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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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.