

Exploring the early workings of emerging Clinical Commissioning Groups

Dr Kath Checkland
Dr Anna Coleman
Dr Imelda Mcdermott
Dr Julia Segar
Dr Andrew Wallace
Ms Rosalind Miller
Dr Christina Petsoulas
Prof Stephen Peckham
Prof Stephen Harrison

Disclaimer

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Key aspects of reforms (commissioning)

- PCTs abolished
- Clinical Commissioning Groups taking over responsibility for commissioning
- CCGs established as 'Pathfinders' in early 2011, currently applying for 'authorisation', set to take over by April 2013
- NHS Commissioning Board overseeing this process – bureaucratic and time consuming, most early applicants 'authorised with conditions'
- CCGs will be performance managed by NHSCB against 'Clinical Commissioning Group Outcomes indicator set' (CCGOIS)

CCG's internal organisation

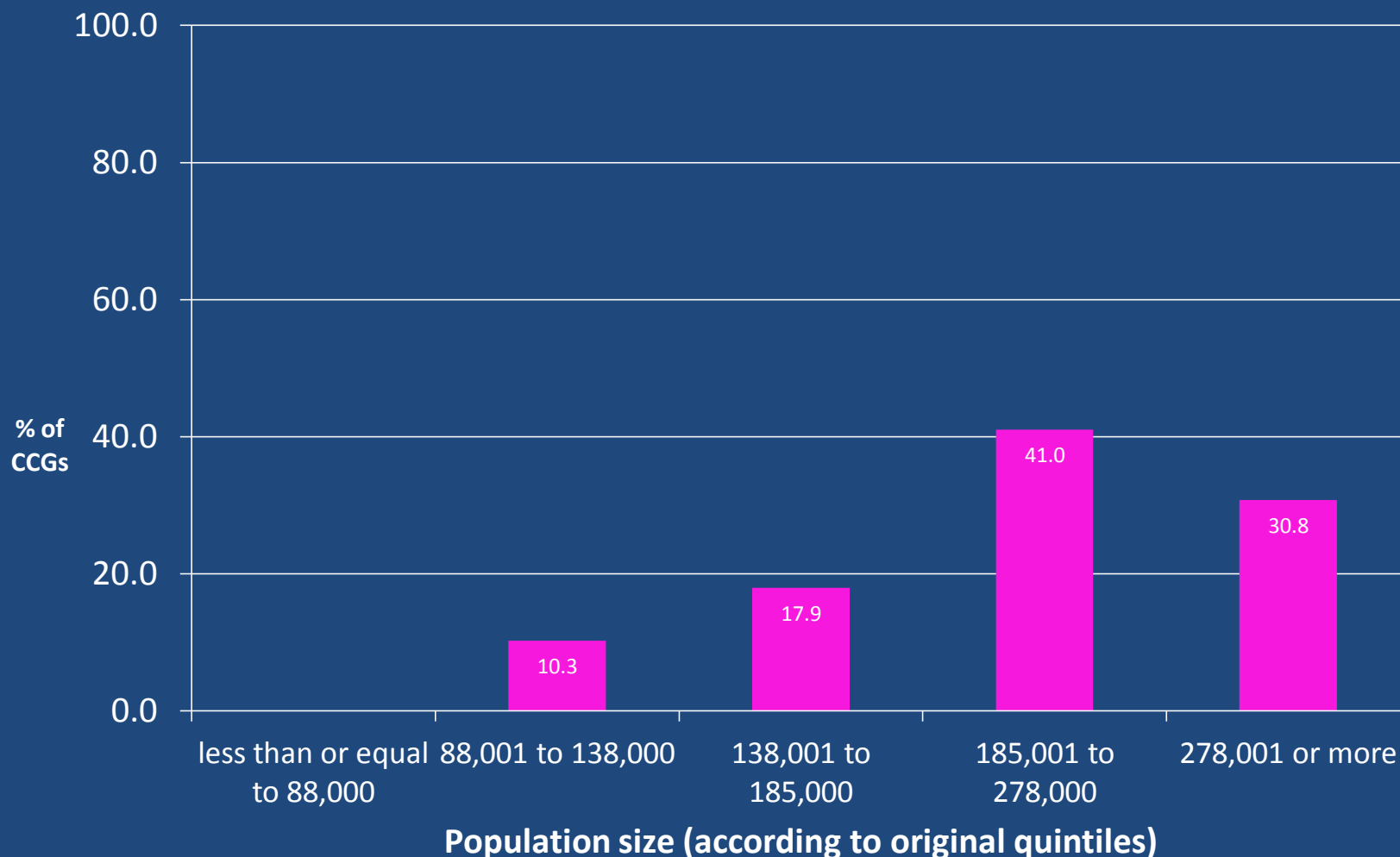
- '3 at the top' – Chair, Accountable Officer and Chief Finance officer
- AO can be GP or manager – about 25% GP
- Most Chairs are GPs
- All three initially selected by CCG, but subject to NHSCB ratification process
- NO central 'blueprint' for organisation/ structure
- Practices must be 'members' of a CCG – unclear what this will really mean as yet
- CCG must have a 'geographical footprint'

Methods

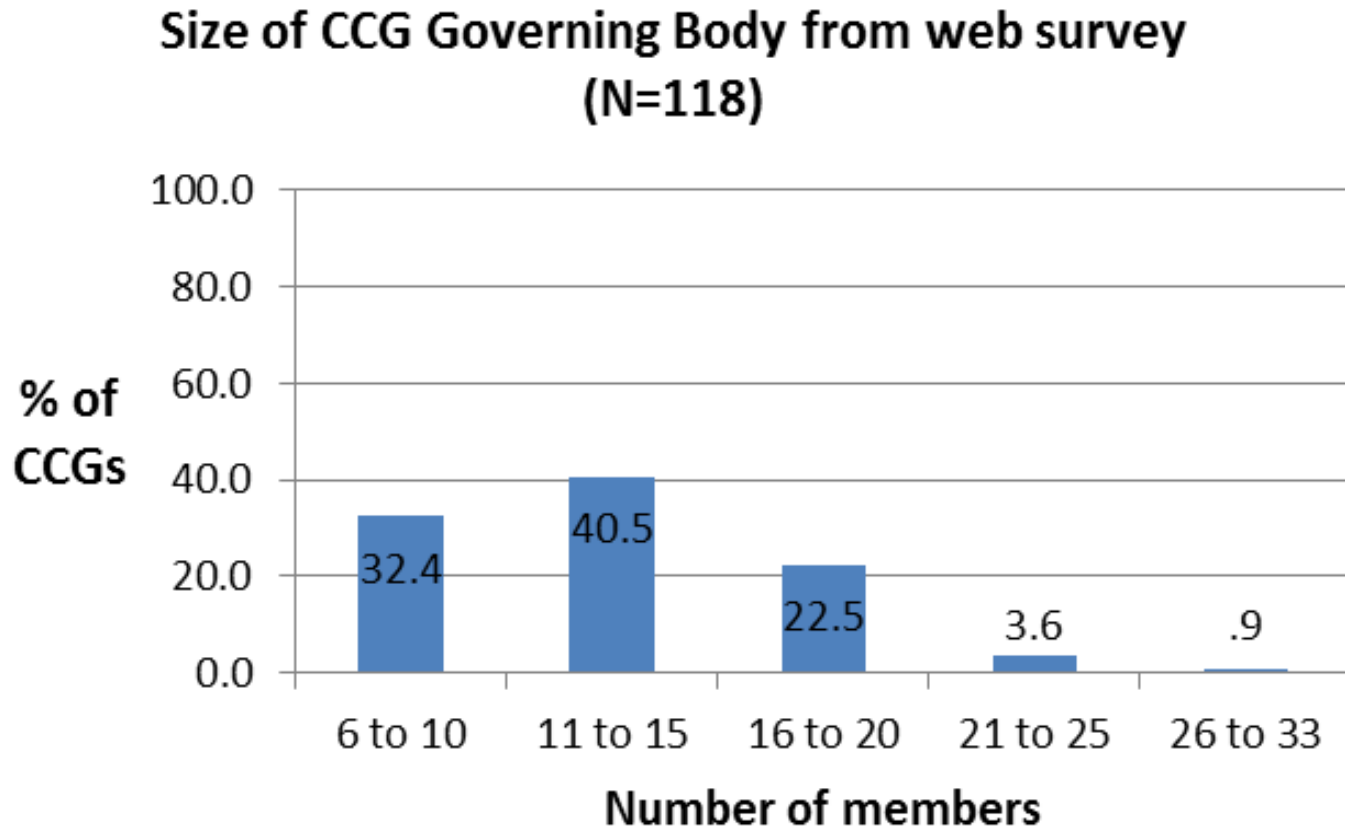
- 8 detailed qualitative case studies, using observation, interviews and document analysis
 - Maximum variety sample, purposively selected, taking account of: size; pathfinder 'wave'; SHA; complexity of local health economy (eg number of providers); relationship with LA boundaries
 - Sept 2011-June 2012
- Web-based surveys at 2 points in time (Dec and April), focusing upon factual data to do with size, structures, governance arrangements. Second survey also asked about commissioning plans
- Telephone interviews in May/June – followed up to provide wider perspective on issues raised in case studies

CCG size (survey)

Population size of CCGs from 2nd web survey

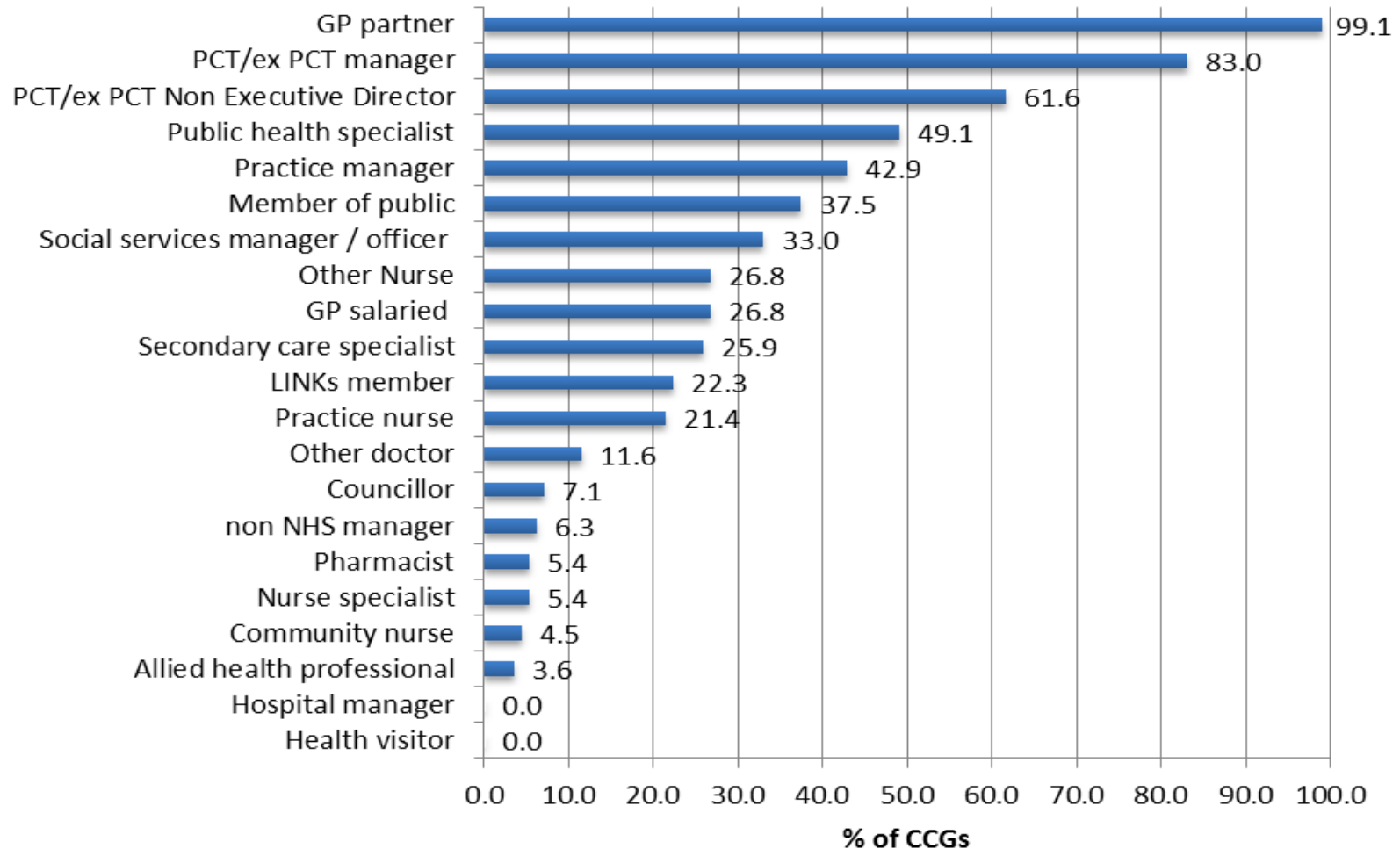


Governing body sizes (survey)



Governing body membership

Percent of CCGs with a particular member on GB (N=118)



CCG structures

- Very variable – difficult to make comparisons. Most include:
 - Governing body (will be statutory body)
 - Operational bodies of some kind – may include some kind of smaller ‘executive group’ which does day to day work, as well as various workstreams etc
 - Locality groups – local groups of GPs
 - Council of Members – group of representatives from every practice
 - Some also have some sort of wider reference group, providing advice and bringing in eg secondary care colleagues

Management & costs

- Running costs allowance significantly less than PCTs
- Study site CCGs mostly started off wanting to employ commissioning staff, but ability to do this limited
- Considerable issues associated with HR/staff transfer etc – great uncertainty for managers
- Senior GPs all working many more hours than they are paid to do - ?sustainability

And I spent yesterday, six hours in a Joint Strategic Needs Assessment on the Health and Well-being Board, for which I have not been paid, and I won't get paid. That's why I am still catching up on my clinical work, and I came in at 7 o'clock this morning to do all my paperwork and spent till 8 o'clock last night doing that. So I spend hours and hours of unpaid work. So I maybe do two days a week, and this is sometimes in my own time or my free time -- doing the work that needs to be done. [GP ID 218]

Commissioning support

- CSUs developing alongside CCGs
- Concerns include:
 - Size of CSUs compared with CCGs – CSU may ‘have their own agenda’
 - Requirement to ‘sign up’ before they are clear what CSU can offer
 - How will they monitor CSU work and hold them to account – potential costs in time and effort?

We've just had a meeting today about quality assurance. You have to know that what you're getting from any commissioning support organisation is robust and correct. So that you end up pulling a whole bunch of people to check what they're doing is the right thing, or [is it easier to] just employ the people and check them yourself? I think we're struggling a bit with that at the moment, because we don't know precisely what the CSU are going to offer and what quality assurances they'll be able to offer us. [GP ID 283]

Factors affecting progress and development 1

- The calibre and personalities of the ***leading individuals*** within the CCGs ***note: need for succession planning***
- ***History*** was important - 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. Some very supportive, others less so

Factors affecting progress and development 2

- ***Locally specific factors*** had a significant impact on how CCGs developed and approached their task. Eg issues with providers, crossing LA boundaries
- The ***national political context*** has affected the development of CCGs. Case study CCGs do not wish to be seen either as 'supporters' or 'opponents' of the national policy; claim to be working to improve care for patients regardless of the national policy situation. Widespread support for the idea of greater clinical involvement in commissioning, but many believe that this could have been achieved without the need for the current expensive national reorganisation

Approaches to being a 'membership organisation' 1

- How far is the CCG 'owned' by its members?
 - Variable
 - Smaller sites generally more likely for members to feel that they 'own' it
- Communication – three approaches:
 - Communication 1 way process, 'informing' members
 - Communication limited 2 way process – 'informing' members and 'gathering intelligence'
 - Communication true 2 way process - members setting the agenda

Approaches to being a 'membership organisation' 2

- Locality groups: what are they for?
 - Lack of clarity common
 - Should they have substantial devolved budgets?
 - How do they feed in to the strategic agenda?
 - Are they the main forum for engaging practices? If so, what is relationship with any 'council of members'?
- Performance management of practices
 - How far is this a CCG role?
 - If CCG sees itself as performance managing practices, how does this square with maintaining engagement?

External relationships

- HWB
 - Some CCGs see themselves as ‘co-owners’ of HWB, others just attend meetings
 - Practical issues can dominate – eg time to attend meetings
- LA
 - Some striving for increased integration – eg co-location, joint posts etc
 - Others much more arms length
 - Issues for those CCGs crossing LA boundaries
- PH
 - Some have PH fully integrated into CCG governing body, others see PH as more arm’s length ‘service provider’

Approaches to commissioning & contracting

- Early days – most planned service changes small scale/local
- Some claims to GPs ‘adding value’ to the contracting process – ‘having a clinical voice in the room’ BUT time-consuming/costly
- ?will CCGs be able to effectively influence practice referral/prescribing behaviour?
- Some concern about ‘any qualified provider’ & future role of monitor – sense that local integration key to saving money
- Concern for the future

I think, we'll have a chance to develop some services and that'll be clinician led, and that's good, but, I think, we'll be faced, before very long, with disinvestment decisions, which won't be good and we'll be paying for and will alienate us from our colleagues, who never want to face the reality, we'll have to lose some services. You know, we're only at the start of the efficiency savings we're meant to and, I think, you know, trying to keep the service together, over the next five years is going to be really, really hard and, I think, if you can't have the carrot of small scale local improvements to keep you motivated, you're not going to be wanting to be around for the other stuff. [GP ID 184]

Ongoing important issues:

- Costs associated with additional clinical time – many GPs working much more than they are paid to do - ?sustainable
- Relationship between CCGs and their CSU
- Tension between integration and competition – role of Monitor?
- Relationship between NHSCB and CCGs – degree of freedom/control
- Meaning of being a ‘membership’ organisation and future role of Localities