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# Clinical commissioning

## GPs in charge?

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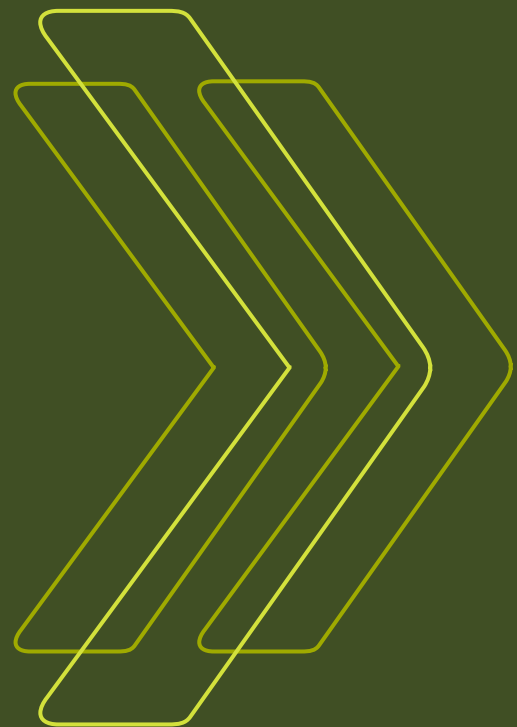
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# Key messages

- Effective clinical involvement and clinical leadership are essential components of high-quality commissioning. They are critical to the success of efforts by clinical commissioning groups (CCGs), vanguard sites, other emerging integrated provider organisations and sustainability and transformation plans (STPs) to transform out-of-hospital health and care provision and move the NHS to a more financially sustainable position.
- CCGs have secured better clinical engagement than previous forms of commissioning and are now seen by the majority of their GP members as an influential part of their local health economy. However, GPs report that this is yet to translate into significant improvements in the quality of general practice. This is perhaps unsurprising, given that CCGs have had the option to commission general practice only since 2015.
- Despite the progress made, CCGs' clinically led model of commissioning is at risk if three external barriers are not addressed. First, CCGs feel that they are not currently given the autonomy they need to involve GPs effectively in decisions about the design of local services. Second, reduced running-cost budgets and the transfer of new functions with little or no additional resource are making it difficult for CCGs to develop a high-quality clinically led commissioning function. Third, financial pressures mean CCGs are frequently required to take tough prioritisation decisions and many do not feel they have the support from politicians and NHS England to keep the public on board as they do this.
- There are a number of factors that are likely to lead to changes in the structure and role of CCGs over the next few years. The NHS must build on the progress CCGs have made so far and work to spread that learning by embedding clinical involvement in planning decisions wherever they happen in the system.



## Recommendations for national leaders

In order to support CCGs to build on the progress they have made and to address continuing barriers to effective clinical involvement, NHS England and the Department of Health should:

- provide clinical leaders with the **developmental support** and training they need to do the job properly
- work with the royal colleges to promote commissioning as a **rewarding career option** for clinicians and ensure it has the same status as research, training and clinical work. The enthusiasm among GPs and other clinicians to get more involved in commissioning should be harnessed and must not go to waste
- set out clearly the role that CCGs can take in **developing new models of care**, including scaled-up forms of primary care, to empower them to take bold action to drive transformation efforts locally
- learn the **lessons from the primary care co-commissioning** process before transferring further commissioning responsibilities to CCGs, including the reasons behind the delays experienced in transferring functions and resources to CCGs
- recognise that the current moratorium on voluntary mergers between CCGs **is not sustainable** indefinitely due to tightening commissioning budgets. However, mandatory mergers should be avoided
- outline a clear strategy for the **future of commissioning** support that recognises the likely changes in CCGs' support needs over the next few years, as the role of CCGs changes
- provide CCGs with '**air cover**' for **tough decisions** about how to prioritise funding, by being honest with the public about what is achievable with the money available.

The commissioning system is evolving in response to growing financial and operational pressures and the new care models being implemented in the wake of the *NHS five year forward view* (Forward View). However the planning and



purchasing of care is done in the future, clinical involvement will be key. To embed clinical involvement in planning decisions across the NHS, as the role that commissioning plays in the system changes, the NHS will need to:

- publish a **vision for the future of NHS commissioning** that recognises the multiple overlapping planning and delivery structures that are developing in different ways across the country. This vision must address the risk of fragmentation created by the multiple organisations now undertaking commissioning-like work, including STPs, vanguards and other new integrated provider organisations; and outline a core set of principles that should underlie commissioning across a complex system
- make a clear statement reaffirming the principle of **local clinicians being at the heart of the commissioning process** to ensure clinical leaders shape the direction of change. Beyond CCGs, this includes strong clinical involvement in the STP process, new integrated models of commissioning health and social care, and new integrated delivery organisations
- ensure that any structural changes to the commissioning system are **evolutionary and flexible** to adapt to local conditions, rather than centrally mandated. In terms of clinical engagement (and morale in the commissioning workforce), the worst option would be a centrally mandated restructuring of CCGs
- retain some **'localness'** in health care decision-making. Despite the development of STPs and the benefits of working at scale, there needs to be recognition that CCGs will continue to operate in different groupings for different purposes, and they need to retain sufficient flexibility to do so
- ensure commissioning organisations have sufficient **autonomy** to work with GPs and other clinicians to take decisions that are in the best interests of their patients. Clinical involvement is difficult when responding to multiple central requests within tight timescales
- ensure that requirements for CCGs to **manage conflicts of interest** apply across the NHS, including in provider organisations that take on responsibilities for NHS procurement decisions.



## Lessons for commissioners

There are also important lessons from our research about what CCGs can do to make the most of clinical involvement in the here and now. Over the past four years, CCGs have developed a range of strategies to work more closely with general practice. Effective strategies include CCGs' efforts to:

- **engage with all GPs in a local area** by embedding clear and open lines of communication between the CCG governing body and GPs, for example through regular face-to-face contact with practices
- **maximise the contribution of CCG GP leaders** by being clear about why clinicians are being engaged and refining committee structures to focus GP time on areas where they can add value. Also broadening involvement by getting practice nurses, pharmacists and others to fulfil a range of clinical roles in the CCG
- **develop the next generation of GP leaders** by creating roles that allow GPs to 'test the water' before taking on clinical lead or governing body posts
- **drive improvement in general practice** by taking a leading role in facilitating the development of new provider models
- **manage conflicts of interest** through complete transparency and by supporting the development of lay members, who play an increasingly important scrutiny role
- **collaborate effectively with other local commissioners** while also retaining local ties and identity
- **effectively procure commissioning support** by building strong relationships with commissioning support units (CSUs) and the other CCGs with whom they are commissioning a particular support service.



# 1 Introduction

Clinical involvement and clinical leadership are essential components of high-quality commissioning. Research from the NHS and elsewhere shows that clinically led approaches to planning and designing health services are more likely to be effective and innovative than those that do not involve clinicians (McDermott *et al* 2015; Miller *et al* 2015). In line with this, clinical commissioning groups (CCGs) were designed to put GPs at the heart of NHS planning decisions. This report looks at what progress CCGs have made, in the three years since their launch, in implementing this model and what needs to be done to build on this.

This is the final output of a four-year research project, led by The King's Fund and the Nuffield Trust, which has followed six CCGs from their pre-authorisation phase to where they are now.

The report aims to share learning from CCGs' experience so far about securing effective GP involvement in commissioning, and to make recommendations about what needs to be done to ensure that the GP voice is heard in the future. The lessons in this report are not only relevant to policy-makers and CCGs looking to develop their model, they also provide important learning for other organisations across the NHS that are involved in the planning and design of services. These include new integrated provider organisations, who are increasingly taking on commissioning-like work, and the emerging place-based planning approach, in which commissioners and providers are collaborating across local areas to transform care through sustainability and transformation plans (STPs).

Section 2 sets the context for clinical commissioning and describing the factors that are driving changes in the role and structure of CCGs. Section 3 outlines findings from earlier rounds of our research about CCGs' progress so far in securing GP involvement in commissioning and transforming general practice. In Section 4 we set out what CCGs told us they have learnt about seven key areas relating to GP involvement. Section 5 highlights three national challenges that are inhibiting CCGs' ability to do this effectively. Section 6 provides recommendations for national bodies about how to secure clinical involvement across the NHS.





This report summarises the experience of CCGs within the current system of commissioning and providing health care in England. We do not seek to assess whether the current system is the right one going forward in the context of new models of care and developing STPs. As we have argued in work published separately, it is likely that NHS commissioning will have to become more strategic and integrated in response to changes in the NHS provider and commissioner landscape (Ham and Alderwick 2015; Jupp 2015). This report highlights the need to build on the progress CCGs have made and embed clinical involvement throughout the new system, as the role of commissioning changes.

## Our research

The King's Fund and Nuffield Trust have, since 2012, been following six CCGs that were selected to broadly represent the characteristics of CCGs across the country. Our work focuses on three specific aspects of their development:

- how CCGs have established themselves as GP-led commissioning organisations, particularly the way they work with member practices and the extent of GP involvement in their activities
- CCGs' role in supporting quality improvement in general practice
- the structures and processes that support GP involvement and quality improvement in general practice.

This report is based on:

- focus groups held with CCG leaders in the six CCGs between October 2015 and January 2016 that form phase three of this research. The focus groups involved 51 participants who were a mixture of CCG governing body members (including GPs, lay members and CCG managers), other GPs, clinicians and senior management staff. The majority of attendees, but not all, had a formal role in the CCG. At the focus groups, we asked CCG leaders and members to consider what lessons they have learnt since 2012 and what they think the future of commissioning will look like.



- earlier research with these six CCGs, which has been published in two previous reports ([Holder et al 2015](#); [Naylor et al 2013](#)). The field work for phase 1 and 2 of our research was carried out between 2012 and 2014 and included the observation of 36 CCG meetings and 147 interviews with CCG leaders (both clinical and non-clinical), GP members, practice managers and senior representatives from other key organisations such as NHS England area teams, commissioning support units and health and wellbeing boards
- an annual online survey of GPs and practice managers in the six CCGs that was fielded in January/February each year between 2013 and 2016. Full results from the survey and more detail about its methodology are published in separate slide packs ([Holder et al 2016](#); [Robertson et al 2015](#))
- discussions with key stakeholders working in national bodies and other local CCGs
- literature on the development and operation of clinical commissioning.



## 2 Setting the context: factors driving change in CCGs

Clinicians have been involved in commissioning in the NHS since the purchasing function was first separated from provision in the early 1990s. However, it was not until the creation of clinical commissioning groups (CCGs) in 2013 that GPs were put firmly at the forefront of the commissioning process.

CCGs were created by the Health and Social Care Act (2012) as membership organisations made up of local GP practices, which have a legal responsibility for spending around two-thirds of the NHS' commissioning budget. These organisations put the responsibility for the funding and design of local health services in the hands of local GPs, based on the logic that their daily interactions with patients give them an in-depth understanding of their practice population, and makes them well-placed to design health services that meet local needs ([Department of Health 2010](#)). Their close links with GPs also make CCGs well placed to help transform the way care is provided outside hospital, a core ambition for the NHS over the next five years ([NHS England et al 2014](#)).

Since their launch the responsibilities of CCGs have continued to undergo significant change. Below we outline four key factors driving change and discuss what each could mean for the role and structure of CCGs.

### The transfer of new responsibilities to CCGs

The 2012 Act gave CCGs responsibility for commissioning the majority of secondary and community care services, and a legal duty to work with NHS England to improve quality in primary care. In 2015, under a new policy of primary care co-commissioning, CCGs were given the option to commission general practice either themselves or in collaboration with NHS England ([NHS England 2016h](#)).



The majority have now taken on that new role, and their responsibilities may expand further over the next few years if plans to delegate some specialised services to CCGs are implemented.

Although this shift of commissioning responsibilities from NHS England to CCGs reduces some of the fragmentation in commissioning that occurred in 2012, additional responsibilities have not always been matched with additional resources (as discussed on p 47) and many CCGs are struggling to do more with less. The new responsibilities provide opportunities for CCGs to do more to transform general practice, but they come with the risk that commissioning decisions may be affected by conflicts of interest more frequently. Approaches CCGs have taken to both of these issues are discussed in the next section of this report (*see* p 19).

### Changes to the structure of NHS providers

Innovative provider organisations have been working to integrate primary, community and acute care services for several years ([Ham and Curry 2010](#)), but it took the publication of the Forward View at the end of 2014 to give these reforms real momentum and pace ([NHS England et al 2014](#)). The Forward View outlines seven ‘radical new care delivery options’ for the NHS to develop by 2020 that involve providers from different parts of the health service coming together to deliver a more joined-up service for patients. These include new multi-specialty provider organisations in which GPs and community health care providers come together to provide a wide range of out-of-hospital services for patients, including much of the ambulatory care activity that currently takes place in hospital. To speed up implementation, these new models of care are being fast-tracked in a series of vanguard sites across the country ([NHS England 2016c](#)).

The shape of general practice is also changing. GPs are forming networks and federations to improve patients’ access to care and deliver a wider range of services across larger populations ([Baird et al 2016](#); [Rosen et al 2016](#); [Smith et al 2013](#)). Many of these GP federations form the core of the multi-specialty provider model outlined above.

These changes will have major implications for the role of CCGs that are already starting to award large outcomes-based capitated contracts to multi-specialty



groups of providers to provide a wide range of services for their local populations (Addicott 2014). These large provider organisations or networks are in some cases acting as a ‘lead provider’ that then subcontracts with others – taking on some of the service design and procurement responsibilities traditionally associated with commissioners. If this trend continues, commissioners are likely to step back from much of the day-to-day contract management to take on a more strategic commissioning role. This more strategic role would involve CCGs defining broad outcomes and measuring the performance of the system as a whole (Ham and Alderwick 2015). As part of this, CCGs may start to operate over larger geographical areas to make best use of scarce commissioning resources.

Under this scenario, where the line between commissioning and providing in the NHS is blurred and commissioning-like work is undertaken by providers as well as commissioners, it is important that GPs and other clinicians are involved in planning and procurement decisions wherever they take place in the health system. This underlines the relevance of this report’s findings to new integrated provider organisations, as well as CCGs.

### **The movement towards place-based approaches to planning and STPs**

The urgent need to transform out-of-hospital care is one of the drivers behind current moves towards a place-based approach to planning local NHS services at scale. New approaches to planning care across larger geographical areas will affect the role and structure of CCGs in the future.

The NHS planning guidance for 2016 introduced a new programme of place-based planning for the NHS up to 2020/21 (NHS England *et al* 2015). It asked all of the NHS providers and commissioning organisations in local areas to come together to write sustainability and transformation plans (STPs). These are multi-year plans designed to tackle the immediate financial challenge and accelerate implementation of the Forward View. The 44 STP geographic footprints each involve an average of five CCGs, but range from one to as many as twelve (NHS England 2016a). This new planning process means that, while CCGs will still commission services individually, some high-level decisions about how to drive transformation will be taken, as part of the STP, as a group with other local commissioners and providers. This is part of



a movement towards place-based approaches to health care delivery and planning where, rather than focusing on competition, providers and commissioners work collaboratively across traditional organisational boundaries to develop and deliver services for patients ([Ham and Alderwick 2015](#)).

This more collaborative approach further blurs the line between the purchasing and providing functions in the NHS. Through STPs, providers are playing an important part in decisions about what health care services should be delivered across local areas. It also means some key decisions will be taken across a number of CCGs, rather than by individual CCGs. This type of collaboration between commissioners is not new, as CCGs already collaborate in different groupings for different purposes (*see p 38*) but the STP does create a new single grouping that will take some key decisions about finance and transformation.

For CCGs, a key challenge will be working out what unique role they can play in these new, larger structures, an important part of which will be ensuring that decisions taken across local areas still benefit from clinical input. If transformation plans are to be successful, GPs must feel a sense of ownership of the new agenda. However, it is currently not clear how the GP community will be involved in developing STP plans. Around half of the 44 STPs are led by CCG representatives, but just four are led by clinical leaders from CCGs ([NHS England 2016d](#)). This underlines the relevance of messages in this report about sustaining clinical engagement with those involved in the STP process.

### **Integration of health and social care commissioning**

In the November 2015 Spending Review, the government made a commitment to integrating health and social care by 2020 ([HM Treasury 2015](#)). This will be a locally led process: local authorities and health care commissioners have been asked to agree their own approaches to joining up health and social care services and better integrating their commissioning functions. This builds on efforts to pool health and social care funding through the Better Care Fund, which has seen £5.6 billion pooled so far, with a further £1.5 billion announced as part of the Spending Review that will be added in 2017.



It was noticeable that, during the first few years of our research, the agenda to integrate both the provision and commissioning of health and social care was at the forefront of NHS reform efforts and featured prominently in discussions we had with CCG leaders and in CCG meetings that we observed as part of the research (Naylor *et al* 2013). In the latest phase of our research, while many CCGs were working towards integrating aspects of health and social care services, moves to integrate the commissioning of these services were, overall, less prominent in our discussions with CCGs about their future. One of the key structures developed to enable integration across health and social care – health and wellbeing boards – are yet to have a major influence (Holder *et al* 2015; Humphries and Galea 2013). Furthermore, an evaluation of the Department of Health’s health and social care integration pioneers identified a number of national barriers to joint commissioning (Erens *et al* 2016). This emphasises the distance still to travel before health and social care is commissioned in a fully integrated way.

There is a range of options for joining up health and social care commissioning (Humphries and Wenzel 2015; Commission on the Future of Health and Social Care in England 2014). Whatever solution local areas choose, the direction of travel is clear, and moves to work more closely with local authorities will add to the varied patchwork of commissioning arrangements that are likely to develop over the next few years.

### Our case study CCGs

It was within this changing policy landscape that we traced the evolution of six CCGs between 2012 and 2016. During this time, we have seen these CCGs respond in different ways to all four of these factors driving change. For example, while some are already thinking about how their role and function might change over the next few years, and even considering the transfer of staff from the CCG to provider organisations, others (in particular, CCGs where there are no vanguard sites) have not started to think about these issues and do not see them as relevant to their local health economy. While some have eagerly taken on fully delegated co-commissioning responsibilities for general practice, others were keen to continue commissioning collaboratively with NHS England. This suggests that a mixed economy of CCGs is likely to develop over the next few years, with some moving at a faster pace than others towards a more strategic model of commissioning.



Within this context, we now turn to look at the findings from our research in more detail to consider whether and how CCGs have secured GP involvement in commissioning and what barriers are standing in the way of them getting the most value from their GP-led structure. We also reflect on these four policy drivers to outline what commissioners and national policy-makers should consider in order to maintain the clinical voice in commissioning.





## 3 Strengthening the GP voice in commissioning: progress so far

However the commissioning sector changes over the next few years, effective clinical engagement and clinical leadership will be an important part of enabling the NHS to balance its finances and transform out-of-hospital care ([Alderwick \*et al\* 2015](#)).

Research about clinical commissioning groups (CCGs) and previous commissioning structures found that GPs add value to the commissioning process and that clinically led approaches to commissioning are more likely to be effective and innovative than approaches that do not involve clinicians ([McDermott \*et al\* 2015](#); [Miller \*et al\* 2015](#)). Outside the commissioning sector, research on clinical leadership in provider organisations in the NHS and elsewhere shows that involving clinicians (GPs and others) in management and planning decisions is key to developing high-performing organisations and ultimately improving the quality of patient care ([Clark and Nath 2014](#); [Dickinson \*et al\* 2013](#); [Reinertsen \*et al\* 2007](#)).

This section outlines findings from earlier stages of our research about the progress CCGs have made in securing GP involvement in their commissioning processes.

### Finding from our previous research

CCGs are membership organisations: their decisions should reflect the views of the GP practices that make up their membership. However, we know that a clinically led organisational structure does not guarantee effective clinical involvement, and that clinical involvement does not guarantee that new services will be designed around patient needs. Over their first three years in operation (and almost five years since they started to establish themselves in shadow form), CCGs have had to develop their approach to working with GPs and have faced significant challenges.



Our research has explored these issues by considering how CCGs involve GPs in their work, what role CCGs have taken in supporting quality improvement in general practice, and the structures and processes they have put in place to support these two aims.

Over the past four years, we have seen CCGs make some progress in these areas ([Holder \*et al\* 2016](#); [Holder \*et al\* 2015](#); [Robertson \*et al\* 2015](#); [Naylor \*et al\* 2013](#)). Specifically, we have found evidence that:

- **CCGs have secured better clinical engagement than previous forms of commissioning.** Our survey conducted between 2013 and 2016 found that more than 70 per cent of CCG members were at least ‘somewhat’ engaged with the work of their CCG throughout the period. This compares favourably to the results of similar surveys conducted during practice-based commissioning ([Wood and Curry 2009](#))
- **CCGs are seen as an influential part of their local health economy** by the vast majority (83 per cent) of the GPs and practice managers who responded to our survey and we observed CCG leaders playing an important role in working with local partners to shape services
- CCG leaders and members were **increasingly accepting of the role of CCGs in influencing primary care** and had implemented initiatives to improve the quality of care
- **CCGs have been particularly successful in improving relationships between practices** and facilitating the review of comparative data. GPs also said that CCGs had changed their prescribing patterns and referral pathways
- **GP leaders in CCGs feel increasingly confident in their role.** The proportion who told us that they have the support they need to make evidence-based decisions rose from 46 per cent to 60 per cent between 2014 and 2016. We also found that the majority of leaders reported that they plan to stay in their role for the foreseeable future.



Despite these successes, CCGs are not yet seen as being as fully clinically led as they could be. Earlier components of our research have highlighted the following challenges.

- Although overall levels of engagement remained constant, when asked in more detail about their sense of involvement with the CCGs work, GPs without a formal role in the CCG reported **low levels of influence over commissioning decisions** (in 2016, 20 per cent felt that they could influence the work of the CCG if they wanted to) and the majority did not feel the organisation was owned by its members (23 per cent felt it was owned by members). This situation appears to be worsening, with these figures declining since 2014.
- There is evidence to suggest that **the sustainability of clinical involvement at a leadership level could be at risk** because, although the majority of leaders reported wanting to stay in their roles for the foreseeable future, we also observed a waning of enthusiasm among some GP leaders alongside increasing competition for leadership roles, as a result of the rise in number of at-scale GP provider organisations.
- **GPs report that CCGs have not yet had a significant impact on the quality of care they provide or patient experience of GP services**, though this is in line with evaluations of integrated and community-based care interventions that note that a significant amount of time and resources are needed before benefits for patients are realised ([Bardsley et al 2013](#)).

As CCGs face these challenges, they have developed a range of strategies to embed clinical involvement in their organisations. In the next section of the report, we outline the learning from our research on seven key issues that CCGs face when developing their GP-led structure. This will provide insights for CCGs and others involved in NHS planning about effective approaches to working with general practice.



## 4 Seven issues for CCGs and strategies for improvement

This section draws together learning from the experience of CCGs so far about effective strategies that have helped them develop their clinically led model of commissioning.

More than four years after CCG leaders took up their posts, we held focus groups with governing body members, senior managers and GPs in six CCGs and asked them to reflect on what they had learnt so far about involving GPs in their work and transforming general practice (*see p 8*).

Seven key areas of learning emerged:

- engaging the GP community in commissioning
- maximising the contribution of GP leaders
- succession planning
- improving the quality of general practice and implementing new models of care
- managing conflicts of interest
- collaboration with other commissioners
- working effectively with commissioning support services.

In the sections that follow we describe each area of learning in turn and share lessons from CCG leaders and the research literature about effective approaches to addressing them. In each area, we also outline key issues for the future.



## Engaging the GP community in commissioning

### The issue

Clinical commissioning groups, along with previous forms of commissioning, aim to involve GPs from across their local area in the work of the CCG, in order to better understand the needs of local patients, commission services that meet those needs, identify and address poor-quality care, and harness clinical support for service transformation.

CCGs have a unique structure among statutory health and social care bodies: they are membership organisations consisting of local GP practices, in which GPs have a direct and executive role in making decisions about how they invest public funds. Being a membership organisation means that, as well as being accountable to NHS England, patients and others, the CCG is accountable to their member practices and vice versa ([Imison et al 2011](#)). Every GP practice is legally required to be part of a CCG and must nominate one GP to represent the practice in discussions with the CCG. These practice representatives provide CCGs with close links to GPs across their area but do not guarantee their engagement. Beyond these formal structures, CCGs have to establish strong relationships and clear lines of communication with GPs across their patch and put processes in place to act on issues identified through those channels.

Levels of GP engagement with CCGs vary widely across the country ([Holder et al 2015](#); [McDermott et al 2015](#)) but, in general, clinical engagement appears to be greater than with previous models of commissioning ([Smith et al 2010](#); [Wood and Curry 2009](#); [Curry et al 2008](#); [Lewis et al 2003](#); [Glennerster 1994](#)). Key to this is having local, well-known and approachable GPs, who are perceived as being more accessible than PCT managers had been in the past, on CCG governing bodies ([Naylor et al 2013](#)). It is unrealistic to think that all GPs in an area would want to be involved in the work of their CCG, but engendering a broad feeling of engagement (or at least minimising disengagement) among the GP community is necessary to enable CCGs to innovate and implement new service models.

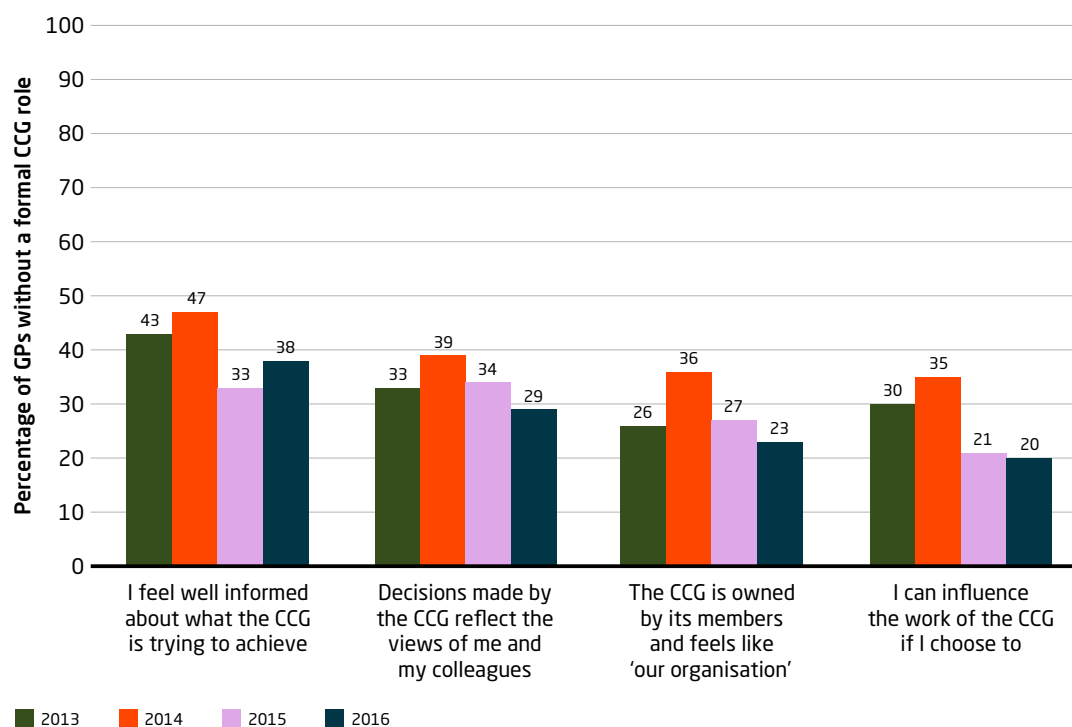
During their first three years in operation, the CCGs we have been working with have broadly maintained engagement with the majority of their GP members: our survey found overall levels of engagement among GPs and practice managers were almost unchanged between 2013 (73 per cent engaged) and 2016 (72 per cent engaged).



However, core aspects of the membership model are not working as envisaged. In 2016, GPs who did not have a formal role in their CCG were less likely than they had been two years earlier to report that they felt well informed about what their CCG was trying to achieve, that the CCG’s decisions reflected their views or that they could influence the CCG’s work if they chose to (*see* Figure 1). Strikingly, given the membership model on which CCGs are based, only 23 per cent of GPs without a formal role in the CCG felt the organisation was ‘owned by its members and “feels like our organisation”’ in 2016 (*see* Figure 1). There are a number of possible reasons for these results: GPs told us that CCG managers had more influence over

**Figure 1 GP views on ownership and influence on CCG decision-making**

*To what extent do you agree with the following statements?*  
 (Percentage who ‘strongly agree’ or ‘agree’)



**Notes:** Base: GPs without a formal role in the CCG, n=107–108 (2016), 107–109 (2015), 142 (2014), 77–79 (2013). Respondents who skipped the question were excluded from the distribution

**Source:** Nuffield Trust and The King’s Fund survey of CCGs (2013, 2014, 2015 and 2016)



commissioning decisions than GPs on the governing body and we heard from CCG leaders that, at times, they did not have the time or resources to adequately consult the membership.

### Strategies for improvement

Based on past experiences of clinical commissioning and examples we observed in our case studies, the following actions have helped commissioning organisations develop effective relationships with GPs.

- **Demonstrating the two-way benefits of GP involvement and identifying ‘quick wins’.** These can be done by listening to the concerns of GP practices and systematically addressing items on their ‘worry list’. An example from one CCG we are working with was an online quality reporting mechanism that gathers intelligence from members about issues with local services. Things that make the day-to-day working lives of GPs easier will be effective in securing their buy-in and can help to create a ‘virtuous cycle’ whereby clinicians observe instances of successful commissioning, engage more in the process, and create further successes (Checkland *et al* 2014).
- **Devolving some decision-making responsibilities to localities or member practices,** particularly when commissioners are operating over a large area. Locality structures are relatively common in large CCGs, but they operate in different ways across the country. One of the CCGs we are working with devolved budgets and responsibility for setting commissioning strategies to its localities. Over the past 20 years of clinical involvement in commissioning, structures that give local clinicians autonomy over decisions about services and budget allocation have been shown to secure significant clinical engagement (Miller *et al* 2015).
- **Embedding clear and open lines of communication between the governing body and GPs.** There is no ‘one size fits all’ solution for this and commissioners should work with GPs to decide which engagement initiatives work best locally. Approaches used by the CCGs we have been working with include:
  - having named managerial support linked to individual practices
  - maintaining direct personal contact, eg, through formal or informal practice visits



- CCG-wide networking meetings to communicate key developments
- utilising the relationship that local medical committees (LMCs) have with practices as a line of communication to raise awareness of local CCG-led initiatives.

### Considerations for the future

- **Efforts to involve GPs in commissioning decisions are fragile and being put at risk by a loss of autonomy among CCGs.** Leaders from all of the CCGs that we have been working with highlighted the risk that top-down direction and control from NHS England would crowd out GPs' engagement with the commissioning process. Central requests to submit strategies and provide information often come with tight timeframes that do not allow CCGs to properly consult with their membership and foster local support for, and ownership of, their approach. One example is the primary care co-commissioning process, where CCGs had to make quick decisions about what level of delegated responsibility to take on, that allowed for little detailed consultation with their members. The lack of CCG autonomy was a strong theme from our focus groups and is discussed further in Section 5.
- **Challenges in engaging the broader GP community in commissioning decisions will be intensified as CCGs start to work across larger geographies** and collaborate more with other commissioners and providers, as is starting to happen through the sustainability and transformation plan (STP) process. To ensure service design benefits from clinical input, commissioners must ensure detailed decisions continue to be taken locally, so clinical involvement and buy-in can be secured.





## Maximising the contribution of GP leaders

### The issue

While CCGs are accountable to all their members, in reality the majority of GPs across a local area have little contact with their CCG. The small cadre who take on leadership roles – either as members of the governing body, clinical leads or as GP-practice representatives – are critical to ensuring that commissioning decisions (and ultimately patients) benefit from clinical insight and GPs' knowledge of local population need.

Securing clinical leadership in commissioning requires CCGs to, first, recruit those who are interested in undertaking the additional responsibilities and, second, ensure that they are properly supported to do their job and that their time is used effectively.

GPs are a limited resource and practices across the country are finding it difficult to fill vacancies (Baird *et al* 2016). Consequently, it can be difficult to find GPs with the time available to fulfil a leadership role (Kaffash 2013). The requirements in terms of attending meetings and handling large volumes of reading and email, for example, are highly time-consuming (Checkland *et al* 2014; Perkins *et al* 2014; Segar *et al* 2014). In our most recent survey, two in five CCG GP leaders told us they did not have the time necessary to fulfil their role in the CCG and just over a third felt their commissioning role was having a negative impact on their clinical work (Holder *et al* 2016).

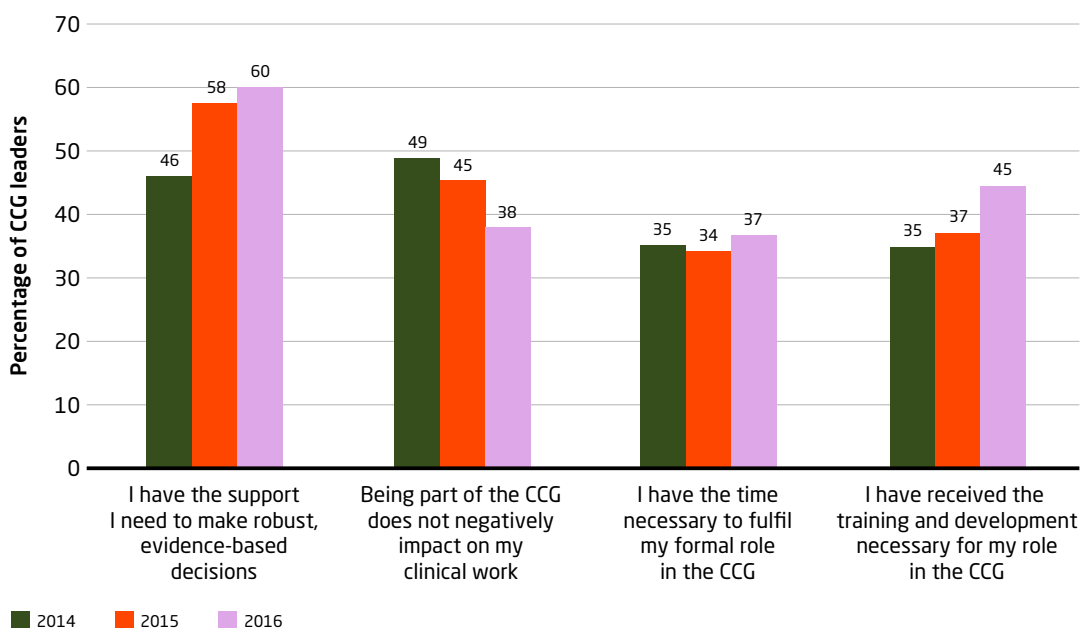
Commissioning also requires a different skill set to clinical work, meaning some GP leaders have to undergo a steep learning curve to acquire the necessary skills and understanding of – for example – financial data, their statutory responsibilities, how to approach collaborative working with managers and clinicians across the local health economy and the need to focus on population needs across the CCG rather than the needs of individual patients or practices (Holder *et al* 2015). Unless GP leaders are supported to contribute effectively to the commissioning process, the rationale for clinical commissioning is undermined.

Despite these challenges, GP leaders are becoming more confident in their commissioning role over time – in our survey they report improvements in the support and training they have received from their CCG (see Figure 2 below).



**Figure 2 CCG leaders' views on support and training for their role**

*To what extent do you agree with the following statements?*  
(Percentage who 'strongly agree' or 'agree')



**Note:** Base: GPs and practice managers who hold a formal role in their CCG. 2014 n=84–89; 2015 n= 85–89; 2016 n=100–101

**Source:** Nuffield Trust and The King's Fund survey of CCGs (2014, 2015 and 2016)

Although this section focuses on maximising the value of GP leaders, we also observed CCGs taking advantage of other clinicians such as practice nurses and pharmacists to fulfil a wide range of clinical roles in the CCG – from the governing body, to being members of sub-committees or leads for specific areas such as integration, mental health or quality. Our previous research also identified practice managers as an underused but engaged resource for CCGs and, in some CCGs, practice managers took on important roles on the governing body and elsewhere in the CCG ([Robertson et al 2015](#)). To get best value from their links with clinicians and other NHS staff, CCGs must properly support these leaders as well as the GPs who work closely with the CCG.



## Strategies for improvement

All of the CCGs that we are working with are refining and improving the way they work with their GP leaders with the aim of getting more value from the limited time they have to put into their commissioning work. There is a recognition that this is a work in progress and CCGs are still developing the best approach. Some approaches are detailed below.

- **Refining their internal committee and management structures**, including:
  - **clarifying the purpose of each committee and focusing GP input on clinical discussions** where they can bring the most benefit. For example, one of the CCGs we are working with is looking to change the relationship between the clinical cabinet and the governing body, and the roles that GPs play in these, in order to avoid repeating discussions of similar issues on both
  - **ensuring that clinical leadership posts have clear links to teams within the CCGs' management structure**. In one CCG we are working with these links were not clear, making it difficult for GP leaders to identify who they should work with within the CCG to enact change. The CCG is now redesigning its management structure to address this. As part of this it is also refining its clinical leadership roles to ensure they reflect the priorities of the CCG. It is hoped that this will create a clear thread from the CCGs' strategic objectives through its clinical leadership structure to the management teams that undertake the day-to-day work of the organisation, making it easier for GP leaders to implement change
  - **reducing the amount of 'red tape'** and not overburdening GPs with multiple lengthy documents to read ahead of each meeting.
- **Providing GP leaders with targeted support**. Effective approaches include:
  - investing in robust induction processes and buddying new clinical leaders with more experienced ones
  - ensuring all GP leaders have clear objectives fully aligned to the objectives of the CCG, supported by personal development plans and an underpinning appraisal process
  - investing in the professional development of GP leaders – where possible, alongside nurse, managerial and other CCG leaders – and protecting time to do this



- exploring different types of locum support that provide GPs with backfill that covers their clinical *and* administrative time, to ensure that GP practices are fully compensated for the time GP leaders spend doing work for the CCG
  - ensuring that GP leaders have enough time to fulfil the role, and that their availability and core CCG meetings are aligned.
- **Developing and maintaining strong partnerships between GPs and managers** that make best use of both groups' time. The management literature ([Studer Group](#); [Institute of Healthcare Management 2015](#); [HSJ 2012](#)) outlines the following key success factors for manager-clinician partnerships:
  - open communication and conflict solving
  - mutual trust
  - providing management training support and skill-building for clinicians
  - ensuring commitment and continuity of clinicians in a role
  - making active efforts to involve clinicians and to select clinicians with the right aptitude to these roles
  - learning about each other's roles and responsibilities (and ensuring they are clear)
  - matching the management structure and the clinical leadership structure.

### Considerations for the future

- **National bodies should support commissioners in developing their clinical leadership.** Our research, and research by others, has shown that GP leaders need a significant amount of training and support to enable them to develop into their new commissioning roles ([NHS Clinical Commissioners 2016](#); [Holder et al 2015](#)). At the moment, CCGs are finding training and development increasingly difficult to fund as their management budgets are reduced each year. NHS England should play an important role in providing training for GP (and other) commissioning leaders and facilitating leadership networks to allow leaders to share learning and best practice. Clinicians involved in planning services in other bodies, such as STPs or NHS provider organisations, should also have access to training and support in the commissioning skills needed to do their jobs effectively.



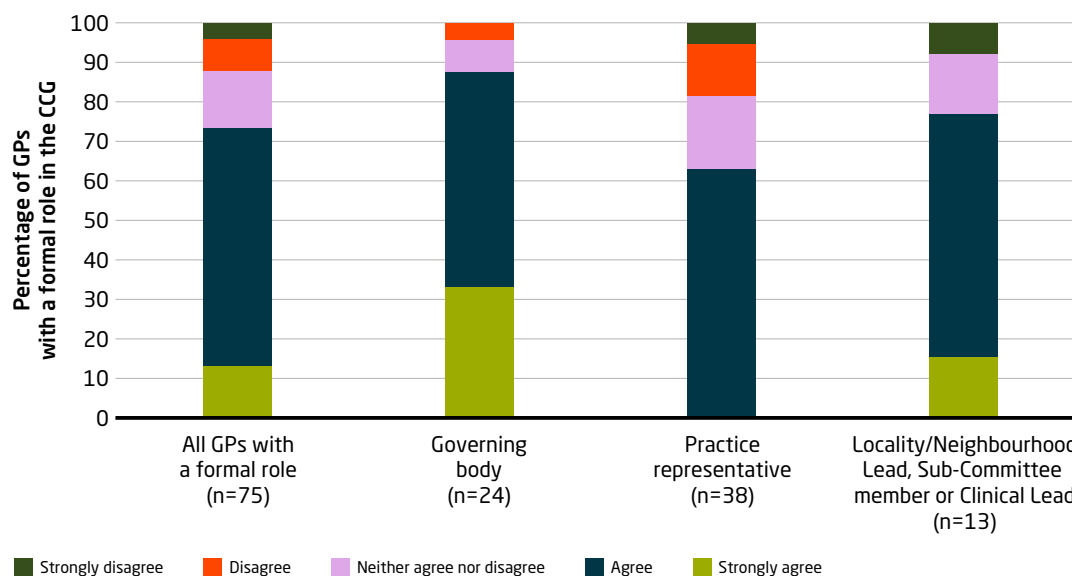
## Succession planning

### The issue

Given the pressures on GPs’ time, effective succession planning is key to ensuring the sustainability of clinically led organisations. There will be significant turnover in CCG leadership teams over the next few years. Many CCG governing members and chairs will reach the end of their terms of office in 2016 or 2017 and there are few new GP leaders emerging to take their place (Holder *et al* 2015). Although our survey found the majority (71 per cent) of GP leaders plan to continue in their roles for the foreseeable future (see Figure 3), the current generation of leaders cannot continue indefinitely. We heard from leaders – clinical and managerial – that they are feeling under increasing pressure in their roles, which may begin to affect their desire to stay in post.

**Figure 3 GP leaders’ plans to continue in their CCG roles for the foreseeable future**

*To what extent do you agree with the following statement: I plan to continue in my CCG role for the foreseeable future*



**Note:** Base: GPs with a formal role in the CCG. Respondents who skipped the question were excluded from the distribution

**Source:** Nuffield Trust and The King’s Fund survey of CCGs (2016)



Finding clinical leaders interested in commissioning work can be challenging. Past experiences of clinical commissioning have shown that it is often the same small group of GPs who take on commissioning work and there are many GPs who are uninterested in or sceptical about getting involved (Miller *et al* 2015; Sabey and Hardy 2013; Curry *et al* 2008). This is echoed in CCGs, where there is some reluctance among the CCG membership to take on leadership roles (Segar *et al* 2014).

Additionally, the options for those GPs who are interested in leadership roles outside the CCG are expanding. Local GP practices are increasingly working together at scale and leadership roles in emerging GP federations may be more attractive to GPs than commissioning roles, as they are more closely related to GPs' clinical practice. These new provider organisations may 'siphon off' a considerable amount of scarce clinical leadership talent (Storey *et al* 2016).

Difficulties recruiting clinical leaders in the NHS are not restricted to CCGs. A survey of medical leaders in NHS provider and commissioning organisations, conducted by the Hay Group in 2014, found that 45 per cent were uncertain about remaining in their roles for more than five years and 58 per cent had little or no confidence that they had successors in place (Hay Group 2014). The main barriers were leadership roles being perceived as unattractive by potential successors, a lack of support for potential successors from their colleagues and a lack of leadership experience among potential successors (Hay Group 2014).

Within CCGs, succession planning is not only an issue for GP leaders; CCGs told us they are also struggling to recruit leaders to other governing body positions (for example secondary care representatives on their board and lay members) and to key roles within their internal management structure. Outside the commissioning sector there are also swathes of board-level vacancies in NHS trusts (Janjua 2014).

### Strategies for improvement

When developing their strategy for succession planning, commissioners should consider the following.

- **Harnessing the enthusiasm among GPs to get more involved in commissioning.** Our survey showed 16 per cent of GPs who are not currently on the CCG governing body would be interested in getting more involved in



the CCG in the future – this would be more than enough if converted into active participation (Holder *et al* 2016). Despite a sense from other research that GPs can be reluctant to get involved in commissioning, during our research we were struck by the positive stories told by GPs about why they got involved with their CCG (*see* Box below). Sharing these kinds of perspectives might be one approach to attracting new GPs to commissioning roles. A recent survey of GP trainees found that 14 per cent would be interested in taking on commissioning work as part of a portfolio career (Charles 2016). The challenge is to ensure they are not deterred once they begin working as fully qualified GPs.

### GP leaders' reasons for taking on clinical commissioning roles

*...because I believe in [system] transformation and this is the way forward*

*...I saw this as an opportunity to change things that affect my clinical life*

*...I thought it's a really exciting opportunity and I believed in it*

*...an opportunity to look at a broader base than my own practice and make it better for patients*

*...to make real improvement on the ground*

(Selected quotes from focus groups with CCG leaders held from September 2015 to January 2016)

- **Creating commissioning roles that allow GPs to 'test the water'** without taking on the full responsibilities of a governing body post. This allows commissioners to obtain valuable input from GPs without the considerable time commitments associated with a full CCG role. Examples of these 'experimental' roles that we have come across in our study include:
  - clinical advisory posts – clinical leads responsible for specific areas who are not governing body members
  - GP Associate posts on the governing body – a development post that gives GPs experience of working for the CCG at board level



- a fellowship programme in which GPs work in the CCG for one day a week on projects of interest
  - part-time roles for GP trainees in the CCG, incorporating commissioning in their training as a way of building an understanding of commissioning in the next generation of clinical leaders
  - engaging GPs as ‘consultants’ on specific CCG strategies (eg, prescribing/ medicines optimisation).
- **Ensuring the focus is on succession planning for the *whole* governing body**, including the lay members, registered nurses, secondary care doctors and managers. These other members of the governing body play a critical role. Supporting current incumbents to do their job well will help the CCG attract new candidates to the roles. Briefings from NHS Clinical Commissioners outline tips for making the secondary-care doctor role an effective one and for better supporting lay members ([NHS Clinical Commissioners and Hunter Healthcare 2016](#); [NHS Clinical Commissioners and RCP 2015](#)) (for more information about supporting lay members *see* p 35).

### Considerations for the future

- **Commissioning organisations need to work with NHS England and the royal colleges to harness the enthusiasm within the clinical community to be involved in commissioning roles.** An increase in demand for clinical leaders – be that within provider organisations, CCGs or collaborative commissioning arrangements across local areas – will add to existing difficulties in recruiting GPs to commissioning posts. To widen the pool of clinicians willing to take on these roles, the Royal College of General Practitioners and other national bodies should work to raise the profile of commissioning as a rewarding and respected career option for GPs and other clinicians. As part of this, they should encourage more women to take on leadership roles. Although 70 per cent of the CCG workforce are women and just over half of GPs, only a quarter of CCG GP leads are female and there are 29 CCGs in which all GP leads are male ([NHS Clinical Commissioners 2015](#)).





## Improving the quality of general practice and implementing new models of care

### The issue

General practice is dealing with increasing demand and rising patient expectations while simultaneously struggling with workforce pressures, constrained funding growth and variable quality of care (Baird *et al* 2016; Nuffield Trust 2015). Resulting efforts to improve the quality of care and address some of the structural issues facing general practice have required the collaboration of commissioners and providers to 'scale-up' general practice into networks or federations and develop new models of care that integrate primary, community and secondary care services (NHS England 2016g; Rosen *et al* 2016; NHS England *et al* 2014; Smith *et al* 2013). CCGs have also been given increasing responsibility and control to manage the quality of care. The introduction of primary care co-commissioning means that the majority of CCGs now have responsibility for commissioning GP services, including managing practice-level contracts, either solely or in collaboration with NHS England. CCGs are taking over this role at a moment of crisis in general practice that has created significant operational issues as surgeries close and commissioners struggle to find new providers to replace them. These challenges provoked the publication of the GP Forward View in April 2016, a plan from NHS England to stabilise and transform general practice (NHS England 2016g).

That plan acknowledges that local commissioners have an important role to play in stimulating and supporting local efforts to improve general practice; CCGs, however, have experienced a number of challenges in doing this.

The membership model upon which CCGs are formed is dependent on collaboration and trust between the governing body and its members (*see* p 20), and the way in which CCGs approach their new general practice commissioning responsibilities (as a result of the new co-commissioning policy) could have a profound effect on their ability to maintain this relationship (Holder *et al* 2015). For example, our survey suggests that GPs value the education and training provided by CCGs but are far less supportive of CCGs' use of performance management mechanisms, something that is part of CCGs' role in co-commissioning general practice (Holder *et al* 2015).

CCGs are also concerned with how their involvement in the design and quality of general practice is perceived more widely and the risk of exposing themselves to



legal challenge from other potential providers. The CCGs we have been working with have taken a diverse range of approaches to facilitating the formation of GP provider groups, with some investing financial resources and others limiting themselves to facilitating conversations between providers. Some GP leaders in these CCGs reported feeling personally nervous about their new role and, recently, there have been a small number of high-profile resignations by CCG GP leaders and one suspension of an accountable officer as a result of perceived conflicts of interest while tendering for new services (Hazell 2016).

At a practical level, the transfer of responsibilities from NHS England to CCGs as part of co-commissioning appears to have taken much longer than originally anticipated, meaning that CCGs have been delayed in implementing changes. Similarly, CCGs were concerned about being able to undertake this additional work with reduced management budgets and alongside the existing time pressures facing GP leaders (*see p 24*).

Despite these challenges, our research suggests that these clinically led commissioning organisations are well placed to lead this change. Our survey indicated that GPs felt that CCGs had more influence over their clinical behaviour than other organisations such as NHS England and the Department of Health, and 70 per cent reported that their CCG was encouraging changes to the way that primary care is organised (eg, the formation of federations). NHS England reports that primary care co-commissioning has already proved beneficial in some CCGs and benefits include: a more joined-up vision for primary care at the local level; increased clinical leadership; support for the development of new models of care; and improved arrangements for GPs to work together ([NHS England 2016h](#)).

### Strategies for improvement

The CCGs we have been working with have taken a wide range of approaches to developing general practice. Strategies that they told us were effective include the following.

- **Commissioners taking a leading role in supporting the development of new provider models** capable of supporting transformation in primary care. CCGs are well placed to lead an active debate locally and to facilitate discussions between providers. If local general practice providers are interested in working



more collaboratively or at scale, research suggests that the main barriers (and thus areas where CCGs might provide support) are: getting all parties to sign up to the agreement; understanding what the benefits are for practices; finding the time to lead this change; and uncertainty around choice and competition regulations, organisational development and leadership (Kumpunen *et al* 2015). The next section shares learning about managing conflicts of interest.

- **Create a supportive environment that fosters trust between commissioners and practices.** Our research demonstrated that this can be done most effectively through face-to-face site visits and contact time and informal training with experienced GPs. Other tools that were recommended by our CCGs were: clinical assembly events; focused single topic meetings (such as prescribing); clinical discussion forums; toolkits for practices; incentive schemes; development of templates for practices; performance dashboards; and connecting local practices to discuss performance issues.
- **Peer review** is seen as a more impactful way of changing clinical practice than top-down targets from the CCG.
- Taking advantage of co-commissioning as an opportunity to **clarify the boundaries between CCGs' and NHS England's work in general practice.** This is an area where the split of responsibilities has often been unclear in the past (Holder *et al* 2015; Naylor *et al* 2013). Two CCGs told us that co-commissioning had led to improved relationships between the two organisations and another explained that they had drawn up a memorandum of understanding for both to use. Areas that have required clarification include dealing with complaints and counter fraud.

### Considerations for the future

- **NHS England should learn the lessons from the primary care co-commissioning process before transferring further commissioning responsibilities to CCGs,** as is being considered with specialised commissioning. This includes the reasons behind the delays experienced in transferring functions and resources to CCGs. The combination of a lack of resources and extra commissioning responsibilities was felt by some to be unsustainable.
- **There also needs to be a consistent national message about CCGs' role in developing new models of care** and where the boundary lies between facilitating



transformation and anti-competitive behaviour. A clear statement on what role CCGs can take in developing new models of care and supporting general practice to operate at scale would help them be bold without overstepping the mark. If the NHS want transformation to happen at a pace, it must use the resources within CCGs and the links they have with general practice to make that happen.

## Managing conflicts of interest

### The issue

GPs' clinical knowledge enables them to design well-co-ordinated services that fit the needs of their local population, but the benefits from clinical involvement in commissioning come with the risk that decisions are influenced by GPs' personal interests, particularly when awarding contracts for primary care services. The perception that a conflict of interest has occurred can be as damaging to a CCG as an actual conflict that affects decision-making. The risk of perceived conflicts is high – in addition to their own provider activities as GPs, one in three GP governing body members has been found to have financial links to private providers beyond their own GP practice ([Iacobucci 2013](#)).

The CCG leaders involved in our research generally felt conflicts were well managed, but there were some concerns voiced by other GP members. Our survey of GPs and practice managers across six CCGs found that, at the beginning of 2016, 20 per cent did not feel conflicts of interest were well managed in their CCG ([Holder \*et al\* 2016](#)). The actual percentage varied between CCGs from 7 to 30 per cent. Examples of both potential and perceived conflicts of interest have made front page news (Smith and Lay 2015), and have been highlighted by the Public Accounts Committee ([House of Commons Committee on Public Accounts 2014](#)) and our own research in the past ([Holder \*et al\* 2015](#)). In response to these concerns, NHS England is developing additional guidance with new requirements for how conflicts of interest are managed in CCGs ([NHS England 2016f](#)).

While the debate about conflicts of interest focuses on the award of new contracts, CCGs have actually awarded relatively few new contracts since 2013 ([National Audit Office 2015](#)). However, conflicts of interest can also affect decisions to renew or roll over old contracts and the performance management of existing contracts. Although conflicts arise most frequently for GPs, they also occur for other governing body members and for CCG managers.



The desire to avoid conflicts of interest can lead to the stifling of innovation and potentially act as a barrier to developing new services (Curry *et al* 2008). In seeking to manage conflicts of interest without paralysing local decision-making, commissioners face challenges, that include:

- understanding the extent of clinical involvement that is appropriate in the design and contracting of a new service if the majority of GPs in a local area are part of a GP organisation that is a potential provider of the service
- identifying conflicts in contracts that award a capitated payment to a lead provider (who then sub-contracts with others). In some of these cases, the full supply chain is not known at the time a contract is awarded
- making the most of their relationships with local GPs to facilitate transformation in primary care (for example by supporting local vanguards) while keeping within fair procurement rules and maintaining public confidence
- ensuring external scrutiny mechanisms such as lay members are well used but that clinicians are still involved in decisions.

While some NHS leaders believe managing conflicts is relatively straightforward and there is a low risk of wrongdoing, others think that a few high-profile negative cases could lose public confidence and threaten the whole commissioning model. They are wary of the experience during GP fundholding, when conflicts of interest became a major area of public concern and contributed to the model being abolished.

#### Strategies for improvement

The Health and Social Care Act placed a legal duty on CCGs to manage both actual and perceived conflicts of interests, and NHS England and Monitor have developed guidance to support them in doing this (NHS England 2016f; Monitor 2013). Rather than repeat that guidance here, we highlight a few key issues that were deemed important by the CCG leadership teams and other key stakeholders that we spoke to when developing this report.

- **Think broadly about who can provide external scrutiny of commissioning decisions.** The CCGs that we worked with drew on a range of local stakeholders that included non-GP governing body members (lay, secondary care and nursing representatives), commissioning support units, GPs from neighbouring CCGs (sometimes via the LMC) and patients. As CCGs, local



authorities and providers come together across local areas to develop joint strategies; the involvement of these organisations in CCG decision-making will also help mitigate conflicts.

- **Transparency is key – if in doubt, disclose.** This involves embedding a culture of openness throughout the organisation and not just within the governing body. One CCG we worked with published declarations of interest for all GPs within the CCG on its website. Conflicts can occur for all staff (not just clinical staff). Perceived conflicts of interest are an issue even if they have no impact on patient care. In their guidance on conflicts of interest NHS clinical commissioners, the Royal College of General Practitioners and the British Medical Association recommend clinical leaders think about the ‘Paxman test’ – would explaining the situation to an investigative journalist cause embarrassment? If so, the interest should be declared and dealt with appropriately ([Royal College of General Practitioners et al 2014](#)).
- **Lay members have an increasingly important external scrutiny role** on governing bodies and primary care commissioning committees and need to be properly supported to fulfil that role effectively. For CCGs, the requirement is increasing to three lay members on the governing body ([NHS England 2016f](#)) – and even before this announcement some of the CCGs we have been working with told us they have had difficulties recruiting lay members with the skills necessary to perform the role. A recent report ([NHS Clinical Commissioners 2016](#)) recommended that CCGs:
  - provide a comprehensive induction programme for lay members that ensures they have adequate understanding of the NHS context (both national and local) to fulfil their role
  - ensure lay members have ongoing support through annual appraisals, ongoing 1:1s and formative feedback from senior CCG staff to help them develop in their roles
  - ensure lay members have up-to-date job descriptions that clearly outline their core responsibilities and indicate which are of highest priority
  - ensure lay members are not overloaded with additional work, and that their work is properly recognised as they take on new responsibilities. A survey by NHS Clinical Commissioners found that lay members are contracted for 3.4 days per month on average but work for 5.7
  - take advantage of support and mentoring opportunities provided by the NHS Clinical Commissioners Lay Members Network.



## Considerations for the future

- **Commissioners need regularly updated examples of how to deal with conflicts to ensure potential conflicts don't paralyse decision-making.** CCGs currently take different approaches to managing conflicts of interest. Case studies showing best practice in different situations would help ensure a consistent approach. NHS England guidance requires GPs to step down from decisions when a conflict arises. However, in the reality of day-to-day commissioning, it can be difficult for CCGs to ascertain exactly what involvement this means GPs can have in procurements. Can they contribute to tender documents and service specifications that feed into the decision-making process? Do they need to step out of discussions about a contract or just stand down when the decision is being made? The case studies developed by NHS England as part of their latest guidance should continue to be updated to ensure they cover the latest issues affecting CCGs.
- **A single approach to managing conflicts of interest should apply across the NHS.** New provider organisations are starting to be awarded large contracts to provide care for a local population and so have taken over some of the procurement decisions about how to spend money within that contract that were previously the remit of the CCG. They are perhaps more likely to be conflicted when taking decisions and are not currently subject to the same requirements for public transparency as CCGs. The cross-system task and finish group that has been set up to develop a single approach to conflicts of interest across the NHS must ensure that providers undertaking commissioning-like work are subject to the same transparency requirements as CCGs.

## Collaboration with other commissioners

### The issue

The heterogeneous nature of health and social care services means that commissioners inevitably collaborate in different groupings for different purposes. A given CCG may commission some services unilaterally, others in collaboration with one or two neighbouring CCGs, and still others on a whole-county basis involving perhaps three or four CCGs. Some CCGs commission services from several major providers, and collaborate with different groups of CCGs in relation to each while, in some larger CCGs, some commissioning decisions are taken at a sub-CCG level within locality



groups. Local authorities and commissioning support units are also important partners in their commissioning work. The nature and pattern of these collaborations depends significantly on the population size covered by the CCG, which varies considerably – the largest having 13 times the population of the smallest. This all makes for a highly complex picture and places significant demands on leaders in terms of the multiple relationships they must build and sustain.

The potential benefits of working collaboratively with neighbouring commissioners include:

- obtaining economies of scale
- getting strategic alignment with neighbouring commissioners
- having a greater degree of influence over large providers
- avoiding duplicating similar pieces of work
- sharing ideas and learning
- bringing about improvements in patient care, for example through more effective integration of services.

However, these need to be balanced against the benefits of locally responsive decision-making structures that require a smaller geographical footprint. An important dilemma for CCGs addressed below is how to seize the benefits of scale without losing the benefits of localism.

An increasing number of CCGs have chosen to formalise collaborative working through the use of joint posts or shared teams and functions. For example, around 20 per cent of CCGs in England share their chief operating officer with one or more neighbouring CCGs (based on analysis of The King's Fund contact database). Financial considerations have been one of the drivers for this, along with difficulties in filling senior vacancies. In the CCGs involved in our research, there were also examples of commissioning teams, contracting teams, finance teams and clinical engagement meetings being shared with another CCG, and most of those involved envisaged that the extent of shared functions would increase over time. There are also examples of CCGs having joint posts with local authorities, and merging commissioning teams across the organisations.





Recent movements towards place-based approaches in health and social care require new forms of collaboration involving CCGs and other local partners, increasingly set within the context of policy ambitions around devolution (McKenna and Dunn 2016). A significant new requirement, included in planning guidance published in late 2015, is that CCGs and providers agree a planning footprint for the purpose of developing place-based STPs for the five-year period beginning 2016/17 (see Section 1). These developments make the need for successful collaboration – among commissioners, and between commissioners and providers – more vital than ever.

### Strategies for improvement

- **Sharing roles and functions.** CCGs involved in our research found that in some cases joint posts and shared functions made sense strategically and financially. For example, in areas where several CCGs commission services from a single main acute provider there may be a case for sharing commissioning staff. Some CCGs have found that sharing other teams (eg, finance teams) has helped them to get maximum value from their management allowance. Exploring which roles and functions can be usefully shared may help to put the CCG on a sustainable footing for the future.
- **Retaining local identity.** Leaders looking to share functions across a number of organisations will also need to work hard to maintain the local identity of each constituent part. CCGs have worked hard to engage member practices and will be conscious of jeopardising the fruits of these efforts. One of the CCGs we are working with, which had developed successful shared functions with its neighbour, highlighted the importance of consulting with member practices before implementing new joint working arrangements, to ensure there is discussion about what functions should be shared and support for the overall approach. Imposing shared functions without buy-in risks alienating member practices. There also needs to be a commitment to continue working with practices on a local basis, and recognition that some functions are best performed in small local groupings, for example peer review of practice performance.
- **Allowing collaborative arrangements to evolve over time.** A lesson from CCGs in our research was that sharing functions is often best seen as a developmental process. At first, sharing a relatively limited set of functions



may carry fewer risks. Over time it may be possible and helpful to do more at the shared level, as trust and relationships strengthen between the parties involved.

In collaborating with other local partners, commissioners should pay heed to lessons from research on successful system leadership ([West et al 2015](#)). In particular, this highlights the importance of:

- **building a shared sense of purpose** with partner organisations – in order to promote buy-in from the clinical community this should be based on improving the quality of patient care and/or population health
- **frequent and sustained personal contact** between the leaders of the organisations involved, with a commitment to openness and rapid resolution of conflicts
- **building a culture of mutual concern and interdependency**, where the success or failure of one is seen as the success or failure of all.

### Considerations for the future

- **Be permissive of locally defined solutions.** NHS England should avoid mandatory mergers, which risk undoing the hard work CCG leaders have put into building relationships with their member practices. It may be necessary for CCGs to work at greater scale, but this should be through voluntary arrangements and will often not require full merger. However, there may be some places where the case for merging organisations is compelling, meaning the current moratorium on voluntary mergers may not be sustainable indefinitely.
- **There is also no ideal size for a CCG.** Our research included CCGs of very different sizes and, as described above, there are pros and cons to being large or small. It is worth noting that, in the case of primary care trusts (PCTs), there was no correlation between PCT size and its performance as a commissioner (as measured in the world-class commissioning assurance process).
- **A single definition of place does not make sense for CCGs.** As well as focusing on their own local population, CCGs need to work in a range of larger geographical groupings for different purposes. In many cases these groupings



are not neatly drawn and they often overlap. The STP process requires CCGs and providers to define a single geographic footprint across which they will plan to balance their finances and implement the Forward View. There needs to be recognition that within and across these STP footprints, CCGs will continue to operate in different groupings for different purposes, and will need to retain sufficient flexibility to do so. As the STP process develops, the challenge will be making sure that the right decisions are made at the right level, and that the inevitable complexity does not become fragmenting and distracting for CCGs and local health care providers.

### Working effectively with commissioning support services

#### The issue

One argument for the creation of commissioning support units was that, by carrying out many of the administrative functions involved in commissioning and contracting, they enable CCGs to be lean, clinically led organisations.

Clinical commissioning groups can choose what proportion of their running-cost budget is spent in-house and what proportion is used to procure external support. Getting this balance right and maximising the value they get from the services they commission externally is a major issue for CCGs, which are increasingly looking for ways to generate cost savings because of year-on-year real term reductions in their running-cost allowances.

Commissioning support units (CSUs) are the main providers of external support services to CCGs, though there are other private and voluntary sector providers. CCGs vary widely in the extent to which they purchase commissioning support and they often collaborate with neighbours to commission some services as a group. Among the CCGs we have been working with, the proportion of their running-cost budget used to buy services from CSUs ranged from 12 to 67 per cent in 2014/15 ([Holder et al 2015](#)).

By procuring support services externally, CCGs have the opportunity to benefit from: economies of scale (as CSUs provide support functions to a large number of CCGs); access to specialist expertise that may not exist within the CCG; shared learning from the support organisations' work with other CCGs; and the ability to shop for support in a market and secure best value.



However, there are associated risks, which include: a loss of control over the quality of the service (effective contracting should address this, but many CCGs have complained of issues with the quality and timeliness of some CSU services and have consequently moved services back in house); a less tailored service (when support needs are procured by a large group of CCGs); a loss of local knowledge and personal relationships with providers and other local stakeholders (for example, when CSUs manage local provider contracts); a loss of opportunities to develop the skills of CCG staff; and the costs of the procurement process, which can be relatively high for small CCGs in terms of their overall running-cost allowance.

The market for commissioning support has had a shaky start. There were 19 CSUs in 2013/14 and these have now reduced to six following a series of mergers and closures. CSUs are currently hosted by NHS England and moves to establish CSUs as independent organisations by the end of 2016 appear to be on hold. All CCGs are required to re-procure their current package of commissioning support services by July 2016 but there is a high degree of uncertainty about whether this commitment will be met.

### Strategies for improvement

When procuring external commissioning support, commissioners should ensure they do the following.

- **Consider the merits and challenges of different models of support:** consultancy support, joint delivery and outsourcing (*see* Table 1). Certain services are more amenable to being commissioned externally than others. One of the CCGs we have been working with found that they could effectively outsource services that could be managed only via a contract with clearly defined performance indicators.



**Table 1** The merits and challenges of different models of commissioning support

	Consultancy	Joint delivery	Outsourcing
<b>Definition</b>	<ul style="list-style-type: none"> <li>• Short-term advice or support</li> </ul>	<ul style="list-style-type: none"> <li>• CCG and external staff work together on delivery over a longer time period</li> </ul>	<ul style="list-style-type: none"> <li>• Responsibilities are transferred to an external organisation with more appropriate skills</li> </ul>
<b>Recommended for</b>	<ul style="list-style-type: none"> <li>• Supporting strategic planning</li> <li>• General organisational development</li> <li>• Identifying needs and clarifying aims of longer term support</li> </ul>	<ul style="list-style-type: none"> <li>• Delivering transformational change across a wider range of commissioning functions</li> </ul>	<ul style="list-style-type: none"> <li>• Specialist skills needed infrequently</li> <li>• Skills that are cheaper to procure externally than build in house</li> <li>• The more practical aspects of commissioning</li> </ul>
<b>Merit</b>	<ul style="list-style-type: none"> <li>• Relatively simple to procure</li> <li>• Provides quick access to new skills and knowledge</li> </ul>	<ul style="list-style-type: none"> <li>• More opportunity and incentive to fully implement ideas and to transfer skills to the CCG</li> <li>• Risk sharing can promote partnership working and make support more affordable</li> </ul>	<ul style="list-style-type: none"> <li>• Can be more cost-effective than building skills internally</li> </ul>
<b>Challenges</b>	<ul style="list-style-type: none"> <li>• Less opportunity for skills transfer</li> <li>• Less opportunity to overcome relationship barriers</li> <li>• Risk of limited legacy and poor return on investment</li> <li>• Risk of lack of local ownership, especially when used to develop strategies</li> </ul>	<ul style="list-style-type: none"> <li>• Requires a significant investment to create real partnerships</li> <li>• Needs the right infrastructure – eg, shared office space</li> <li>• Danger of role creep leading to sub-optimal use of external staff</li> </ul>	<ul style="list-style-type: none"> <li>• Risk of ‘outsourcing a mess’ need to clarify what is required prior to outsourcing.</li> <li>• Full outsourcing raises questions about accountability and governing financial risk</li> </ul>

Adapted from: [Naylor and Goodwin \(2010\)](#)



- **Build strong relationships with the CCGs they are collaborating with for the procurement** and with the providers from whom they procure services. The CCGs we have been working with told us that the most successful support contracts were based on strong relationships.
- **Draw on evidence about the effective use of external providers in other sectors.** The management consultancy literature identifies the following key success factors for commissioning external support:
  - carefully select a provider that meets your needs in terms of both its capabilities and its working style
  - ensure that the goals of the procurement are clearly articulated and are understood by the CCG and the provider. This shared vision should be set out in language that reflects the CCG's needs rather than the provider's expertise and products. A number of CCGs we have been working with said difficulties with their CSU contracts stemmed from service specifications not being clear
  - identify clear evaluation criteria by which success will be judged
  - agree what is required and expected of the CCG and the provider in order to achieve these goals
  - the CCG should be closely involved in and committed to the work for which the provider has been commissioned
  - the CCG must have a willingness and the capacity to change
  - the work must have strong, visible support from the senior management team in the CCG, who will ideally identify a named individual to manage the relationship between the two parties.

Adapted from Naylor and Goodwin (2010). Sources: Bronnenmayer *et al* 2016; Badrick and Preston 2002; McLachlin 1999; Jang and Lee 1998; Gable 1996.

- Use resources available from NHS England to support procurement decisions, which include:
  - template agreements and service specifications: [www.england.nhs.uk/resources/resources-for-ccgs/#csu](http://www.england.nhs.uk/resources/resources-for-ccgs/#csu)
  - case studies of effective CSU services: [www.england.nhs.uk/commissioning/comm-supp/csu/csu-benefits/](http://www.england.nhs.uk/commissioning/comm-supp/csu/csu-benefits/)
  - free dedicated procurement and legal support to commissioners using the lead provider framework: [www.england.nhs.uk/lpf/sup-comms/](http://www.england.nhs.uk/lpf/sup-comms/)



## Considerations for the future

- **As the commissioning sector evolves, commissioning support services will need to adapt to its changing support needs.** For example, if CCGs start to take on a more strategic role and operate over larger geographies (*see* Section 1) their commissioning support needs will change. While commissioners operating over larger areas will benefit from greater buying power, the economies of scale that attract smaller CCGs to externally provided services will become less attractive and many may start to consider bringing services in house. This has played out in Manchester, where commissioning support services for the whole area are (for now at least) hosted by one of the local CCGs (Williams 2015b).
- **It will be increasingly difficult to maintain the quality of commissioning support services as CCG running-cost budgets come under greater pressure.** The CCGs we have been working with were concerned about the quality of their commissioning support. In the latest round of re-procurement, commissioning support contracts have been let for dramatically lower budgets. As running-cost budgets reduce further, services that used to be sustainably run within the CCG may cease to be so and this could force more outsourcing. To avoid a race to the bottom for commissioning support, CCGs and NHS England need to track the quality of service provided by commissioning support organisations and share this information.



## 5 Three national challenges

As well as telling us about issues they experienced when trying to secure GP involvement and effective approaches to overcoming them, the CCG leaders we spoke to during our focus groups highlighted some external challenges that were constraining their efforts to embed GP involvement in their organisations across the seven areas we discussed. These are broader factors that are inhibiting CCGs' ability to commission effectively and threaten the sustainability of clinically led commissioning. Below we summarise what we heard about these three challenges, which are: a lack of autonomy, a lack of resources and difficulties retaining public support. As with messages in the rest of the report, these are challenges that are likely to inhibit GP involvement in emerging planning and provider structures, in the NHS as well as CCGs, which must be addressed if the NHS is to be successful in transforming care.

### Lack of autonomy

The Health and Social Care Act was designed to reduce top-down control in the NHS, through the creation of NHS England, and the transfer of commissioning powers and budgets to local GPs. During our research we have seen that, in practice, the reality of the last few years has been a tightening of central control (*see* Box below).

During our focus groups we asked CCG leaders what one message they would want us to feed back to government and national policy-makers (*see* Box below). The most frequent response was a call for more autonomy. There was a sense of frustration at the frequency of requests to implement new initiatives and to provide information to tight timescales. CCG leaders told us they were given little time to develop coherent strategies, making it difficult to properly consult with their own GPs, let alone other organisations and patients (*see also* p 20).





## Messages from CCG leaders to NHS England and the Department of Health

During our focus groups, we asked governing body members and senior managers what message they would like to send to policy-makers and NHS leaders. Here are some of the most common responses.

- ***Be facilitative. Less bureaucracy and more trust.***  
NHS England should take a more facilitative and less didactic approach to working with CCGs. This involves trusting CCGs, giving them earned autonomy, allowing them the time and space to try out innovations and develop local solutions to local problems. There is no one size fits all solution for the NHS.
- ***Allow CCGs to succeed before changing the structure.***  
CCGs need a period of stability. NHS England should be mindful of the productivity lost due to structural reform and very clearly articulate the benefits of any future changes before implementation.
- ***Think through the consequences of centrally made decisions and what impact they will have on small organisations with a lack of resources to enact them.***  
When extra functions are delegated to CCGs they should be accompanied by additional resources; this has not happened in the past.
- ***There are so many things that the centre holds us to account for that sometimes this limits our capacity to deliver on ideas coming up from our membership.***  
Too much micromanagement from NHS England leads to frustration from CCGs about the amount of time they spend 'feeding the beast' with data returns and responding to urgent requests for information. The CCG assurance process should provide the oversight needed to allow CCGs to get on with their jobs.
- ***Resources should be invested in health and social care outside of hospital.***  
Policy-makers and NHS leaders should shift their focus from the acute sector to out-of-hospital care. The NHS will be able to reduce its reliance on hospitals only if it invests more in the community.
- ***They are forcing us to waste millions of pounds on things that are urgent to the Department [of Health] but not necessarily the most important to our population, for example the four-hour A&E target. It's important but we could have spent that money on better outcomes for our patients.***  
NHS initiatives such as waiting times targets for elective care and A&E are politically driven and force an unwelcome shift in CCGs' focus away from what is important to local patients.



During the first few months of 2016, after our field work was completed, a number of new central requirements have been placed on CCGs, further weakening their autonomy. These include instructions about how to use resources (eg, [NHS England 2016e](#)) and additional planning requirements in the 2016 planning guidance ([McKenna and Dunn 2016](#)). This approach is making it difficult for CCGs to reap the benefits of their links with general practice and generate the support necessary from local clinicians and the local community to drive transformation.

### Lack of resources

Although CCGs received a small growth in funding in 2016/17 of 3.4 per cent ([NHS England et al 2015](#)), this increase will be used to cover a range of pre-existing commitments and leaves CCGs with little, if any, money free to fund transformation ([Appleby et al 2016](#)). At the same time, running-cost budgets have reduced from £25 per head of population in 2013/14 to £22.07 in 2016/17 and are expected to drop to £21.46 by 2020/21 ([NHS England 2016b](#)). Tight resources make it challenging for CCGs to properly support their clinical leaders and to work effectively with general practice.

The CCGs we have been working with have looked for different ways of operating at lower cost. Some have made savings by sharing posts with neighbouring CCGs (*see p 38*). Others have looked to make savings on their commissioning support spend (*see p 42*). All of the CCGs we have been working with brought at least some externally commissioned services in house in 2014/15 or were considering doing so and, across England, large support contracts are being awarded for much smaller sums of money than in the past (Renaud-Komiya 2015; Williams 2015a). While these lower-cost services help CCGs remain within their operating budgets, it is difficult to see how the quality of commissioning support can be maintained as contract values drop. This in turn will make it difficult for CCGs to operate effectively.

Resourcing has also been an issue for the CCGs that have taken on new primary care co-commissioning powers. CCG leaders told us that the personnel and budgets to support these new functions have been slow to transfer (*see p 32*). Although some told us they are enthusiastic about the principle of taking on these new roles, they emphasised the difficulty of doing so with no extra resource. Some are addressing this by investing money from their existing budgets to recruit primary care commissioning staff; others are sharing primary care commissioning resources with



their neighbours. However, they are finding it difficult to identify adequate resources to deliver extra functions within lower running-cost budgets.

Taken together these resource challenges are making it extremely difficult for CCGs to keep their heads above water and maintain a high-quality, clinically led commissioning function. There is a growing concern among some CCG leaders that, sooner or later, decision-makers at the national level will respond to the current financial challenges by introducing further reforms to commissioning structures, for example by requiring CCGs to merge into bigger organisations (*see* p 38). This might generate some savings through economies of scale, but risks undoing the hard work that CCG leaders have done in terms of building a relationship with their member practices.

### Retaining public support

The slowdown of NHS funding growth means CCGs increasingly have to take tough decisions about how to spend NHS money on behalf of their local population, which may be controversial with the public. Their new co-commissioning powers in primary care mean conflicts of interest arise more frequently as they take those difficult decisions about how to prioritise funding. Taken together, these two issues raised concerns in the minds of CCG leaders involved in our research about how to take the public with them as they work to transform services within tightening budgets. The financial context makes good public engagement more important than ever. However, doing this properly costs money, which is not readily available in the current climate.

Many of the CCG leaders we spoke to expressed concern about whether they would be supported by NHS England, the Department of Health and politicians when making the difficult decisions that have been necessitated by the squeeze on commissioning budgets. These include decisions to decommission services in order to invest elsewhere, and decisions to support new models of care and award contracts to providers based in general practice.

This list of challenges paints a difficult picture for CCGs, which are being asked to implement multiple major transformation schemes with limited resources and little ‘political cover’. During the four years of our research, we have heard growing frustration among CCG leaders that they are not given the freedom to develop services in a way they know is right for patients locally.



To have a chance of addressing the dual challenge of bringing the health service into financial balance, and transforming the shape of out-of-hospital care, the NHS needs to build on the best of what CCGs have achieved over the past three years and ensure clinical involvement is secured in planning decisions taken across the NHS. In the next section of this report we turn to the question of what the NHS needs to do to secure the clinical voice.



## 6 Conclusion and recommendations

This report has summarised the progress that six clinical commissioning groups (CCGs) have made in enacting the GP-led model of commissioning established by the Health and Social Care Act (2012) and shared some of the learning that they have picked up along the way.

Over the past four years, our research shows that CCGs have secured better GP engagement than previous forms of commissioning; their close links with GPs provide a key connection with patients that is essential to delivering transformation at scale across the NHS.

Although the process has been challenging (and significant issues remain), CCGs have learnt a great deal about how to engage GPs in their work, support improvements in the quality of general practice and develop the internal structures and processes necessary to get best value from their clinical leaders.

However these links with GPs are fragile. A lack of resources and autonomy are making it difficult for CCGs to effectively engage with their GP members and the pool of GPs currently interested in commissioning work is limited. The potential for conflicts of interest complicates GP involvement in primary care commissioning, though this is an area where their expertise can add most value. Within this context, the NHS needs to secure GP involvement in commissioning by addressing these barriers and building on the significant progress CCGs have made since 2013.



To support the continued development of clinical commissioning groups, the Department of Health and NHS England need to:

- **provide clinical leaders with the developmental support** and training they need to do the job properly
- **work with the royal colleges to promote commissioning as a rewarding career option for clinicians** and ensure it has the same status for health care professionals as research, training and clinical work. The enthusiasm among GPs and other clinicians to get more involved in commissioning should be harnessed and must not go to waste
- **set out clearly what role CCGs can take in developing new models of care**, including scaled-up forms of primary care, to empower them to take bold action to drive transformation efforts locally
- **learn the lessons from the primary care co-commissioning process before transferring further commissioning responsibilities to CCGs**, including the reasons behind the delays experienced in transferring functions and resources to CCGs
- **recognise that the current moratorium on voluntary mergers between CCGs is not sustainable indefinitely** due to tightening commissioning budgets. However, mandatory mergers should be avoided
- **outline a clear strategy for the future of commissioning support** that recognises the likely changes in CCGs' support needs over the next few years, as the role of CCGs change. The strategy should acknowledge the slow progress made in attempts to establish commissioning support units (CSUs) as independent organisations, and the significant barriers that remain to doing so
- **provide CCGs with 'air cover' for tough decisions** about how to prioritise funding, by being honest with the public about what is achievable with the money available.



The commissioning system is also evolving in response to growing financial and operational pressures and the new care models being implemented in the wake of the Forward View. New place-based planning structures are emerging, most recently seen across the 44 geographic footprints defined for the development of sustainability and transformation plans (STPs). We have argued, in work published separately, that NHS commissioning will have to become more strategic and integrated in response to these developments ([Ham and Alderwick 2015](#); [Jupp 2015](#)). However the planning and purchasing of care is done in the future, clinical involvement will be key. To build on the progress that CCGs have made, and embed clinical involvement across the NHS as the role that commissioning plays in the system changes, the NHS will need to:

- **publish a vision for the future of NHS commissioning that recognises the multiple overlapping planning and delivery structures that are developing in different ways across the country.** This vision must address the risk of fragmentation created by the multiple organisations now undertaking commissioning-like work, including STPs, vanguards and other new integrated provider organisations; and outline a core set of principles that should underlie commissioning across a complex system.
- **make a clear statement reaffirming the principle of local clinicians being at the heart of the commissioning process** to ensure clinical leaders shape the direction of change. Beyond CCGs, this includes strong clinical involvement in the STP process, new integrated models of commissioning health and social care, and new integrated delivery organisations.
- **ensure that any structural changes to the commissioning system are evolutionary and flexible to local conditions**, rather than centrally mandated. In terms of clinical engagement (and morale in the commissioning workforce), the worst option would be a centrally mandated restructuring of CCGs
- **retain some ‘localness’ in health care decision-making.** Despite the development of STPs and the benefits of working at scale, there needs to be recognition that CCGs will continue to operate in different groupings for different purposes, and they need to retain sufficient flexibility to do so. The key will be making sure that the right decisions are made at the right level, and that the inevitable complexity doesn’t become fragmenting and distracting for CCGs



- **ensure commissioning organisations have sufficient autonomy to work with GPs and other clinicians** to take decisions that are in the best interests of their patients. Clinical involvement is difficult when responding to multiple central requests to tight timescales
- **ensure that requirements for CCGs to manage conflicts of interest apply across the NHS**, including in provider organisations that take on responsibilities for NHS procurement decisions.

Over the past four years, we have seen the six CCGs we have been working with put a great deal of time and effort into engaging with their GP members to improve the quality of care locally, despite external challenges and an ever-changing policy environment. As the structure and role of CCGs evolves over the next few years, the NHS must build on the achievements outlined in this report. Putting the voices of GPs and other clinicians at the heart of NHS commissioning decisions will be an important part of enabling the NHS to balance its finances and transform out of hospital care.





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Clinical commissioning groups (CCGs) were designed to put GPs at the heart of NHS planning decisions. In a four-year project, The King's Fund and the Nuffield Trust followed six CCGs from their pre-authorisation phase to where they are now.

*Clinical commissioning* looks at what has been learnt about effective GP involvement in commissioning and makes recommendations for the future. This information is relevant for CCGs, those working on sustainability and transformation plans, and the new integrated provider organisations that are increasingly undertaking commissioning-like work, as well as national policy-makers.

The report reveals that:

- CCGs have secured better clinical engagement than previous forms of commissioning
- CCGs face seven key challenges in embedding clinical involvement in commissioning and have developed a range of strategies to overcome these
- three national barriers are inhibiting effective clinical involvement in CCGs: lack of autonomy; budget and resource constraints; lack of support for tough prioritisation decisions
- there are several clear steps the NHS needs to take to build on what CCGs have learnt and embed clinical involvement in planning decisions.

The GP engagement secured by CCGs provides key connections with patients which are essential to transformation across the NHS. Although the process has been challenging, significant issues remain and links with GPs are fragile. The report highlights the need to build on the progress CCGs have made and embed clinical involvement throughout the new system, as the commissioning system evolves in response to financial pressures and changes in the structure of NHS providers.

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