The changing role of CCGs in general practice

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Two years since CCGs were introduction in to primary care the King’s Fund and the Nuffield Trust look at how they have performed and outline what is needed to enable them to succeed.

Almost five years after Lansley’s reforms were introduced, the NHS has survived its first funding crisis. Clinical Commissioning Groups (CCGs), in place for less than two years, now face a second, even larger round of cuts. On top of that, they are being invited to take more responsibility for primary care via co-commissioning agreements with NHS England and to integrate services with the social care sector. And there’s an election in May, in which the NHS will be a major political battleground. All this would be hard enough if CCGs were the lean and efficient drivers of change they were intended to be, but they’re starting to look a bit shaky and frayed at the edges.

Risk or reward? The Changing Role of CCGs in General Practice, a report from the King’s Fund and the Nuffield Trust, is drawn from work carried out in early 2014, based on a survey of 270 GPs, 70 interviews with GP leaders and CCG members, and a review of board papers for six representative CCGs. It’s divided into three parts: GP involvement with CCGs, CCG involvement in developing primary care, and what should now happen.

GP involvement in CCGs

CCGs were set up to give GPs a direct role in running the NHS and so make the service more responsive to the needs of patients. The proportion of GPs who say they are “at least somewhat” engaged with the process (71 per cent) changed little between 2013 and 2014. The report spins this positively: this is higher engagement than was achieved with practice-based commissioning or GP fundholding. But the converse view is that more GPs are now no more than somewhat engaged or moderately/completely disengaged (up 58 to 65 per cent). Further, only about half of GPs felt well informed about decisions and that CCGs reflected their views, and 40 per cent said they felt able to influence the CCG. In other words, a lot of GPs are not very interested or actively involved in meeting the coming challenges.

GPs say time spent on CCG work is time lost to patient care and there are signs that enthusiasm is waning among the leaders who’ve done much of the work so far. In 2013, 19 per cent of GPs surveyed felt highly engaged with the work of their CCG; in 2014 the figure was
12 per cent. Among GPs who were members of CCG governing bodies, less than 40 per cent said they had enough time to do the job. About one-third of respondents said they’d had sufficient training and about one-half had enough support to take robust decisions. The term of office for many governing body members will end in 2016/17 but there is a lack of succession planning to train leaders to replace them.

Faced with a large workload and pressure from NHS England to act quickly, GPs report that governing body meetings sometimes rubber-stamped decisions already made by the executive, with little discussion of strategy and planning. Respondents generally felt that conflicts of interest were being handled adequately but the report did not share their confidence, citing examples to support its view. This will be a concern as CCGs begin to commission more primary care services.

CCGs were supposed to be small and nimble but pressures on funding and workload mean that being bigger is better and many are pooling expertise and resources with their neighbours. There is widespread dissatisfaction with Clinical Support Units, prompting some CCGs to brings services in-house, a move that inevitably increases the size of the CCG. The report notes that such changes increase the burden of bureaucracy shouldered by CCG members and risks diminishing the influence of GP members.

CCG involvement in developing primary care

More GPs now accept that CCGs have a role in developing primary care, including influencing prescribing, use of unscheduled care, referrals, access to services and quality of care.

This acceptance did not extend to monitoring GP performance, which could prove difficult for CCGs that enter co-commissioning agreements with NHS England. The peer-to-peer relationships within CCGs is a major strength and it will be threatened if they have to manage contract compliance and GP performance. There may be sanctions available to a CCG but in practice no-one was prepared to support effective action against an under-performing practice.

Half of CCG leaders believed their work had affected patient experience compared with 20 per cent of GP members. On the other hand, two-thirds of GPs said the CCG had influenced their referral pathways and prescribing patterns, with one-third and one-half noting improved relationships with other health professionals and GP practices. Some CCG leaders expressed frustration that change in primary care was too slow, the product of confusion about the boundary of responsibilities between CCGs and NHS England, poor communication and lack of capacity.

What should now happen?

The report makes several recommendations for CCGs and NHS England to ensure current commissioning is sustainable and to maximise the benefits of the new co-commissioning arrangements. The enthusiasm of clinical leaders and the strength of the GP membership voice must be maintained. CCGs need to manage conflicts of interest and their relationship with NHS England should be clarified. Finally, and perhaps most optimistically in the current climate, CCGs need adequate funding to take on their new functions.

Declaration of interests

None to declare.

Steve Chaplin is a pharmacist who specialises in writing on therapeutics.