

## **Exploring the early workings of emerging Clinical Commissioning Groups: Final report**

### **Executive Summary**

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## List of abbreviations

|       |                                                  |
|-------|--------------------------------------------------|
| A&E   | Accident and Emergency                           |
| APMS  | Alternative Provider Medical Services            |
| AO    | Accountable Officer                              |
| CCG   | Clinical Commissioning Group                     |
| CFO   | Chief Financial Officer                          |
| CoM   | Council of Members                               |
| COO   | Chief Operating Officer                          |
| CQC   | Care Quality Commission                          |
| CSS   | Commissioning Support Service                    |
| DH    | Department of Health                             |
| GB    | Governing Body                                   |
| GMS   | General Medical Services                         |
| GPCC  | GP Commissioning Consortia                       |
| H&WB  | Health and Wellbeing Board                       |
| LA    | Local Authority                                  |
| NHS   | National Health Service                          |
| NHSCB | NHS Commissioning Board                          |
| PBC   | Practice Based Commissioning                     |
| PCT   | Primary Care Trust                               |
| PEC   | Professional Executive Committee                 |
| PH    | Public Health                                    |
| PMS   | Personal Medical Services                        |
| PPI   | Patient and Public Involvement                   |
| QIPP  | Quality, Innovation, Productivity and Prevention |
| SHA   | Strategic Health Authority                       |

## Executive summary

### **Introduction**

This report presents the findings from a study of developing Clinical Commissioning Groups (CCGs) in England. The aim of the study was to explore the early experiences of emerging Clinical Commissioning Groups as they set themselves up as 'Pathfinders' and moved towards authorisation, investigating the factors that had affected their development and drawing out lessons for the future. The specific research questions addressed in this report are:

- What have been the experiences of Pathfinder CCGs over the past year?
- What factors have affected their progress and development?
- What approaches have they taken to:
  - Being a membership organisation?
  - Developing external relationships?
  - Commissioning and contracting?
- What lessons can be learned for their future development and support needs?

### **Background**

The Pathfinder programme was set up to enable aspirant CCGs to move forward under existing legislation. The programme was announced in October 2010 and the first Pathfinders were established in January 2011. There were five waves of Pathfinders, and by the end of this process virtually the whole of England was covered by an emerging CCG. At the start of this research there were 259 Pathfinder CCGs; at the end of the research period there were 212 emerging CCGs moving towards authorisation. This executive summary presents the key findings of a study covering the time up to the first applications for authorisation. The first section of the results is structured chronologically, highlighting the issues that arose and were important as the CCGs developed. This is followed by a summary of the factors that were found to affect progress and development. A third section provides more detail relating to the experiences of being part of the Pathfinder programme. The final three sections of the results present the findings relating to those issues which were less time-dependent, drawing out thematically the evidence that we found. The final section of this Executive summary draws together some of the key lessons arising from the research.

**Disclaimer:** at the time this research was carried out, CCGs were officially sub-committees of their local PCT Cluster. Technically they should be referred to as 'emerging CCGs' as CCGs will not officially exist until after they have been authorised. However, actors on the ground routinely refer to themselves as a CCG. In this report, therefore, where the term CCG is used, this refers to emerging CCGs which are awaiting authorisation.

### **Methods**

The overall study design involved detailed qualitative case studies in eight CCGs, along with national web surveys at two points in time and telephone interviews with a random sample of CCGs. Data were collected between Sept 2011 and May/June 2012. Qualitative data collection included: interviews with a wide variety of GPs and managers (96 in total); observation in meetings (146 meetings, 439 hours); and study of available documents. The web surveys were carried out in December and April/May. Response rates were 41% and 56% respectively. A total of 38 telephone interviews were carried out (response rate 38%). As a result of significant delays in obtaining the information needed to carry these out, telephone interviews are ongoing at the time of writing this report. All data sources (apart from telephone interviews) were

analysed together, and the results presented here represent a synthesis of the case studies with the national-level data.

The strength of this approach has been the quantity and depth of the data collected. The case studies have provided a detailed picture of CCG development, whilst the web surveys have provided descriptive data which has set these findings in a national context. This triangulation of data sources provides confidence that our findings are relevant to the wider population of CCGs. The main weakness of the approach has been in the speed with which the research was carried out, limiting the time available for reflection. Change was constant throughout the research, and the picture provided must be viewed as a snapshot of a developing situation. In addition, the data obtained from telephone interviews was incomplete at the time of writing this report, and aspects of this data have therefore only been included where they provide additional context.

## **Results**

Overall, we found evidence of a great deal of activity and hard work on the ground by those involved with the development of CCGs. Governing body GPs and local managers are working together with a great deal of energy and commitment to implement the changes.

### **The journey so far: Pathfinder experiences from inception to applying for authorisation**

CCGs have undergone a great deal of change and development since the inception of the Pathfinder programme. We found that:

- Survey responses suggest that most CCGs initially set themselves up in ways which reflected previous administrative groupings, some dating back some time, including, for example, the recreation of Primary Care Group boundaries
- Early Pathfinder applicants (from both case studies and survey) told us that they believed that they would derive some benefit from being ‘early adopters’, but felt that this had been lost once the programme was extended
- The *Strategic Health Authority (SHA) led risk assessment* process was a potent driver of activity in case study sites. As part of this, some groups felt themselves to be pushed towards mergers which were initially unwelcome, and which were experienced as a hindrance to development.
- *Structures and governance* remain areas in which rapid and ongoing development is occurring. Structures adopted so far are complicated and multi-layered, and it remains unclear how CCGs in the case study sites will address the need to be accountable both upwards to the NHS Commissioning Board (NHSCB) and downwards to their members and to the public at large. Our research suggests that there are a number of significant outstanding issues relating to CCG structures that need to be addressed:
  - What is the relationship between the ‘assurance’ level and the ‘operational’ level within CCGs, and are both groups clear as to their responsibilities?
  - What is the relationship between the ‘assurance’ level and the wider GP membership?
  - Who is responsible for setting the overall strategy and forward plans of the CCG?
  - What is devolved to what level within the organisation, and who can make decisions about which issues?
  - How much overlap in activity and responsibilities is there between the different organisational levels?
- Whilst case study CCGs are aware of the issue of *conflicts of interest*, it remains unclear how these will be addressed

- *CCG governing bodies* were developing and changing throughout the research period in response to changing guidance. Particular issues which arose in both the case studies and surveys include: the difficulty of bringing in new GP leaders (with only one out of eight case study sites achieving this); the requirements to appoint a nurse and a hospital consultant, which were not welcomed by the majority of case study sites; the gender balance of CCG Governing Bodies, with most dominated by male GPs; and little representation from other clinical groups such as Allied Health Professionals or Pharmacists
- The movement of *Commissioning Support* from the Primary Care Trust (PCT) Cluster into a new, standalone organisation has been experienced as difficult by most of our case study CCGs, as they have been asked to sign initial agreements with organisations which are not yet fully formed and about whose capabilities they are unsure. Emerging CCGs are anxious to retain both trusted staff and a local focus. This transition process has caused considerable disruption for both emerging CCGs and the managers working with them
- Most CCGs responding to the survey have nominated a preferred *Accountable Officer* and a *Chair*. In the case studies we found little appetite for open recruitment for these posts, with CCGs preferring to appoint those currently working with them to the senior posts. Guidance on this issue was found by some in the case study sites to be confusing, and the late issuing of the Human Resources guidance relating to staff appointments (in May 2012) was felt to have been a problem by all the case study sites
- Preparing for the authorisation process was acknowledged by case study sites to be very labour and time intensive, with some expressing concern that this had distracted from the 'real work' of commissioning. The interactive self-assessment tool was generally felt to have been useful, and support from PCT Clusters and SHA Clusters was valued highly.

### **Factors affecting progress and development**

Whilst our case study CCGs were quite different across a range of characteristics, we found some common factors affecting their development:

- The calibre and personalities of the *leading individuals* within the CCGs (both GPs and managers) had a significant impact on the way that the CCG developed in each area
- *History* was important, in terms of both individual and institutional histories. All of the GPs who initially adopted the main leadership position in each case study site (either as Chair or AO) had been in a local leadership role in the past. Historical relationships are regarded as an important strength, and have an impact on how the current task is perceived and approached.
- *PCT Clusters* have been managing a difficult situation between 'letting go' to enable CCG development whilst maintaining control of the system. At best, this relationship has been extremely supportive and helpful, but in other areas there have been frustrations, with CCGs complaining that their local PCT Cluster was trying to be too controlling. Trust and good interpersonal relationships have been the key enablers of supportive interactions
- The degree of closeness in relationships between case study CCGs and their local *SHA Cluster* have varied. Some SHA Clusters issued detailed guidance which was not always consistent with the messages from the DH as a whole, but regional workshops and meetings were felt to be particularly helpful
- As might be expected, *locally specific factors* had a significant impact on how CCGs developed and approached their task. Some of these factors are time limited – for

example, the fall out from mergers is likely to settle over time. However, others, such as struggling local Trusts and crossing Local Authority (LA) boundaries are issues that will continue to impact upon these CCGs over time

- *The national political context* (including, for example the legislative ‘pause’) has affected the development of CCGs. In general, our case study CCGs do not wish to be seen either as ‘supporters’ or ‘opponents’ of the national policy; rather, they see themselves as working to improve care for patients regardless of the national policy situation in which they are operating. There is widespread support for the idea of greater clinical involvement in commissioning. However, many believe that this could have been achieved without the need for the current national reorganisation

### **Pathfinder experiences: overall assessment of the Pathfinder approach**

Findings from the case studies and surveys suggest that:

- The Pathfinder process was a very effective way of generating momentum and achieving sign up for the development of CCGs. Participants generally regarded becoming a Pathfinder as a ‘badge’ that they needed to achieve in order to gain credibility and to begin their development
- In terms of practical support, national and regional meetings were regarded as helpful, especially those at which national leaders were present. Other aspects of the Pathfinder programme (eg online forum) were not prominent in our case study sites, and were not mentioned by survey respondents
- Opportunities to network with peers were valued
- In general, the early promise that Pathfinder CCGs would be able to influence the overall direction of the policy was not felt to have been fulfilled. There was a perceived disconnect between early encouragement to develop their own ways of doing things and an emerging sense that there was an official agenda which must be adhered to
- Evidence from both case studies and surveys suggest that the lack of clear guidance (especially in the early stages) has been a particularly problematic issue for many groups
- Individuals in leadership positions have found the process to be challenging but personally rewarding
- There is a clear appetite amongst CCGs for the NHS Commissioning Board to avoid being too directive to CCGs, allowing them to develop and to respond to local needs with a minimum of central directives

### **Approaches to being a membership organisation**

Findings from case studies and surveys suggest that CCGs are still working out what it means to be a membership organisation.

- From the case studies, some smaller CCGs are working hard to ensure that their organisations are perceived as being ‘owned’ by their members. In larger CCGs we did not see this
- Communication with the membership is seen as important by all case study CCGs. We identified three different approaches to communication:
  - as predominantly a one way process, focused upon ‘informing’ the membership
  - as a limited two way process, with the emphasis upon both informing the membership and capturing ‘usable intelligence’ from the clinical front line
  - as a full two way process, focused upon capturing the views of the membership to set the direction of the group as well as on keeping them informed
- The role, purpose and remit of Locality groups (within CCGs) remains unclear, especially in those groups which have merged. In particular, there is lack of clarity over the extent

to which Locality groups should have responsibility for budgets and for commissioning decisions. This was found in the case study sites and is backed up by the findings of the telephone interviews

- Case study CCGs and survey respondents regard the performance management of practice behaviour relating to commissioning such as referrals and prescribing is regarded as a legitimate role for CCGs, and this builds upon work that was already underway in all sites. There is a potential tension between the desire to be a meaningful membership organisation and the perceived need to manage performance.

### **Approaches to the development of external relationships**

CCGs are aware of the importance of their external relationships. From the case studies and surveys we found that:

- The comprehensive nature of the current reorganisation has generated concerns about disruption to existing partnership working with external organisations
- Most legacy PCTs had well developed systems for working with their Local Authorities (LA), and there is a general recognition that closer integration between health and social care will be vital if current services are to be maintained. Some case study sites report improved relationships with their LA since beginning their CCG journey, and are keen to develop even closer relationships by, for example, co-locating or sharing commissioning support staff. However, there is some lack of clarity about the rules relating to this.
- Health and Well Being Boards (H&WB) are in different stages of development across our case study sites. Joint development sessions between CCGs and H&WB are valuable, but there are still some uncertainties about how CCGs and H&WBs will work together in future. In particular, the following issues arose:
  - The exact demarcation of responsibilities
  - Maintaining a local focus in those areas with a two tier LA
  - Different ways of working between CCGs and Local Authorities
  - The number of meetings GP members on H&WBs will be required to attend
  - The impact of politics, particularly if a Council changes hands
  - The lack of formal powers for either CCGs or H&WBs to influence each other's work
- There are widespread concerns expressed in both case studies and surveys as to how Public Health will function in the new system
- Patient and public involvement (PPI) is something to which all of our case study sites were committed. However, they continue to wrestle with familiar issues, such as who is a valid 'representative', and in which aspects of the commissioning process can PPI be most effective/have legitimacy. Current approaches appear to build upon existing approaches developed by PCTs.
- The development of National and Local Healthwatch is proving slow in many areas
- All of our case study sites recognise the importance of working with their neighbouring CCGs, with both formal and informal collaborations under development. It is not yet entirely clear how sharing personnel between different statutory bodies will work in practice, in particular we found differing opinions as to whether shared posts would also allow sharing of other statutory functions such as audit
- Case study developing CCGs are clear that engaging productively with their local providers will be vital. There are some concerns about managerial dominance of providers and the strength of large Foundation Trusts
- Some other existing local partnerships have been disrupted by the change, and case study participants were unclear how, for example, some local actors such as Community Pharmacists will contribute in the future

- Overall, the current reorganisation involves changes to many aspects of local health economies simultaneously. Many of these changes are occurring at different rates (eg CCGs are more developed than local Heathwatch in most areas), and it will therefore be some time before the new relationships can be fully defined and functional.

### **Approaches to commissioning and contracting**

CCGs have not yet taken formal responsibility for commissioning and contracting. We found that:

- Most case study sites had been through some sort of prioritisation process for commissioning, which informed their ongoing strategic plan.
- In the second survey, three quarters of CCGs had already, or planned to, set up new services in the next 12 months and two fifths had changed or planned to change some providers of existing services.
- Most changes to services to date reported by the survey respondents and observed in the case study sites had been small in scale, short term pilots or linked to local enhanced services or innovation funding and only small scale decommissioning had occurred if at all.
- Commissioning was in a state transition and tensions could be seen between the various levels of organisation (ie PCT Clusters, CCGs and Localities) in some case study sites.
- Many of the case study sites made claims about the 'added value' of having clinicians (almost exclusively GPs) involved in both commissioning and contracting. It is too early for there to be any evidence to back up these claims.
- There were some issues caused by time constraints faced by GP commissioners, and case study GPs were beginning to realise that their new role will mean shouldering greater responsibility and accountability for commissioning decisions

### **Conclusion**

Our study has shown that there has been a great deal of hard work undertaken by both GPs and managers involved in the development of CCGs. The picture is one of flux, with ongoing change affecting the emerging CCGs themselves, as well as the wider context around them. There is an ongoing commitment to the idea of GP-led commissioning (we found little evidence of involvement of other clinicians), with evidence of enthusiasm for involvement in local service development. Some claims were made about the added value that GPs bring to the contracting process, which it is currently too early to verify. The most difficult aspect of the process as experienced by our participants was the fact that many aspects of the NHS (and associated Local Authority structures) have been changing at the same time, generating disruption and confusion. We have highlighted in this report the issues that arose for our respondents as they moved through each stage of the process so far. We were told that GP involvement in commissioning was already being strengthened prior to the current reorganisation, and many respondents expressed the belief that many of the objectives of the current changes could have been achieved within existing structures. This research reports the very early stages of the development of CCGs, and must be interpreted with this in mind. However, we believe that many of the specific issues highlighted in our results will continue to be pertinent to the ongoing development of the new system architecture.

### **Lessons relevant to the further development of CCGs**

We draw the following lessons from our findings:

- Implementation processes such as the Pathfinder approach, that aspire to actively engage front line staff in shaping the direction of travel, carry with them the risk of raising expectations that may not be met, resulting in disillusion for the staff involved. This risk may be mitigated by ensuring that there is clarity for all involved over which aspects of the programme are open to modification and which are the subject of higher level strategic decisions. In addition, ways need to be found to ensure that those who do engage at an early stage in providing active feedback continue to feel valued throughout the later stages of the process.
- CCGs would welcome greater clarity and timeliness of guidance. Whilst they do not want to be directed from above, they would like a clearer statement of what the eventual overall structure will look like, with clear guidance as to what is and is not 'allowed'. Within this clear structure they would like to be given the autonomy to innovate and develop their own local organisational responses.
- CCGs would also welcome greater clarity over the new role of the NHS Commissioning Board and its relationship with CCGs.
- The NHS Commissioning Board should identify specific points of contact for local CCGs. Personal contacts are valued, and CCGs are keen to be able to get to know and work consistently with particular local NHS Commissioning Board personnel.
- Clarity is required urgently over the employment destinations of managerial/commissioning staff. Experienced and valued staff members are under great strain and some are leaving due to the uncertainty about their employment prospects.
- At a local level, the process of clarifying roles and responsibilities between CCGs and their developing CSS needs to be expedited.
- The NHS Commissioning Board could usefully encourage CCGs to pay attention to their membership, including the developing role of their Locality groups/Council of Members. In the longer term, the ability of CCGs to change GP behaviour will depend upon their perceived legitimacy, which in turn depends upon the approach that they take to engaging members.
- Our research suggests that CCGs need to consider: the degree of autonomy devolved to Localities; the role of the members in contributing to strategy development; approaches to quality improvement/performance management; and the extent to which the CCG may be a vehicle for the transfer of expertise and resources between practices.
- In order to develop a new generation of clinical leaders, NHS Commissioning Board resources could usefully be devoted to encouraging a model of incremental engagement that builds upon GPs' commitment to local clinical innovation. In addition, these aspirant leaders will require ongoing access to training and development support
- CCGs need to provide opportunities for aspirant leaders (including female GPs, non-principal GPs and other health care professionals) to become engaged in commissioning activities in an incremental way

The rapid pace of change and the short timescale over which the research has been conducted have been challenging, and this report therefore presents a picture of a changing landscape. However, the data collected have been both detailed (in the case study sites) and broad (in the surveys) in scope; we are therefore confident that the findings presented here are relevant to the wider population of CCGs.