

The evolution of clinical commissioning: Learning from local experience

Very early findings

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Project aims

- help policy-makers understand the development of and challenges facing CCGs
- help CCGs themselves by spreading good practice and learning
- facilitate learning and innovation in CCGs
- add to the international evidence base on clinical commissioning

Focus in year one

- Understanding the development of the organisational and governance structures of the CCGs
- Understanding the challenges they foresee
- Exploring the relationship between GPs as providers and their CCG leadership
- Exploring the respective roles of the CCG and the LAT in terms of performance management/quality improvement of general practice

Methods & timeline

Year one:

Site recruitment	Summer 2012
Interviews with GPs & CCG leadership	Autumn/Winter 2012/13
Interviews with LAT, CSU, LMC	Autumn/Winter 2012/13
Observations of governing body meetings & GP fora	Autumn/Winter 2012/13
Survey of all GPs	February 2013
Publish	June 2013

CCG structures

- Sites vary in terms of structures
- 4 CCGs have some sort of locality structure
- Two CCGs are part of multi-CCG alliances with shared accountable officers
- Variable use of CSU
 - one has opted for very slim structure with heavy use of CSU
 - several share a number of functions across neighbouring CCGs
 - others have more support in-house
- Different terminology used to describe leadership and GP membership groups/localities

Overall impressions

- A great deal of hope that they can make a difference BUT coupled with realism about the financial situation & scepticism about whether ‘the top’ will devolve real power
- Widespread uncertainty about how things are going to work
- Sites are at very different stages of development
- Importance of history
 - Most have emerged out of existing GP groups (PBC or PCG)
 - One site came about after a merger encouraged by the cluster
 - Strong history of GPFH and/or PBC in most sites

CCG leadership

- High levels of respect for clinical leads (in general) - but sometimes seen as “distant” in larger CCGs
- Most have willingly taken on board roles but some only did so because ‘no-one else would’
- Some suspicion about non-clinical management - “the same people from the PCT who I don’t have trust or confidence in”
- Some CCG managers feel caught between two cultures and competing sets of objectives
 - “LATicising”
 - Responding to local annoyances Vs strategic imperatives

Member engagement

- Leaders fairly positive about levels of engagement so far
- A sense of goodwill, but members don't always believe they have real influence over the CCG
- How to create the “golden thread” connecting members, localities, executives, alliances?
- Authorisation process has damaged engagement - CCGs had to divert resources away from member relationship
- “Waiting to see”... risk of further policy change in 2-3 years
- Some GPs opposed on principle - don't think GPs should be involved in “unpleasant rationing decisions”

Primary care development

- Widespread recognition that CCGs have a role to play - but lots of nervousness
- Relative role of CCG/LATs very unclear and highly sensitive
 - Risk that primary care development will fall between the two
 - LAT will not have sufficient capacity or local sensitivity to do quality improvement - will have to devolve to CCG
- How can CCG do this without losing member ownership and becoming “another PCT”?
- Some fear the CCG could become more authoritarian if the financial position declines
- Separation of responsibility for proactive development from reactive intervention could be problematic

Mechanisms for influencing practices

- Mainly peer review of comparative data
- Some using financial incentives (but others deliberately decided not to)
- A few continuing work of PCT support teams (e.g. prescribing)
- LATs waiting to see what NHSCB operating framework looks like - not currently sure what levers they will have
- CCG leaders not always confident they have sufficient leverage over member practices
- Some GPs do not feel the CCG has any authority over them

Impact

- Some say formation of CCG has improved GP-GP relationships
- Some report formation of CCG has made the acute trusts more responsive and more willing to engage in dialogue about patient flows/care pathways
- One GP felt clinical relationships between primary & secondary care are being damaged by “administrative arms race” over coding
- Referrals coming down for the first time in site E

Main challenges

- How to be different from a PCT when lots of the things that need doing are necessarily similar
- Economic situation could override everything else and mean potential benefits are not realised
- Balancing engaging Vs influencing members
- Organisational development: developing policies, protocols
- Governance concerns: dealing with COIs, deciding where decisions are made & where power lies
- Developing an effective relationship with CSU
- Small window of opportunity to make clinical commissioning a success - *“There needs to be very quick progress and it’s scary because we’re all floundering”*



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