CCM0004

Written evidence submitted by the NHS Clinical Commissioners

Executive summary

- Clinical commissioning is an essential feature of the NHS in England. Since Clinical Commissioning Groups (CCGs) were established they have been successfully responding to the needs of their populations, engaging with their local clinicians, and stewarding the limited NHS pound to deliver improved health outcomes.
- The vast majority of CCGs are performing well. As noted by the National Audit Office (NAO), CCG performance (both financially and according to the CCG Improvement and Assessment Framework) does vary – but this reflects both the wider pressures on the NHS and often historic difficulties in their local health economies.
- CCGs are doing more for less – their role has been changing since they were formed, and the amount they spend on their running costs has decreased.
- The NHS landscape is evolving and the role of clinical commissioners must be at its heart. We agree that stability and avoiding top-down reorganisation are essential to facilitate further progress. Retaining a clinical commissioning function in emerging systems (ICS and STPs) and at the more local 'place' level will be crucial.
- Our members have flagged that there are some potential barriers to achieving integration of health services. We believe there are several ways these could be addressed to facilitate further collaborative working between commissioners and providers in a local area, thereby creating a better service for their patients.

1. NHS Clinical Commissioners

1.1. NHS Clinical Commissioners (NHSCC) is the membership body of Clinical Commissioning Groups (CCGs). Established in 2012, we have over 91% of CCGs in membership. We offer a strong national voice for our members on specific policy issues and support them to be the best they can to commission services effectively for their local populations.

1.2. We welcome the Public Accounts Committee's inquiry into the current and future role of CCGs. Our members are a crucial part of the NHS in England, responsible for approximately two-thirds of the total NHS England budget and with statutory responsibility to improve the health of their local populations.

2. The current role, successes and performance of CCGs

2.1. CCGs work to achieve the best possible health outcomes for their local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, and more recently, primary care.

2.2. Commissioning is an ongoing process. CCGs must constantly respond and adapt to changing local circumstances. They are responsible for the health of their entire population and are also measured by how much they improve outcomes.

2.3. One of the key successes CCGs have had is their ability to engage with clinical leadership. As noted by the National Audit Office, the King's Fund and the Nuffield Trust found that CCGs have "secured better engagement from clinicians than previous forms of commissioning"[1]. We have heard from our members that clinical leadership is able to "win hearts and minds" of other colleagues working in their local area, so this established relationship must be maintained.

2.4. CCGs have also been successful in other ways. They have led work on prevention and early diagnosis – taking a longer-term view which means that fewer people suffer ill health, people are diagnosed earlier and given the right support, and working across boundaries to ensure people live longer and healthier lives[2].

2.5. Their ability to bring partners together is also an essential feature as the NHS becomes more integrated. CCGs have their roots in their community and play a system leadership role, which means they have been able to commission care for people closer to home, ensure people get the right support at the right time, make care more efficient and care more effectively for frail older people[3].

2.6. CCGs have a unique perspective – their responsibility to improve the health of their population and their grounding in their locality means they have a holistic and long-term view. This can mean they drive improvement in the wider determinants of health that other parts of the NHS may not address. For example, in Manchester a CCG-led programme supported people to address underlying issues contributing to unemployment and help people find and maintain jobs that best suit their individual needs.

2.7. The majority of CCGs are performing well. One measure of performance – the CCG Improvement and Assessment Framework - shows that 58% are outstanding or good. The NAO report also flagged that "many of the indicators used are not solely within the control of CCGs".

2.8. In some cases CCGs that have not been measured as outstanding or good have been working in areas which have historically struggled, which suggests that there may be ongoing challenging issues inherent in that geography rather than due to the CCG's actions.

2.9. A minority of CCGs are 'under directions' – these vary in their extent and what they entail. It is helpful that NHS England introduced their Commissioning Capability Programme in 2018. This is providing support to some CCGs and should complement the assurance processes through the CCGIAF and use of directions. NHSCC is pleased to offer post-programme support to Commissioning Capability Programme participants through peer learning events and buddying.

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1 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Clinical_commissioning_web_pdf.pdf

2 https://www.nhscc.org/latest-news/delivering-a-healthier-future/

3 https://www.nhscc.org/policy-briefing/leading-local-partnerships/

3. **How CCGs are achieving improved health outcomes with limited resources**

   3.1. CCGs are doing more for less – their role has been changing since they were formed, and the proportional amount they spend on their running costs has decreased.

   3.2. CCGs delivered their role for just 1.4% of total net expenditure in 2017/18. Even including the £434m CCG staff costs contributing to programmes in 2017/18 means their running costs are less than 2% of their overall expenditure.

   3.3. In context, this is level of running costs is relatively low within the NHS – as the Carter review highlighted that corporate and administrative costs in trusts varied between 6 – 11% using 2014/15 data[4]. Moving to system working means that it may be appropriate to ensure that all parts of the NHS are aiming to achieve consistency in reducing running costs.

   3.4. CCGs are also subject to a further 20% reduction in their running costs allocations by 2020/21. They will make every effort to improve their efficiency by finding new working arrangements (including formal mergers) and rooting out tasks that do not add value.

   3.5. However, there is a risk that cutting this too abruptly and too significantly means that CCGs might fail to commission effectively. As noted in a recent analysis[5], the NHS might perform better with more management. CCGs combine clinical leadership with managerial support and the complementary efforts of both should be recognised.

   3.6. In the context of wider pressures on the NHS, it is unsurprising that some CCGs have more recently overspent against their planned expenditure. The NHS is facing growing demand with limited resources so 'overspending' is not a signal of CCG failure but that the NHS overall had insufficient funding.

   3.7. Similarly, the NAO report flagged that CCGs have struggled to attract and retaining leadership – this difficulty is not unique to CCGs as other parts of the NHS have also found this difficult.

4. **The future direction of clinical commissioning and our recommendations**

   4.1. Our members are crucial components and leaders within the evolving NHS. As noted by the NAO, there is further work to integrate services, whether this is between health and social care, or at a 'system' level with the formation of Sustainability and Transformation Partnerships (STPs) and now Integrated Care Systems (ICSs). Clinical commissioning should continue to play a key role within systems.

   4.2. When working in this new system architecture, our members have said they will be taking on more strategic functions when working at scale[6].

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

[5] https://theconversation.com/what-the-nhs-needs-is-more-managers-104455

4.3. In addition, we note that the NAO report flagged the tension in 'balancing commissioning at scale and remaining responsive to local needs'. This means it's crucial to ensure there is also a clinical commissioning function at *place* level too, so that the NHS services are bespoke to the needs of their local community.

4.4. When moving to system and place working, and whilst retaining clinical commissioning functions, it is important these changes occur in a relatively organic fashion – occurring from the 'bottom up' and at an appropriate pace. We therefore agree with the conclusions of both Amyas Morse and Meg Hillier that the NHS and commissioning specifically need stability, as a top down reorganisation would be destabilising and an unhelpful distraction.

4.5. We know that the forthcoming NHS Long Term Plan will shed more light on the future direction of clinical commissioning – this needs to be clear but not overly prescriptive in how clinical commissioners will continue to play their role in improving the health of the population.

5. **Potential barriers to integration and ways to address these**

5.1. As noted in the NAO report, the NHS is going through several developments which impacts on the role of CCGs. The emergence of STPs and ICSs means that some CCGs have come across or perceive barriers to working in a more integrated way.

5.2. Our members have flagged five areas where efforts could be made to address these:

- Shared responsibility
- Accountability and governance
- Regulation and assurance
- Competition, procurement and choice
- Payment reform

5.3. Shared responsibility: currently, CCGs have a statutory responsibility to improve health outcomes for their local population, as do local authorities as part of their role in providing public health and care[7]. When working collaboratively, it should be made clear that other actors (such as Trusts providing healthcare services) also have this responsibility.

5.4. Accountability and governance: there are some duties where it needs to be clear who retains responsibility for them when working as a system, and it also has to be clear how decisions can be made with regards to governance. Clarity from NHS England and Improvement is helpful, as some areas have examples of how they have already achieved these new forms of governance, such as establishing new committees or appointing people to shared posts.

5.5. Regulation and assurance: there are several different regulators holding different parts of the NHS to account. Whilst we do not need an additional regulator, these bodies should work in tandem and aim to reduce duplication, as well as measuring CCGs, other commissioners and providers for the most relevant and appropriate outcomes, in addition to holding the wider system to account.

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[6] https://www.nhscc.org/latest-news/strategic-comm/

[7] https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06844

5.6. Competition, procurement and choice: CCGs may perceive that the requirement to put contracts out for competitive tendering could be a barrier to integration with providers delivering a high quality service. Further reassurance from regulators that this is not always necessary may help[8]. Patient choice requirements and involvement of the Competition and Markets Authority may also need a fresh look to stop CCGs feeling restricted in their ability to integrate.

5.7. Payment reform: by using the Payment by Results tariff payment system as a default, this may mean that commissioners and providers fall back on this option rather than finding a more suitable way to pay for services (for example, using incentives and payment that could be based on outcomes rather than activity). The recently published planning guidance[9] included first steps towards a blended payment approach, showing that this is already being considered.

5.8. To successfully overcome these barriers, it is clear that many steps can be taken without resorting to primary legislative change. A new NHS bill would be an unhelpful distraction at a time when many of the Health and Social Care Act changes from 2012 are only now being fully embedded, and in many cases, a lot of progress is already being made to integrate parts of the NHS and improve patient experience and health outcomes.

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[8] https://improvement.nhs.uk/resources/how-secure-good-outcomes-patients-when-awarding-contracts/
[9] https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting/