

Risk or reward?

The changing role of CCGs in general practice

Research report

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About this report

As clinical commissioning groups (CCGs) settle into their central role in the reformed NHS, the full scale of the challenges they face is becoming clear. This report, part of a joint project by the Nuffield Trust and The King's Fund, aims to understand the development of CCGs, and to support them by spreading good practice and learning. It tracks the development of six CCGs, selected to broadly represent CCGs across England. The report, which is based on a survey, interviews, observations and reviews of board papers, considers two research questions: how CCGs are functioning as membership organisations and how they are supporting the development of primary care in their local area.

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Executive summary

A central component of the NHS reforms that were implemented in England in 2013 was the introduction of 211 general practitioner (GP)-led clinical commissioning groups (CCGs), which have responsibility for over two thirds of the NHS commissioning budget.

While the main commissioning responsibility of CCGs has been to purchase acute and community services on behalf of their populations, they also have an important role in promoting quality improvement in primary care. This role has been carried out in conjunction with NHS England, which has overall responsibility for the commissioning of primary care services.

Over the last year there has been a clear policy direction from NHS England regarding the commissioning of primary care: from April 2015, CCGs will have the option to apply for joint or delegated responsibility for some primary care commissioning activities currently undertaken by NHS England area teams, as part of the co-commissioning policy. However, the future policy landscape for commissioning remains fluid, with the 2015 General Election approaching and the implications of the Five Year Forward View pointing to yet more change to commissioning roles and responsibilities (NHS England and others, 2014). CCGs' expanding remit in primary care development provides them with an opportunity to strengthen their peer-led improvement activities, but also brings with it certain risks; issues that are explored in this report.

This is the second report¹ from a joint research study by the Nuffield Trust and The King's Fund that tracks the development of six CCGs selected to broadly represent CCGs across England. The research for this report was conducted between January and March 2014, and included a GP survey (with 279 responses), 70 interviews with both GP leaders and GP members of CCGs, and a review of board papers. The analysis explores the involvement of CCGs in primary care from two main perspectives: how they are functioning as membership organisations; and how they are supporting the development of primary care in their areas.

Key findings

In our case study sites we found that **the sustainability of clinical involvement in commissioning was at risk** due to waning levels of GP leader engagement in CCGs, potential problems in the recruitment and retention of leaders, and significant pressures on GPs' time and capacity. Specifically we found that:

- CCGs had broadly maintained levels of engagement from their GP members (according to participants in our survey).

¹ The first report was published in 2013: Naylor and others (2013).

- However, the initial enthusiasm among some GP leaders had started to wane, as less than half reported that they had the support, time and resources to undertake their role effectively.
- Over the next few years, CCGs could face a challenge in retaining their GP leaders, as many reach the end of their initial terms of office and new, potentially more attractive leadership posts arise in GP provider organisations.
- We observed that the complex external environment, tight deadlines from NHS England and, at times, inefficient internal governance structures meant that engaging and applying the member voice in decision-making was sometimes difficult. Some of the CCGs had begun to review their governance structures to ensure that GP time was used to best effect.

Our research suggests that **the benefits provided by the shift towards CCGs co-commissioning primary care could be compromised by potential conflicts of interest, reductions in running cost budgets and strained relationships with fellow GPs and NHS England.** Our fieldwork was carried out before the details of the co-commissioning policy were announced, but the analysis offers a number of insights that should be considered. Specifically we found that:

- CCG leaders and members who took part in this research agreed that their CCG had a legitimate role in local efforts to develop primary care; a change from the more cautious views held a year earlier.
- However, few members felt that it was appropriate for CCGs to performance-manage GPs. This implies that CCGs may face difficulties maintaining good relationships with GP members if they take on new contract management responsibilities as part of co-commissioning.
- CCG leaders questioned whether they had sufficient resources or time to carry out their expanding role (these views were expressed even before the co-commissioning policy was announced).
- In our research, although the majority of interviewees felt conflicts were being dealt with adequately, we found examples of decisions where there was the potential for, or the perception of, a conflict having occurred. Conflicts of interest will arise more frequently as CCGs take on an extended role in primary care commissioning.
- As was found in the first year of our research, some GPs remained unclear about when they were accountable to their CCG or to NHS England. The distinction risks becoming even more confusing as co-commissioning redefines the boundaries once again.

Considerations for CCGs and NHS England

This report outlines five key areas of work that CCGs and NHS England must focus on in order to ensure that the current model of commissioning is sustainable and maximises the benefits of new co-commissioning arrangements:

- 1 Sustain the enthusiasm of clinical leaders** – To sustain clinical involvement, CCGs and NHS England must invest in a clear primary care leadership strategy that supports current clinical leaders and trains a future cadre.
- 2 Maintain the strength of the GP membership voice** – As CCGs evolve, and commissioning responsibilities develop, CCGs need to explore ways to ensure that the membership voice remains strong in the decision-making process. CCGs will need to demonstrate how GP involvement is impacting their decisions, and maintain a peer-to-peer, supportive relationship rather than focusing excessively on contract compliance and performance management.
- 3 Manage conflicts of interest** – In order to maintain buy-in from members, external organisations and the public as they take on additional commissioning responsibilities, CCGs need to ensure that they are able to demonstrate transparency in their governance processes and should develop the role of lay and other non-GP members of governing bodies.
- 4 Be clear about the relationship with NHS England** – NHS England and CCGs will need to work closely with one another to ensure that the distinction between their roles is understood by GP members. NHS England needs to ensure that CCGs have adequate additional resources to support their expanded role in primary care development.
- 5 Ensure that CCGs have adequate funding to take on new functions** – Management budgets will be reduced from April 2015 at the same time that some CCGs will take on additional commissioning responsibilities. Without adequate resources, some CCGs may struggle to fulfil their new roles effectively.

1. Introduction

Since their inception, the main focus of clinical commissioning groups (CCGs) has been on commissioning secondary and community services for their local populations. However, CCGs also have an important role in supporting improvement in primary care, and this role is now set to grow significantly (see Box 1.1 on page 9 for a description of commissioning and CCGs).

In the Five Year Forward View, the six major organisations that oversee the NHS outlined their vision for the health service in 2020 (NHS England and others, 2014). At its core are new, more integrated organisational provider models that all depend to some extent on re-shaping primary care. Through their primary care co-commissioning policy, detailed below, NHS England has indicated that CCGs will play a central role in supporting that change (NHS England and NHS Clinical Commissioners, 2014).

In this second report from a joint Nuffield Trust and King's Fund programme of research that tracks the progress and activities of six CCGs (chosen to be representative of CCGs across England), we detail the findings from a GP survey, interviews and observations in the CCGs, and desk research that was conducted in spring 2014 to explore three research questions:

1. How involved are GPs in the activities of the CCG, and what relationships are being built between them and CCG leaders?
2. How are CCGs discharging their responsibility to support quality improvement in general practice, and how well placed will they be to do so?
3. What structures and processes are CCGs developing in order to facilitate the above?

In our first report (Naylor and others, 2013) we argued that clinical commissioners had an important window of opportunity to help bring about improvements in general practice, and found that some CCGs were taking positive early steps. In this second report, we describe the progress made over the year since CCGs took on their full legal powers. As the majority of CCGs ready themselves to take on greater responsibilities in primary care, our findings on how they have involved their GP members in decision-making and the approaches they have taken to primary care development provide us with an understanding of the potential of their new role, and some of the possible risks and challenges.

The changing role of CCGs in primary care

Current role

Although the core function of CCGs is commissioning acute and community care, legislation conferred on them a legal duty to support quality improvement in primary care. Core primary care commissioning responsibilities are held by NHS England area teams, who agree and manage GP contracts and commission other primary care services. The distinction is already blurred with some CCGs contracting GPs to deliver some services. And, this is set to expand significantly for interested CCGs. In our first report we explained how CCGs and area teams had some separate and some overlapping responsibilities in primary care that were still being clarified (Naylor and others, 2013).

Future role

In May 2014, NHS England announced that CCGs would be invited to 'co-commission' primary care (NHS England, 2014a). This policy gives CCGs the option to take on a variety of additional responsibilities from April 2015, choosing from three levels:

1. Greater involvement in primary care decision-making: closer collaboration with NHS England area teams.
2. Joint commissioning arrangements: functions exercised by a new joint committee (between the CCG and NHS England area team), with the option to pool funding for investment in primary care.
3. Delegated commissioning arrangements: functions exercised by new CCG primary care commissioning committees, chaired by a lay person and with a majority of lay and CCG executive members.

(See Box 1.2 on page 10 for a more detailed explanation; NHS England and NHS Clinical Commissioners, 2014)

Initially, these responsibilities will be limited to general practice but NHS England is also developing plans to give CCGs more responsibility for commissioning specialised services.

It has been announced that CCGs will not receive additional resources to fund these new responsibilities; alongside facing a ten per cent cut in their running cost budgets in 2015/16 (NHS England, 2014b); and should agree local arrangements for sharing staff resources with area teams where appropriate (NHS England and NHS Clinical Commissioners, 2014). Area teams are themselves undergoing a process of restructuring and will be merged from 27 to 14 larger regional offices in order to reduce costs by 15 per cent (Calkin, 2014). There may of course be some CCGs who choose to remain as they currently operate and not undertake any additional commissioning responsibilities.

Box 1.1: Description of commissioning and CCGs**What is commissioning?**

Commissioning is the process of deciding which services to purchase to best suit the needs of a given population. Clinical commissioning refers to a process by which clinicians are given a primary role in this activity. See Naylor and others (2013) for a review of previous attempts at clinical commissioning.

What are CCGs?

CCGs are clinically led NHS organisations created by the Health and Social Care Act 2012. They replaced primary care trusts as the statutory bodies responsible for planning and commissioning the majority of NHS health services (excluding primary and some specialised care) in April 2013. CCGs were intended to put responsibility for the design of local health services into the hands of local GPs. This is based on the logic that through their daily interactions with patients, GPs gain an in-depth understanding of their practice population, which makes them best placed to design health services that meet local patients' needs. There are currently 211 CCGs in England, covering registered populations of between 70,000 and 900,000.

CCGs are membership organisations, meaning that the decisions made should reflect the views of those involved. However, unlike other membership organisations, all GP practices in England must belong to a CCG. Each practice nominates a representative – usually a GP, but in some cases a practice manager or other colleague – to represent them at a members' forum. Each CCG is led by a governing body which consists of a mixture of general practice representatives, members of the CCG executive team, other clinicians and lay representatives.

CCGs are distinct from the previous incarnations of clinical commissioning GP fundholding in the 1990s (HM Government, 1990) and practice-based commissioning in the 2000s (Department of Health, 2001) in two main ways: first, joining a CCG is a mandatory requirement for GPs and second, the CCG is intended to operate on a membership model whereby the organisation is led by GPs and represents all GPs in its catchment.

Box 1.2: Optional additional co-commissioning responsibilities**CCG responsibilities 2014/15**

- Legal duty to promote quality improvement in primary care.
- Delegated responsibility for design of local enhanced services (LES) (that pay GPs for additional services on top of their core contract).
- Commissioning of GP out-of-hours services.

CCG optional additional joint or delegated co-commissioning responsibilities in 2015/16

- General practice commissioning: review or renew existing GP contracts, award new ones including ability to design Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts, establish new practices in an area and approve practice mergers.*
- General practice contract performance management.*
- General practice budget management.
- Complaints management.
- Design and implementation of local incentive schemes (e.g. new local incentives to replace Quality and Outcomes Framework (QOF) payments, LES and directly enhanced services (DES)).
- Making decisions on discretionary payments such as returner/retainer schemes for GPs seeking to return to general practice after a break.

*CCGs who choose the first 'greater involvement' level of co-commissioning can be involved in discussions about these areas but will have no decision-making role.

Primary care responsibilities retained by NHS England

- Dental, eye health and community pharmacy commissioning (although CCGs can be involved in discussions).
- Performance management of individual GPs: medical performers' list, appraisal and revalidation.

(NHS England and NHS Clinical Commissioners, 2014)

The health and social care context

During this second year of our research, the NHS has continued to strain under severe financial pressure: at the end of 2013/14, around a quarter of NHS trusts and foundation trusts were in deficit, as were one in ten CCGs (National Audit Office, 2014a). In general practice, although patient satisfaction has remained high, the workforce has been under pressure due to a shortage of GPs and diminishing resources (Dayan and others, 2014; and the British Medical Association survey 2014¹ which reports increased workloads and low levels of morale). General practices have been increasingly seeking to join together in informal networks or more formal federations

1 Note: This survey (British Medical Association, 2014) was carried out by the trade union and professional body for doctors. The survey is carried out quarterly. This iteration took place between 4 and 24 February 2014 and was completed by 420 GPs (response rate of just over 50 per cent).

in the anticipation that by operating at scale they will be well placed to provide coordinated, multi-disciplinary care of the kind required to respond to the changing needs of the population (Smith and others, 2013).

While health care budgets have been protected from real-terms cuts, adult social care budgets have decreased by 12 per cent in real terms since 2010 through five consecutive years of spending cuts (Association of Directors of Adult Social Services, 2014). To address this imbalance and promote more integrated models of care, the government created the Better Care Fund to shift resources from hospitals to the community by pooling at least £3.8 billion of funding (£5.3 billion based on current plans) into a joint health and social care budget in 2015/16 (National Audit Office, 2014b). At least £1.9 billion of this pooled budget must come from existing CCG allocations.

This context is an important consideration for our research questions. First, it may be more difficult to engage GPs in commissioning while they experience so much pressure from their provider responsibilities. Second, the financial context and the drive to keep patients out of hospital means that the success of CCGs in leading or supporting change is even more critical.

Report structure

Following a brief outline of our methodology and case study CCGs, this report explores how engagement of GP members and leaders has developed throughout the year, and the current and future challenges facing CCGs. The report then goes on to detail CCGs' expanding role in supporting quality improvements in primary care, and the opportunities and complexities that have arisen as a result. The report concludes with an analysis of what this evidence tells us about upcoming policy challenges for CCGs as they face a year in which budgets will continue to be constrained and, for some, their role will be expanded to primary care.

Findings from the first year of this research were published in 2013 (Naylor and others, 2013) and a more detailed summary of the survey findings discussed in this report was published in 2014 (Robertson and others, 2014).

2. About this research

Approach

Our project set out to follow the development of CCGs in six case study sites over three years, from 2012 to 2015, to understand how CCGs are operating with their GP members and the influence they have over primary care provision. A report was published at the end of the first year, based on research conducted between October 2012 and March 2013, before CCGs took on full statutory responsibilities (Naylor and others, 2013). This report details the second year of research, which was conducted almost one year after CCGs took on statutory responsibilities, in early 2014. Further research is due to be conducted this year, 2015.

The six case study sites were selected at random in 2012, using a stratified approach to ensure that we included CCGs of various sizes and from all four regions of NHS England. We ensured that the sites represented a wide range in terms of level of deprivation, and included both urban and rural areas. The sites have been anonymised in this report.

The six case study sites in year one all continued to take part in year two and we collected information through largely the same methods as in year one:

- documentary analysis of documents relating to the CCG, particularly board papers
- semi-structured interviews with 70 key individuals – those with and those without a formal role in the CCG
- observations of 18 meetings, the majority of which were CCG governing body and member engagement meetings
- an online survey of member practices with 279 responses, primarily from GPs without a formal role in the CCG (an approximate response rate of 28 per cent).

See Appendix 1 for a detailed report on the research methods used and Appendix 2 for characteristics of the case study sites. In both the interviews and the survey, particular efforts were made to reach GPs who had no formal role within the CCG.

Site profiles

CCGs across England are highly diverse in terms of population size and profile, and our case study sites reflect this diversity. Table 2.1 provides a summary of their characteristics (approximate values are given to protect anonymity).

Table 2.1: Case study site characteristics

Site	Population (thousands)	Number of practices	Approximate budget (millions)	Deprivation	Location
A	200–300	20–30	£200	Medium to low	Mainly rural
B	500+	60–70	£600	Low	Mixed urban/rural
C	100–200	30–40	£200	Very high	Urban
D	300–400	40–50	£400	High	Urban
E	100–200	10–20	£200	High	Urban
F	200–300	30–40	£300	Low	Rural

Note: Population/budget data for 2014/15 were taken from: www.england.nhs.uk/wp-content/uploads/2013/12/ccg-allocation-big-table-v2.pdf

Appendix 2 provides further detail about the historical context and demographic profiles of our case study sites.

3. GPs' involvement in CCGs

Key findings

- During their first year as fully established commissioning organisations, our survey of GPs found that the CCGs in this study had broadly maintained levels of engagement from their GP members, despite the financial and demand pressures on general practice.
- However, there is evidence that the initial enthusiasm among some of the GP leaders who are most closely involved with the work of their CCG has started to wane.
- CCGs in this study were not always getting maximum value out of the involvement of clinicians in commissioning. Some had begun to review their governance structures in an attempt to ensure that valuable GP time is used to best effect.
- CCGs faced challenges in involving members in decision-making while operating in a complex external environment that often required them to work at scale with neighbouring CCGs and other health and social care organisations, and to respond to central requests from NHS England.
- All CCGs in this study moved some externally commissioned support services in-house in 2014/15, or were considering doing so, giving them more control over the service provided. As running cost budgets reduce in 2015/16, they could find it challenging to achieve efficiency savings in their internal operations without the economies of scale available to commissioning support units (CSUs).
- The sustainability of clinical involvement in the current model is at risk unless resources are invested to support clinicians currently in leadership positions to fulfil these new roles that are very different from their day-to-day clinical work, develop emerging leaders and undertake succession planning.

In this chapter we consider the extent to which this new form of commissioning is enabling clinicians to design local health services and any challenges that are being faced. We asked our participants about their levels of 'engagement'; understood as their level of interest, enthusiasm, involvement and support for the CCG (although in the survey, terms were not defined). In order to understand the impact of this engagement, we also asked participants whether they felt that decisions taken by the governing body reflected their views, and if they felt as though they 'owned' and felt able to influence the CCG. Taken together, these findings give us an indication of the perceived impact of GPs' engagement and their functioning as membership organisations.

In the first year of our research, we found that GPs were optimistic about what the new commissioning system could achieve, and there was a strong commitment from CCG leaders to making the new arrangements work (Naylor and others, 2013).

Engagement among GPs was highly variable, with GP leaders being more positive than GP members. However, engagement was generally better than under the previous commissioning arrangements. Our first report suggested that work was needed to ensure that this enthusiasm would continue, particularly given the pressurised environment GPs are operating within. In the second year of our research, we revisited these issues in order to understand what developments had occurred, looking specifically at the extent to which CCGs have the relationships and structures in place to ensure that the views of their GP member practices feed into their decision-making processes, and how and why leaders' enthusiasm for commissioning has changed over time.

Where this chapter presents survey results, the term 'leaders' refers to those who have a formal role in the CCG (clinical and non-clinical governing body members, locality leads and practice representatives) and 'members' refers to those who do not have a formal role in the CCG. As outlined in Appendix 1, a small proportion of survey respondents were practice managers and non-clinical governing body members. However, for ease of reading, survey respondents will be referred to as 'GPs' from this point onwards.



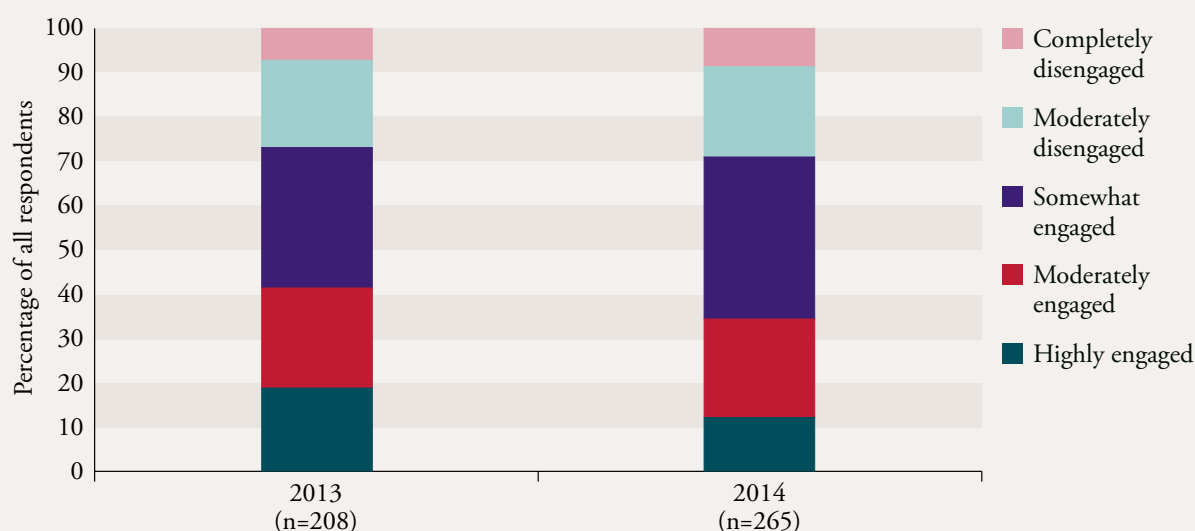
CCGs have largely sustained levels of GP engagement during their first year as fully established commissioning organisations

Overall levels of GP engagement

“... we [CCGs] live or die by GP engagement. If there's no GP engagement we're sort of pointless organisations really, and the mantra is to avoid becoming a PCT [primary care trust] because clearly what we want to avoid is just sort of hide-bound, remote organisations – that we just need to maintain that membership feel.”
(Chief finance officer)

Our research indicates that CCGs have largely sustained levels of GP engagement during their first year as fully established commissioning organisations. In January 2014, 71 per cent of GPs reported being at least somewhat engaged in the work of their CCG (Figure 3.1). This was similar to the level of overall engagement reported in February 2013 (73 per cent) (Naylor and others, 2013) and remains much higher than previous commissioning models. During practice-based commissioning, over half of GPs felt 'not at all' or 'not very engaged' (Wood and Curry, 2009), and if engagement is understood to be comparable with signing up to the scheme, GP fundholding covered only 50 per cent of the population after successive waves of enrolment (Glennerster, 1994).

Figure 3.1: How engaged do you feel with the work of the CCG? 2013 and 2014



Notes: Respondents who skipped the question were excluded from the distribution. Per cent highly engaged with work of CCG down from 19 per cent (2013) to 12 per cent (2014), $p < 0.05$. Per cent highly/moderately/somewhat engaged 73 per cent (2013) and 71 per cent (2014); difference not significant at $p < 0.05$.

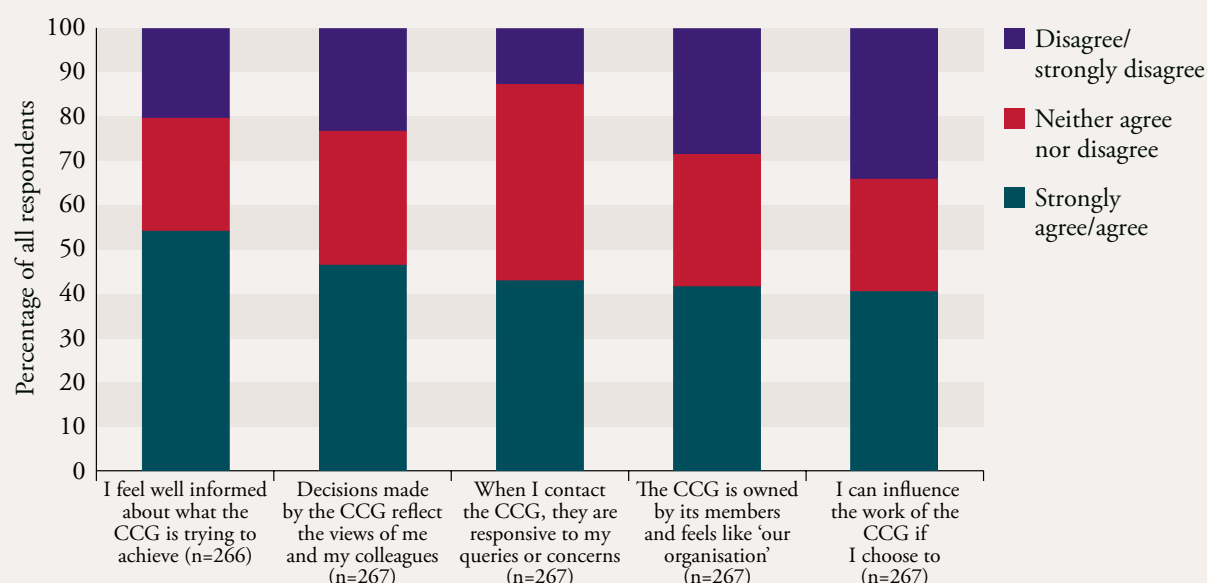
“ GPs were more positive about the level of influence they had over the CCG than in previous commissioning arrangements

A national survey of more than 5,000 GP practices conducted for NHS England at a similar time to ours (spring 2014) also found that the vast majority of GPs felt they were engaged at least a fair amount with their CCG (82 per cent). The research, conducted by Ipsos MORI, showed that engagement had declined slightly since the previous round of their survey was fielded two years earlier, during the CCG authorisation process (87 per cent; Ipsos MORI, 2014).

Analysis of the impact of this engagement revealed a mixed picture. Over half of GPs who responded to the survey (54 per cent) felt well informed about what the CCG was trying to achieve; and 46 per cent felt that decisions made by the CCG reflected the views of themselves and their colleagues (see Figure 3.2). These figures remain largely unchanged from the previous year and echo findings discussed on pages 22 to 23 about the functioning of some of the internal governance structures.

Despite this varied picture, when asked to reflect on current and past commissioning arrangements, GPs were more positive about the level of influence they had over the CCG than in previous commissioning arrangements. Forty per cent of GPs who responded to our survey reported that they could influence the work of their CCG, compared with just 13 per cent who felt they could influence the work of their primary care trust (PCT) in the past.

Figure 3.2: Levels of ownership and influence over the CCG, 2014



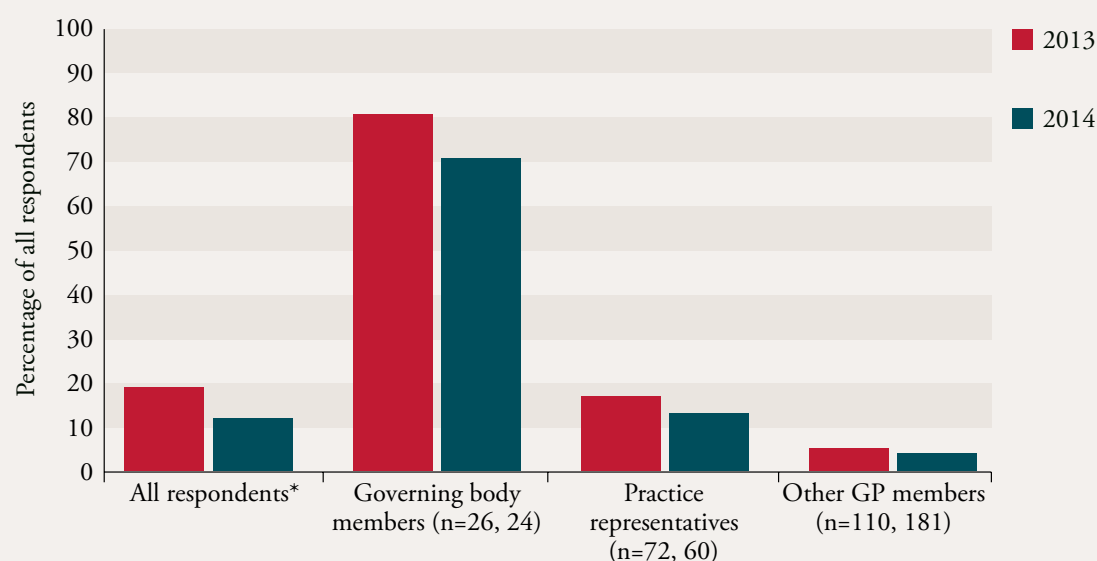
Notes: The question asked was: 'To what extent do you agree or disagree with the following statements?' Respondents who skipped the question were excluded from the distribution.

Variations in perceptions of the CCG

Engagement by role within the CCG and practice

Beneath these overall trends in engagement, our survey indicates that enthusiasm had started to wane among the core group of GPs who work most closely with their CCGs. Between 2013 and 2014 there was a significant decrease in those who reported being 'highly engaged' in the work of their CCG (from 19 per cent in 2013, to 12 per cent in 2014; Figure 3.3) due to a decrease in the proportion of governing body members and, to a lesser extent, practice representatives who were highly engaged.

Figure 3.3: Change in the proportion of GPs highly engaged in the work of their CCG by role, 2013 and 2014



Note: Practice representatives include locality/neighbourhood leads, CCG practice representatives and CCG sub-committee members.
* Statistically significant result.

It was suggested by some that this drop-off in engagement among CCG leaders over time may be because of the pressures in general practice and GPs feeling more committed to protecting their own practice, perhaps at the expense of time spent on CCG-related work. From page 20 we discuss the factors identified in our research that might explain this trend.

“... people have become far more protectionalist about their own provider role... and some of the altruism is lost... I think we’ve got another year window of opportunity to make some big changes... in my view we’re being too slow.”
(Governing body member)

Attitudes towards engagement also varied according to respondents’ role in the practice. Practice managers¹ who responded to the survey expressed levels of engagement that were higher than those GPs without a formal role in the CCG. In 2014, 85 per cent of practice managers reported being at least somewhat engaged; compared with 71 per cent of GP principals and 59 per cent of salaried GPs. In all of our CCGs, practice managers were able to attend CCG meetings either as representatives of their practices or out of interest. Two CCGs in particular actively encouraged practice managers to attend and contribute to CCG meetings or forums, and in one a practice manager sat on the governing body in a non-voting capacity. One CCG leader described practice managers as “probably the most stable part of the system in many respects” and they “represent the business and can think about the mechanisms by which they can influence the working lives [of GPs]” (GP governing body member).

 there remains a disparity between leaders’ and members’ sense of ownership of the CCG

Ownership and influence by role within the CCG

Looking at the impact of GPs’ involvement in the CCG, similar to in 2013, the survey in 2014 showed that there remains a disparity between leaders’ and members’ sense of ownership of the CCG, with the former more likely to report ownership of, and engagement with, their CCG (Figure 3.4). As we reported last year, if this disparity continues over time, there is a risk of CCGs losing their connection with their members and repeating the pattern of diminishing clinical involvement of previous commissioning formations.

¹ Although our survey was aimed at GPs, a small number of practice managers also responded (n=47 in 2013 and n=28 in 2014; see Appendix 1 for a full breakdown of respondents by type).

Figure 3.4: Levels of influence and ownership by role within the CCG, 2014

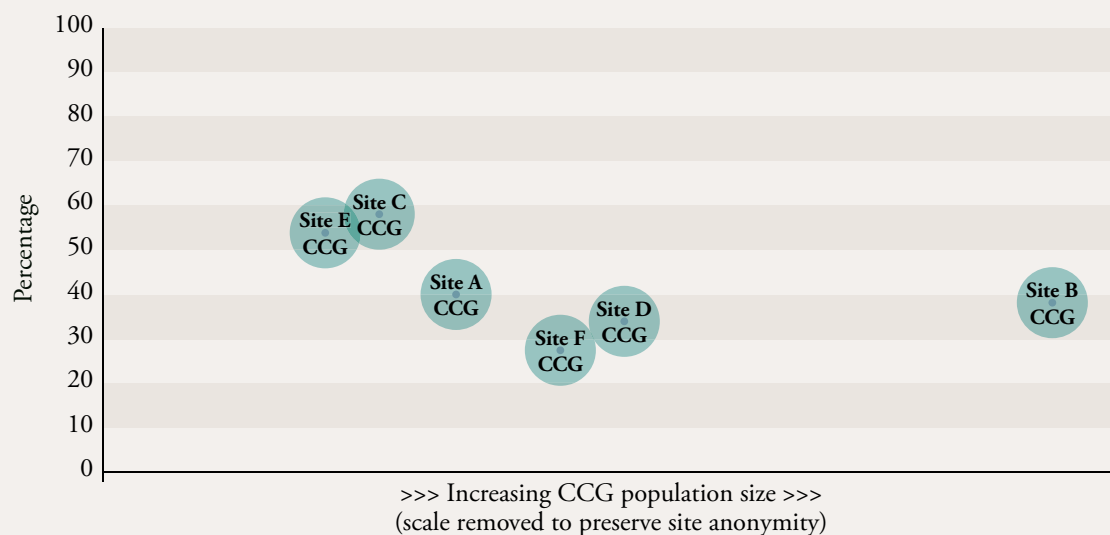


Note: Practice representatives include locality/neighbourhood leaders and sub-committee members.

Variations by size of CCG

One major factor affecting the degree to which GPs felt a sense of ownership over the CCG was the size of their CCG, with the highest levels of ownership reported in the smallest two CCGs (Figure 3.5).

Figure 3.5: "The CCG is owned by its members and feels like "our organisation"': percentage of all respondents agreeing or strongly agreeing, by site, 2014



Note: Site A n=49, site B n=63, site C n=47, site D n=39, site E n=30, site F n=39.

Some larger CCGs have locality structures in place below their governing body that cover smaller areas, and are often based on pre-existing groupings such as practice-based commissioning clusters or local authority boundaries. These arrangements work in different ways across the country, but in site B in this study, the locality groups are highly developed and hold devolved decision-making power and budgetary responsibility. The greater sense of ownership that can be generated in these smaller groupings may explain why the level of ownership reported in CCG B is higher than in two of the smaller CCGs in the study (Figure 3.5). As one GP locality chair commented:

“... I think GP practices work more effectively if people know each other and are caring for the same group of patients.”

(GP locality chair)

Challenges to sustaining GPs' engagement and influence in CCGs

In this section we consider a number of issues that relate to the organisation and function of the CCG that may be barriers to engagement for GP leaders and practice representatives. These difficulties and frustrations go some way to explaining the declining enthusiasm reported by this group in our survey. Our research has identified these challenges as:

- pressure on GPs' time and capacity
- leadership development
- internal governance structures
- responding to requests from NHS England
- external structures: operating in a complex system.

Pressure on GPs' time and capacity

There is a growing recognition that general practice is coming under increased pressure, fuelled by a real-terms decrease in funding in 2013/14, and difficulties recruiting and retaining GPs, who recently reported their lowest levels of job satisfaction for a decade (Dayan and others, 2014). Within this context it is unsurprising that a lack of time and capacity in primary care were the most commonly cited barriers to engagement with clinical commissioning during interviews in both 2013 and 2014. In the second year of our research, GPs told us they had very little or no spare capacity to take an active interest in their CCGs. GPs in four of our case study CCGs reported that engagement in their CCG's activities came at a cost to patient care and to themselves. Some GP interviewees who had taken on formal roles in the CCG also reported difficulties in finding the time to complete training courses.

This was also reflected in survey responses from GP governing body members and member representatives, less than 40 per cent of whom reported they had the time necessary to undertake their CCG role (Figure 3.6). This is unsurprising given the findings of other research that the time commitment required for CCG work ranged up to 24 hours a week for one clinical chair (Checkland and others, 2014).

Figure 3.6: Experience of GPs with a formal role, 2014



Notes: The question asked was 'You told us you have a formal role in the CCG. To what extent do you agree or disagree with the following statements?'. Base: respondents who reported they were a member of the CCG governing body, practice representative, locality/neighbourhood lead or sub-committee member. Respondents who skipped the question were excluded from the distribution.

Leadership development

For GPs, particularly those on the governing body, their work with the CCG is very different from their day-to-day clinical practice, and our research suggests that some are struggling with their new commissioning role. Thirty-five per cent of the governing body members and practice representatives who responded to our survey felt that they had received the training and development that they needed to fulfil their role (Figure 3.6). Forty-six per cent believed they had the support necessary to make robust, evidence-based decisions.

GP interviewees highlighted a number of challenges in moving from wearing their 'practice hat' to their 'corporate hat'. For example, GP leads in two sites described the difficulty in getting to grips with the size of the CCG compared with their own practice, and the challenge of considering the whole CCG, not just their own patients. Others commented on an unexpected need to learn about, and deal with, organisational politics, particularly when consulting the membership on potentially difficult decisions, as this governing body member explains:

"I think one of the things I hadn't taken account of is how much this was to do with people and politics with a small p... So I think what I hadn't realised was just how much it would be about making sure that you have healthy, balanced relationships, not colluding, and the whole healthy challenge thing is quite tricky, and all of those things have been new."
(GP governing body member)

GP leaders on governing bodies also described a learning curve on which they had to learn new skills to interpret financial information and work to understand the extent of their accountabilities for the decisions made by the CCG.

In addition to the need for support and training to take on these new roles, an accountable officer from the executive team at one of the CCGs acknowledged that there were challenges around building GP confidence:

“But initially, actually they were quite nervous of it, so although you think of these GPs as leaders, actually they are not naturally. Because they’ve run their own, in the scheme of things, tiny businesses, but actually these are big organisations. And by the time that you’re looking at spend around urgent care, you’re talking about many millions of pounds. So it was quite nerve-wracking. And also, the whole issue about being accountable for the decision, again, is fairly new to them.”

(Accountable officer)

Developing the skills and confidence of GP leaders was a work in progress for our CCGs that will require continued focus if they are to sustain clinical involvement in their operations.

Internal governance structures

In addition to training GPs for leadership roles, it is important that CCGs are structured in a way that allows them to use GPs’ time effectively and maximise the value gained from the time clinicians put into the commissioning process. Our interviews and observations revealed issues with the functioning of governing bodies and member councils that meant they were not always maximising the value of clinical involvement (see Box 1.1 on page 9 for an outline of the internal structure of CCGs).

Governing bodies

The governing body meetings observed by the research team were generally procedural in nature, with agendas that focused on updates from other meetings and performance reports. GPs and governing body members interviewed in five of our sites reported that it sometimes felt like their meetings were rubber-stamping decisions which had been discussed and agreed by the executive:

“As to the actual governing body decisions a lot of decisions have been discussed at executive level so the managers are all fully up to speed and sometimes the GPs are... the first time they hear about it is in the paper, so... also some of the board GPs are more involved than others, so the managers often will feel that they’ve got clinical buy-in because a couple of people have been consulted.”

(Locality chair)

The breadth of governing body agendas and the length of meeting papers (for example, in March 2014 the average length of meeting papers across our case study CCGs was 282 pages, with one CCG reaching 560 pages) meant that during our observations of meetings there was little time for discussion of strategy and commissioning plans. In recognition of this, some of our CCGs were making changes to their governance structures to try to maximise clinical involvement. One of the CCGs involved in this research had set up a governance committee to take many of the day-to-day procedural items away from the governing body. Another had established four programme boards to oversee its four main areas of commissioned activity, which were each chaired by a GP.

Member councils

Although CCG constitutions describe member councils as forums for representatives to feed the views from their GP practice into the CCG decision-making process, and approve particular plans and strategies, they were described by interviewees as being mainly for one-way information-giving and not being an effective mechanism for influencing the CCG:

“It ends up being a meeting with 30 to 40 people in the room, including, they always tend to bring in support staff to sit round in the back and that size of meeting is never, ever going to be terribly effective. So I mean, the intent without a doubt is practice engagement. The effect is a feeling that we can’t really influence anything.”

(GP practice representative)

Nine GP interviewees spread across all of our sites said they did not believe their CCG was being transparent and meaningfully including everyone in their decision-making. GP interviewees who felt they had influenced decisions reported that they had done so through informal contacts. They were positive about being able to approach GPs on their governing body informally – clinician to clinician – with queries or concerns, and they felt listened to; not all GPs felt this was possible within PCTs in the past. Generally, members reported good relationships with GPs on the governing body who were well known, respected and approachable. In a small number of cases, however, members felt that leaders were ‘out of touch’ with the realities of working under the current pressures of the primary care system and did not represent their views.

Responding to requests from NHS England

CCG leaders in three sites reported that demands from NHS England with tight deadlines often left them with little time to institute a proper consultation process, either with members of their CCG or other stakeholders. In particular, they highlighted requests for strategy and planning documents to tight timescales. For example, on 20 December 2013, CCGs had been asked to submit five-year strategic plans and two-year operational plans to NHS England by 14 February 2014. This timescale meant that in one CCG, the governing body did not sign off the strategic plan before it was sent to NHS England. We observed a lay member challenging the chair on their lack of involvement in the process during a governing body meeting. The lay member was told the document was formulaic and not the route through which governing body members should influence CCG strategy.

External structures: operating in a complex system

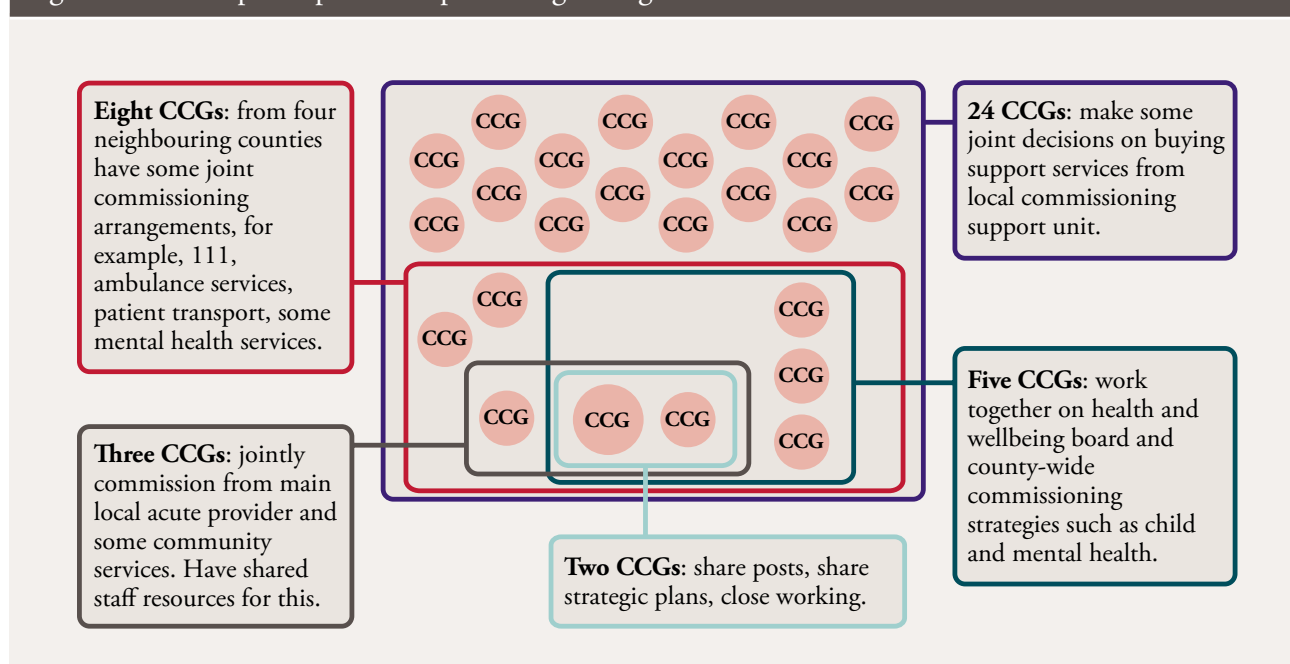
CCGs operate in a complex and varied local environment, in which they form partnerships with a range of other organisations including neighbouring CCGs and local authorities. The extent of these joint working arrangements varies across the country, partly driven by the size of each CCG (there is a ten-fold difference between the population covered by the smallest compared with the largest CCGs in England) and other factors such as whether CCG boundaries are co-terminus with the local authority.

Joint arrangements enable CCGs to make efficiency savings through the shared use of resources, and help local organisations produce coordinated strategies and have greater influence over providers. However, these processes also lengthen the decision-making process and require extra meetings with external partners that are an additional call on

CCG leaders' time. Other research has found that having accountability arrangements with multiple bodies risks a mismatch – and at times a conflict – with their respective agendas (Checkland and others, 2014). CCGs need to manage these external relationships as well as internal ones, while maintaining members' influence over the decision-making process.

We observed that four of the CCGs in this research had established formal joint working arrangements with neighbouring CCGs for purposes such as developing their Better Care Fund plan (working with other CCGs in their local authority area) or negotiating acute service contracts (with CCGs in a local provider's catchment). An example of the web of formal and informal partnership working arrangements is illustrated in Figure 3.7.

Figure 3.7: Example of partnership working arrangements

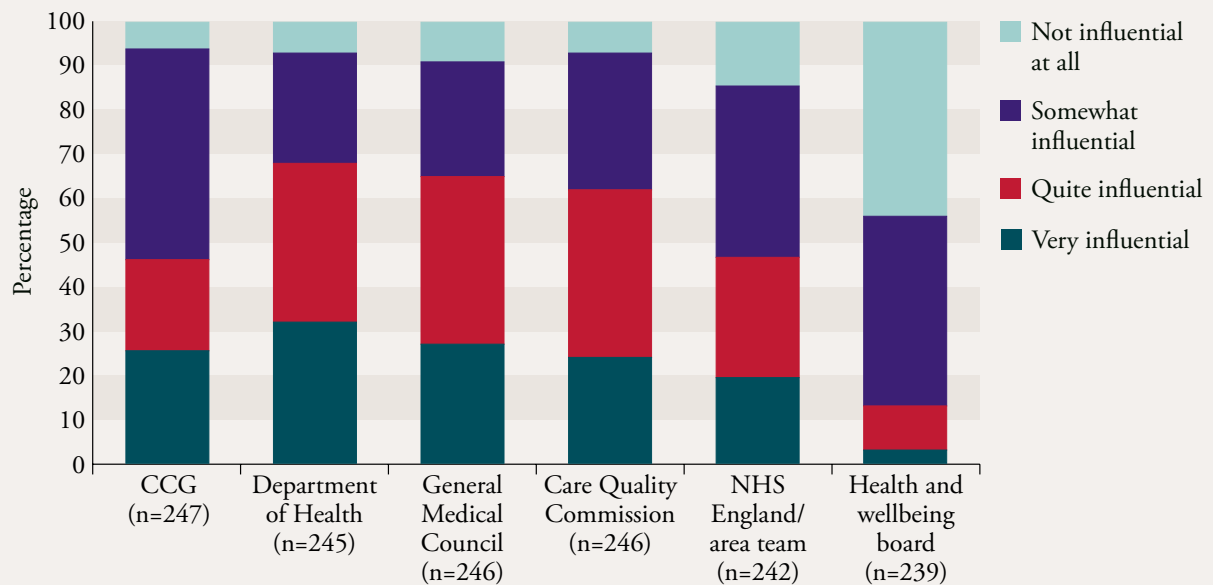


Working with non-NHS organisations is another important part of this web of joint working arrangements. CCGs and local authorities have a number of joint responsibilities which are overseen by the health and wellbeing board. Although they have been in existence for as long as CCGs, health and wellbeing boards were described by interviewees as being at an early stage in their development. Interviewees noted the importance of developing relationships and trust between the many parties involved in the boards and described the challenge of coordinating such a diverse group. In two-tier local authorities, this required an additional layer of coordination.

The health and wellbeing boards in our case study sites were not mentioned as key in shaping the local agenda; interviewees in two sites described them as signing off plans rather than driving their development or implementation. In line with this, the overwhelming majority of GPs who we surveyed reported that the health and wellbeing board had very little influence over their day-to-day work (see Figure 3.8). Although not surprising, given the strategic focus of the health and wellbeing boards' work, this finding does give an indication of the low profile these organisations have among the

general practice community, and the additional work that needs to be done if joint health and social care commissioning is to influence the shape of primary care services in the future.

Figure 3.8: Influence over GPs' work by organisation, 2014



Notes: The question asked was 'What degree of influence do you feel each organisation has over your work?'. Respondents who skipped the question were excluded from the distribution.

Future challenges

The environment within which CCGs work is evolving and, during the latest phase of this research, two upcoming changes presented themselves as potential issues for the future of clinical commissioning. These were the changes in arrangements for commissioning support services, and concern around the recruitment and retention of GP leaders.

Evolving arrangements for commissioning support services

In 2014/15, CCGs received around £25 per head of population to spend on running costs. They could choose how much of that budget to spend on their own 'in-house' management costs and how much to spend on external support from CSUs and other external support providers. In the first round of research we reported that some CCGs had chosen to outsource a large amount of their management costs to the local CSU in order that they could remain a small, flexible team and gain economies of scale from outsourcing functions to an organisation that covered multiple CCGs. As one governing body member noted, this meant that they were reliant on the CSU performing well:

"I hope our confidence is not misplaced. But there's a huge risk around this, huge."
(Governing body member, 2013)

For 2014/15, all of our case study sites had decided to bring at least some services in house, or were considering doing so. Table 3.1 shows the services provided by CSUs to CCGs and the areas where services have been brought in house, or where there were plans to do so. For some this was occurring only at the margins, while for others there was a large shift of services in house.

Table 3.1: Changes to the management services procured from commissioning support units (CSUs) in 2014/15

Key						
• CSU provides at least some services in this area						
← all or part of this service has been moved in house						
←? considering moving all or part of this service in house						
* all or part of this service moved from CSU to an alternative provider						
	CCG A	CCG B	CCG C	CCG D	CCG E	CCG F
2013/14 CSU spend per head of population	£7	£12.50	£10	£9	£10	£17
2014/15 CSU spend per head of population	£6	£3	£7	£7	£10	£16.50
Business intelligence	•	←	•	•	←?	•
Support for redesign			←		•	•
Communications and patient and public engagement	←		←	•		
Procurement and market management (agreeing contracts)	*		←	•	•	•
Provider management (monitoring contracts)	•		•	•	•	←
Business support/back office	←	←	•	←	•	←

Note: Service groupings taken from NHS England (2013).

Although there were positive comments about particular services and individuals from the support units, all sites reported some dissatisfaction and there was a common complaint about CSUs being unresponsive. Many highlighted national data-sharing issues that affected the quality of the business intelligence service that the CSUs were able to provide (although there was recognition that this was a national issue and that a workaround had been found). This clinical chair talks about the difficulties that led to CSU services moving in house:

“It just wasn’t up to standards, we weren’t getting any of the information we needed, we weren’t getting the response we needed. I think we had serious concerns about the leadership of the CSU and the senior leadership within it and the ability of staff to deliver the work that we needed. So... and I made that decision [to move most CSU services in house] actually pretty quickly in the middle of... or the beginning of last year.”
(GP chair)

Moving services in house raises both risks and opportunities for CCGs. In many cases, it involves bringing CSU staff into the CCG, which takes them closer to the staffing structure of their predecessor PCT. This could be beneficial as it gives the organisation more control over the quality of their support services. However, it also moves away

from the leaner, GP-led organisation originally envisaged. One of the reasons for outsourcing functions to external providers was their ability to achieve economies of scale by providing services to a number of CCGs at once. As CCG running cost budgets are reduced in 2015/16 (NHS England, 2014b), and the structure of the commissioning support market continues to change (Welikala, 2015), we can expect to see further changes in the mix of in-house and outsourced commissioning support. CCGs will be challenged to find savings in the services they provide internally without the efficiencies available to CSUs by operating at scale.

Succession planning for GP leaders

Succession planning is a key issue for CCGs which, over the next few years, will see their original governing body members come to the end of their terms of office, often with few new or emerging leaders developing to take over from them. This echoes previous forms of commissioning where research indicated that it was often the 'usual suspects' taking on central roles, with the majority of the GP community not interested in commissioning roles (Curry and others, 2008).



CCGs spoke about the need to encourage more GPs to take on leadership roles and to give younger or newer members leadership training

The length of tenure for governing body members is set by each CCG, and in our case study sites GP leaders will reach the end of their terms in 2016 or 2017 (although they are able to stand again). Other researchers have noted that this creates an inbuilt discontinuity of the senior leadership (Checkland and others, 2014) and as international examples suggest, stability in leadership can be a key factor in establishing a successful health care organisation (for example medical groups in the United States, which spent time and resources identifying and developing new leaders; Thorlby and others, 2011). Two of our CCGs had mitigated against the risk of all leaders leaving the organisation at the same time by staggering the terms of their governing body members.

A CCG leader from an area seeking to develop a strong GP provider federation highlighted the potential for there to be competition for leaders from the developing GP provider organisations, as was seen in Corby recently where the CCG chair announced he was stepping down in order to lead a local primary care provider (Health Service Journal, 2014). This will mean two local organisations attempting to draw leaders from a fairly small pool of GPs who are interested in, or feel able to undertake, leadership roles.

Several interviewees across four CCGs spoke about the need to encourage more GPs to take on leadership roles and to give younger or newer members leadership training. In three of the CCGs, GPs were encouraged to take on small pieces of work or small areas of responsibility, in the hope that they could be nurtured into taking on leadership positions as these became vacant. One CCG offered a developmental role on the CCG governing body for less experienced GPs. Continuing and building on these efforts will be essential if CCGs are to sustain strong clinical leadership in the future.

4. CCGs' involvement in primary care development

Key points

- CCG leaders and members in this research agreed that their CCG had a legitimate role in local efforts to develop primary care; a change from more cautious views held a year earlier.
- However, few members felt that it was appropriate for CCGs to performance-manage GPs. This implies that CCGs may face difficulties maintaining good relationships with members if they take on new contract management responsibilities as part of co-commissioning.
- CCG leaders questioned whether they had sufficient resources or time to carry out their expanding role. These concerns were raised even before the details of the co-commissioning policy were announced.
- Conflicts of interest will arise more frequently as CCGs take on an extended role in primary care commissioning. In our research, although the majority of interviewees felt conflicts were being dealt with adequately, we found examples of decisions where there was the potential for, or the perception of, a conflict having occurred.
- As was found in the first year of our research, some GPs remained unclear about when they were accountable to their CCG or NHS England. The distinction risks becoming even more confusing as co-commissioning redefines the boundaries once again.
- The future challenge for CCGs will be to ensure that they sustain a peer-to-peer, supportive relationship, rather than focusing excessively on contract compliance and performance management. Some of this is within CCGs' control (that is, what mechanisms they use to implement their new responsibilities), but some of it may depend on the resources and time available to CCGs to maintain these relationships.

Our interest in primary care development included:

- the activities the CCGs had instigated to monitor or improve the quality of existing services
- commissioning decisions that meant contracting with GP practices
- CCGs' involvement with any restructuring of primary care.

In the months preceding the authorisation of CCGs, when we undertook our first year of research, we found that the approaches taken to develop primary care varied significantly. For some, GP leadership and influencing one another's clinical practice

were already commonplace, but others were wary of undertaking this role. The reasons for this caution were numerous:

- not wanting to be seen to be ‘policing’ colleagues
- a concern over resources
- diverting attention from CCGs’ primary purpose
- the impact on GP engagement
- resistance to doing a job that was seen by some as NHS England’s and wanting to wait and see how the relationship with NHS England developed.

We reported that the largest factor in determining the CCG’s approach was the local area context that the CCG had inherited and what activities the PCT had established. For example, while all of the case study CCGs shared comparative data and used financial incentives, the extent of this work varied. Some CCG leaders strongly opposed the idea that their responsibilities would be considerably extended into primary care development.



The proportion of GPs who felt that the CCG has a legitimate role in influencing their clinical work has increased

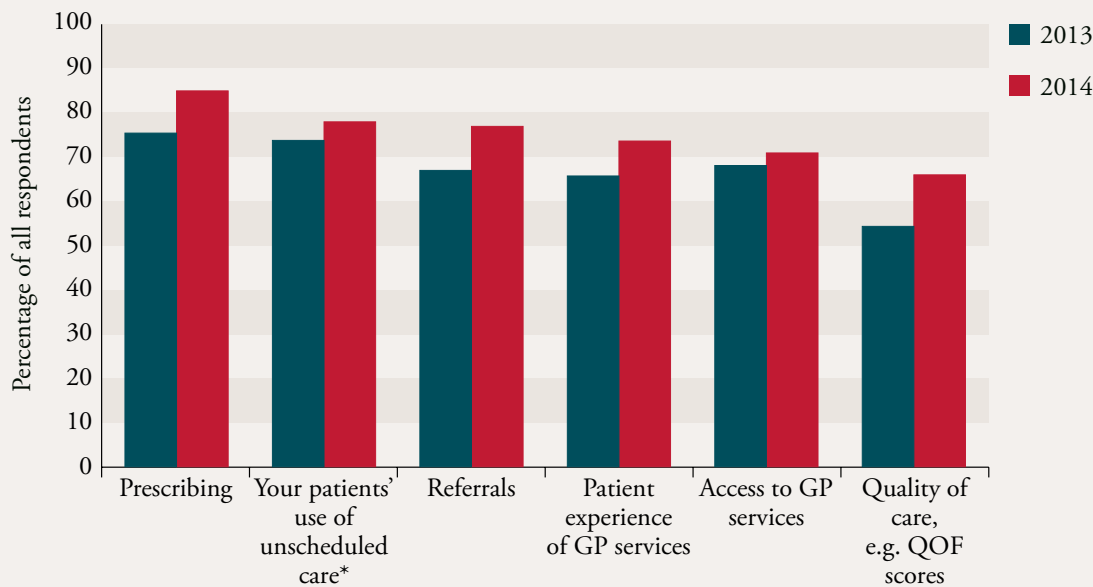
Our latest phase of research suggests that there may have been a shift in opinion and there was widespread acceptance among CCG leaders that primary care was within their remit. Many of those who signalled a note of caution in year one of our research had invested more of the CCG’s time and resources into primary care quality. The following quotes are from the same CCG chair in 2013 and then in 2014:

“[It’s] fairly clear that [CCGs] will not have a role in policing or monitoring practices, and if they try to thrust that upon us I would resist that quite strongly... as far as I’m concerned that role sits squarely with the local area team.”
(Chair, 2013)

“... I think there has been a bit of a sea change there, yes. I think 12 months ago I would have said absolutely not, I’m not interested in performance, it’s not my bag, but it’s increasingly clear that NHS England are not going to take that on either so someone has got to do it and I think it is going to probably fall in our laps, yes.”
(Chair, 2014)

Additional evidence for this change in attitudes can be drawn from our survey. The proportion of GPs who felt that the CCG has a legitimate role in influencing their clinical work has increased over the last year, as illustrated in Figure 4.1. The increase was significant for prescribing, referrals and the quality of care provided, with 85 per cent now agreeing that the CCG should try to influence their prescribing patterns.

Figure 4.1: CCGs' role in influencing GPs' clinical practice, 2013 and 2014



Notes: The question asked was 'To what extent do you agree or disagree that the CCG has a legitimate role in trying to influence the following aspects of your clinical practice/work' (percentage who 'strongly agree' or 'agree'). In 2013, the question asked about 'your clinical practice' and in 2014 about 'your work'. * In 2013, patients were asked separate questions about the CCG's role in influencing patients' use of 'emergency' and 'out-of hours' services. There was just a one per cent difference in responses to the two questions and we present the average. In 2014, one question was asked about 'use of unscheduled care' (including emergency services or walk-in centres). N=211-212 (2013), N=247-249 (2014). Respondents who skipped question were excluded from the distribution. Prescribing, referrals and quality of care increased from 2013 to 2014 ($p < 0.05$); patient experience increased ($p < 0.1$); other trends are not significant.

It is likely that these increases are in part due to the direction being set centrally (including integration agendas such as the Better Care Fund). They also reflect the work CCGs have put into maintaining engagement and building trust with the GP membership.

In our interviews with CCG leaders and GP members, the most commonly cited reasons for why CCGs should have an expanding role in developing primary care were:

- financial – developing primary care should have a positive impact on secondary care expenditure (for which CCGs are responsible)
- necessity – the CCG is stepping in to fill a void created by a lack of capacity within NHS England area teams. There is a “leadership vacuum” (practice manager) with regard to supporting and developing primary care
- expertise – it makes best use of the knowledge within CCGs; it is a logical forum for discussions about how to improve primary care
- relationships – CCGs have built trust with GPs and are therefore best placed to support them to change
- engagement – supporting change in primary care increases GP engagement in the CCG more widely.

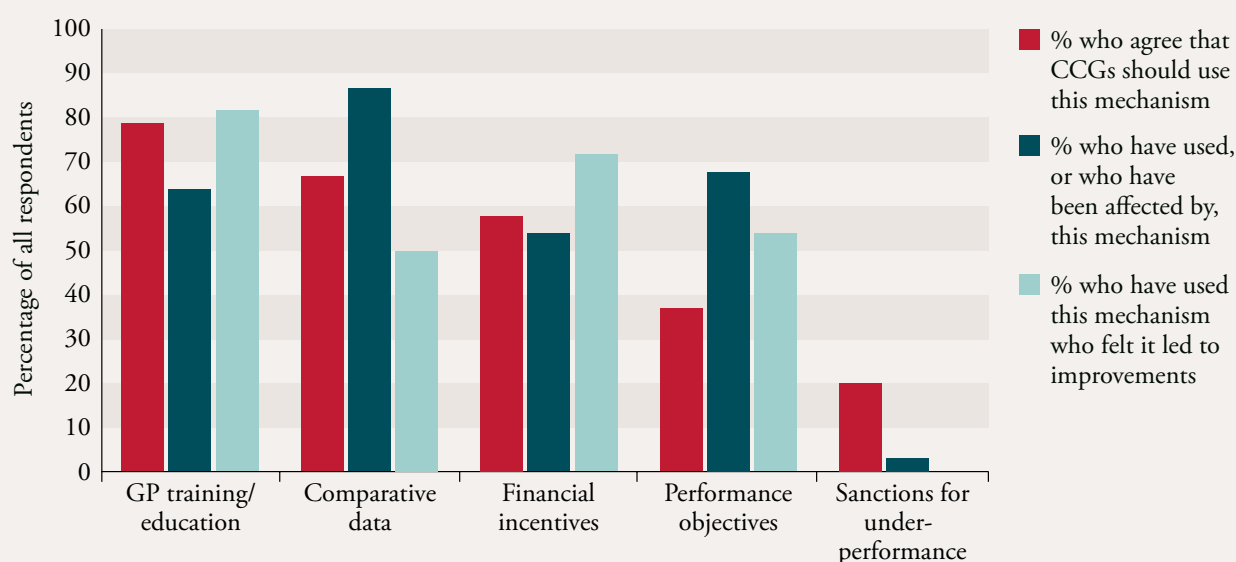
This is not to suggest that attitudes towards CCG involvement in primary care development were universally positive. CCG leaders in this study expressed doubts about how they could be expected to develop and manage these expanding work programmes alongside their primary responsibility to commission secondary care and

other services, without extra resources. This and other governance issues are discussed later in this chapter.

Mechanisms for driving primary care improvements

There are a number of mechanisms available to CCGs to support quality improvement in general practice. These range from education or peer support through to the provision of financial incentives. In this round of research we explored how GPs had reacted to their use and their perceptions of the mechanisms' impact (outlined in Figure 4.2). Similar to last year, training and education was particularly favoured by GPs as a way of supporting quality improvement; a mechanism which approximately two thirds had used and the vast majority felt was beneficial. As with last year, the use of sanctions for under-performance was least favoured.

Figure 4.2: Use of mechanisms within CCGs, 2014



Note: See Robertson others (2014) for full questions asked. Governing body members have been excluded from the analysis. Only those who said they had been affected by the mechanisms were asked to comment on whether they had led to improvements.

All of our CCGs reviewed performance data – of the CCG as a whole and of individual practices. The data – examples are given below – were routinely reviewed at governing body meetings, as well as at certain committee meetings, and in some CCGs at a more local level where GPs were brought together to reflect on one another's performance and share ideas on how to improve. Two thirds of GPs who responded to our survey felt that sharing comparative data was an appropriate role for CCGs, and of those who had used this mechanism, half felt it had driven improvements.

The majority of the sites shared practice-level performance data with GPs that identified practices within the group. A few interviewees suggested that this appealed to GPs' "competitive side" and helped to stimulate change. Similarly, peer-pressure in practice-based commissioning was found to be the most effective method of influencing GP referral behaviour (Curry and others, 2008).

“Yes, I think, it does drive up a standard because you, kind of, think ‘oh we’re not as good as them... we really need to do something about that’...”

(GP, without a formal role in the CCG)

Commonly reviewed indicators included:

- practice-level data with financial implications for the CCG: outpatient referrals, accident and emergency (A&E) attendances, non-elective activity, prescribing costs, certain care pathways (some CCGs standardised the results to reflect individual practice patient populations)
- practice-level data with a quality/public health focus: certain QOF indicators, Every One Counts¹ and the GP patient survey.

There are differences of approach in terms of how CCGs are using performance data. In a few CCGs, colour coding was used to illustrate whether a practice’s performance was improving or deteriorating, and one CCG had developed a complex ranking system where scores were assigned to each of the indicators so that practices could be given a final composite score. GPs in these practices had been sharing named practice data for many years and so the CCG had simply built on an existing scheme set up by the previous PCT.

In contrast, in one of our CCGs the governing body had only recently started regularly distributing CCG-level performance data to practices and still did not share named, practice-level data because of a concern about monitoring practices too heavily and risking disengagement. In this CCG, practice-level data were reviewed by the executive, but no action was taken where outliers existed. More recently, the CCG has expressed its intention to extend its work in this area.

As our survey showed, GPs had mixed reactions as to whether or not reviewing comparative data led to improvements (Figure 4.2), and this view was also expressed in our interviews. One GP noted that it was possible to go from “hero to villain” from one month to the next, and as one CCG leader commented, the numbers only show a partial story and many outliers can be understood once an explanation is given. A small number of GPs from different CCGs reported that they continued to have reservations about how far they wanted to be evaluating the performance of their colleagues:

“... as member practices I don’t think we can really go and criticise our peers or our colleagues because it’s not really our place to do so and it’s probably very easy to criticise us as well in return.”

(GP practice representative)

With respect to financial mechanisms, all of our CCGs used community-based services contracts² to support improvements in primary care. Contracts covered a wide range of uses, from commissioning GPs to provide clinical services in the community such as phlebotomy, to commissioning new services such as additional GP cover in nursing homes. In some cases, GPs were being reimbursed using these financial mechanisms for their engagement with CCG activities (such as meeting attendance), which may have contributed to the sustained levels of engagement shown in our survey. Financial

¹ For more information, see www.england.nhs.uk/everyonecounts/

² For more information about the different primary care contracts, see www.bma.org.uk/practical-support-at-work/commissioning/nhs-standard-contract-faqs

incentives were perceived by the majority of GPs who had received them to be effective in bringing about improvements.

Addressing under-performance

At the governing body level, the majority of the CCGs in this research used comparative practice data as a way of identifying practices that were outliers in terms of their performance, for example for referral or prescribing rates. The intention is then that CCGs could instigate a process of providing peer support (for example through joining up highly performing practices with those that are outliers) or practice visits by CCG leaders to identify how improvements could be made. In one CCG, if this process does not work, it has a policy by which the under-performing practice would be asked to explain itself to the members' council (this had not been used to date). None of the CCGs had set performance objectives for practices (unless they were used to monitor specific financial incentives). Some CCG leaders were reluctant to be seen to be setting performance targets out of concern that it would be taking GPs back to the days of PCTs and disengage the membership:

"I'm loath to use those kinds of words [performance management] because they [the membership] will roll their eyes and say, 'here we go, it's all over again'. So it's a really fine line we have to tread."

(Chair)

As NHS England holds GP contracts, the ways in which CCGs can currently address under-performance beyond these peer support methods remain limited. The ultimate sanction the CCG has is to expel a practice from the group. Last year, our research indicated considerable scepticism about whether this was a realistic option and, to date, this mechanism has not been used anywhere in England (Naylor and others, 2013). A similar issue emerged under practice-based commissioning, where PCTs acknowledged that they were unlikely to sanction against under-performing groups unless it was an extreme case (Curry and others, 2008). However, CCGs' influence on performance may be set to change as some take on contract management responsibilities for some GP services as part of co-commissioning arrangements with NHS England.

CCGs' impact on primary care

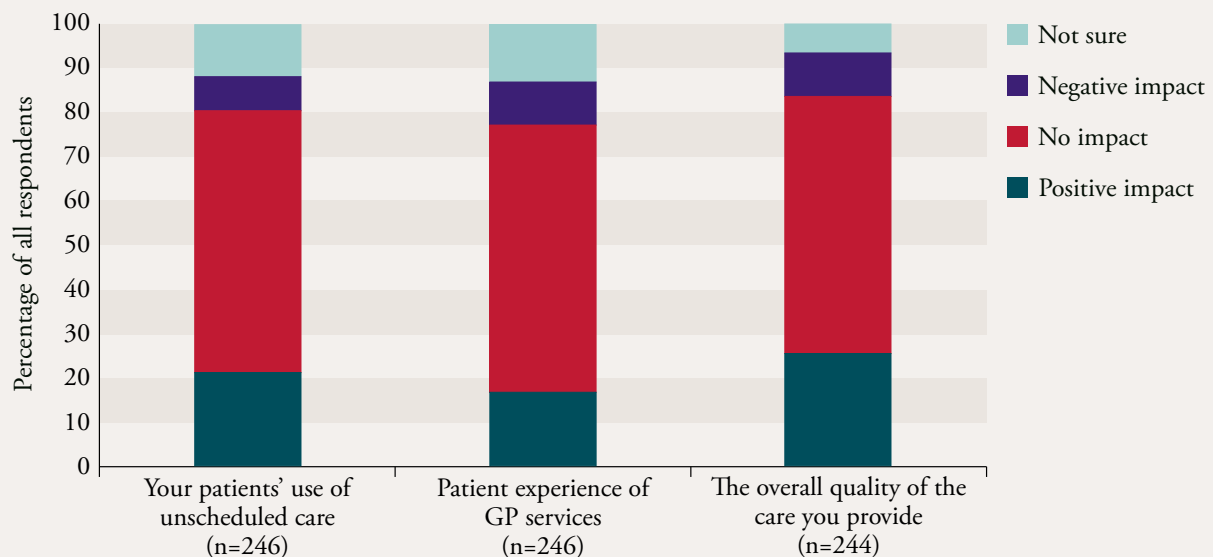
In addition to understanding how attitudes to CCGs' involvement in primary care development have changed in their first year, and the activities undertaken, we were also able to explore the perceived impact on GPs and their patients.

Similar to the previous year in which the survey was conducted, the majority of survey respondents felt that the CCG had made no impact on patient experience of GP services or the quality of care provided in primary care (61 and 58 per cent respectively; see Figure 4.3). However, what Figure 4.3 masks is that, similarly to last year, there is variation between survey respondents, with CCG leaders more likely to report a positive impact compared with the membership. For example, just under 50 per cent of CCG leaders felt that there was a positive impact on patients' use of unscheduled care, compared with around 20 per cent for the rest of the membership.

While the vast majority of GPs perceived no impact on their patients, when asked about the impact of the CCG on their clinical practice, around two thirds of GPs who responded to the survey reported a significant or small change to their referral pathways and prescribing patterns. CCGs also had an impact on GPs' relationship with other practices (around half reported a positive impact) and GPs' relationship with other health care professionals (around a third reported a positive impact).

These findings are not completely unexpected, as previous research suggests that it can take a number of years for structural reform to translate into tangible improvements for patients (Bardsley and others, 2013) and that in the case of a previous commissioning structure – Total Purchasing Pilots – the size of the pilot and the scale of their aspirations were related to how long they needed to make progress (Mays, 2001). Therefore, these results should be interpreted with sensitivity and not be understood to be a reflection of the potential for CCGs to deliver impact.

Figure 4.3: Perceived impact of CCG on patient experience, 2014



Notes: The question asked was 'What impact has being part of the CCG had on your work in the following areas (all respondents)?'. Respondents who skipped the question were excluded from the distribution.

With regard to the development of primary care, our CCG case studies had drawn up plans and, in some cases, had piloted or tendered for initiatives that extended capacity in general practice to ease pressures in emergency and out-of-hours services. This work had also taken the form of encouraging or facilitating the development of new models of primary care; either structural changes or different ways of working between practices. Indeed, extending the role of primary care was often noted as an important ambition for the future and one that would allow for large-scale change.

"[If CCGs could get] further, faster on developing federations... you get an accelerated improvement, [and] it's also sustainable, because again, it's rather than CCGs saying 'these are the things you need to do' it's very much organic."
(Chief finance officer)

Many of the CCGs had developed plans for future primary care development (and in a couple of cases the CCG had written strategy documents), detailing how they were planning to support, improve or shape primary care. Within those plans, some of the ideas included:

- improving care for specific groups such as people with long-term conditions and end-of-life care
- addressing policy priorities such as integrated care, seven-day working and moving care into the community – five of the six CCGs in this research had set up access to GPs in A&E and/or walk-in centres
- development of new general practice groups: development of local accountable care organisations; scaling up primary care; strengthening joint working across practices.

The Better Care Fund and the Prime Minister's Challenge Fund¹ were both mentioned as opportunities for CCGs to lead this change. However, some concerns were raised about the Better Care Fund. While some saw this as a way to drive forward the integration agenda, others were concerned about the financial impact of putting CCG resources into social care.

Considerations for primary care development and 'co-commissioning'

Our research indicates that as well as being an opportunity, moving towards co-commissioning presents three challenges for CCGs in the near future. The first relates to the clarity of the relationship between CCGs and NHS England area teams, the second is about how CCGs deal with conflicts of interest and the third relates to relationships within CCG. See Box 1.2 on page 10 for an outline of the co-commissioning proposals.

CCGs and NHS England area teams – roles and responsibilities

Understanding the division between NHS England area teams and CCGs in their responsibilities to support quality improvements in primary care remained a challenge for GP leaders and members alike during the first year of CCG operation. While a certain amount of clarity has been found as a result of the organisations having invested time in building relationships with one another, some concerns remain. It is doubtful that re-defining current arrangements as a result of co-commissioning will improve this situation, at least in the short term.

"... what has been really pretty obvious over the last year is nobody really knowing who owns primary care."

(Practice manager)

In the first round of our research it was unclear how the area teams would interact with practices on quality issues, either directly or working collaboratively with the CCG. The previous interviews with CCG and area team leaders led us to anticipate that the two organisations would work collaboratively on a continuum of support

¹ For more information about the Prime Minister's Challenge Fund, see www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/

and intervention, with area teams becoming increasingly involved with the increasing severity of the concern (see Naylor and others, 2013, p. 33, Figure 7). In this year's research we found that some sites had developed along these lines and had established, for example, joint committee meetings with area teams that tracked the quality of primary care. However, in other sites, the area team had developed separate relationships with practices, using a distinct set of metrics by which to assess performance and directly contacting those who they perceive as under-performing practices. This led to some confusion for GPs and frustration for CCG leaders.

"[NHS England is] in listening mode... They're expecting us to shape and I presume if we're heading off in the wrong direction... then we would have heard long before now. It's very much free rein."

(Chief financial officer)

An ongoing concern was the lack of capacity in area teams and the impact that was having on their relationship with CCGs, as mentioned by the majority of interviewees. The lack of involvement by area teams in some CCGs had been interpreted as an opportunity to design their own approaches to supporting quality in primary care. For example, the area team was often described as having an overseeing role, using the CCG to decide on ideas and priorities (working with the membership) that get signed off by the area team. It is these freedoms that meant, for the majority of CCG leaders, the idea of becoming more involved in primary care development was a natural progression or recognition of work they were already doing.

However, one GP leader described communicating with the area team as "frustrating" and that they came across as "aloof" as a result of their poor communication. Others commented that this distance led the CCG to expect contact from the area team only when they were concerned about something the CCG was doing:

"We don't work in partnership, we work on the basis: no contact is good."

(Director of strategy)

If this relationship is replicated in other areas, it raises questions about the ease with which these organisations will be able to jointly commission services – where CCGs have expressed an interest in sharing the commissioning function under co-commissioning proposals – or about how much relationship-building will need to go into making it operate effectively. Additionally, from a member GP perspective, the further intertwining of CCGs and NHS England area teams in areas where co-commissioning is introduced could lead to further ambiguity about accountability and support.

Conflicts of interest

Managing conflicts of interest is important for demonstrating transparency between leaders and their members, and other external organisations, and for ensuring that CCGs feel able to take decisions that drive change in primary care. The forthcoming introduction of co-commissioning combined with the ongoing ambition to increase the amount of community-based care (as reiterated in the Five Year Forward View: NHS England and others, 2014), means that CCGs will face an increasing number of decisions that may raise conflicts of interest.



CCGs in this study were aware of potential conflicts of interest as a result of their involvement in primary care development

Conflicts of interest for CCGs arise at different levels: deciding which providers to use (particularly where this might lead to a change in the proportion of the budget spent on primary rather than secondary care) and deciding what type of services to tender. All six CCGs in this study were aware of potential conflicts of interest as a result of their involvement in primary care development, but CCG leaders were confident that they were dealing with these adequately. Any concern they did express centred on mitigating the possibility of an outside perception that a conflict had occurred. Some unresolved or potential conflicts identified by interviewees included:

- winter pressures money being spent on services from a company owned by the relative of a governing body member
- initiatives being piloted by the local GP provider organisation to show proof of concept but potentially giving that organisation an advantage in any future procurement process
- business cases being written that were clearly targeted at a specific group of GPs.

There was little acknowledgement of the potential for an inappropriate decision to be made because of conflicted decision-makers. A common approach was for conflicted GPs to leave the room or to use non-clinicians such as lay members of the governing body or staff from the CSU to provide external scrutiny and ensure probity of decision-making. However, this does limit the useful contribution GP leaders could be making, as outlined by one governing body member below, and represents only a mitigation of a core conflict of interest, rather than its removal:

“I realise that conflict of interest is a problem but, you know, GPs are there for a reason, because GPs know how GPs work...”

(GP governing body member)

Box 4.1 gives examples of conflicts of interest in two case study sites and how they were managed.

Box 4.1: Examples of conflicts of interest and how they were managed

Site A. Locally commissioned services review

Conflict: Site A reviewed its local enhanced services payments (now called locally commissioned services; LCS) that were worth over £1 million in 2012/13. This gave CCG leaders the power to take decisions on the structure of payments to GPs for things such as providing phlebotomy services in the GP practice, and payments to GPs for engaging with the CCG and attending CCG meetings.

How it was managed: Decisions about the LCS payments were made by a group that consisted of CCG managers, GPs, practice managers, Local Medical Committee (LMC) representatives and procurement staff from the CSU. Interviewees reported that the LMC provided a lot of constructive challenge during these discussions. Once a plan had been formulated, it was scrutinised by lay members of the governing body at a special session organised by the CCG. They challenged the group on the detail of their proposals and provided assurance that the decision had been made in the best interests of patients and the public.

Site F. Care homes initiative business case

Conflict: A business case for a care homes initiative that was designed so that each nursing home would be affiliated with a single GP practice (where possible) and that this practice would provide additional services to these patients, such as a weekly 'ward round' and regular medication checks, and give new patients a health care plan, and end-of-life care plan. The business case for the tender was first considered at an executive meeting (with GPs asked to leave the room during the executive decision), rather than at a governing body meeting (meaning there was no external scrutiny). The probity of this was challenged by a lay member who felt that this demonstration of transparency should be done in a public forum.

How it was managed: Responding to the concerns raised by the lay member, the CCG wrote a procedure document outlining that any items in which GPs are conflicted must be considered by the governing body rather than its sub-committees, and they should be asked to leave the room during the discussion. The CCG also asked the CSU to lead the tender process, with support from the governing body's lay partners and nurse representative, patient representatives and a GP from a neighbouring CCG. However, although the CSU ran supplier events to give information to GPs, the lack of involvement from the CCG left some GPs feeling unsupported in their application.

With regard to developing new models of primary care, nearly all of the CCGs described a situation where they had facilitated conversations and held events to bring GPs together to discuss these issues, but had withdrawn when it came to making a final decision. However, as one CCG chair suggested, it can be difficult to maintain a distance between the type of services you want to contract and who you want to contract to, particularly when the general consensus is that more care should be delivered in the community:

"...I've got [a commissioning director]... being absolutely purist, who says 'no, no, don't talk about how do we create space for the federation to move into. You shouldn't do that'... I know what the end point, in my view, should look like. And in my world, if primary care

isn't the bedrock of what we do out of hospital, then we've got a problem... So, I'm jumping to the conclusion that groups of practices federated together will definitely be delivering better primary and community care in the future. And [the commissioning director] says 'no, no you mustn't do that, you're the commissioner, you haven't got to worry about who the provider turns out to be'."

(Chair)

However, maintaining separation of roles in order to avoid conflicts of interest could mean that finding GP leaders to drive change in primary care is difficult if the 'usual suspects' have already signed up to being part of the CCG and are therefore unable to participate (and vice versa, as mentioned previously, particularly without adequate succession planning). This may become particularly evident if, as suggested earlier, actively engaged GPs could begin to focus their efforts on developing their own businesses in new models of general practice, rather than continue their interest in commissioning.

Research conducted on practice-based commissioning found that concern over conflicts of interest was a barrier to their progress (Curry and others, 2008); something that CCGs must avoid if they are to drive change in primary care. This is an important issue that is currently being considered by NHS England as part of co-commissioning plans. It has recently announced that CCGs that undertake joint or delegated commissioning responsibilities need to establish a decision-making committee, chaired by a lay partner and with a lay and executive member majority (NHS England, 2014c).

Relationships within CCGs

The closer monitoring of GPs' clinical practice and the way in which tenders for primary care services are being handled have also begun to cause slight tensions within CCGs. This has shown itself in the relationships between CCG leaders and their members where, for example, members in one CCG felt unsupported during a tendering process, leading to criticisms of the leadership. It was also suggested by one interviewee that relationships between GPs could be affected if CCGs asked practices to compete for a sizeable contract, or if the contract was designed to encourage a large number of patients to migrate between practices. Although our latest survey results suggest that the CCG has had a positive impact on relationships between practices, increasing the amount of contracting with GPs could affect this in the near future.

5. Discussion

As the pressures on the NHS and social care have continued to intensify over the last few years, a consensus between policy-makers, commissioners and GPs has emerged that puts primary care at the centre of changes needed to improve the quality of care and meet patient needs (British Medical Association, 2013; Department of Health and NHS England, 2014; Smith and others, 2013). It is clear that CCGs are well placed to lead this change: they have existing links with their GP membership, they have expertise about local primary care services and, for some, they are filling a leadership role that is currently absent.

In comparison to previous attempts to involve clinicians in commissioning, the CCGs in this research appeared to have been relatively successful in securing the support of local GPs, to date. Although the majority felt that CCGs were yet to have a positive impact on patient experience and quality of care, most viewed them as more effective than PCTs. As we found in the first year of our research, there remains an appetite to make the new arrangements a success and this positive start should be harnessed by CCGs as they work with their membership to lead change in primary care.

Extending CCG responsibilities in primary care as proposed under the co-commissioning plans could bring CCGs closer to their members, give them increased levers by which to direct service change in primary care, strengthen the peer-led quality improvement activities the CCG conducts, and control the budget for a larger proportion of their health economy, among other opportunities. However, in this financially difficult period, and depending on how CCGs implement their new role, co-commissioning and other ways in which CCGs are supporting primary care also have the potential to cause disengagement among clinical leaders and their membership if not adequately resourced and supported by GPs. Research on previous commissioning arrangements suggests similar issues: forecast by the findings of this study and research on previous commissioning arrangements: 'History has shown that while GP commissioners start with a strong desire to be nimble clinically focused organisations, they are usually rushed by policy-makers into becoming larger statutory bodies with wide ranging responsibilities and are then deemed bureaucratic and distant from local professionals' (Smith and Mays, 2012).

Our research indicated that few GPs felt performance management or the use of sanctions for under-performance were legitimate roles for CCGs. However, these may be necessary tools for CCGs that start managing primary care services. As articulated by the Royal College of General Practitioners and NHS Clinical Commissioners (2014), there are risks and opportunities in all of the co-commissioning options being offered. Those CCGs that undertake further co-commissioning arrangements could risk losing the membership 'ethos', but gaining the opportunity to influence the support given to primary care (Royal College of General Practitioners and NHS Clinical Commissioners, 2014). Those CCGs that do not apply for changes to their responsibilities may benefit from having continuity in their relationship with the membership, but would be without additional levers to influence NHS England commissioning.

Additionally, the introduction of this expanded remit for interested CCGs comes in a difficult external environment, where budgetary restrictions on the NHS and social care are already putting commissioners and providers under pressure. We outline below the five key areas of work that CCGs must focus on in order to ensure that the current model of commissioning is sustainable and maximises the benefit of new co-commissioning arrangements.

1. Sustain the involvement of clinical leaders

Enthusiasm appeared to be waning among many of the clinical leaders who first established CCGs, and only a limited pool of interested GPs was emerging to replace them. One reason for this was the difficulty GP leaders face in balancing their day-to-day clinical work with their role within the CCG, which will not come as a surprise to those who were involved in previous forms of commissioning and understand that it is a 'labour-intensive and time-consuming' process (Shaw and others, 2014). GP leaders in this research also reported a lack of the training and development necessary to fulfil their role in the CCG, echoing the views of GPs in practice-based commissioning where only 20 per cent of GP leaders felt they had all the necessary skills (Wood and Curry, 2009). Over the next few years there will be increasing demands on GP leaders' time from across the health system, and balancing this with any additional commissioning responsibilities will undoubtedly challenge GP leaders further. Providing clinicians with the resources, time and support to understand and deliver their commissioning role is essential. International evidence reflects similar findings here: in New Zealand's primary care organisations, retaining and nurturing clinical leadership and influence was seen as the single most critical success factor in their development (Smith and Mays, 2007). Evidence from the United States points clearly to the need for heavy investment in leadership, management and training in order to create effective clinical commissioning organisations (Casalino, 2011).

Our survey suggests high levels of engagement in the work of the CCG among practice managers. CCGs should harness the interest of this group, as well as practice nurses and other primary care staff, to broaden the pool of individuals with a deep knowledge of local health services on whom they can draw. As has been highlighted in other parts of the health system, the key will be not only to support the top tier of current leaders, but also to cultivate the depth and breadth of leadership talent across the primary care workforce (West and others, 2014).

Many GP leaders on governing bodies will also reach the end of their terms of office during 2016 and 2017, making succession planning essential to secure the future sustainability of CCGs. We observed positive signs of some CCGs providing training for a broader group of younger clinicians. However, elsewhere it has been reported that many CCGs have stated in their constitutions that GP leaders can only serve for a finite period of time, creating an inevitable instability in their leadership (Checkland and others, 2012). Research with NHS providers suggests that strategic instability and lower staff morale can be caused by board-level vacancies, but that this risk can be negated by having strategies that develop future leaders (Janjua, 2014). This concern should be coupled with the fact that emerging GP provider federations and networks need strong clinical leadership to drive forward change in primary care (Addicott and Ham, 2014) and a role with provider groups may be more attractive to many GPs than roles in the CCG, as they are more closely linked to their day-to-day clinical work.

2. Maintain the strength of the membership voice

As CCG running cost budgets are cut in 2015/16 and local health economies seek to produce the significant savings required by the slowdown in NHS funding growth, commissioners and providers will need to consider what size and configuration of local health and social care organisations are needed to meet that challenge. CCGs are already operating within a complex external environment that requires them to work flexibly in partnerships with a range of other organisations. This collaboration is an important tool for the development of coordinated local strategies and the creation of efficiencies through the joint use of resources. However, CCGs need to ensure that the membership voice remains strong in the decision-making process – something which existing structures do not always seem to deliver – and be able to demonstrate the impact GP involvement is having on their work. They should also ensure that new co-commissioning arrangements do not result in an excessive focus on contract compliance and performance management at the expense of maintaining a peer-to-peer, supportive relationship.

Although only one CCG merger has been approved since CCGs were formally launched in April 2013, it is possible that more may come over the next year. Where mergers take place, our research about engagement within large CCGs points to the importance of developing locality structures that allow for a more distributed model of leadership and a focus on local priorities.

3. Manage conflicts of interest

A further challenge for CCGs is around the inherent conflicts of interest that arise from giving budgetary powers directly to groups of clinicians who are involved in provision as well as commissioning. Forthcoming changes mean that the frequency with which CCGs will be asked to make decisions on areas in which they have a vested interest will increase, further blurring the purchaser–provider split. In order to maintain buy-in from their members and external organisations, CCGs need to ensure that they are able to demonstrate transparency in their governance processes. Equally, support will need to be given to CCGs in order to avoid a situation where concern around conflicts of interest leads to inaction and an unwillingness to take bold decisions (as was the case with practice-based commissioning; Curry and others, 2008).

Members of the CCG board who are not GPs have a key role to play in ensuring that conflicts are adequately managed. In some of our sites, CCGs were starting to use their lay members to scrutinise their decision-making processes, and external bodies such as the CSU to run procurement exercises. A broad range of non-GP commissioners should be given more weight both within governing body meetings, and outside. Where co-commissioning is undertaken by CCGs, this suggestion will be reflected in the new decision-making bodies outlined by NHS England (NHS England, 2014c), and lay partner involvement should be strengthened following the national programme of training recently announced (NHS England and NHS Clinical Commissioners, 2014).

4. Be clear about the relationship with NHS England

As some CCGs take on additional responsibilities from NHS England, the relationship between them will necessarily change. This is important to consider for two reasons. First, some GPs were already confused about the distinction between the organisations,

and the forthcoming arrangements are likely to exacerbate this in the short term. Second, a few of our case study sites told us about capacity issues in the areas teams and how their contact was limited; something which could potentially become more difficult as the area teams are reorganised and their number reduced. CCGs that are given additional commissioning responsibilities under the co-commissioning policy will be able to agree local arrangements for sharing staff with NHS England. However, the risk remains that these resources prove to be inadequate and co-commissioning proves too challenging for GP leaders already feeling the strain of existing commissioning responsibilities.

5. Ensure that CCGs have adequate funding to take on new functions

CCGs have been offered the ability to take on additional commissioning responsibilities at the same time as their running cost budgets are being reduced by ten per cent. Although CCGs that are given these additional responsibilities under the co-commissioning policy will be able to agree local arrangements for sharing staff with NHS England, the risk remains that these resources prove to be inadequate and some CCGs may struggle to fulfil their new roles effectively.

6. Conclusion: balancing the risks and rewards of CCGs' expanding role in primary care development

Our evidence shows that during the first year as fully established commissioning organisations, CCGs took positive first steps in engaging GPs and promoting improvements to the organisation and quality of general practice. However, as the slowdown in NHS funding growth continues, CCGs' responsibilities expand and CCGs seek to operate within reduced management budgets, the challenges they have faced so far will be intensified.

CCGs' success at co-commissioning primary care will depend on the extent to which they are able to maintain their peer-to-peer support focus and therefore whether they can mobilise the primary care workforce to develop and deliver new models of care. As their role in improving or developing primary care progresses, CCGs may struggle to find the capacity to take on new commissioning responsibilities in addition to their current commissioning work, and GP leaders will need to balance new roles with the pressure of their day-to-day clinical practice. CCGs also risk being challenged about conflicts of interest – or allowing them to stall innovation – and alienating their members as they seek to address under-performance.

Additionally, if the NHS moves closer to the Five Year Forward View's vision of a more integrated future system with larger hospital or community-based multi-specialty practices and accountable care organisations (NHS England and others, 2014), the role of CCGs will need to evolve. New larger providers may take on some of the CCGs' responsibilities for coordinating local provision and planning services for their local populations' health needs.

Without structures that encourage innovative and critical input from clinicians, CCGs will not be able to achieve one of their original principles: that commissioning led by clinicians will lead to more appropriate decision-making, better outcomes for patients and more effective use of resources (Department of Health, 2011). As CCGs take on extended roles over the next year, they will need to ensure that they mitigate the risks outlined in this report. If they are able to achieve this, CCGs will be better equipped to use their strength as membership organisations to move beyond small-scale progress and deliver real change at scale for patients.

Appendix 1:

Research methodology

The six case study sites were selected at random in 2012, using a stratified approach to ensure that we included CCGs of various sizes and from all four regions of NHS England. We ensured that the sites represented a wide range in terms of level of deprivation, and included both urban and rural areas.

The CCGs that took part in the research in year one all continued to take part in year two, and we collected information through largely the same methods as in year one:

- documentary analysis of key documents relating to the CCG, particularly board papers
- semi-structured interviews with 70 key individuals – those with and those without a formal role in the CCG
- observations of 18 meetings, primarily CCG governing body and member engagement meetings
- an online survey of member practices with 279 responses, primarily from GPs without a formal role in the CCG.

This second phase of research was conducted in early 2014. See Naylor and others (2013) for details of the first phase of research.

Documentary analysis

Content analysis of governing body board papers and minutes was carried out for each of the case study sites. Papers were selected to cover a period of ten to 12 months between January 2013 and March 2014, depending on availability of papers for each site at the time of analysis.

Analysis focused on content relating to primary care, in particular:

- performance metrics used for general practice
- GP member engagement
- relationship with NHS England related to GP contract management
- primary care initiatives and strategy.

Documentary analysis notes were then coded thematically.

Interviews

Semi-structured interviews were carried out with a total of 70 individuals in year two (Table A1). As in year one, these included:

- CCG leaders (clinical and non-clinical), including the chair and accountable officer of each site, and practice representatives
- GP members and practice managers
- senior managers from NHS England area teams and CSUs
- representatives of local medical committees.

Year two also included interviews with representatives of local authorities.

The interviews covered:

- engagement with the CCG
- the role of the CCG in primary care development
- the impact of the CCG on clinical relationships.

Interview transcripts were coded thematically using qualitative data analysis software.

Table A1: Interview type, 2014		
Role	Type	Number
CCG leaders	Clinical	12
	Non-clinical	21
CCG members	With a formal role in CCG	5
	No formal role in CCG	12
Area team		6
Commissioning support unit		6
Local medical committee		2
Local authority		6
Total		70

Observations

We conducted observations of governing body, member council and locality meetings in each of the six sites (18 in total). Observation notes were coded thematically using qualitative data analysis software, alongside the interview transcripts.

Survey of member practices

In each site, all local GPs were invited to complete an online survey. As in year one, the survey was distributed directly to all member practices by email and CCG intranet systems. Practice managers and other personnel were also permitted to complete this survey. Where possible, questions remained the same as those asked in year one, in order to allow comparisons to be made over time.

A total of 279 responses were received in year two across the six case study sites. More than three quarters of the responses received were from GPs, with the remainder being mainly from practice managers. This has provided an approximate response rate of 28 per cent, based on the number of all GPs across the case study sites. As in year one, respondents were asked questions on the following issues:

- their levels of engagement with the work of the CCG
- the role of the CCG in supporting improvement in general practice
- authority and accountability within the CCG
- the impact of CCGs on professional relationships, clinical practice and patients.

The survey in year two was conducted between January and February 2014 – approximately one year since the first year's survey was conducted. A full summary of survey results, including comparisons over year one and two, is available (Robertson and others, 2014).

Table A2: Survey respondents by role

Role	2013		2014	
	n	%	n	%
GP principal	149	64	198	71
Salaried GP	16	7	34	12
Practice manager	47	20	28	10
Other/skipped	20	9	19	7
Total	232		279	

Appendix 2:

Case study site details

Site A

Site A is a mid-sized CCG serving a mixed population that is largely affluent but with some significant pockets of deprivation. The population is older than the national average and has high rates of dementia.

The CCG was formed out of two practice-based commissioning groups. It does not have a formal locality structure, but does divide members into local groupings for the purposes of undertaking peer review and other activities.

The CCG has a partnership agreement with neighbouring CCGs and a number of board-level posts are held jointly. The main secondary care providers are located outside the CCG boundaries, making the CCG a minority commissioner in most cases.

Site B

Site B is the largest CCG in our research. Overall, deprivation is low, although the population profile varies significantly across the site.

The CCG has a strong history of GP commissioning and has a locality structure with groupings based largely on former practice-based commissioning groups. More powers are delegated to locality level than in our other sites – each locality is allocated an annual commissioning budget by the governing body, and localities have a delegated budget to invest in improving local patient care. Members report a stronger sense of identity with the locality than the CCG governing body as a whole.

The CCG partners with neighbouring CCGs for commissioning of acute and community services.

Site C

Site C is a small, urban CCG with the highest level of deprivation of our case study sites. It has a relatively young population. Mortality rates from cancer and cardiovascular and respiratory diseases are very high, and measures of quality of life for people with long-term conditions are among the poorest in the country.

The CCG was formed on the basis of previous practice-based commissioning groups. It was originally conceived as two separate CCGs, but concerns around sustainability led to a merger. It is beginning to develop locality working and encouraging joint working. It has a relatively large number of small and single-handed practices. The CCG shares a senior post with two other CCGs, and collaborates with neighbouring CCGs through a regional network. The CCG is coterminous with the local authority.

Site D

Site D is a mid-sized CCG. It operates in an urban environment serving a young, deprived population with high levels of mental health and substance abuse problems.

The CCG was formed out of a single practice-based commissioning group and operates with a number of localities that pre-date the CCG. It has close relationships with neighbouring CCGs and local authorities, including joint strategy and performance committees. However, there are no formal alliances.

Site E

Site E is the smallest CCG of our case studies and serves a deprived urban population with high mortality rates, particularly from conditions related to smoking and alcohol.

The CCG consists of a highly cohesive group of practices with a strong local identity and history of collaborative working. The CCG does not have a formal locality structure, but meets with practices in small locality groups as a mechanism for engagement and peer review.

Since its inception, the CCG has worked closely with two neighbouring CCGs as part of an alliance. The alliance has an overarching management team with shared posts and some shared committees.

Site F

Site F covers a mid-sized population that is spread over a wide and largely rural area. It is one of the least deprived CCGs in England and has a population that is significantly older than the national average.

There is a long history of GP commissioning and collaboration in the area. The CCG is part of a formal alliance with two neighbouring CCGs, through which an integrated commissioning plan has been jointly developed.

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