



National Audit Office

Report

by the Comptroller
and Auditor General

NHS England

A review of the role and costs of clinical commissioning groups

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NHS England

A review of the role and costs of clinical commissioning groups

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

14 December 2018

This review of clinical commissioning groups (CCGs) sets out the facts in relation to the establishment, role and cost of CCGs.

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Key facts

195

clinical commissioning groups (CCGs) as at April 2018, down from 211 in 2013

£81.2bn

total net expenditure by CCGs in 2017-18

£1.1bn

net running costs of CCGs in 2017-18

1 April 2013	is the date that CCGs became operational, replacing primary care trusts
78,000 to 1.3 million	is the range in CCGs' population coverage as at June 2018
1.4%	of CCGs' overall net expenditure spent on running costs in 2017-18 (1.5% of gross expenditure)
7%	aggregate underspend across CCGs against their allocated funding for running costs in 2017-18
8	formal mergers of CCGs between April 2013 and April 2018
117	CCGs share an accountable officer with at least one other CCG (as at August 2018)
24	CCGs are currently deemed to be failing, or at risk of failing, to discharge their functions by NHS England (as at October 2018)
£810 million to £500 million	reduction in commissioning support units' income (the organisations that provide support services to CCGs) between 2013-14 and 2017-18

Summary

1 Clinical commissioning groups (CCGs) are clinically-led statutory bodies that have a legal duty to plan and commission most of the hospital and community NHS services in the local areas for which they are responsible. CCGs are led by a Governing Body made up of GPs, other clinicians including a nurse and a secondary care consultant, and lay members. They were established as part of the Health and Social Care Act in 2012 and replaced primary care trusts on 1 April 2013. Since their formation, there have been eight formal mergers of CCGs, which have reduced their number from 211 to 195 as at April 2018. The smallest CCG (Corby) covers a population of 78,000, while the largest (Birmingham and Solihull) covers a population of 1.3 million.

2 Since commissioning was introduced into the NHS in the early 1990s, there have been frequent changes to the structure of commissioning organisations. This looks set to continue, with the role of CCGs evolving as the NHS pursues a more integrated system across commissioners and providers. Consequently, there are likely to be more CCG mergers and increased collaborative working between CCGs and their stakeholders, for example healthcare providers and local authorities.

3 This review sets out:

- changes to the commissioning landscape before CCGs were established;
- the role, running costs and performance of CCGs; and
- the changing commissioning landscape and the future role of CCGs.

Key findings

The NHS commissioning landscape

4 CCGs are the fourth attempt at increasing the involvement of clinicians in the planning and commissioning of local services. Commissioning was introduced into the NHS in the early 1990s, when the purchasing of healthcare services was separated from their delivery. Since then there have been several changes to the structure of NHS commissioning organisations and their population coverage, reflecting the tension between balancing commissioning at scale and remaining responsive to local needs. There have also been attempts to increase the involvement of clinicians in the planning and commissioning of local services (GP fundholding and practice-based commissioning), which achieved mixed results (paragraphs 1.2 to 1.4).

5 CCGs were designed to improve on past attempts to reform the NHS

commissioning structure. The Health and Social Care Act 2012 led to the switch from strategic health authorities and primary care trusts to the establishment of NHS England and CCGs. The main policy objectives of the introduction of CCGs were to enable health services to be responsive to patients' needs and to align clinical and financial responsibility in decision-making. It also looked to avoid the two-tier system introduced under GP fundholding (where some GP practices received budgets from the district health authorities, but others did not) and to transfer real commissioning responsibility to CCGs, which had not occurred under practice-based commissioning (paragraphs 2.2 to 2.6).

The role and running costs of CCGs

6 CCGs' work has expanded. The statutory functions of CCGs, as set out in the Health and Social Care Act 2012, have remained the same, including the planning and commissioning of health services, and the requirement to improve the quality of services and to promote the integration of services. However, the scope of work undertaken by CCGs has expanded, and now includes: being invited to take on delegated responsibility from NHS England for commissioning GP services; and increasing work to integrate the health and social care systems in line with the NHS Five Year Forward View (paragraphs 2.8 to 2.11).

7 Funding for CCGs' running costs has reduced. The funding that NHS England allocated for CCGs' running costs was set at £1.35 billion in 2013-14. It was reduced by 10% in 2015-16 to £1.21 billion and has been held at this level. In November 2018, NHS England confirmed that CCGs' running cost allocation would reduce by a further 20% by 2020-21. In aggregate, CCGs have consistently spent less than their allocated funding for running costs. In 2017-18, CCGs' net running costs were £1.1 billion, a 7% underspend against their allocation. Some running costs have been switched to programme (healthcare) budgets which directly support frontline patient care. In 2017-18, CCGs' net total expenditure was £81.2 billion, with net running costs accounting for 1.4% (£1.1 billion). This has reduced from £1.2 billion in 2014-15. Staff costs make up 57% (£693 million) of CCGs' running costs (paragraphs 2.12 to 2.15).

Measurements of CCGs' performance

8 NHS England's annual assessment of CCGs shows a mixed picture. NHS England has a statutory duty to conduct an annual performance assessment of CCGs. In 2017-18, 42% (87 of 207) of CCGs were rated either 'requires improvement' or 'inadequate'. Ten per cent were rated 'outstanding', with 48% rated 'good'. Two of the 51 indicators used in NHS England's Improvement and Assessment Framework (financial sustainability and quality of leadership) make up 50% of the overall rating and therefore have a significant influence over the overall rating received by CCGs. Seventy one CCGs received a 'red' rating for financial sustainability and 22 CCGs received a 'red' rating for quality of leadership. CCGs deliver results through partnership working with other local stakeholders. As a result, many of NHS England's indicators are not solely within the control of the CCG but are a measure of the CCG's ability to work with stakeholders to deliver improvements to the population's health, for example reducing child obesity (paragraphs 3.5 to 3.6).

9 A number of CCGs are judged by NHS England to be failing, or at risk of failing, to discharge their functions. NHS England monitors the performance of CCGs on an ongoing basis. NHS England has legal powers of direction (for example, to direct a CCG to produce a financial recovery plan) if it thinks a CCG is failing, or is at risk of failing, to discharge its functions. As at October 2018, there were 24 CCGs with active directions issued between 2015-16 and 2018-19. The main reasons for NHS England putting CCGs in directions are issues with performance, financial management and governance (paragraph 3.4).

10 An increasing number of CCGs are overspending against their planned expenditure. Each CCG is required to agree its planned total expenditure for the year with NHS England. In 2017-18, 75 of 207 CCGs (36%) overspent against their plans with the overspend across all CCGs totalling £213 million. This compares with 57 CCGs in 2016-17 and 56 CCGs in 2015-16. The overspend of £213 million includes the release of a 0.5% risk reserve held by CCGs, as well as pressure on CCGs' generic drug budgets. A further 0.5% of planned expenditure was used to create a system reserve managed centrally by NHS England. CCGs made £2.5 billion of savings in 2017-18, 25% more than 2016-17 (paragraph 3.7).

11 CCGs experience problems attracting and retaining high-quality leaders. Both NHS England and the CCGs we spoke to stressed the importance of high-quality leadership. For 2017-18, NHS England assessed 54% (111 of 207) of CCGs as having good leadership. However, CCGs experience significant issues with attracting and retaining high-quality leaders. They cited a range of reasons for this, including: reluctance of staff to step up to senior positions because of the increased pressures; the uncertain future of CCGs; and the lack of access to training and development. NHS England provides some support for leadership development. For example, NHS England introduced its Commissioning Capability Programme in January 2018 (paragraphs 3.8 to 3.10).

12 The Department of Health & Social Care (the Department) and NHS England have not reviewed the introduction of CCGs although most stakeholders provide a positive view of their engagement with CCGs. The Department of Health's impact assessment for the Health and Social Care Act 2012 stated that a post-implementation review would be undertaken following the introduction of CCGs. No review has yet been carried out. The Department has commissioned research by the Policy Research Unit in Commissioning and the Healthcare System to look at aspects of CCGs' performance. NHS England undertakes a survey of CCG stakeholders as part of its annual assessment of CCGs. Most stakeholders provide positive responses. Research by the King's Fund and Nuffield Trust found that effective involvement by clinicians is an essential component of high-quality commissioning and that CCGs have secured better engagement from clinicians than previous forms of commissioning. The research also found that CCGs face barriers to developing an effective commissioning function, such as reduced funding for running costs while taking on additional work. There are also challenges in embedding clinicians' involvement in commissioning, for example engaging with all GPs in the CCG's area and developing the next generation of clinical leaders (paragraphs 3.2 to 3.3 and 3.11).

The future role of CCGs in a changing commissioning landscape

13 A number of developments across the NHS are impacting on the role of CCGs. These include:

- The 2015 Spending Review plan to integrate health and social care by 2020 building on the Better Care Fund which requires CCGs and local authorities to enter into pooled budget arrangements.
- The development of new models of care, such as the ‘multispecialty community provider’ model where GPs and community health providers work together to provide a range of out-of-hospital services. In 2015, 50 vanguard sites were established to lead on developing new care models.
- More emphasis on the wider geographical planning of healthcare services. This led to the introduction in 2016 of 44 sustainability and transformation partnerships (STPs) with the aim of building on earlier work on new models of care. These STPs are made up of CCGs, provider trusts and local authorities, and are based on larger geographical footprints. The number of STPs reduced to 42 in April 2018 following a merger of three STPs.
- The most advanced STPs have become ‘integrated care systems’ where NHS organisations (commissioners and providers), in partnership with local authorities and other organisations (for example GP federations), take collective responsibility for improving the health of their population (paragraph 4.2).

14 CCGs are engaging increasingly in joint working and see themselves becoming more strategic planning organisations. There have been eight formal mergers of CCGs since 2013, reducing their number from 211 to 195. Most CCGs now share an accountable officer with at least one other CCG, and some are establishing formal joint commissioning governance arrangements with their local authority. This has been prompted by: developments across the NHS, with much of the joint working based around STP areas; CCGs gaining a better understanding of the most appropriate commissioning structure for their local area; and pressure to reduce running costs. CCGs see their future role as being that of a strategic planning organisation, with the more operational activities relating to commissioning (such as day-to-day contract management) being subcontracted to provider organisations. NHS England stated that CCGs will continue to take decisions about procurement and awarding contracts in line with the existing legislative framework (paragraphs 4.3 to 4.4).

15 At the time of our work NHS England did not have a written plan setting out its vision for commissioning, but is expected to set this out in its Long-Term Plan for the NHS. NHS England's Long-Term Plan for the NHS, due to be published in December 2018, is expected to set out its vision for NHS commissioning. This is likely to include the strategic planning and commissioning of health and care services to be undertaken within the 42 STPs. Its expectation is for all STPs to become integrated care systems over time. STP partners will come together to design and integrate services to meet people's needs around populations in the range of 150,000 to 500,000, with some arrangements underpinned by more formal contractual arrangements. The future of an 'integrated care provider' arrangement, where one provider holds the overall contract to provide health and care services, has recently been consulted on by NHS England (paragraph 4.5).

16 CCGs are being given the opportunity to take the lead in determining how they will restructure themselves within their local area, with the likelihood of a reduced number of CCGs. NHS England's approach is for the CCGs to take the lead in determining how best to restructure themselves within their STP. While this restructuring is not on the scale of that in 2012, NHS England envisages that this will involve further CCG mergers and joint working arrangements. It expects the number of CCGs to reduce. NHS England sees its role as providing guidance on how local systems should be structured based on learning from exemplar STPs and integrated care systems. It intends to step in where it thinks CCGs are diverging from good practice, but has not set out the criteria it will use to determine when to step in. However, it has indicated during our interviews that factors, including whether arrangements will improve geographic alignment with other organisations such as local authorities and whether there are concerns about performance or capability, will be used in deciding whether to intervene. Our previous work has highlighted the significant upheaval caused by major organisation restructuring which can detract from the core purpose of individual organisations (paragraphs 4.6 to 4.7).

17 CCGs are buying fewer services from commissioning support units. Commissioning support units were established during the implementation of the Health and Social Care Act 2012 to provide support to CCGs and other clinical commissioners. The number of commissioning support units has reduced from 23 in 2013 to five in 2018, largely through mergers. The total income of the units has reduced from approximately £810 million in 2013-14 to £500 million in 2017-18, mainly driven by CCGs bringing services back in-house. CCGs cited a number of reasons for doing this, including: the preference to have in-house capability and more responsive in-house services; a reduction in costs; and concerns about the performance of some services. With increased integration and the potential for larger-scale commissioning organisations, the requirements for external commissioning support may change further (paragraphs 4.8 to 4.11).

Concluding remarks and risks

18 CCGs were created from the reorganisation in how healthcare services are commissioned in the NHS. They were designed to give more responsibility to clinicians to commission healthcare services for their communities and were given resources to do this. NHS England's assessment of CCGs' performance shows a mixed picture. Over half of CCGs were rated either 'outstanding' or 'good', but 42% (87 of 207) are rated either 'requires improvement' or 'inadequate', with 24 deemed to be failing, or at risk of failing. Many CCGs are struggling to operate within their planned expenditure limits despite remaining within their separate running cost allowance. Attracting and retaining high-quality leadership is an ongoing issue.

19 There has been a phase of CCG restructuring with increased joint working and some CCGs merging. If current trends continue, this seems likely to result in fewer CCGs covering larger populations based around STP footprints. This larger scale is intended to help with planning, integrating services and consolidating CCGs' leadership capability. However, there is a risk that commissioning across a larger population will make it more difficult for CCGs to design local health services that are responsive to patients' needs, one of the original objectives of CCGs.

20 CCGs have the opportunity to take the lead in determining their new structures. NHS England is expected to set out its vision for NHS commissioning in its long-term plan for the NHS to be published in December 2018. NHS England has said it will step in where CCGs diverge from its vision of effective commissioning. However, it has not set out fully the criteria it will use to determine when to step in.

21 Our previous work on the NHS reforms brought in under the Health and Social Care Act 2012 highlighted the significant upheaval caused by major organisational restructuring. It is therefore important that the current restructuring of CCGs creates stable and effective organisations that support the long-term aims of the NHS. Following almost three decades of change, NHS commissioning needs a prolonged period of organisational stability. This would allow organisations to focus on transforming and integrating health and care services rather than on reorganising themselves. It would be a huge waste of resources and opportunity if, in five years' time, NHS commissioning is going full circle and undergoing yet another cycle of restructuring.

Part One

The NHS commissioning landscape

1.1 This part provides a brief overview of the changes to the NHS commissioning landscape before clinical commissioning groups (CCGs) were established in April 2013.

1.2 Commissioning was introduced into the NHS under the NHS and Community Care Act 1990, when the purchasing of healthcare services was separated from their delivery, creating an 'internal market'.¹ Commissioning comprises a range of activities, including: assessing needs; planning and procuring services; and monitoring service quality. Since 1990, there have been several changes to the structure of NHS commissioning organisations and attempts to introduce commissioning led by clinicians. CCGs are the fourth attempt at increasing the involvement of clinicians in the planning and commissioning of local services. **Figure 1** on pages 12 and 13 sets out the main changes to the structure of NHS commissioning organisations between 1991 and 2012.

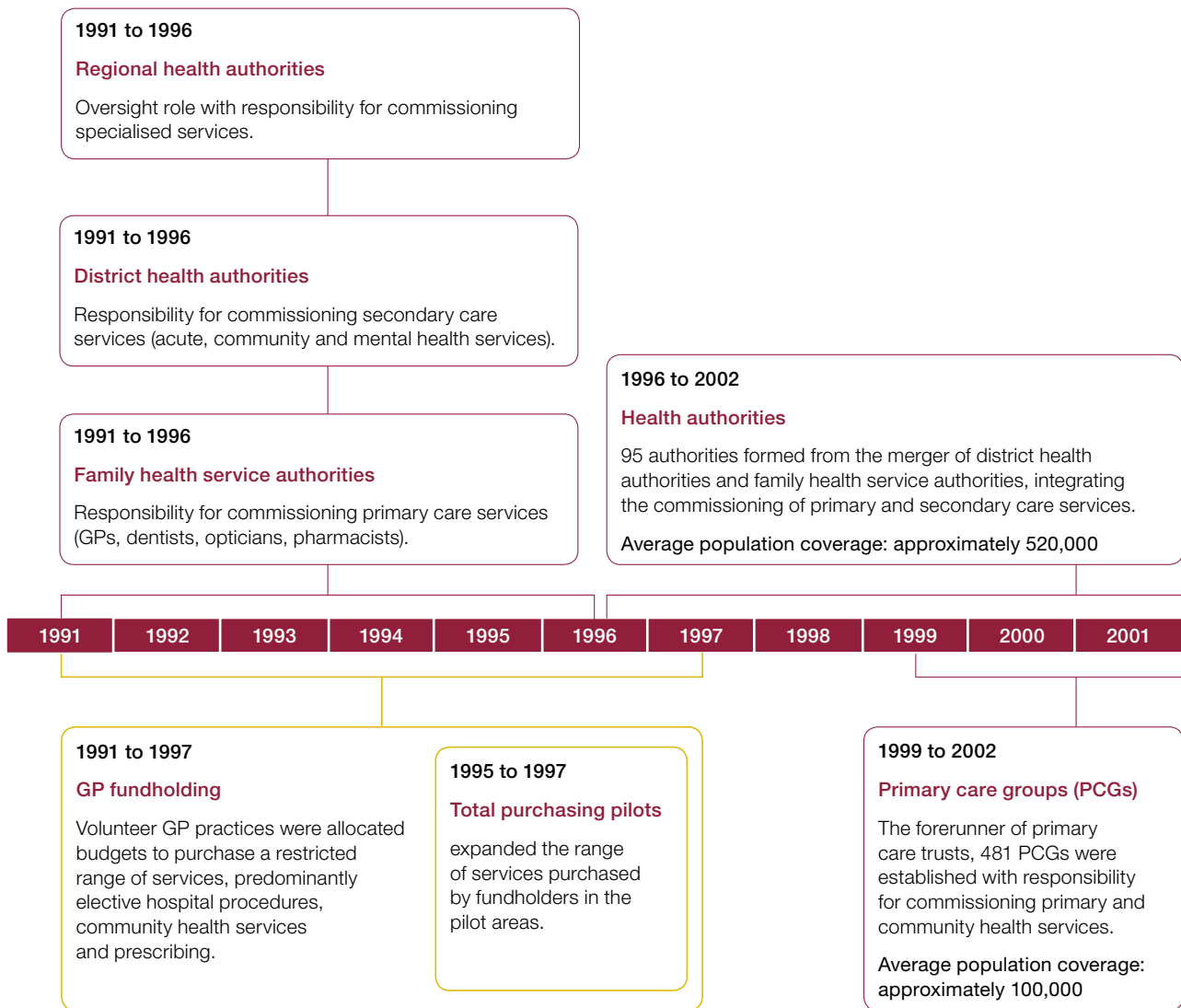
1.3 The frequently changing nature of the NHS commissioning structure reflects the tension between balancing commissioning at scale and remaining responsive to local needs. Commissioning at scale can pool financial risk and specialist expertise and reduce commissioning costs. On the other hand, understanding local needs requires the expertise of clinicians and may in certain circumstances result in a commissioning organisation covering a small population.

1.4 Research has concluded that there is no obvious ideal size of a commissioning organisation, and when CCGs were created in 2013, no specific ideal size was stipulated. Research has also acknowledged that flexible arrangements allowing organisations to work together could produce benefits, and mergers could be a way to increase management capacity. **Figure 2** on page 14 summarises research on the size of commissioning organisations and the impact of initiatives to increase clinical engagement in NHS commissioning.

¹ The National Health Service and Community Care Act 1990, July 1990.

Figure 1
The NHS commissioning landscape, 1991 to 2012

There have been a number of changes to the commissioning landscape since 1990



- Statutory commissioning organisations
- Voluntary initiatives to increase clinical engagement in commissioning

Notes

- 1 From 2006, specialised services were commissioned by 10 specialised commissioning groups of collaborative primary care trusts, organised within the footprint of the 10 strategic health authorities, and a national team responsible for commissioning highly specialised services.
- 2 Population coverage is calculated by dividing the Office for National Statistics' estimated population of England in a given year by the number of organisations: primary care groups (2000), health authorities (2002), primary care trusts (2006 and 2010) and strategic health authorities (2006 and 2010). Figures have been rounded to the nearest 10,000 (100,000 for strategic health authorities).

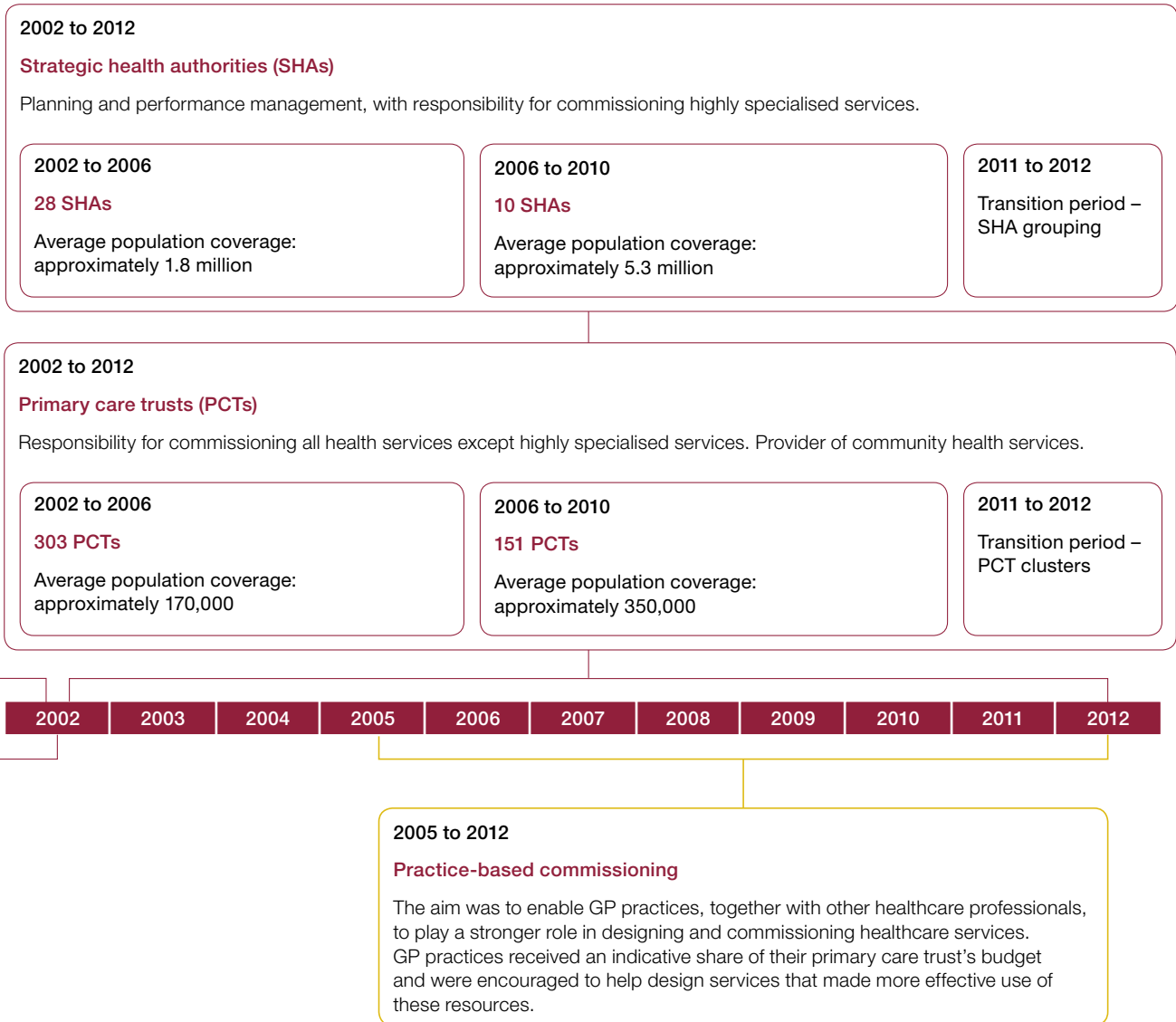


Figure 2

Research into the size of commissioning organisations and the introduction of clinically-led commissioning

Policy Research Unit in Commissioning and the Healthcare System evidence briefing on the size of commissioning organisations

Main messages:

- There is no obvious association between population coverage and measures of performance based on a review of two studies of primary care trusts. [Our analysis of CCG ratings and population coverage supports this message – see paragraph 3.6.]
- Different population coverage is required for different purposes. For example, commissioning services for rare or expensive diseases requires a large population coverage to share the cost of small numbers of high-cost patients. On the other hand, when commissioning local services, commissioning organisations need to be local enough to have a detailed knowledge of the local context and legitimacy among local stakeholders.
- Flexible arrangements and regulations are required to allow commissioning organisations to work together across different population sizes depending on the type of service involved and the degree of financial risk.

Policy Research Unit in Commissioning and the Healthcare System review of schemes to introduce clinically-led commissioning

GP fundholding

Overview of scheme

GP fundholding was introduced between 1991 and 1997. Under the scheme, volunteer GP practices were allocated budgets from the district health authorities to purchase a restricted range of services, mainly elective hospital procedures, community health services and prescribing. By 1997, over half of GP practices were fundholders.

Results

GP fundholders achieved shorter waiting times for their patients; reduced referral rates to hospitals; and reduced prescribing costs. However, they received more than an equitable share of resources and were seen to have higher transaction costs.

Practice-based commissioning

Overview of scheme

Practice-based commissioning (PBC) was introduced in 2005. The aim was to enable GP practices, together with other healthcare professionals, to play a stronger role in designing and commissioning healthcare services, either on an individual practice basis or more commonly across wider consortia of GP practices. GP practices were not allocated a budget but were encouraged to design services to make savings against an indicative budget.

Results

There is some evidence that PBC consortia in areas where primary care trust engagement with consortia was 'strong' saw lower growth in acute hospital activity (in terms of GP referrals and overall inpatient admissions). There was a mixed picture in terms of: the support provided by primary care trusts to PBC consortia; the extent to which primary care trusts involved PBC consortia in decision-making; and the influence consortia leads had over other clinicians and primary care trusts.

Sources: Policy Research Unit in Commissioning and the Healthcare System, *Ideal size of commissioning organisation – briefing note*, evidence note to the Department of Health, February 2017. The Policy Research Unit in Commissioning and the Healthcare System is a collaboration between the London School of Hygiene and Tropical Medicine, the University of Manchester and the Centre for Health Services Studies at the University of Kent.

Department of Health, *Health and Social Care Bill 2011 – impact assessment*, August 2011

Part Two

The role and running costs of clinical commissioning groups

2.1 This part covers: the establishment of clinical commissioning groups (CCGs); their functions and activities; and CCGs' running costs and funding.

2.2 CCGs are clinically-led statutory bodies that have a legal duty to plan and commission most of the hospital and community NHS services in the local areas for which they are responsible. They were established as part of the Health and Social Care Act in 2012 and replaced primary care trusts on 1 April 2013. CCGs are required to have a governing body, which is usually chaired by a GP and made up of GPs, other clinicians including a nurse and a secondary care consultant, and lay members. They are also required to have an accountable officer, who is, in the main, non-clinical.

2.3 NHS England commissions primary care services, for example GPs, dentists and opticians. However, commissioning of primary medical services (GPs) is largely delegated to CCGs. NHS England also directly commissions specialised services and some public health services.² **Figure 3** overleaf sets out the commissioning and funding structure for health services in England.

The establishment of CCGs

2.4 In 2010, the White Paper, *Equity and excellence: liberating the NHS* set out plans for GPs to take the lead in commissioning NHS services. The main policy objectives were to:

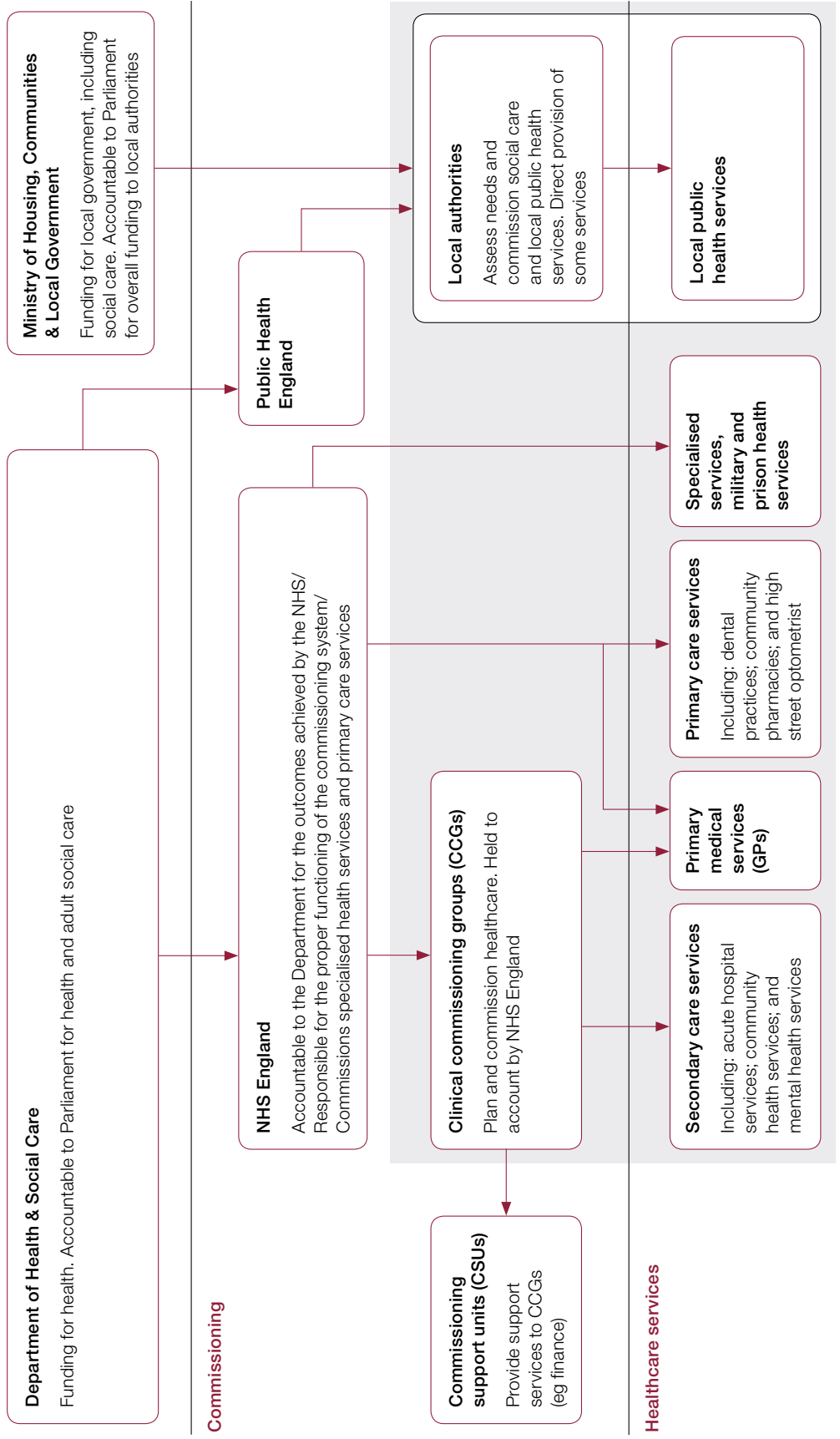
- enable health services to be sensitive to patients' needs and preferences, leading to improved patient experience and quality of care; and
- align clinical and financial responsibility in decision-making, leading to improved efficiency (for example, in referral patterns) and improved value for money.³

2.5 The White Paper stated the intention to learn from previous attempts at GP-led commissioning by making it a requirement that every general practice would be a member of a CCG. Such a structure would avoid the two-tier system introduced under GP fundholding and would also transfer control over budgets, which had not occurred under practice-based commissioning.

² Specialised services are generally provided in relatively few hospitals and accessed by small numbers of patients who usually have rare conditions or who need a specialised team working together at a centre.

³ Department of Health, *Equity and excellence: liberating the NHS*, Cm 7881, July 2010.

Figure 3
The commissioning and funding structure for health services in England (2018)



➔ Main sources of funding

■ Sustainability and transformation partnerships (STPs)

There are 42 STPs made up of NHS organisations and local authorities tasked with improving health and social care in their area.

2.6 Groups of GP practices came together to apply for CCG authorisation during 2012. These groupings were influenced by a range of factors, including: patient flows, differences in local populations, the pattern of professional relationships across a local area, and the population-based limits on funding for running costs. This bottom-up process resulted in a wide variation in the size of CCGs in terms of population coverage.⁴

2.7 As at April 2018, following eight mergers, there were 195 CCGs (see Part Four for further discussion of CCG mergers), with a mean population of 303,000 and a 17-fold variation in population size (**Figure 4** overleaf). In comparison, primary care trusts had a mean population of 350,000 and a 14-fold variation in population size.

The functions and activities of CCGs

2.8 The NHS Act 2006, as amended by the Health and Social Care Act 2012, set out the statutory duties and powers (referred to as the functions) of CCGs (**Figure 5** on page 19 sets out some of the CCGs' main functions).⁵ Within this legal framework, CCGs have the flexibility to decide how to carry out these functions: either by themselves, in groups (for example, through a lead CCG), in collaboration with local authorities, or by using external commissioning support. A CCG retains legal responsibility for its functions, which cannot be delegated to other organisations. We heard of a number of examples where CCGs established joint working arrangements at the time of being established, such as shared senior management teams. CCGs may commission some services on their own and commission other services within a group of CCGs, with one CCG taking lead responsibility for managing the contract. For example, ambulance services are typically commissioned across groups of CCGs.

2.9 To meet their statutory duties, CCGs undertake a wide range of activities, including:

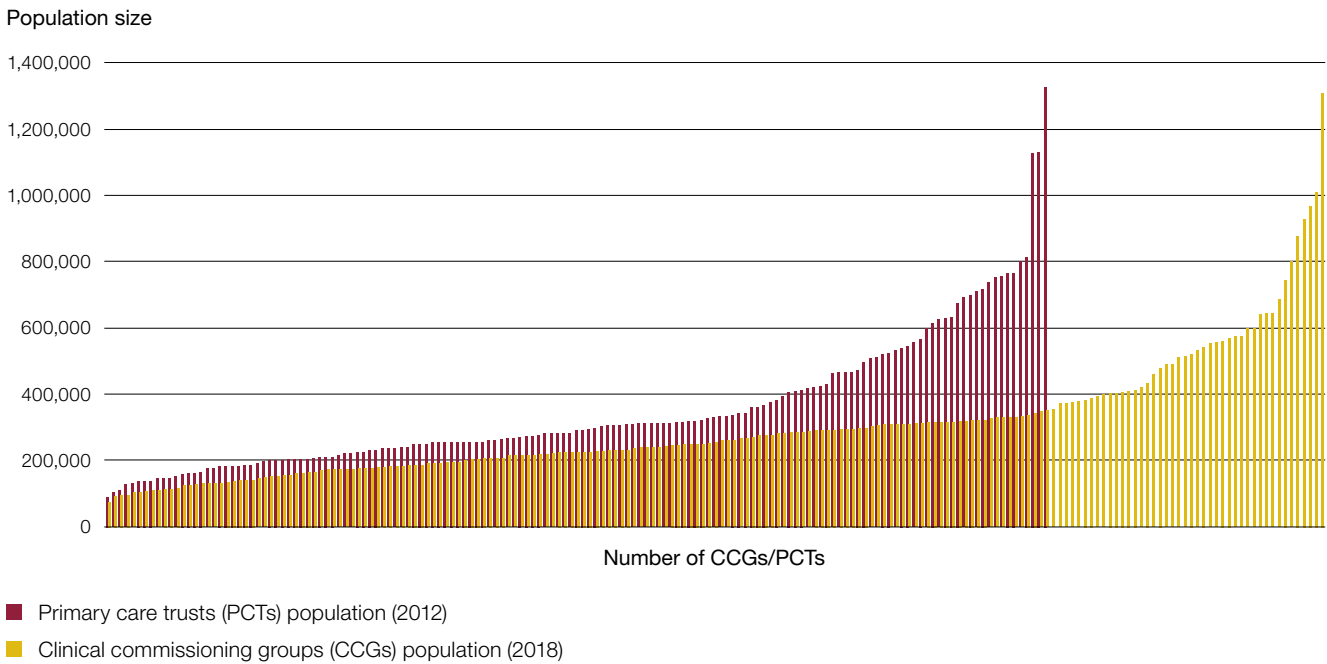
- assessing and planning for local health needs with other local organisations, including healthcare providers and local authorities;
- procuring services from a range of service providers, including: acute hospital trusts; mental health trusts; community health providers; ambulance trusts; GP practices; NHS 111 providers; patient transport providers; and a range of other public and private sector organisations;
- monitoring the quality of services through contract management – the number of contracts CCGs manage can number several hundred, although the contracts will vary in size and complexity;
- working to improve system integration and collaboration across providers and sectors (for example health and social care); and
- other activities including carrying out safeguarding activities for children and adults, undertaking continuing healthcare assessments and improving how medicines are prescribed through medicines management activities.

⁴ Each CCG is responsible for commissioning services for the people registered with its member GP practices.

⁵ Statutory duties are the 'must dos' that CCGs will be legally responsible for delivering. The statutory powers are the things that CCGs have the freedom to do to help meet these duties. Like other organisations, CCGs must comply with a broad range of other legal requirements such as the recent introduction of the General Data Protection Regulation (GDPR) in 2018.

Figure 4
Clinical commissioning groups' registered populations

There is a wide variation in clinical commissioning groups' (CCGs') registered populations



Notes

- 1 CCG data are for June 2018. PCT data are from 2012.
- 2 The median population values are 293,000 for PCTs and 260,000 for CCGs.
- 3 CCG population figures are people registered with each CCG's member GP practices, not the people who live in the CCG's area.

Source: National Audit Office analysis of clinical commissioning groups' member practice populations

2.10 The scope of CCGs' work has expanded since they were established, although their statutory functions have not changed. The CCGs we spoke to most commonly cited the following two additional work areas as having had a significant impact on their workload:

- **Commissioning of GP services**

In 2014-15, NHS England invited CCGs to take on greater responsibility for commissioning GP services, a role previously undertaken by NHS England. As at April 2018, 178 CCGs (91%) had taken on full responsibility for the commissioning of GP services, with the remainder either taking on joint commissioning with NHS England or working more closely with NHS England teams.

- **Work to improve system integration and collaboration**

CCGs have had a leading role in developing and implementing the plans across the 44 sustainability and transformation partnerships (STPs) that were established in 2016 following the Five Year Forward View. The number of STPs reduced to 42 in April 2018 following a merger of three STPs.

Figure 5

Clinical commissioning group functions

Function area	Clinical commissioning groups (CCGs) have a duty to:
Commissioning	<ul style="list-style-type: none"> ● commission specified health services; ● improve the quality of services and reduce health inequalities; ● promote the involvement of patients in decisions about their care; ● enable patient choice in health services provided to them; ● promote the integration of health service provision; ● involve the public in the planning of commissioning arrangements and when services are changed; ● prepare and publish a commissioning plan for the forthcoming financial year;
Finance	<ul style="list-style-type: none"> ● exercise their functions within the resources allocated to them by NHS England; ● comply with any restrictions imposed on them by NHS England; ● prepare and publish an annual report and accounts;
Governance	<ul style="list-style-type: none"> ● publish a constitution, have a governing body and accountable officer;
Cooperation	<ul style="list-style-type: none"> ● cooperate with local authorities; and ● produce joint strategic needs assessments and health and well-being strategies with local authorities.

Note

1 This is a summary of some of the main duties and powers of CCGs but is not a comprehensive list.

Source: NHS Commissioning Board, *The functions of clinical commissioning groups*, March 2013

2.11 CCGs have also taken on the responsibility for some other activities. For example, the responsibility for commissioning a small number of specialised services, such as specialised wheelchair services and morbid obesity surgery for adults, has been transferred to CCGs from NHS England. Furthermore, some CCGs stated that they are taking a greater role in commissioning public health services, which had been transferred from primary care trusts to local authorities. CCGs cited tightening local authority budgets as the main reason for this.

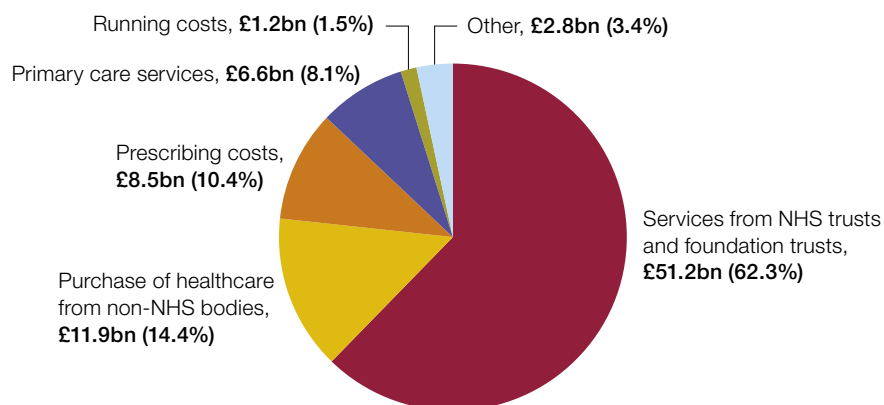
CCGs' running costs and funding

2.12 CCGs' running costs make up a small percentage of their total expenditure. In 2017-18, the total net expenditure across the 207 CCGs was £81.2 billion. The majority of this was for commissioning health services from provider organisations (**Figure 6** overleaf). For example, the largest share of total expenditure (62%) was for the commissioning of services from NHS trusts and foundation trusts. CCGs' running costs made up only 1.5% of total gross expenditure (1.4% of total net expenditure).

Figure 6

Breakdown of clinical commissioning groups' total expenditure, 2017-18

Clinical commissioning groups' (CCGs') running costs make up a small percentage of their total expenditure

**Notes**

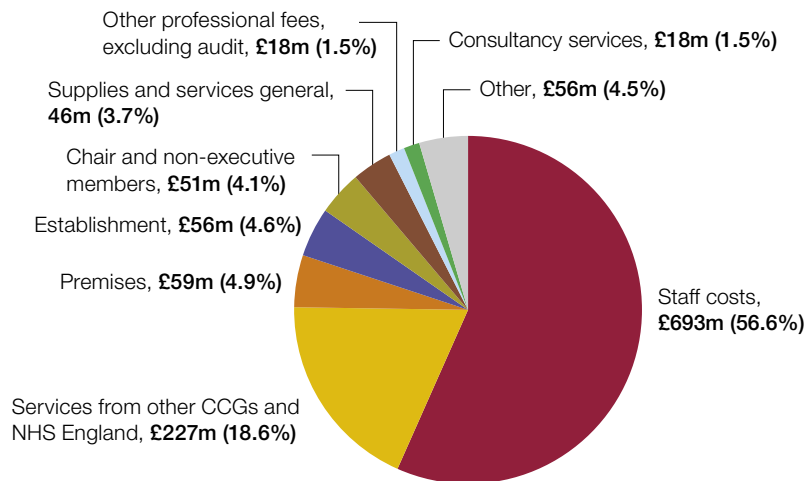
- 1 The breakdown is based on the total gross expenditure of CCGs – £82.2 billion. CCG income is not broken down in the same way as expenditure, so it is not possible to match expenditure and income categories.
- 2 Costs are rounded to the nearest £100 million.

Source: National Audit Office analysis of clinical commissioning groups' annual report and accounts data for 2017-18

2.13 In 2017-18, CCGs' total net running costs, which take into account any income received, were £1.1 billion (gross running costs were £1.2 billion). CCGs' staff costs made up 57% (£693 million) of total gross running costs (**Figure 7**). Not all CCGs' internal costs are classified as running costs, with CCGs having the flexibility to allocate some costs to programme spend (spend relating to the provision of healthcare services which directly support frontline patient care). NHS England's financial guidance to CCGs states that the only costs that can be considered programme rather than running costs are "... activities whose sole or primary purpose is to improve the quality of those (health) services". For example, in 2017-18, CCGs classified £434 million of their staff costs as programme costs, an increase of 89% from 2014-15, when the figure was £229 million. We heard from several CCGs that this often related to staff undertaking activities such as continuing healthcare assessments and improving how medicines are prescribed through medicines management activities.

Figure 7

Breakdown of clinical commissioning groups' total running costs, 2017-18

Staff costs make up the largest percentage of clinical commissioning groups' (CCGs') running costs**Notes**

- 1 The breakdown is based on the total gross running costs of CCGs – £1.22 billion. CCG income is not broken down in the same way as expenditure, so it is not possible to match expenditure and income categories.
- 2 Running cost figures are rounded to the nearest £1 million.

Source: National Audit Office analysis of clinical commissioning groups' annual report and accounts data for 2017-18

2.14 CCGs have consistently underspent against their allocated funding for running costs despite receiving a reduced allocation. CCGs' allocated funding for running costs was set at £1.35 billion in 2013-14 (equivalent to £25 per head of population). This was reduced to £1.21 billion in 2015-16 (equivalent to £22 per head of population), a 10% reduction in nominal terms. The allocation has remained at this level. In November 2018, NHS England confirmed that CCGs' running cost allocation would reduce by a further 20% by 2020-21.

2.15 Figure 8 overleaf shows the historic level of running costs compared to the running cost allocation. In 2017-18, CCGs' running costs were £1.13 billion and their allocation £1.21 billion, an underspend against allocation of 7%. In 2017-18, six CCGs overspent against their running cost allocation. Overspends were mainly due to the recruitment of senior 'turnaround' management and one-off severance costs as a result of establishing a joint management structure. Most CCGs we spoke to agreed that they had a strong incentive to reduce running costs, as any running cost underspend can be used for additional programme spend (spending on the provision of healthcare services). Programme budget cannot be used to fund running costs.

Figure 8

Clinical commissioning groups' (CCGs)' total running cost allocation and performance

CCGs have consistently underspent against their allocated funding for running costs

Year	Running cost allocation (£bn)	Actual running costs (£bn)	Underspend against allocation (%)
2014-15	1.35	1.23	9
2015-16	1.21	1.15	5
2016-17	1.21	1.13	6
2017-18	1.21	1.13	7

Notes

- 1 Data are shown in nominal terms.
- 2 Due to rounding the percentage underspend figure may not exactly reflect the running cost allocation and actual running costs.
- 3 Actual running costs relate to net administration expenditure.
- 4 For 2014-15 and 2015-16 the allocation excludes the Quality Premium allocation. The Quality Premium is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

Source: National Audit Office analysis of clinical commissioning groups' annual report and accounts data

Part Three

Measurements of clinical commissioning groups' performance

3.1 This part describes a number of measures used to assess the performance of clinical commissioning groups (CCGs).

3.2 Neither the Department of Health & Social Care (the Department) nor NHS England have undertaken an overall assessment of CCGs' progress towards achieving their policy objectives. As set out in paragraph 2.4, CCGs' overall policy objectives were to improve patient experience and quality of care and provide value for money. The Department of Health's impact assessment for the Health and Social Care Act 2012 stated that a post-implementation review would be undertaken following the introduction of CCGs.⁶ Such reviews are usually undertaken within three to five years of the policy being implemented. They examine: the extent to which the policy has achieved its objectives; the costs and benefits; and any unintended consequences. To date, no review has been undertaken. The Department has commissioned research by the Policy Research Unit in Commissioning and the Healthcare System to look at aspects of CCGs' performance.⁷

3.3 Research by the King's Fund and Nuffield Trust indicates that the introduction of CCGs has improved clinical engagement in commissioning, but CCGs face a number of barriers and challenges.⁸ The four-year research project by the King's Fund and Nuffield Trust examined clinical engagement in commissioning since the establishment of CCGs. The final report sets out a number of key messages:

- Effective involvement by clinicians and clinical leadership are essential components of high-quality commissioning and CCGs have secured better engagement from clinicians than previous forms of commissioning.
- Three barriers are inhibiting effective clinical involvement in CCGs: CCGs lack autonomy with the frequency of central requests to implement new initiatives and provide information giving them little time to develop coherent strategies and consult with GPs; reduced running cost allocations and additional responsibilities are making it difficult for CCGs to develop a high-quality clinically led commissioning function; and there is a lack of support from NHS England for making tough decisions about prioritising services.

⁶ Department of Health, *Health and Social Care Bill 2011 – impact assessment*, August 2011.

⁷ The Policy Research Unit in Commissioning and the Healthcare System is a collaboration between the London School of Hygiene and Tropical Medicine, the University of Manchester and the Centre for Health Services Studies at the University of Kent.

⁸ R Robertson, H Holder, S Ross, C Naylor, S Machaqueiro, *Clinical commissioning: GPs in charge?* Research report, The King's Fund and Nuffield Trust, 2016.

- CCGs face a range of challenges in embedding clinical involvement in commissioning, including: engaging with all GPs in a local area; maximising the contribution of CCGs' GP leaders; developing the next generation of GP leaders (succession planning); managing conflicts of interest; collaborating effectively with other local commissioners while retaining the benefits of locally responsive decision-making structures; and working effectively with commissioning support services.

3.4 NHS England is responsible for ensuring the effective functioning of the NHS commissioning system. It issues annual or multi-annual planning guidance to CCGs that sets out the performance and financial priorities for the forthcoming year.⁹ Performance against CCGs' plans is monitored monthly by NHS England's local teams. NHS England is supported by legislation in exercising formal powers of direction (for example, to direct a CCG to produce a financial recovery plan) if it thinks a CCG is failing, or is at risk of failing, to discharge its functions. As at October 2018, there were 24 CCGs with active directions issued between 2015-16 and 2018-19. The main reasons for NHS England putting CCGs in directions are issues with performance, financial management and governance.

3.5 NHS England has a statutory duty to undertake an annual assessment of CCGs' performance. To do this, it introduced an Improvement and Assessment Framework in 2016-17.¹⁰ The framework consists of 51 indicators grouped under four categories (**Figure 9**). These are combined to provide an overall rating for each CCG, with two of the 51 indicators ('in-year financial performance' and 'quality of CCG leadership') given a weighting of 25% each within the overall rating. Many of the indicators used are not solely within the control of CCGs. Improvements depend on partnership working across a range of local stakeholders, for example the indicator on the percentage of children aged 10 to 11 who are classified as overweight or obese. NHS England stated that it was continuing to develop its framework and that increasingly the framework was reflecting the requirement for local organisations to work in a more collaborative way to achieve improvements.

Figure 9
NHS England's Improvement and Assessment Framework

Category	Number of indicators	Examples of individual indicators
Better health	9	Percentage of children aged 10 to 11 classified as overweight or obese
Better care	34	Cancers diagnosed at an early stage
Sustainability	2	In-year financial performance
Leadership	6	Quality of CCG leadership

Source: NHS England, *CCG Improvement and Assessment Framework 2017/18*, November 2017

⁹ In 2016, NHS England issued joint planning guidance with NHS Improvement covering the two years from 2017 to 2019. NHS England and NHS Improvement, *NHS Operational Planning and Contracting Guidance: 2017-2019*, September 2016.

¹⁰ NHS England, *CCG Improvement and Assessment Framework 2017/18*, November 2017. Prior to 2016-17 it assessed CCGs using an assurance framework based on a different set of indicators.

3.6 NHS England's rating of CCGs' performance in 2017-18 shows a mixed picture. **Figure 10** overleaf shows that, while NHS England rated over half of CCGs as either 'outstanding' or 'good', a significant number are rated as either 'requires improvement' or 'inadequate'. Not surprisingly, given their high weighting, 'in-year financial performance' and 'quality of CCG leadership' have a significant influence on CCGs' overall rating. All CCGs rated 'outstanding' received the highest score for both indicators, while all CCGs rated 'inadequate' received the lowest score for both indicators. A total of 71 CCGs received a 'red' rating for financial sustainability and 22 CCGs received a 'red' rating for quality of leadership. We found no correlation between CCGs' population size and their NHS England rating.

3.7 An increasing number of CCGs are overspending against their planned expenditure. In 2017-18, 75 of 207 CCGs (36%) overspent against their planned total expenditure agreed with NHS England with the overspend across all CCGs totalling £213 million (**Figure 11** overleaf). This compares with 57 CCGs in 2016-17 and 56 CCGs in 2015-16. The CCGs' overspend of £213 million in 2017-18 includes the release of a 0.5% risk reserve held by CCGs, as well as pressure on CCGs' generic drug budgets. A further 0.5% of CCG planned expenditure was used to create a system reserve managed centrally by NHS England. CCGs made £2.5 billion of savings in 2017-18, 25% more than 2016-17, but only 80% of the savings they planned. The proportion made from one-off savings was 10%.

3.8 Attracting and retaining high-quality leaders within CCGs is a significant issue. Both NHS England and the CCGs we spoke to stressed the importance of high-quality leadership in determining the performance of CCGs. For 2017-18, NHS England assessed 54% (111 of 207) of CCGs as having good leadership. Of these, 26 (13%) CCGs were rated very good with practice that could be replicated as an exemplar. However, 22 (11%) CCGs received the worst 'red' rating.

3.9 Most of the CCGs we spoke to stated that attracting and retaining high-quality leaders (for example, an accountable officer or chief finance officer) was difficult. They cited a range of issues, including: reluctance of staff to step up to senior positions because of the increased pressures; the uncertain future of CCGs; and the lack of access to training and development.

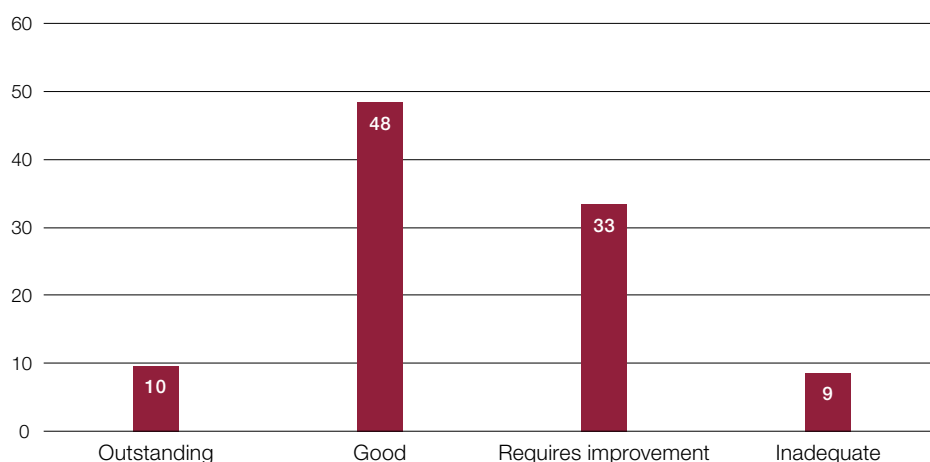
3.10 NHS England provides some support for leadership development. For example, NHS England introduced its Commissioning Capability Programme in January 2018. One key component of the programme is leadership development through a combination of personal coaching, workshops and expert seminars. NHS England's local teams also provide ongoing support and guidance to CCGs. A number of CCGs we spoke to were positive about their relationship with their local NHS England team and the support they receive.

Figure 10

Clinical commissioning groups' assessment ratings, 2017-18

58% of clinical commissioning groups (CCGs) are rated either 'outstanding' or 'good'

Percentage of CCGs

**Note**

1 There were 207 CCGs in 2017-18.

Source: NHS England

Figure 11

Clinical commissioning groups' (CCGs) under/over spend against planned total expenditure

An increasing number of CCGs are overspending against their planned expenditure

	2015-16	2016-17	2017-18
CCGs total under/(over) spend against plan (£m)	(15)	154	(213)
Number of CCGs overspending against plan	56	57	75

Notes

- 1 The total under/over spend is shown in nominal terms.
- 2 The total under/over spend reflects CCGs' in-year performance against their planned expenditure agreed with NHS England. It does not take into account any cumulative surplus/deficit.

Source: CCGs under/over spend – NHS England annual report and accounts 2017-18; Number of CCGs overspending – Comptroller and Auditor General, *Sustainability and transformation in the NHS*, Session 2017–2019, HC 719, 19 January 2018; National Audit Office analysis of CCG expenditure

3.11 The performance of CCGs is generally viewed positively by other stakeholders. NHS England undertakes a survey of CCG stakeholders as part of its annual assessment of CCGs. These stakeholders include: GP member practices; local Healthwatch offices; NHS providers (acute, mental health and community); local authorities; and other CCGs they collaborate with. **Figure 12** shows a selection of survey results across all stakeholder groups. Most stakeholders provide positive responses.

Figure 12

NHS England's clinical commissioning group (CCG) stakeholder survey results

The performance of CCGs is generally viewed positively by other stakeholders

Survey questions	2015 (%)	2016 (%)	2017 (%)
Engagement: Overall, how would you rate your working relationship with the CCG? (percentage very/fairly good)	79	76	75
Commissioning: I have confidence in the CCG to commission high-quality services for the local population (percentage strongly/tend to agree)	68	64	63
Leadership: The leadership of the CCG has the necessary blend of skills and experience (percentage strongly/tend to agree)	68	64	65
Monitoring services: I have confidence that the CCG effectively monitors the quality of the services it commissions (percentage strongly/tend to agree)	63	61	61

Note

1 Number of responses: for the questions on engagement, commissioning and monitoring services, the number of responses was 8,512 (2017), 8,244 (2016), and 8,472 (2015). For the question on leadership, the number of responses was 8,516 (2017), 8,244 (2016), and 8,472 (2015). Over half of responses are from CCGs' member GP practices: 4,733 (2017), 4,341 (2016), and 4,531 (2015).

Source: Ipsos MORI Social Research Institute, *CCG 360° Stakeholder Survey – National report*, July 2017

Part Four

The future role of CCGs in a changing NHS landscape

4.1 This part looks at: the recent developments across the NHS which have or will impact on clinical commissioning groups (CCGs); the move to increased joint working between CCGs; how CCGs see their future development; and how the role of commissioning support units is changing.

4.2 Since the establishment of CCGs in 2013, there have been a number of ongoing developments across the NHS that have or will impact on the role of CCGs. In the main these have been prompted by the publication of the NHS's *Five Year Forward View* in 2014 and NHS England's developing thinking on the structure of NHS commissioning:¹¹

- **Health and social care integration:** The 2015 Spending Review set out a plan to integrate health and social care by 2020. This would build on the Better Care Fund, which requires CCGs and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.
- **New models of care:** The Five Year Forward View set out a range of new models of care to bring providers together to provide more joined-up services. These included 'multispecialty community providers', in which GPs and community health providers work together to provide a range of out-of-hospital services and 'integrated primary and acute care systems', joining up GP, hospital, community and mental health services. In 2015, 50 vanguard sites were established to lead on developing new care models.
- **Place-based approach to planning healthcare services:** In 2016, 44 sustainability and transformation partnerships (STPs) were established, which brought together CCGs, local authorities and a range of providers and other organisations. The aim of the partnerships is to plan health and care services across larger geographical areas to enable services to be provided in a more coordinated way and, in doing so, build on earlier work on new models of care. The average partnership population is 1.3 million, with a range of 500,000 to 3.2 million. The number of STPs reduced to 42 in April 2018 following a merger of three STPs.

- **Integrated care systems and providers:** As STPs and new models of care have developed, the most developed (14 as at September 2018) are working towards becoming 'integrated care systems' where NHS organisations, in partnership with local authorities and other organisations, take collective responsibility for improving the health of their population. This may involve awarding an Integrated Care Provider contract for the provision of local services to an 'integrated care provider', which may subcontract with other care providers.

4.3 These developments across the NHS, along with CCGs gaining a better understanding of the most appropriate commissioning structure for their local area and the potential to reduce running costs and operate more effectively within their budget, have encouraged CCGs to engage increasingly in mergers and joint working. For example:

- There have been eight formal mergers of CCGs since 2013, with six coming into force in April 2018. This has reduced the number of CCGs from 211 to 195. NHS England informed us that it expects to approve further mergers to come into force in April 2019, which will further reduce the number of CCGs. A number of CCGs we spoke to that currently have shared accounting officers indicated that it was likely that at some point they would engage in a merger. NHS England expects the number of CCGs to reduce over the next few years.
- As at August 2018, 117 CCGs had a joint accountable officer (with 36 accountable officers covering these 117 CCGs). This has increased from 30 CCGs with joint accountable officers at the end of 2015-16.¹² A number of these arrangements mirror the structure of the local STPs, with one accountable officer across the CCGs in a partnership area. CCGs are also sharing other senior managers, such as chief finance officers, and establishing joint committees and teams.
- There are examples of CCGs establishing formal joint commissioning governance arrangements with their local authority.

4.4 Beyond joint working, most CCGs we spoke to saw their future role as being that of a strategic planning organisation, with the more operational activities relating to commissioning (such as day-to-day contract management) being subcontracted to provider organisations under an integrated care provider model. A number of them thought the likely implications would be a reduction in the number of staff CCGs employ (with staff being transferred to provider organisations) and changes to the skills mix of staff. NHS England stated that CCGs will continue to take decisions about procurement and awarding contracts in line with the existing legislative framework.

¹² Two groups of CCGs that had joint accountable officers at the end of 2015-16 formally merged in April 2018: NHS Berkshire West CCG; NHS East Berkshire CCG.

4.5 At the time of our work, NHS England did not have a formal written plan setting out its vision for commissioning with measurable objectives, milestones and expected benefits. It is expected to set this out in its Long-Term Plan for the NHS, due to be published in December 2018. This is likely to include the strategic planning and commissioning of health and care services to be undertaken within the 42 STPs, with the expectation that all partnerships become integrated care systems over time. STP partners will come together to design and integrate services to meet people's needs around populations in the range of 150,000 to 500,000, with some arrangements underpinned by more formal contractual arrangements. The future of an integrated care provider arrangement, where one provider holds the overall contract to provide health and care services, has recently been consulted on by NHS England.¹³

4.6 CCGs are being given the opportunity to take the lead in determining how they will restructure themselves within their local area. While this restructuring is not on the scale of that in 2012, NHS England envisages that this will involve further CCG mergers and joint working arrangements. It expects the number of CCGs to reduce. NHS England sees its role as promoting good practice based on learning from exemplar STPs and integrated care systems. It will look to encourage CCGs to adopt good practice on how local systems should be structured and stated that it will step in where it thinks CCGs are diverging from good practice. NHS England has not set out the criteria it will use to determine when to step in. It already considers a range of factors when authorising CCG mergers including whether the merger will improve the geographic alignment with other organisations such as local authorities.¹⁴ NHS England indicated during our interviews that it will consider factors such as improving the alignment of organisations, such as local authorities, and whether there are concerns about performance or capability when deciding whether to intervene. Following its announcement of a further reduction in CCGs' running cost allocation (see paragraph 2.14), NHS England stated it would adopt a more flexible approach to CCG mergers, by considering applications during the year, instead of on an annual basis. It would particularly support approaches that align a single CCG area with a single Integrated Care System.

4.7 We have looked at previous organisation restructuring across government including a report on the NHS reforms brought in under the Health and Social Care Act 2012.¹⁵ That report concluded that the reforms had been successfully implemented by the Department of Health. While it found that the estimated administration cost savings outweighed the costs of the reforms, it highlighted the significant costs, time spent by staff on implementing the reforms and the upheaval caused by this major restructuring.

¹³ See NHS England website: www.engage.england.nhs.uk/consultation/proposed-contracting-arrangements-for-icps/.

¹⁴ NHS England, *Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution*, November 2016.

¹⁵ Comptroller and Auditor General, *Managing the transition to the reformed health system*, Session 2013-14, HC 537, National Audit Office, July 2013.

The role of commissioning support units

4.8 Commissioning support units were established during the implementation of the Health and Social Care Act 2012 to provide support to CCGs and other clinical commissioners. The range of services they provide includes: transactional services such as human resources and financial services; transformation support such as service reconfiguration; procurement support; and clinical support, such as undertaking continuing healthcare assessments. Their customers include: CCGs, NHS trusts and foundation trusts; NHS England; the Department for Health & Social Care (the Department); and local authorities. Commissioning support units are legally part of NHS England, but their staff are employed by the NHS Business Services Authority. As at July 2018, commissioning support units employed just over 6,800 staff (6,300 full-time equivalent). They receive no central budget or allocation from NHS England or the Department but rely entirely on income from the services they provide to customers.

4.9 The number of commissioning support units has reduced over time from 23 in 2013 to five in 2018. NHS England stated that this has been driven by customer requirements for greater economies of scale (with the rationalisation process run by NHS England largely through a process of mergers). The five remaining commissioning support units are not restricted to offering their services to a particular region and can therefore work with customers across the country. CCGs and other public sector customers can procure commissioning support units' services through NHS England's lead provider framework, which includes the five commissioning support units together with three private sector providers.

4.10 The total income of the commissioning support units has been reducing over time, from approximately £810 million in 2013-14 to £500 million in 2017-18. This fall in income is mainly accounted for by CCGs bringing services back in-house (**Figure 13** overleaf). CCGs we spoke to cited a number of reasons for doing this, including: the preference to have in-house capability and more responsive in-house services; a reduction in costs; and concerns about the performance of some services. NHS England stated that commissioning support units are accountable to their customers for their performance. Between November 2017 and July 2018, customer satisfaction in commissioning support units has been good, averaging around 4 out of 5.¹⁶

4.11 As the NHS commissioning landscape continues to change, with increased integration and the potential for larger-scale commissioning organisations, the requirements for external commissioning support may change further. NHS England stated that it is confident that the business cases for all five commissioning support units demonstrate their ongoing viability.

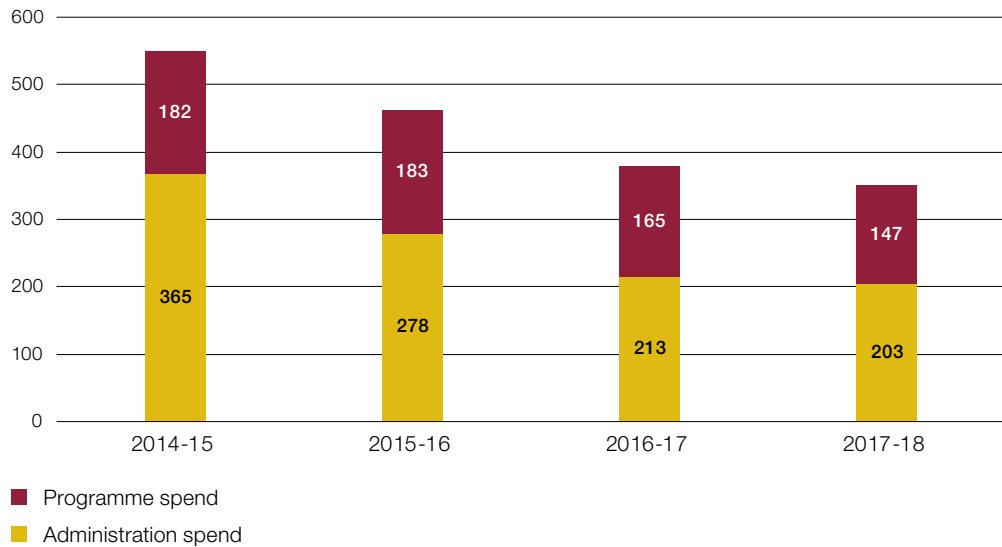
¹⁶ The July 2018 results are based on 170 responses from commissioning support unit customers out of a total of 206 requests, a response rate of 83%.

Figure 13

Clinical commissioning groups' spend with commissioning support units

Clinical commissioning groups' (CCGs)' spend with commissioning support units has reduced over time

£ million



Note

1 Data are shown in nominal terms.

Source: National Audit Office analysis of clinical commissioning groups' annual report and accounts data

Appendix One

Our review approach

Scope

1 This review of clinical commissioning groups (CCGs) sets out the facts in relation to the establishment, role and cost of CCGs. It covers:

- the NHS commissioning landscape before CCGs were established;
- the role and running costs of CCGs;
- measurements of CCGs' performance; and
- the future role of CCGs in a changing NHS landscape.

2 We carried out our review between June and October 2018.

Methods

3 We reviewed policy documents, guidance and reports from the Department of Health & Social Care and NHS England. We also reviewed reports and analysis by other organisations, including: the King's Fund; the Nuffield Trust; NHS clinical commissioners; and the Policy Research Unit in Commissioning and the Healthcare System.

4 We analysed data from CCGs' annual reports and accounts for the years 2014-15 to 2017-18. We used this to understand CCGs' overall expenditure and their running costs, and how these are changing over time. We also analysed ratings data from NHS England's CCG Improvement and Assessment Framework for 2017-18 to understand the variation in ratings and the extent to which indicators on financial sustainability and leadership impact on CCGs' overall ratings. We also looked at results from NHS England's annual survey of CCGs' stakeholders to understand stakeholders' views on CCGs' engagement, commissioning, leadership and monitoring of services. We also looked at data on the total income of commissioning support units over time.

5 We interviewed officials from NHS England to understand how they monitor and rate the performance of CCGs. We also discussed NHS England's plans for the future role of CCGs and the part NHS England is playing in shaping this. We also interviewed NHS Clinical Commissioners.

6 We conducted 15 interviews with senior officials at CCGs, primarily chief finance officers. These included CCGs that: have been part of a formal merger; have established joint working arrangements with other CCGs or local authorities; or have a joint accountable officer and other senior staff. During the interviews, we covered a range of topics including: CCGs' running costs; CCGs' leadership; and the future role of CCGs.

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