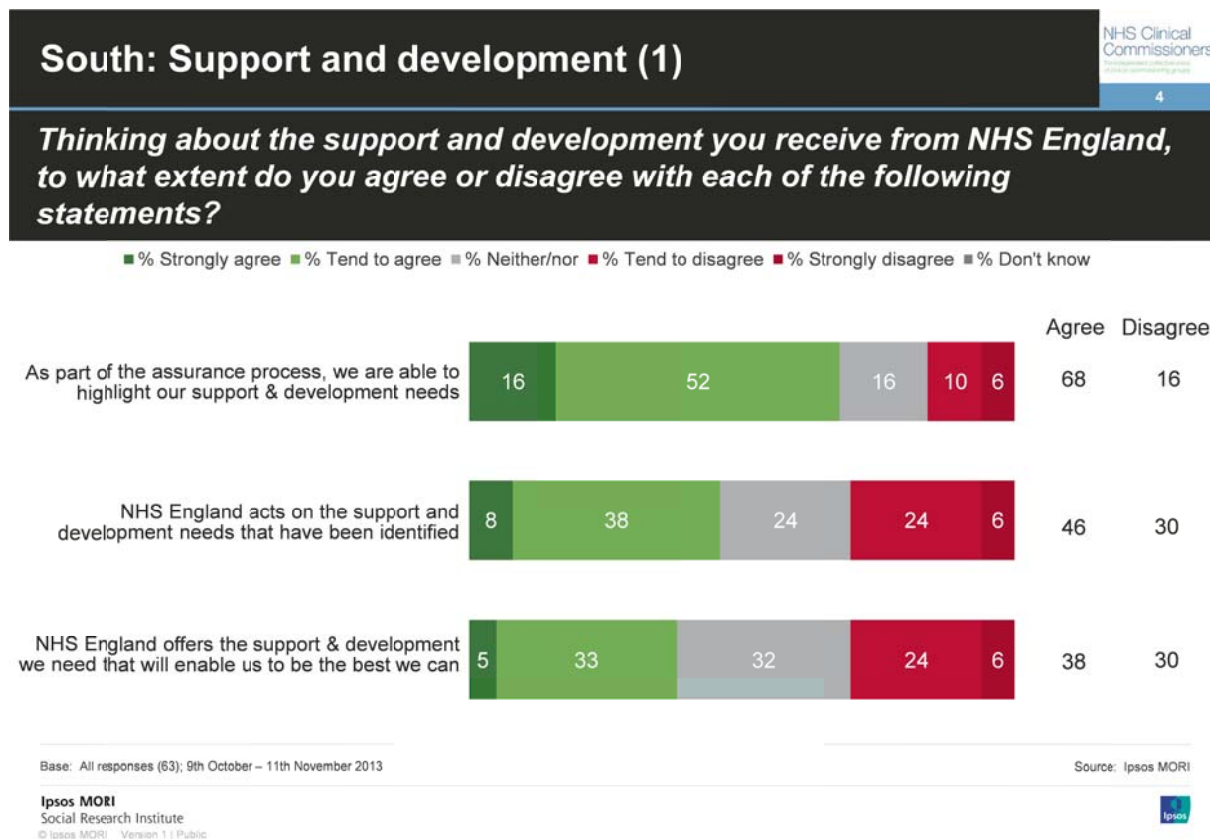
*National team is not very visible to us at the CCG. Some mixed messages about level of empowerment. Allocation of winter pressure monies seems to create perverse incentives. Regional and area teams both appear competent and committed to different ways of working. Specialist commissioning has had a difficult year with the transition and financial adjustments remain unresolved at this point.*

*NHS England visible through diktats only. Regional Team mostly visible to AT rather than CCGs. AT intent and culture show purpose in developing and supporting CCG but limited capacity.*

Looking at differences between the regions, CCG leads in the South offered mixed views of support and development and assurance. In line with the national picture, just over half agreed that NHS England works effectively with them to support and develop the CCG to be the best it can (52%, compared with 47% nationally). In some respects, they were more positive about the support and development role. In particular, more than three in five agreed that NHS England works with them as partners (62%, compared with 54% nationally), while



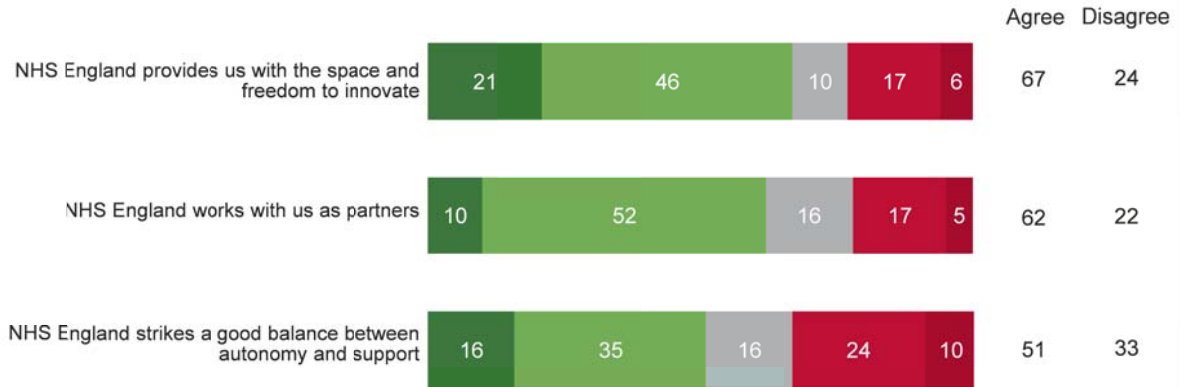
opinion was more strongly positive about the space and freedom the CCG has to innovate (21% *strongly* agreed, compared with 15% nationally). However, more disagreed that NHS England acts on the support and development needs that are identified within the CCG (30% disagreed, compared with 23% nationally).



## South: Support and development (2)

Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (63); 9th October – 11th November 2013

Source: Ipsos MORI

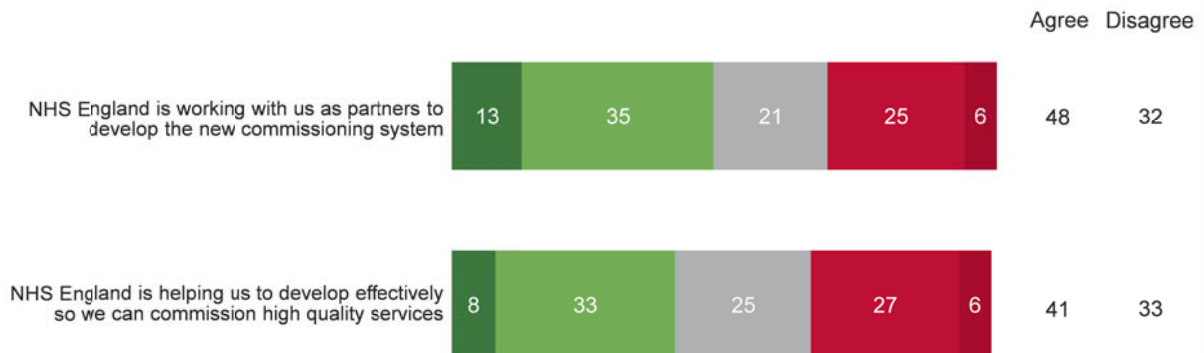
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## South: Support and development (3)

Thinking about the support and development you receive from NHS England, to what extent do you agree or disagree with each of the following statements?

■ % Strongly agree ■ % Tend to agree ■ % Neither/nor ■ % Tend to disagree ■ % Strongly disagree ■ % Don't know



Base: All responses (63); 9th October – 11th November 2013

Source: Ipsos MORI

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From the free text comments around support and development, CCG leads in the South were both more likely to say NHS England is supportive (28%, compared with 20%

nationally) and that it is not (23%, compared with 16% nationally). Positive comments about the area teams' intentions towards support and development were often accompanied by caveats.

*NHS England have been good at directing us to where to go to for further support and advice and providing a steer. They have provided encouragement to aspire further. However, there have also been examples when we have expected that further information might be forthcoming and it's just not there at AT or regional level. e.g. Call to Action – guidance material too little and too late for our local needs.*

*I have raised the need for more formal support for key members in my team to have on-going coaching/ personal development – it does feel a little like we have to sort this for ourselves and there is little meat left on the bone in terms of our running cost budget to do this properly.*

*Our AT do try to support us as much as they can, but they just seem low on numbers, with too many small CCGs consuming their time.*

Turning to NHS England's assurance role, CCG leads in the South were less positive than others. Fewer agreed that NHS England works effectively with them in its assurance role (67%, compared with 75% nationally). In the free text comments, they were particularly likely to say that NHS England is not held to account or that accountability is one-sided (30%, compared with 21% nationally).

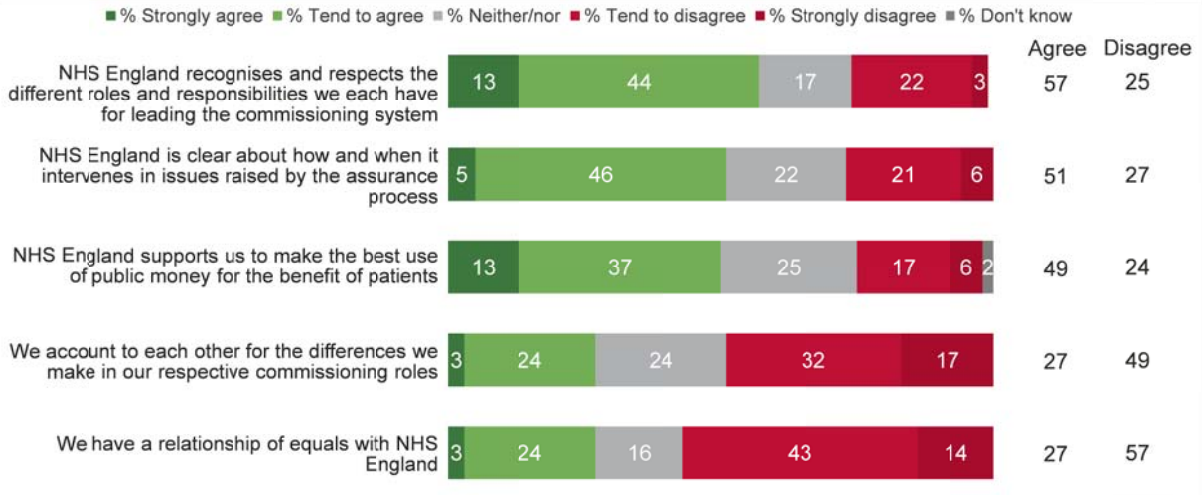
*I have had no experience of NHS England accounting to us. Sometimes the lines are blurred about system leadership and the providers play on this. I don't currently think we have an equal partnership.*

Interestingly, when asked about assurance more generally, nearly half agreed that NHS England supports them to make the best use of money for the benefit of patients (49%, compared with 40% nationally), but fewer than in other regions agreed that the most recent assurance process added value to what they can do to secure the best outcomes for patients (30%, compared with 40% nationally).

## South: General relationship with NHS England over assurance

NHS Clinical Commissioners  
 7

*Thinking about your general relationship with NHS England around assurance and how you hold each other to account, to what extent do you agree or disagree with each of the following ...?*



Base: All responses (63); 9th October – 11th November 2013

Source: Ipsos MORI

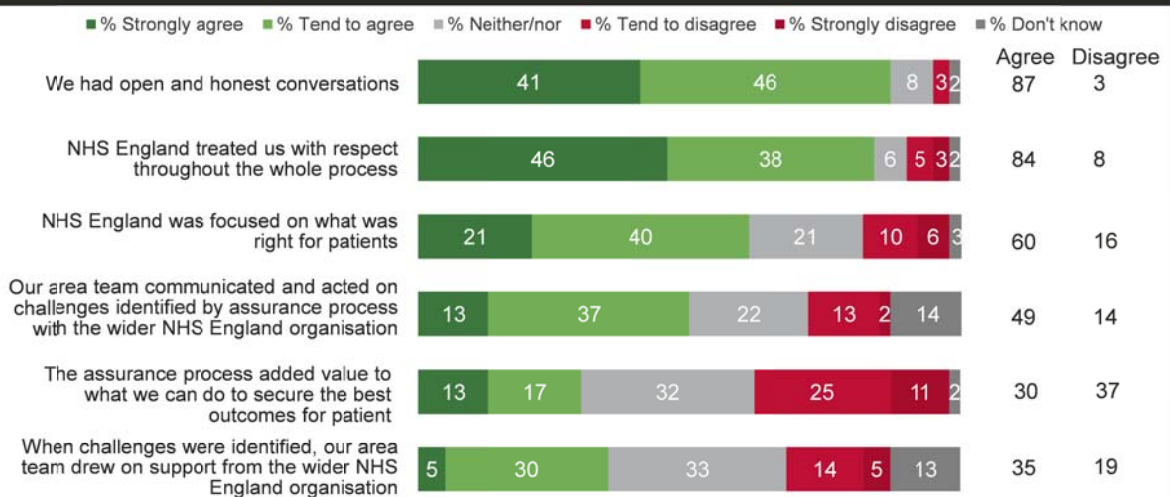
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## South: Views of the most recent assurance process

NHS Clinical Commissioners  
 8

*Thinking now about NHS England's most recent assurance process with your CCG, to what extent do you agree or disagree with each of the following statements?*



Base: All responses (63); 9th October – 11th November 2013

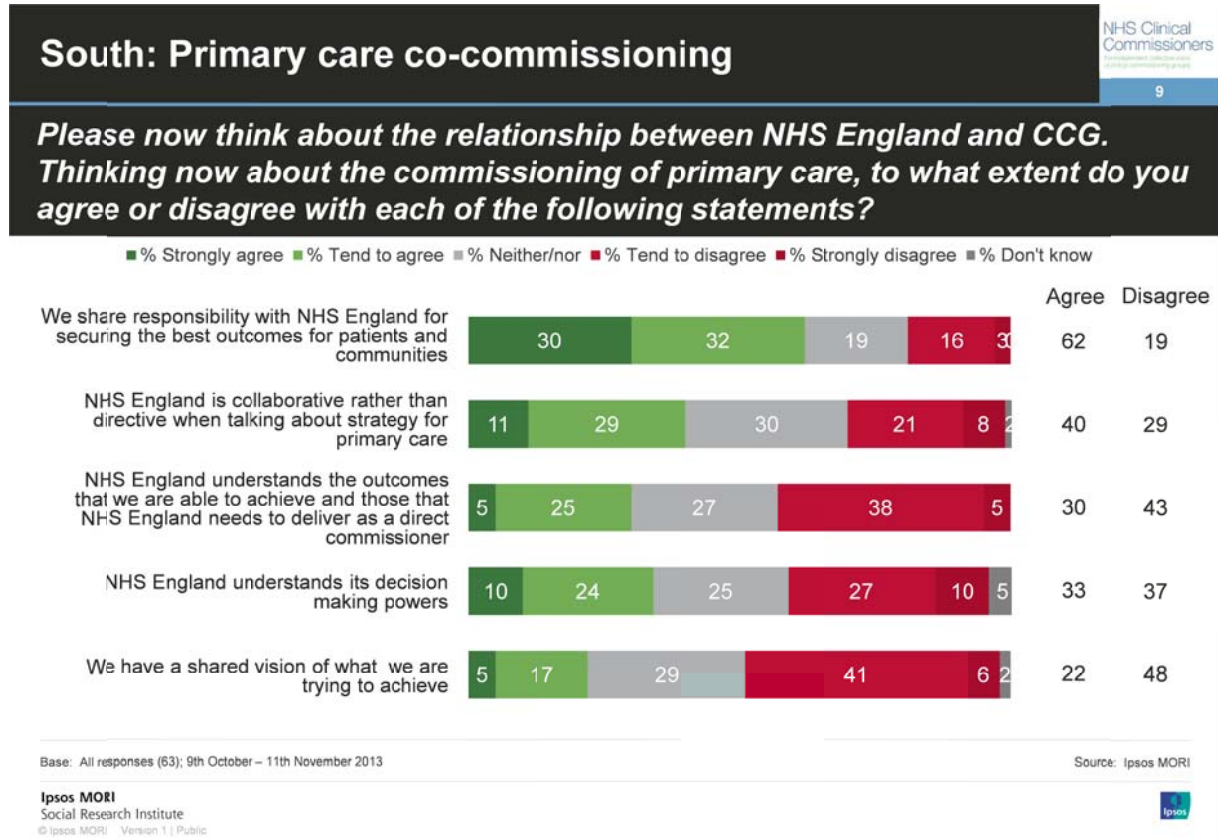
Source: Ipsos MORI

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Although broadly in line with the national picture for primary care commissioning when asked about specific aspects, CCG leads in the South were less likely to agree to the more general

question that NHS England works effectively with them as a co-commissioner of primary care services (13% agreed, compared with 19% nationally). This may be linked to sharing a common vision with NHS England about what can be achieved through primary care commissioning, as fewer agreed that there was a shared vision here (22%, compared with 31% nationally).



It may also be linked to a view from the free text comments that more resources or capacity is needed within NHS England (43%, compared with 25% nationally).

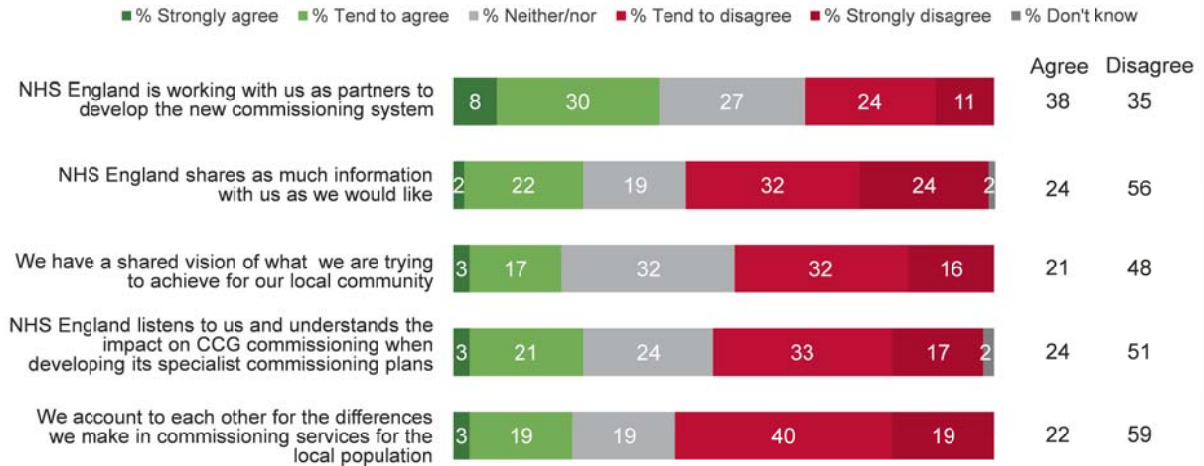
*We feel we need to drive the primary care agenda even though we don't commission it as NHS England don't seem to have the experience or capacity to do this.*

While still negative about specialised commissioning on balance, relationships around specialised commissioning seemed to be working better in some respects than in the other regions. Three in ten CCG leads agreed that the area team they work with for specialised commissioning works effectively with them to enable them to do a great job (29%, compared with 20% nationally), while around one in five agreed that NHS England works effectively with them when operating as a co-commissioner of specialised services (22%, compared with 15% nationally).



## South: Specialised commissioning

**Please now think about the relationship between NHS England and CCG. Thinking now about how the area team has worked with you on specialised commissioning arrangements, to what extent do you agree or disagree with each of the following ...?**



Base: All responses (63); 9th October – 11th November 2013

Source: Ipsos MORI

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In the free text comments, CCG leads in the South were more likely than elsewhere to point to a good working relationship around specialised commissioning (38%, compared with 19% nationally). They were less likely to say that communication is poor or that there are budget or finance issues (both 16%, compared with 29% and 28% respectively nationally).

*Our team is working with specialist com. teams in a cooperative way. There seems much to untangle and clarify.*

This is likely to be linked to the two areas in which CCG leads in the South were also more positive when asked about specialised commissioning in more detail, areas which suggest there is more of a two-way relationship in the South than elsewhere. Around one in four agreed that NHS England listens to them and understands the impact on CCG commissioning when developing its specialist commissioning plans (24%, compared with 16% nationally), and that NHS England and the CCG account to each other for the differences they make in commissioning services for the local population (22%, compared with 16% nationally).

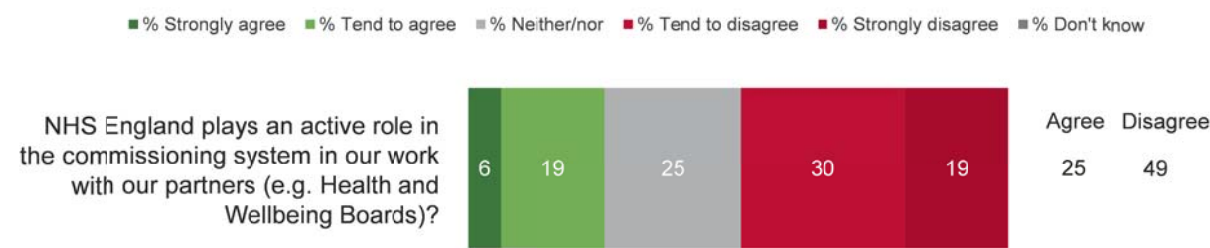
However, it is important to note that there was still room for improvement in the view of CCG leads in the South. In line with the national picture, in the free text comments still around one in five of those providing comments said the working relationship was poor (22%), that NHS England is disjointed (18%) or that it makes decisions remotely (16%).

When asked about NHS England's involvement in the wider health system, CCG leads in the South were significantly less positive about the active role played by NHS England in the

commissioning system in CCGs' work with their partners (49% disagreed they play an active role, compared with 38% nationally).

## South: Working with partners

*Please now think about the relationship between NHS England and CCG. To what extent do you agree or disagree with the following statement ...?*  
*NHS England plays an active role in the commissioning system in our work with our partners (e.g. Health and Wellbeing Boards)?*



Base: All responses (63); 9th October – 11th November 2013

Source: Ipsos MORI

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## 10. Area team findings

This chapter of the report provides a summary of the survey findings for each area. It seeks to summarise the views of CCG leads within each area team. Please note that the number of responses within each area is very low. In addition, not all CCG leads invited to take part in the survey responded and so this analysis is necessarily based only on those within each area team who responded. For each area, the number of CCGs is given, along with the total number of potential<sup>9</sup> and actual respondents. In addition, the response rate and the number of CCGs within each area that are represented in the findings are indicated. As a result of these low numbers and varying response rates, the results should be interpreted with caution. The analysis presented in this chapter is therefore qualitative, providing further detail on the free text comments in order to better understand more local issues. Please also note that not all CCG leads provided free text comments; those who did so may hold stronger opinions than those who chose not to add further detail.

For each area team, the findings for specialised commissioning are also reported. Please note that only 10 teams have responsibility for specialised commissioning and so the findings do not always link back to the specific area team under which they are reported. For each region, the teams responsible for specialised commissioning are listed.

### 10.1 London

*Specialised commissioning in London is undertaken by the London regional team.*

#### North West London

Too few responses were provided from CCGs within the North West London NHS England Team (one) and so analysis cannot be provided.

|   |    |
|---|----|
| Number of CCGs in the region            | 8  |
| Number of CCGs represented in responses | 4  |
| Number of potential respondents         | 12 |
| Number of actual respondents            | 1  |
| Response rate                           | 8% |

<sup>9</sup> Please note that although three leads were invited to take part in the survey from each CCG, some leads represented more than one CCG and so the potential number of respondents does not equal three multiplied by the number of CCGs.

## North Central and East London

|   |     |
|---|-----|
| Number of CCGs in the region            | 12  |
| Number of CCGs represented in responses | 6   |
| Number of potential respondents         | 33  |
| Number of actual respondents            | 11  |
| Response rate                           | 33% |

Of the 11 CCG leads responding from North Central and East London, three agreed that their NHS England team works effectively with them to enable them to do a great job, while five disagreed. The CCG leads in this NHS England team tended to be particularly negative about specialised commissioning, with all 11 leads disagreeing that the team they work with for specialised commissioning works effectively with them to enable them to do a great job and that NHS England works effectively with them as a co-commissioner of specialised services. Although opinion regarding specialised commissioning was negative nationally, leads from North Central and East London seemed more concerned than leads overall in this regard.

Turning to NHS England's specific roles, free text comments on support and development suggested that the NHS England team does not have the capacity to deliver support. Two also mentioned that development offers are from private providers, which they did not welcome.

Views were mixed on the assurance process, with a small number saying it generally works well and others saying there is confusion about roles, that questions are not answered by the area team, or that there is a lack of mutual assurance. However, from the quantitative data, still nine leads agreed that there were honest and open conversations and that they were treated with respect, reflecting positive findings nationally in this regard.

On primary care commissioning, CCG leads providing comments suggested that the NHS England team does not currently have a strategy and lacks the capacity to be able to develop a strategy. The quantitative data suggested that the relationship is not mutual here (for example, eight said NHS England was not collaborative and nine said it didn't understand the outcomes that each was able to achieve).

For specialised commissioning there was a sense from both the closed and the free text questions that there is a lack of joint working and consideration of the impact of decisions on CCGs.

## South London

|   |     |
|---|-----|
| Number of CCGs in the region            | 12  |
| Number of CCGs represented in responses | 11  |
| Number of potential respondents         | 35  |
| Number of actual respondents            | 16  |
| Response rate                           | 46% |

The CCG leads responding from South London had mixed views about the NHS England team, with seven of the 16 agreeing it works effectively with them to enable them to do a great job and six disagreeing. This was in contrast to a generally more positive outlook towards area teams nationally. Looking specifically at support and development, CCG leads were at times undecided, although on the whole more leads agreed than disagreed with each specific aspect asked about. It seemed like the relationship here was still developing, with some good examples of support such as CFO and CO networks.

The relationship around assurance seems to be working well; 12 of the 16 leads agreed that NHS England works effectively with them in its assurance role. The findings tended to reflect the national picture, with a few saying it worked well and others that it was not mutual. There was a sense among a few CCG leads that the NHS England team sometimes performance managed, at times as a result of perceived central pressure.

As was the case across England, relationships were less strong around primary care co-commissioning; 12 of the 16 CCG leads in South London disagreed that NHS England works effectively with them as a co-commissioner of primary care. Leads were fairly divided; some pointed to a good relationship, others suggested there had been very few discussions about primary care, while others again said there were good personal relationships that were helping despite challenges. Many mentioned capacity as an issue impeding the NHS England team, while there were also mentions of financial challenges within the system.

For specialised commissioning, similar challenges emerged as elsewhere in England. Many of the CCG leads in South London who provided further details commented on the financial implications of specialised commissioning.

## 10.2 Midlands and East of England

*Specialised commissioning in the Midlands and East of England is undertaken by the East Anglia, Leicestershire and Lincolnshire and Birmingham and the Black Country area teams.*

## Arden, Herefordshire and Worcestershire

|   |     |
|---|-----|
| Number of CCGs in the region            | 7   |
| Number of CCGs represented in responses | 5   |
| Number of potential respondents         | 19  |
| Number of actual respondents            | 6   |
| Response rate                           | 32% |

Of the six leads who responded from CCGs within the Arden, Herefordshire and Worcestershire local area team, four agreed that the area team works effectively with them to enable them to do a great job and two disagreed. Those who provided free text comments (all of whom agreed their area team was working effectively) reiterated this relationship albeit that one also said that the team was still developing while another said that approaches differed between individuals within the area team and that the focus of the directors was not always clear.

Turning to the specific roles that NHS England has, the six leads tended to be positive rather than negative about support and development, although caveats were again added in the free text comments (for example a need for greater leadership, lack of an interface between CCG and NHS England around co-commissioning and a need to maintain this approach rather than regressing).

The views of CCG leads about assurance were similar to those seen nationally. For example, while four of the six agreed they had honest and open conversations as part of the recent assurance process, four of the six disagreed there was a relationship of equals with NHS England around assurance more generally. Those who provided further comments made a variety of points, including a belief that the relationship is 'parent-child', that not enough information is shared, and concerns about the speed of resolution or leadership for issues facing the wider health economy such as reconfigurations.

From the quantitative data, it appeared that the relationship between the area team and CCGs on primary care commissioning is developing. For example, four of the six CCG leads responding agreed that NHS England understands the outcomes the CCG can achieve and those that NHS England needs to deliver, and four of the six agreed that NHS England understands its decision-making powers – both generally more positive than the national findings. However, three disagreed and only one agreed that NHS England is collaborative here, and this was reflected in free text comments in which those answering requested greater partnership working or communication or a clearer strategy. One felt there is not enough investment in primary care and that the split in primary care commissioning between CCGs and NHS England does not work well.

CCG leads were mostly negative about specialised commissioning, for example with five of the six disagreeing NHS England is working with them as partners or shares as much information with them as they would like, reflecting negativity nationally on this issue. Three of the four who went on to provide further detail referenced financial pressures.

## Birmingham and the Black Country

|   |     |
|---|-----|
| Number of CCGs in the region            | 7   |
| Number of CCGs represented in responses | 5   |
| Number of potential respondents         | 21  |
| Number of actual respondents            | 8   |
| Response rate                           | 38% |

Among the eight CCG leads who responded from CCGs within the Birmingham and the Black Country area team, five agreed that the area team works effectively with them to enable them to do a great job and two disagreed. The two who disagreed suggested that leadership could be stronger or that it currently reflects the old system rather than the ways of working. Two other leads referenced short notice requests for information from the regional team (and indeed five of the eight disagreed that the regional and national teams enable them and their area team to do a great job).

The leads were often divided regarding NHS England's support and development role. In the free text comments, while one said this is the strongest area for working together, others said support was limited or too generic, or that it was focused on avoiding failure rather than supporting continued success.

CCG leads working with the Birmingham and the Black Country area team were also divided about assurance more generally, although seven of the eight agreed that NHS England is clear about how and when it intervenes in issues raised by the assurance process. A number argued in the free text comments that the relationship can never be equal when it has dual roles as a resource allocator and a partner, or as an organisation setting both its own funds and CCGs' allocations. On the process itself, some leads felt it worked well and was productive, while two argued that it was more focused on hard measures or money as opposed to what is best for patients.

On primary care commissioning, the findings within the area broadly reflected those nationally, although none said there is a shared vision and six of the eight disagreed that NHS England understands the outcomes the CCG can achieve and those that NHS England needs to deliver. In the free text comments, while two CCG leads pointed to good joint initiatives, others pointed to a lack of resources within NHS England and a desire for this function to be carried out by CCGs instead.

On balance, leads were negative about specialised commissioning. Reflecting the findings across England as a whole, the CCG leads highlighted this as an area of concern, dominated by financial discussions. While one lead was much more positive about specialised commissioning locally, they felt that the national strategy did not reflect local challenges.

## Derbyshire and Nottinghamshire

|   |     |
|---|-----|
| Number of CCGs in the region            | 10  |
| Number of CCGs represented in responses | 10  |
| Number of potential respondents         | 26  |
| Number of actual respondents            | 16  |
| Response rate                           | 62% |

Nearly all of the CCG leads responding from CCGs within Derbyshire and Nottinghamshire agreed that the area team works effectively with them to enable them to do a great job (13 of the 16), making them more positive than the national average. In the free text comments, there was a strong sense – although by no means universal – that although relationships with the area team are good, this team lacks the ability to make decisions. The regional and national teams felt more distant and two leads suggested that the area team shields CCGs from regional team requirements.

On balance, CCG leads were positive or neutral with regard to NHS England's support and development role. Among those who provided free text comments, one saw this as a particular strength of NHS England, while three suggested the area team is supportive but not intrusive in this area. One lead argued that offers of support tend to be centralised.

Turning to the most recent assurance process, CCG leads in Derbyshire and Nottinghamshire were generally positive, although – as nationally – less so about assurance more generally and holding each other to account. Those leads who commented further often reflected on positive discussions as part of the relationship around assurance. However, as nationally, there was not a feeling that assurance is two-way. A couple of leads felt that the area team is hindered by national requirements.

As across England, relationships were more difficult with regard to primary care commissioning, although there seemed to be some stronger areas (for example, 10 of the 16 leads agreed that NHS England is collaborative rather than directive). In the free text comments, leads were divided. Some talked of good relationships and examples of collaboration, others suggested this was slow to begin or still developing and others still referred to the primary care agenda as confusing, or even non-existent.

Relationships seemed less well formed around specialised commissioning, with at least nine of the 16 leads consistently disagreeing with each specific aspect asked about. There was a suggestion from two leads that relationships had worsened rather than improved over time, while others who provided comments suggested that communication was poor. Two also wanted great involvement from NHS England in discussions with providers.



## East Anglia

|   |     |
|---|-----|
| Number of CCGs in the region            | 8   |
| Number of CCGs represented in responses | 8   |
| Number of potential respondents         | 22  |
| Number of actual respondents            | 12  |
| Response rate                           | 55% |

Of the 12 leads who responded from CCGs within the East Anglia area team, seven agreed that the area team works effectively with them to enable them to do a great job and three disagreed. In the free text comments, while a few leads pointed to good relationships, others thought relationships were working less well, or were one-sided. A number commented on NHS England more generally, for example saying that there is replication between the area, regional and national teams, that the central team is too 'metropolitan' in its work, or that the region reflects the previous system in its style and approach.

CCG leads were fairly divided in their views of support and development. Few provided further comments about support and development specifically, although one felt that this area was given less emphasis by the area team and another that it needed to be more two-way. One lead did not feel comfortable sharing developmental needs with the area team.

On assurance, there was a mixed view. A number of those providing comments felt that the assurance process was one-sided, with a couple arguing that the area team was either 'behind' CCGs in terms of outlining their objectives and monitoring performance, or that the CCGs sometimes know better about commissioning. One lead felt this relationship was still developing while another saw it as focusing on the bottom line rather than on transparency. While a few commented positively on the recent assurance process, with one referencing a willingness to work differently (albeit more among some individuals than others), a couple also mentioned a less flexible approach to finances or a need to bypass the area team on specific issues.

CCG leads in East Anglia tended to be divided with regard to primary care co-commissioning. Of the leads who commented further, many suggested that the relationship was in its infancy. There was a wish among one or two for there to be strong two-way communication as the relationship develops and an appreciation that CCGs have good knowledge to add about local care.

Specialised commissioning was an area in which the CCG leads within this area team were more negative than nationally. In the free text comments that were provided, CCG leads referenced difficult discussions about finances and the general lack of a relationship – although one said there are plans to improve this.

## Essex

|   |     |
|---|-----|
| Number of CCGs in the region            | 7   |
| Number of CCGs represented in responses | 5   |
| Number of potential respondents         | 20  |
| Number of actual respondents            | 10  |
| Response rate                           | 50% |

Among the 10 CCG leads who responded from CCGs within the Essex area team, seven agreed that the area team works effectively with them to enable them to do a great job and two disagreed (the other neither agreed nor disagreed). In the free text comments, although some referred to good relationships, there were often caveats (for example, that the area team sometimes gets in the way of local relationships, capacity issues or a need for a freer flow of information). Some leads also referenced a lack of clarity in roles and blurred boundaries between the different parts of NHS England. One also referred to an old style performance management approach.

CCG leads were fairly divided in their views of NHS England's support and development role. This was reflected in the free text comments; while a couple referenced a good relationship here and point to specific support that has been provided, a couple of others were critical of the offer that is available, saying that is too prescriptive or irrelevant. Capacity to deliver was also questioned by a couple of leads. One lead argued that support and development needs to be two-way while another, although generally providing good feedback, did not see it as a relationship of equals.

Linked to this, eight of the 10 leads did not think they have a relationship of equals around assurance. They were otherwise generally more positive than negative about assurance, and more so when asked about the most recent assurance process, as was the case nationally. However, although not universal, a number of CCG leads in Essex suggested that relationships here were more of the traditional SHA/PCT approach, or that the area team was making too many interventions.

Around primary care commissioning, views were fairly mixed, although none disagreed that the area team is collaborative (six agreed it is and the other three neither agreed nor disagreed). Unlike the national picture, it seemed from most of those who provided free text comments that a primary care strategy had been developed and CCGs had been involved. Leads were keen to build on this, with a few citing risks that need to be avoided. For example, one pointed to a concern that the area team would only deal with failure and poor performance rather than being able to drive vision and development, as a result of national issues and resource constraints. Another pointed to important areas that were not on the NHS England agenda, while another wanted more joint working in this area.

On some aspects of specialised commissioning, CCG leads were divided, although they were more negative about NHS England listening to the CCG and understanding the impact of decisions on CCG commissioning (five of the 10 disagreed it does this) and accounting to

each other for the differences made (six disagreed that this happens). Many of those providing further detail commented that there is little interaction with the specialised commissioning team, with concerns about the sharing of relevant information.

### Hertfordshire and the South Midlands

|   |     |
|---|-----|
| Number of CCGs in the region            | 7   |
| Number of CCGs represented in responses | 5   |
| Number of potential respondents         | 21  |
| Number of actual respondents            | 10  |
| Response rate                           | 48% |

Nearly all of the CCG leads responding from CCGs within Hertfordshire and the South Midlands agreed that the area team works effectively with them to enable them to do a great job (nine of the 10), making them particularly positive. Even where links to the area team were thought to be good, some of the leads providing comments felt they were simply a communication channel through which the regional team worked. The regional, national and specialised commissioning teams seemed more distant, as was the case nationally.

On some aspects of support and development, CCG leads were more positive than negative about NHS England, although opinion was more divided on whether or not NHS England acts on the needs identified and NHS England helping them to develop effectively so they can commission high quality services. Only one of the 10 leads agreed that it offers them the support and development needed to enable them to be the best they can. From the free text comments, those who agreed generally often went on to say that concrete support and development had not yet been provided. Two also referenced area team involvement with providers or partners that they felt was too much.

CCG leads were generally more positive than negative about assurance, although less so with regard to accounting to each other and having a relationship of equals. In the free text comments, a range of different views about assurance were given. While three felt it was not a relationship of equals, another felt the relationship was developing in the right direction – although some areas were working better than others. One wanted more local discretion, while another wanted their local knowledge to be taken into account by the area team when acting. The discussions themselves seemed to work well, although there were mentions of potential improvements, for example to look for solutions during discussions, suggested changes to the scorecard, or a wish for NHS England to act nationally on issues when needed.

Views of primary care commissioning broadly mirrored those of the national picture. In the free text comments, a couple of leads referred to commissioning being undertaken by CCGs rather than NHS England. There seemed to be more contact with the area team for primary care commissioning than for others. A few felt that the area team focuses on managing poor performers rather than necessarily implementing a vision or strategy.

As was the case nationally, CCG leads who responded from the Hertfordshire and the South Midlands area were much less positive about specialised commissioning, with none agreeing there is a shared vision, that the two organisations account to each other, or that NHS England shares enough information with them. Those providing additional comments said that the specialised commissioning team is remote, while others referred to difficulties with the funding.

### Leicestershire and Lincolnshire

|   |     |
|---|-----|
| Number of CCGs in the region            | 7   |
| Number of CCGs represented in responses | 7   |
| Number of potential respondents         | 21  |
| Number of actual respondents            | 12  |
| Response rate                           | 57% |

Among the 12 CCG leads who responded from CCGs within the Leicestershire and Lincolnshire area team, nine agreed that the area team works effectively with them to enable them to do a great job and none disagreed (the other three neither agreed nor disagreed). Those who provided free text comments generally echoed this view, with a few referencing a more remote regional team, although this was not seen as an issue (except for one lead who described short notice requests about performance from the regional team).

CCG leads from Leicestershire and Lincolnshire were more positive about support and development in their area than leads nationally. This was reflected in the free text comments, for example with one lead mentioning the organisational development aspect of the assurance process and another talking about how NHS England asks the CCG to identify its own needs while also themselves identifying what development they think the CCG needs. However, one lead referred to an old SHA way of doing things and high levels of bureaucracy, while another said it is early days, particularly to determine the capability of the area team to do this.

The views of CCG leads of assurance differed, with views of the most recent assurance process generally more positive, as was the case nationally. Leads providing more detail talked about frank discussions and positive processes, although one lead stated that they were unsure what value the process added. Looking at assurance more generally and holding each other to account, while there were more positive areas such as recognising and respecting the different roles and responsibilities, leads were less positive with regard to having a relationship of equals or accounting to each other for the differences made, as was the case nationally. The free text comments referenced a good relationship with the area team, although some contrasted that with other parts of NHS England. Two others suggested it was a one-way process.

Within Leicestershire and Lincolnshire, CCG leads tended to be particularly positive about primary care commissioning in the closed questions. Of those providing further comments, some talked about being fully engaged or having a shared vision or appreciation of the

challenges, albeit sometimes with caveats (such as that a joint plan would be a further improvement). Two leads were less positive, with one saying that the CCG could have been better engaged, perhaps with more visits to the area, and the other that GPs should be more involved.

CCG leads who responded also tended to be more positive about specialised commissioning; for example, 10 of the 12 agreed that NHS England is working with them as partners to develop the new commissioning system. The free text comments provided were divided. It potentially seemed that more discussions were happening than in other areas. A couple of leads referred to challenging conversations around the finances that had been resolved. Another was more critical of these discussions, while a fourth was keen to see how the relationship would evolve now that the discussions were resolved. Other comments included that NHS England's activities in this area were less visible and that there could be more CCG involvement.

### Shropshire and Staffordshire

|   |     |
|---|-----|
| Number of CCGs in the region            | 8   |
| Number of CCGs represented in responses | 7   |
| Number of potential respondents         | 22  |
| Number of actual respondents            | 11  |
| Response rate                           | 50% |

Nearly all of the CCG leads responding from CCGs within Shropshire and Staffordshire agreed that the area team works effectively with them to enable them to do a great job (nine of the 11). In the free text comments, leads referenced these good relationships, although many of those who provided comments also said that specialised commissioning was not working well. A couple of leads raised questions about the regional team, suggesting that it may take more of a 'top down' approach.

On the whole, CCG leads were more positive than negative about support and development. Those who provided free text comments were divided in their views. Some felt that support and development had taken more of a back seat. They were generally not negative, more waiting to see – although one said there was too much form-filling. Two others talked about good relationships in this area.

CCG leads in Shropshire and Staffordshire were generally positive about assurance and the most recent assurance process, although less so about NHS England and the CCG accounting to each other or having a relationship of equals. This reflected national patterns, although leads here tended to more positive than nationally across the board. This was reflected in the free text comments, and more specific areas were also raised such as meetings not being well attended by NHS England or it lacking resources, or difficulties with neighbouring CCGs and area teams. Most of the free text comments about the most recent review process were positive, mentioning good discussions and relationships.

As for the other roles discussed above, CCG leads were generally positive about primary care commissioning, again being more positive than CCG leads nationally. In the free text comments, the views put forward differed. One argued that the messages within the area team were inconsistent, with some more open to the ways of working than others. Three others felt there could be more joint working, for example by having more local presence. One lead also suggested it would help if they had agreement and clarity on budget transfers. Finally, one lead said they were underfunded and that this presented a challenge, although the area team is thought to understand.

In contrast to the other roles that NHS England has, CCG leads in Shropshire and Staffordshire were more negative than positive about specialised commissioning. In the free text comments, some raised the financial issues that had occurred. Some felt that the process is not transparent or two-way, sometimes with a disconnect with CCG commissioning.

### 10.3 North of England

*Specialised Commissioning in the North of England is undertaken by the Cumbria, Northumberland, Tyne and Wear, South Yorkshire and Bassetlaw and Cheshire, Warrington and Wirral Area Teams.*

#### Cheshire, Warrington and Wirral

|   |     |
|---|-----|
| Number of CCGs in the region            | 6   |
| Number of CCGs represented in responses | 6   |
| Number of potential respondents         | 16  |
| Number of actual respondents            | 9   |
| Response rate                           | 56% |

Of the nine leads who responded from CCGs within the Cheshire, Warrington and Wirral area team, seven agreed that the area team works effectively with them to enable them to do a great job and one disagreed. Among those who provided further detail, a number described the lack of a relationship with the regional and national teams, although a couple who mentioned the area team specifically pointed to good personal relationships and a supportive atmosphere. Many mentioned specialised commissioning as an area for concern, as was the case nationally.

CCG leads were more positive than negative about NHS England's support and development role. There were very few free text comments to explain views here. While one commented that the area team had been supportive of their reconfiguration programme, another felt there were a plethora of support offers for the CCG to navigate and concerns about support in primary care commissioning.

For the most part, leads were again more positive than negative about assurance and the most recent assurance process, although more disagreed that they have an equal



relationship with NHS England. Again, few comments were provided although those who did comment referenced a good local relationship. There were caveats, however: that it wasn't possible to escalate differences of opinion; that too much work was required around data assurance although the process could be more productive; and that the relationship with the regional team was less useful.

CCG leads were far less positive about primary care co-commissioning. The free text comments provided suggest that this is linked to perceived under-resourcing within the area team and a lack of capacity and expertise to fulfil its role. A couple mentioned that bureaucracy for GP practices has increased or that the relationships between NHS England and practices were poor and the impact of this on CCG member practices. There was a feeling among a few leads that CCGs are having to lead in this area, albeit without increased resources.

As was the case nationally, leads within Cheshire, Warrington and the Wirral were less positive about specialised commissioning. Many of those providing free text comments referred to funding and the impact of that on CCGs.

### Cumbria, Northumberland and Tyne and Wear

|   |     |
|---|-----|
| Number of CCGs in the region            | 8   |
| Number of CCGs represented in responses | 5   |
| Number of potential respondents         | 20  |
| Number of actual respondents            | 8   |
| Response rate                           | 40% |

Of the eight leads who responded from CCGs within the Cumbria, Northumberland and Tyne and Wear area team, five agreed that the area team works effectively with them to enable them to do a great job and three neither agreed nor disagreed. When providing further detail, the focus was on the challenges around specialised commissioning. The regional team was generally thought to be distant, and a couple questioned the area team's role within NHS England – although a couple also recognise the efforts made by the area team to establish a good working relationship.

On balance, views of support and development within the area team were either positive or fairly divided. Few comments were made about support and development, although there was a sense among some that the area team was accessible (albeit that one felt the team did not always follow through on requests for support).

CCG leads from Cumbria, Northumberland and Tyne and Wear tended to be negative or divided around assurance more generally, although they were more positive about the most recent assurance review process. Negative views seemed to stem from two-way accountability, with six of the eight disagreeing that they have a relationship of equals with NHS England and that NHS England and the CCG account to each other for the differences they make. This view was reflected in the free text comments. In the most recent review process, discussions seemed constructive although a couple explained that there were no

particular difficulties to discuss. One lead found the pre-meeting helpful, although also mentioned changing goalposts in short timescales due to national needs.

The leads in Cumbria, Northumberland and Tyne and Wear tended to be divided in their views of primary care commissioning, although no leads said the area team was not directive rather than collaborative in this area. In the free text comments provided, it was felt that much greater clarity and understanding of the respective roles and responsibilities is required.

Views of specialised commissioning were also mixed, but often called partnership working into question. A number of the free text comments referenced financial discussions and suggested that there had been little engagement beyond those discussions. One lead said there had been good initial joint working on budgets and risk sharing for specialised commissioning, but that greater information sharing would help and more joint work was needed urgently to clarify the finances. Another felt the CCG/specialised commissioning split was unhelpful.

### Durham, Darlington and Tees

|   |     |
|---|-----|
| Number of CCGs in the region            | 5   |
| Number of CCGs represented in responses | 5   |
| Number of potential respondents         | 15  |
| Number of actual respondents            | 8   |
| Response rate                           | 53% |

Among the eight CCG leads who responded from CCGs within the Durham, Darlington and Tees area team, seven agreed that the area team works effectively with them to enable them to do a great job and just one disagreed. Those providing further comment on NHS England, albeit generally from a positive perspective, did comment on the regional team (a sense that it was not visible and they were unclear about its remit) and the national team (one felt that NHS England nationally is probably still too centralist and controlling). A couple of leads referenced the previous system, with one saying that *parts* of the area team act like a continuation of SHAs, and the other that there is confusion around the roles of NHS England and CCGs, with the CCG needing greater autonomy. Specifically talking about the area team, one lead felt the team does not take enough action, while another felt the ways of working still need to be established around primary care.

Views about the support and development CCGs receive from NHS England were mixed. While six of the eight agreed NHS England provides them with the space and freedom to innovate, four disagreed (and only two agreed) that NHS England strikes a good balance between autonomy and support. In the free text comments provided, reference was made to resource issues and capacity. Again, views were mixed; among some, there was a feeling that the area team has not been able to *act* to provide support, while others said, for example, that working relationships require additional development, with one referencing more of a 'top down' approach.

As was the case nationally, CCG leads in Durham, Darlington and Tees were generally more positive than negative about the most recent assurance process (particularly with reference to the area team's focus on what was right for patients and their acting on challenges identified by the process) but a little more ambivalent about assurance more generally and how the two organisations hold each other to account. Of the free text comments were provided, views were again mixed. While one felt assurance was a mutual and generally productive process, another felt that relationships were less good. One lead felt it worked well when it was possible to debate issues and challenge NHS England. Finally, one lead suggested that the relationship around assurance is different with different parts of the area team, but that all organisations have the challenge of balancing increasing requirements with lower resources. It seemed from a couple of leads that other issues had been raised separately, outside of the assurance process, which could have been included.

CCG leads were generally more positive about primary care commissioning than nationally, with five of the eight leads agreeing that NHS England is collaborative around primary care commissioning (and none disagreed). However, it was not generally felt that there was a shared vision (two agreed and four disagreed) or that NHS England understands the outcomes the CCG is able to achieve and those NHS England needs to deliver (three agreed and five disagreed). The free text comments suggested a need to clarify boundaries, with some concern about difficult relationships with practices. As was the case nationally, there was a feeling these relationships need to develop further.

This was also the case for specialised co-commissioning, about which the CCG leads were more negative than positive. Again reflecting the national picture, the leads mentioned financial and budgeting issues and the risk that presented to them, while a couple were also concerned about defining specialised services. For the most part, they felt there was little collaboration in this area.

## Greater Manchester

|   |     |
|---|-----|
| Number of CCGs in the region            | 12  |
| Number of CCGs represented in responses | 9   |
| Number of potential respondents         | 33  |
| Number of actual respondents            | 12  |
| Response rate                           | 36% |

Of the 12 leads who responded from CCGs within the Greater Manchester area team, nine agreed that the area team works effectively with them to enable them to do a great job and two disagreed. In the free text comments provided, a couple felt that relationships with the area team were still developing, but that they needed greater clarity on the respective roles. As nationally, the regional and national teams appeared more remote. A couple of leads suggested the area team is under-resourced and itself under pressure from the regional or national team. A few leads mentioned challenges around commissioning.

CCG leads in Greater Manchester were particularly positive about NHS England's support and development role, with greater positivity than was found nationwide. In the free text comments, while a few referenced a good relationship here and provided examples of where support was offered, others felt they needed source their own support. Support and development around commissioning is again mentioned by a couple of leads, while one again said the area team is under resourced, although working arrangements were generally good.

Leads were also particularly positive about NHS England's assurance role. The free text comments provided referred to good relationships, although many were again concerned about commissioning, including how CCGs could hold NHS England to account, capacity concerns and how they felt that NHS England performance manages primary care, which can lead to tensions. On the process itself, a couple described mature conversations while a couple of others referred to constructive meetings (albeit one-sided). Elements of the process were thought to be good, for example learning about best practice and around major system reform, although other element could potentially be improved, for example around co-production on federating practices. One felt the process was too rigid, and another that it was summative rather than formative.

In the closed questions, the 12 CCG leads who responded were generally more positive than negative about most areas of primary care commissioning. For example, nine of the 12 agreed that NHS England is collaborative rather than directive. In the free text comments, some had been involved with developing a strategy, but there were concerns about the clarity of respective responsibilities and governance. One lead described the relationship as poor.

As was the case nationally, CCG leads in Greater Manchester were often more negative than positive about specialised commissioning. There were mixed views in the free text comments. Most of those commenting felt that there was a disconnect between CCGs and specialised commissioning, with more work on the relationship required here, while a couple described better relationships – albeit that one of these felt the two could often work in parallel rather than collaboratively.

## Lancashire

|   |     |
|---|-----|
| Number of CCGs in the region            | 8   |
| Number of CCGs represented in responses | 7   |
| Number of potential respondents         | 22  |
| Number of actual respondents            | 13  |
| Response rate                           | 59% |

Among the 13 CCG leads who responded from CCGs within the Lancashire area team, 10 agreed that the area team works effectively with them to enable them to do a great job and three disagreed. Views in the free text comments were mixed. While a couple described 'top down' relationships, a couple of others suggested relationships were better. One lead felt the

area team was restricted by the national framework, while a few mentioned concerns about commissioning.

On balance, leads were more positive than negative about NHS England's support and development role, although they were equally divided on whether NHS England helps them to develop effectively so they can commission high quality services. Again, views in the free text questions were mixed. One lead thought there was not enough resource to invest in development, while another wanted the resources to buy their own, more tailored support. One felt they did have autonomy but that there was less emphasis on development. Another suggested that the NHS structure created a tendency towards behaving like the older system rather than the ways of working.

Views were slightly more mixed for assurance generally and holding each other to account, although they were more positive about the most recent review process, as was the case nationally. This was reflected in the small number of free text comments provided. While one said they had worked hard to develop a collaborative relationship, another described a strong relationship with a focus on addressing challenges and determining solutions which are sustainable for patients. Another lead felt the process provided little constructive help, with a fourth arguing that the process was one-way with little understanding of their roles and responsibilities or a membership organisation with elected leaders. On the most recent process, a couple were as yet undecided, with one saying it was still bureaucratic although improved and another pointing to data limitations. One felt it was too frequent and should be two-way.

Views were also mixed on primary care commissioning; although six agreed NHS England is collaborative, seven disagreed that it understands its decision-making powers. Few free text comments were provided. While one lead thought NHS England had been inclusive and supportive, one had heard some positive noises but was waiting to see if actions could match that, particularly with resource constraints. Another had initiated discussions about a joint strategy. A couple of these leads felt the approach is one of performance management, or that the drive and creativity to reform primary care lies with CCGs.

CCG leads in Lancashire were more negative than positive about specialised commissioning, reflecting the national mood. One lead pointed to an example where they could not work jointly with the NHS England team, while another felt that resources were driving decisions. One lead described how a good relationship had been developed, albeit still with concerns if roles and responsibilities are not clearly defined. Another lead highlighted difficult beginnings for specialised commissioning but thought that it could be a major positive if the national specification and the derogation process are properly applied.

## Merseyside

|   |     |
|---|-----|
| Number of CCGs in the region            | 6   |
| Number of CCGs represented in responses | 6   |
| Number of potential respondents         | 15  |
| Number of actual respondents            | 11  |
| Response rate                           | 73% |

Views of the Merseyside area team among CCG leads were mixed. While one agreed that the area team works effectively with them to enable them to do a great job, four disagreed and five neither agreed nor disagreed. This contrasts with a more positive view of area teams nationally. Among those providing free text comments, a number referenced old SHA-style behaviours or performance management, with one lead suggesting this was a result of a conflict in roles. One lead felt there was a lack of clarity in the roles of the area and regional team, resulting in short notice changes to the assurance process. A couple of leads referenced difficulties with direct commissioning, while one also pointed to financial issues with specialised commissioning.

Merseyside CCG leads were often – but not always – more negative than positive about the support and development they receive. A few leads suggested that the good intentions are there but not the capacity to deliver on them, while others again mentioned a performance management relationship or over-focus on operational issues having an impact on development. One lead said this support is accessed in-house.

Leads were more negative than nationally with relation to assurance more generally and holding each other to account. They were less negative about the most recent assurance review process compared with the assurance system in general (although still negative on balance). In the free text comments, a couple of leads felt that the assurance process was one-way. One lead suggested that the assurance process is still unclear and raised a concern about the scorecard rating them for services commissioned by NHS England rather than the CCG. Another lead felt the relationship was not working so well, with changing and unrealistic requirements and at times discussions that did not feel supportive, underpinned by behaviours that seemed to relate more to the old system than to the ways of working, however this lead pointed to good relationships with individuals and improvements as the system is settling down. On the process itself, some CCG leads described changing requirements, inaccurate data or incorrect coding. A couple also argued that the discussions could be more constructive.

Views about primary care commissioning were mixed. Although six of the 11 felt NHS England is collaborative, leads were more negative than positive about other aspects; for example, seven disagreed that NHS England understands the outcomes the CCG is able to achieve and those that NHS England needs to deliver. In the free text comments, a couple of leads said NHS England's was only able to administer national contracts. Although a couple suggested relationships are developing, they still had concerns about the ability of NHS England to deliver, for example, citing gaps in knowledge about contractual requirements



and difficulties with practice payments GP contracts, while another thought there was a reluctance to manage these contracts.

Views on specialised commissioning were either evenly divided, or more negative than positive. In the free text comments, a few leads described good relationships with the specialised commissioning team, although a couple still wanted CCGs to be heard more. A couple also mentioned concerns about top-slicing.

### North Yorkshire and the Humber

|   |     |
|---|-----|
| Number of CCGs in the region            | 8   |
| Number of CCGs represented in responses | 7   |
| Number of potential respondents         | 24  |
| Number of actual respondents            | 9   |
| Response rate                           | 38% |

Nearly all of the CCG leads responding from CCGs within North Yorkshire and the Humber agreed that the area team works effectively with them to enable them to do a great job (eight of the nine). In the free text comments provided, leads emphasised these good relationships, while they felt the regional and national teams were more remote. One felt that responsibilities were not clear for all issues, while a financial lead requested greater local flexibility in financial reporting ledgers.

CCG leads tended to be more positive than negative about NHS England's support and development role. Few free text comments were provided, although one lead felt the area team offered good support but was less sure about NHS England more widely. Another referenced good support from the Managing Director and primary care team.

On balance, CCG leads were also positive about assurance, particularly about the most recent assurance review process. One lead described a very positive relationship that relies on individuals, in which the area team attend internal meetings where performance and assurance are discussed. Another thought the relationship would be more challenging as the QIPP gets more challenging. On the process itself, one lead said the discussion was robust and mutual, although though there was a risk that area teams would be pushed towards performance management (as they felt had been seen in Winter Preparedness). Another lead thought that local intelligence could be better taken into account in reporting, although the review enabled them to give more detail and use 'softer intelligence' to give a more rounded view.

On some aspects of primary care commissioning, CCG leads were positive, although they were evenly divided on having a shared vision and on whether NHS England understands the outcomes the CCG is able to achieve and those that NHS England needs to deliver. Few free text comments were provided, although one felt that NHS England should lead more on primary care commissioning, one that there was no choice but to work together given that the CCG depends on primary care to be able to deliver, and one that there is not yet clarity of responsibilities.

Leads tended to be more negative than positive about specialised commissioning, as was the case nationally. There seemed to be less joint working with the team responsible for specialised commissioning, with one describing the relationship as developing. One lead felt that NHS England could focus more on what is affordable longer term.

### South Yorkshire and Bassetlaw

|   |     |
|---|-----|
| Number of CCGs in the region            | 5   |
| Number of CCGs represented in responses | 5   |
| Number of potential respondents         | 15  |
| Number of actual respondents            | 10  |
| Response rate                           | 67% |

Among the 10 CCG leads who responded from CCGs within the South Yorkshire and Bassetlaw area team, nine agreed that the area team works effectively with them to enable them to do a great job. In the free text comments, there was a feeling among some that area teams were constrained, for example by the single operating model, inexperienced staff, unclear rules, emerging guidelines for specialised commissioning and clarity around responsibilities for primary care. One lead suggested personal relationships were the basis of a good relationship, while another was positive about the people but thought there was less connection due to distance and a greater focus on political priorities. One lead was concerned about specialised commissioning.

In some respects CCG leads were positive about NHS England's support and development role, although less so about the impact of that support in developing the CCG. Few leads provided further comments; while one said there was no clear offer, another thought the area team were doing what they could, but that they were limited by national inflexibility.

CCG leads in South Yorkshire and Bassetlaw were generally positive about assurance, and particularly so about the most recent assurance process. However, reflecting national findings, in the closed questions they were more negative about NHS England and the CCG accounting to each other (seven disagreed) and having a relationship of equals (three agreed and four disagreed). Again, in the free text comments there was a feeling that the national team could do more to enable assurance and a more equal relationship. Commissioning and NHS England's capacity here was mentioned as an area of concern within assurance by a couple of leads. In terms of the most recent process, some leads referenced good, or open and honest discussions, while one felt the joint focus on patient quality and safety works well. One lead thought it was too focused on short term performance issues, while another wanted more clinical input and felt the scorecard didn't accurately reflect progress.

The views of CCG leads about primary care commissioning were mixed, remaining broadly in line with the national picture. Those leads commenting often referenced structural concerns around primary care commissioning. These included a lack of clarity over roles that has delayed CCGs' plans, and a belief that this role should sit with CCGs given their local

knowledge. One lead felt decisions were sometimes imposed on them, while another said current working was mainly administrative.

Views on specialised commissioning were also mixed; although six agreed that NHS England is working with them as partners in this area, six disagreed that the two organisations account to each other. In the free text comments, some of the leads suggested that working relationships are good here – albeit that they can still be developed further and in one case were thought to rely on the skills and expertise of key individual. One lead felt that plans are unclear or delayed, with another arguing that the system is too fragmented and more joint working is required.

## West Yorkshire

|   |     |
|---|-----|
| Number of CCGs in the region            | 10  |
| Number of CCGs represented in responses | 9   |
| Number of potential respondents         | 27  |
| Number of actual respondents            | 16  |
| Response rate                           | 59% |

CCG leads from CCGs based within West Yorkshire were ambivalent in terms of how effectively the area team works with them to enable them to do a great job. While four agreed, seven disagreed and six neither agreed nor disagreed. In the free text comments, a few leads said that they did not find the area team helpful, but instead that they made things more difficult at times. Leads felt that the area team can focus a little too much on performance measurement with regard to its assurance role. Some also questioned the respective influence of the area and regional team; at times they felt with too much involvement from the centre, with one lead arguing that NHS England is disconnected from CCGs. Although a few also described a good or improving relationship with the area team, issues were raised by some leads, such as frequently requesting data with little notice, lack of clarity or slow processes and concerns about capacity to commission effectively.

Views on NHS England's support and development role were mixed although positive opinion outweighed negative opinion in most areas (with, for example, nine of 17 leads saying that NHS England works with them as partners in this role), remaining broadly in line with the national picture. In the free text comments provided, there was a sense among some leads that there is not a support and development offer in place, questioning either the knowledge and experience of the team to do this, whether it is able to act on concerns, or being more focused on or assurance or accounting to central teams. This is not universal – a few referenced stronger relationships and a commitment to their CCG.

CCG leads tended to be less positive about NHS England's assurance role generally and holding each other to account. CCG leads were not always negative about the area team and relationships, for example, with one saying it is possible to access support and advice from the leadership team. However, as was the case nationally, many referred to the more one-way direction of assurance. They were generally more positive about the most recent

assurance review process (with 16 of 17 leads agreeing that they had open and honest conversations), although the views given in the free text comments were more mixed. While many described good and supportive meetings with open and honest conversations, or the area team facilitating cross CCG discussions, a couple of leads felt there was not much trust or that the process did not add value, particularly as no CCG-specific feedback was given. A few other leads also felt that the process should be more tailored to individual CCGs.

On balance, CCG leads in West Yorkshire tended to be negative rather than positive about primary care commissioning. For example, of the 17 leads who responded in this area, 13 disagreed that they have a shared vision with NHS England of what they are trying to achieve. In the free text comments, many leads said that primary care strategy was lacking and it generally (though not universally) did not seem like there was a collaborative relationship here. One felt there were differences within the area team, with the contracting relationship working better than the relationship with the quality and safety team, although another lead asserted that NHS England lacks understanding of the GP contracts. One lead thought that primary care commissioning sits better with CCGs.

The CCG leads were particularly negative about specialised commissioning and many of those providing free text responses described disconnected relationships with poor communication and a lack of understanding of the impact of NHS England's actions on CCGs. One lead felt there was a poor understanding of the ambiguity around the distinction between local and specialist services. One lead suggested that relationships may improve with CCGs' push for shared principles.

## 10.4 South of England

*Specialised commissioning in the South of England is undertaken by the Bristol, North Somerset, Somerset and South Gloucestershire, Wessex and Surrey and Sussex area teams.*

### Bath, Gloucestershire, Swindon & Wiltshire

|   |     |
|---|-----|
| Number of CCGs in the region            | 4   |
| Number of CCGs represented in responses | 4   |
| Number of potential respondents         | 12  |
| Number of actual respondents            | 8   |
| Response rate                           | 67% |

Of the eight leads who responded from CCGs within the Bath, Gloucestershire, Swindon & Wiltshire area team, four neither agreed nor disagree that the area team works effectively with them to enable them to do a great job, while two agree and two disagreed. The free text comments mentioned that the area team are supportive, but that staff turnover means that relationships still need developing. Some CCG leads felt that the area team currently focus on their assurance role, and that as relationships develop the CCGs and area team will need to work more closely together to deliver great outcomes. Views of the other levels of NHS England were less positive – no CCG leads in this area felt that they work effectively with

their specialised commissioning team, while only one felt they work effectively with each of the regional and national team. A few comments expressed a belief that national level input can be too prescriptive and that this can disrupt and hinder the local agenda.

CCG leads in Bath, Gloucestershire, Swindon & Wiltshire were mixed in their views of NHS England's support and development role. The one area of almost unanimous positivity related to the ability to highlight support and development needs as part of the assurance process, where seven of the eight leads agreed. Many of the free text comments again referenced the positive working relationships. However, there was a sense that the area team lack autonomy and that communication could be stronger and more timely.

Leads in this area expressed some concerns about NHS England's assurance role, and tended to be more negative than others. The free text comments referred to a lack of two-way accountability and reflected the fact that seven of the eight CCG leads who responded disagreed that they have a relationship of equals with NHS England. CCG leads felt there is a lack of clarity around roles and responsibilities for commissioning. Leads were far more positive about the most recent assurance process than nationally. The majority of leads felt that the process was open and honest (seven of eight leads) and focussed on what was right for patients (six of eight leads). Despite this, a couple of leads thought that financial issues were not adequately addressed, and that a lack of flexibility meant that there was nothing to be gained from being open when discussing this aspect.

Reflecting the national picture, CCG leads in Bath, Gloucestershire, Swindon & Wiltshire were mixed in their views of primary care commissioning. Again, financial considerations were seen as a concern, with some leads saying that while they were told to find additional finance for specialised commissioning, the area team did not make the same commitment for primary care.

There was particular reference to local considerations in the area of specialised commissioning, with some CCG leads saying that the specialised commissioning specifications have been developed nationally, and are not suitable for more rural communities. It was felt that this is not currently appreciated by the NHS England team.

### Bristol, North Somerset, Somerset & South Gloucestershire

|   |     |
|---|-----|
| Number of CCGs in the region            | 4   |
| Number of CCGs represented in responses | 4   |
| Number of potential respondents         | 12  |
| Number of actual respondents            | 7   |
| Response rate                           | 58% |

All seven leads who responded from the Bristol, North Somerset, Somerset & South Gloucestershire area said that their area team works effectively with them to enable them to do a great job. Leads in this area were also on balance positive about their relationships with their specialised commissioning team and the regional team, more so than nationally. Comments provided by leads in this area mentioned strong working relationships with the

area team, and an increased focus on collaborative working rather than performance management. The area team was widely seen as challenging but supportive. Despite these positive local relationships, there was a perception that demands from the regional and national teams can be time consuming. A couple of comments also referred to a lack of clarity at the national level.

Reflecting the strong relationships with the local area team, leads were very positive about the support and development offered to them. Free text comments referred to the open conversations that leads have with their area team, although a couple of comments mentioned a need for more formal on-going coaching.

As was the case nationally, there was a sense that assurance is one-way. Generally, however, leads felt that the good intent shown by both the CCGs and the area team helped them reach mutually agreed solutions when discussions are more challenging. Looking at the most recent assurance process, leads in Bristol, North Somerset, Somerset & South Gloucestershire said that the meetings were positive and focussed on what needed to be achieved for the local population. A few comments raised queries about the balanced scorecard – these generally referenced national level issues, such as a limited amount of time to assimilate the scorecard data, and a perception that the scorecard wasn't balanced. Even here, however, CCG leads felt that they were able to have supportive, albeit challenging, conversations with their area team.

Views on primary care commissioning were more positive than nationally. Again, CCG leads felt that they have a good dialogue about strategy and a shared vision with the area team. Despite this, a couple of comments expressed a concern that the area team needs more support from the wider NHS England team, both in terms of the resource available to them, and the freedom/autonomy to allow contractual changes to support critical areas.

In contrast to their relationships with their area team, CCGs in Bristol, North Somerset, Somerset & South Gloucestershire were more negative about specialised commissioning. Particular concerns mentioned included perceived unilateral decision making by NHS England without CCG involvement, unresolved financial risks, and a general lack of clarity around responsibility for quality.

### Devon, Cornwall & Isles of Scilly

|   |     |
|---|-----|
| Number of CCGs in the region            | 3   |
| Number of CCGs represented in responses | 2   |
| Number of potential respondents         | 9   |
| Number of actual respondents            | 5   |
| Response rate                           | 56% |

Three of the five leads who responded from the Devon, Cornwall & Isles of Scilly agreed that their area team works effectively with them to enable them to do a great job, while only one disagreed that this was the case. Leads were less positive about their relationships with the national and regional teams. When providing free text comments about their relationship with



NHS England, a few of the leads mentioned that relationships often reflected a more performance management approach.

Views on support and development were mixed in this area. While one lead said that the CCG has good links with NHS England, another felt that they had not had a positive experience, and that it felt like they were working alone with regard to their development.

Leads in Devon, Cornwall & Isles of Scilly were more negative about the assurance role. Three of the four leads who provided a comment on this role mentioned a performance management approach and, as is the case nationally, a one-way assurance process. One lead said that the focus on targets meant that the assurance process was perhaps not as targeted as it could have been on delivering an optimally functioning system.

Generally, leads in this area viewed primary care commissioning as their greatest concern, reflecting a national pattern. They thought that the area team is under-resourced in this area, with one lead saying that commissioning should sit with the CCG in order to avoid fragmenting primary care from the commissioning of other services. In light of this, CCG leads in this area did not feel that they have a shared vision. However, one lead felt that there had been recent discussions about how primary care should be commissioned jointly, and that this had helped to clarify the roles of the CCG and area team.

CCG leads in this area also expressed concerns about specialised commissioning. All of the leads who commented on this area mentioned financial concerns, in particular referencing issues with specialised commissioning budgets. Many of the comments on this role mentioned the more distant relationships that CCGs have with their specialised commissioners. Where progress was made, some leads thought this was achieved despite the system.

### Kent & Medway

|   |     |
|---|-----|
| Number of CCGs in the region            | 8   |
| Number of CCGs represented in responses | 8   |
| Number of potential respondents         | 20  |
| Number of actual respondents            | 6   |
| Response rate                           | 30% |

All six of the leads who responded from the Kent and Medway area agreed that their area team works effectively with them, with two strongly agreeing. In the free text responses, leads mentioned positive and respectful relationships with the area team. Relationships with the regional and national were more mixed, with leads either having little contact with these teams or feeling that they adopt a more 'top down' approach to relationship management.

CCG leads in this area were generally positive about the support and development role delivered by NHS England. Only two leads in this area commented on the support and development available from their CCG. One of these classified the support role as light

touch, while the other spoke of support as collaborative in principle, but more command and control in practice when dealing with finance.

Reflecting national comments, CCG leads in this area emphasised the one-way nature of assurance. As such, they were less likely to view their relationship with NHS England as one of equals in this particular function. Despite this, leads said that the area team is supportive and on the whole models the ways of working well. While it was felt that the assurance process was fair and well communicated, there was a sense that it did not add too much value, since it simply reflected CCGs' own views of their positions.

Again, the views of CCG leads in the Kent and Medway area reflected the national picture when discussing primary care commissioning. In particular, there was a concern that primary care commissioning is under-resourced as a result of staff leaving the NHS. One comment made reference to a passing of responsibility from the area team to CCGs where roles are unclear.

Specialised commissioning was an area of particular concern for leads in Kent and Medway. There was strong criticism of the baseline exercise, with delays causing financial uncertainty for CCGs. Comments suggested that the area team did the best that it could to support CCGs despite difficult circumstances, but that perhaps they could have been more challenging. These issues have preoccupied discussions on specialised commissioning and have meant that CCGs have not developed a shared vision with the area team.

## Surrey & Sussex

|   |     |
|---|-----|
| Number of CCGs in the region            | 12  |
| Number of CCGs represented in responses | 12  |
| Number of potential respondents         | 32  |
| Number of actual respondents            | 15  |
| Response rate                           | 47% |

Among the 15 leads who responded from Surrey and Sussex, only five felt that their area team works effectively with them, while nine disagreed, making them less positive in this regard than leads nationally. Relationships with the regional and national teams seemed less strong, with only one and none leads respectively agreeing that their regional/national team enables them to do a great job. Free text comments suggested that CCG leads see the area team as under-resourced and, as such, lacking the capacity to act collaboratively. Furthermore, leads in this area felt that the area team lack authority to act independently, instead acting as a middleman for the national team. There was also a sense that the area team focuses on assurance and is less strong on support and development, and commissioning.

When discussing support and development, a few CCG leads in this area said that they make these arrangements themselves. A number of CCG leads talked about good personal relationships with area team personnel, who they saw as good communicators who are

motivated to act with CCGs. However, there was a perception that a lack of resources limits what the area team can achieve in the delivery of this role.

Reflecting this, there was a feeling that the assurance process was one-sided, with CCGs unable to hold the area team to account. For example, of the 15 leads who responded within Surrey and Sussex, 12 disagreed that the CCGs and NHS England account to each other for the differences they make. Positive comments were made about the approach of the area director, offering support and putting patients first. However, some leads felt that the assurance process didn't always involve the right people and as a consequence that meetings were not always as productive as they could be. Furthermore, there was a sense among respondents that the process is directed by the national team, with messages coming from the centre via the area team. This was a source of frustration for some leads, since they have no direct contact with the national team and feel they receiving messages second or third hand.

CCG leads in Surrey and Sussex felt that the lack of resource at area team level means that they are pushing the local primary care agenda. For example, 11 of 15 leads disagreed that they have a shared vision with NHS England. There was a perception that the area team struggles to work collaboratively in this area and sometimes hands over some elements of primary care commissioning where responsibility is unclear. There were strong concerns about the viability of primary care commissioning in the long term and the flexibility of the single operating model to accommodate local considerations.

Views on specialised commissioning were more mixed. For example, 12 of the 15 leads who responded disagreed that CCGs and NHS England account to each other for the differences we make in commissioning services for the local population. While CCG leads felt that this area, too, is under-resourced, they are more optimistic that progress is being made. As with primary care commissioning, some leads in this area felt that the national agenda can impinge on local considerations, and that the specialised commissioning team do not have the ability to fight their corner.

## Thames Valley

|   |     |
|---|-----|
| Number of CCGs in the region            | 10  |
| Number of CCGs represented in responses | 6   |
| Number of potential respondents         | 19  |
| Number of actual respondents            | 8   |
| Response rate                           | 42% |

All eight of the leads who responded from Thames Valley felt that their area team works effectively with them to enable them to do a great job. Views of the national and regional teams were mixed, but on balance more positive than negative. Free text comments on the overall relationship with NHS England said that the relationship is more collaborative than previously and that the area team culture is supportive, though limited by their capacity. A couple of comments suggested that information is sometimes slow in filtering down the

various levels of NHS England. This left some leads feeling that they were left with challenging deadlines imposed by the regional team. Leads contrasted the collaborative approach of the area team with a perceived more directive and bureaucratic approach from the regional and national teams of NHS England.

With regards to the support and development role, CCG leads in the Thames Valley said that their area team listens, and helps where it can, but that it is itself a developing organisation in need of support. As a consequence of this, some leads in this area suggested that CCGs tend to organise their development needs themselves.

CCG leads in the Thames Valley offered more of a sense of a developing a two-way relationship over assurance. They felt that this is something they have pushed for and that NHS England are starting to deliver (although it is still the case that NHS England has the final say). Generally, the assurance process was seen to be proportionate and well-delivered. Relationships were seen as mature and mutually challenging.

As nationally, CCG leads in this area felt that they are driving the primary care commissioning agenda. Leads in this area said that they feel NHS England lacks the capacity and experience to commission primary care rather than simply contracting it. They also expressed a view that national strategy is unclear

Reflecting national views, specialised commissioning was seen as problematic, with concerns about the potential impact of service reconfigurations. A couple of leads said that progress has been made in this area, with CCGs starting to untangle the system with their specialised commissioning team and specifically mentioning that local quality needs are starting to be recognised.

## Wessex

|   |     |
|---|-----|
| Number of CCGs in the region            | 9   |
| Number of CCGs represented in responses | 9   |
| Number of potential respondents         | 26  |
| Number of actual respondents            | 14  |
| Response rate                           | 54% |

11 of the 14 leads who responded from the Wessex area said that their area team works effectively with them. Leads in this area saw their relationship with the area team as still developing but generally supportive. The regional team were perceived as less visible, but a lack of clarity over policy meant the national team were viewed negatively on balance.

CCG leads in Wessex felt that the area team have positive intent regarding support and development, but that they are still trying to determine their role in the new system. A couple of comments suggested that the area team has a large number of CCGs to deal with and has limited capacity.

Leads in this area provided cautious comments about assurance in the free text comments. While they appreciated the positive intent shown by the local area team, there was a sense that they are stretched and have limited support from the wider NHS England organisation. One lead commented on the one-way nature of accountability through the assurance process, and also felt that the assurance process was overly focussed on the red areas, without opportunity to talk through the examples of good commissioning.

In line with national views, CCG leads in Wessex commented that the local area team seems under-resourced to deliver primary care. In general, leads in this area said that CCGs are leading the primary care agenda. However, two leads in this area spoke of recent attempts by the area team to work with CCGs and identify models for the future. They felt that the area team were supportive and did not attempt to dictate to them.

Reflecting national views, some CCG leads felt that they did not have as strong relationships with their specialised commissioning team. In particular, some leads said that they were not aware of strategies to join-up commissioning strategies for the benefit of the local population.





## Appendix A – Statistical reliability

The respondents to the questionnaire are only a sample of the total ‘population’ of CCG leads, so we cannot be certain that the figures obtained are exactly those we would have if everybody had been interviewed (the ‘true’ values). We can, however, predict the variation between the sample results and the ‘true’ values from knowledge of the size of the samples on which the results are based and the number of times that a particular answer is given. The confidence with which we can make this prediction is usually chosen to be 95%, that is, the chances are 95 in 100 that the ‘true’ value will fall within a specified range. The table below illustrates the predicted ranges for different sample sizes and percentage results at the ‘95% confidence interval’:

| Size of sample on which survey result is based | Approximate sampling tolerances applicable to percentages at or near these levels |            |            |
|--|---|------------|------------|
|  | 10% or 90%  | 30% or 70% | 50%        |
|  | ±   | ±          | ±          |
| 30 responses                                   | 10.7  | 16.3       | 17.8       |
| 75 responses                                   | 6.4   | 9.8        | 10.7       |
| 100 responses                                  | 5.4   | 8.3        | 9.0        |
| <b>273 responses</b>                           | <b>2.7</b>  | <b>4.1</b> | <b>4.5</b> |

For example, with a sample size of 500 where 30% give a particular answer, the chances are 19 in 20 that the ‘true’ value (which would have been obtained if the whole population had been interviewed) will fall within the range of  $\pm 4$  percentage points from the sample result.

In order to account for small base sizes, sampling tolerances have been calculated using the Finite Population Correction.

When results are compared between separate groups within a sample, different results may be obtained. The difference may be ‘real’, or it may occur by chance (because not everyone in the population has been interviewed). To test if the difference is a real one, i.e. if it is ‘statistically significant’, we again have to know the size of the samples, the percentage giving a certain answer and the degree of confidence chosen. If we assume 95% confidence interval, the differences between the results of two separate groups must be greater than the values given in the table overleaf:

| Size of samples compared | Differences required for significance at or near these percentage levels |                 |          |
|--------------------------|--|-----------------|----------|
|                          | 10% or 90%<br>±  | 30% or 70%<br>± | 50%<br>± |
| 50 and 50                | 11   | 17              | 19       |
| 50 and 100               | 10   | 15              | 16       |
| 100 and 100              | 8  | 12              | 13       |
| 100 and 150              | 7  | 11              | 12       |
| 150 and 150              | 6  | 9               | 11       |
| 100 and 400              | 7  | 10              | 11       |
| 100 and 500              | 6  | 10              | 11       |
| 200 and 200              | 6  | 9               | 10       |
| 200 and 300              | 5  | 8               | 9        |

## Appendix B – Working group members

A number of people have been involved in a working group overseeing the production of the ways of working and the survey scope, questions and design. These included:

### NHS Clinical Commissioners CCG members:

Ian Atkinson  
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Full editorial control of the survey and the survey report has been retained throughout by Ipsos MORI and NHS Clinical Commissioners.