# Clinical Commissioning Groups – Addressing outstanding size and configuration issues

## 1. Introduction

This "think piece" paper has been prepared to summarise the key issues associated with size and configuration of Clinical Commissioning Groups (CCGs) and propose how they might be addressed to maximise clinical leadership and engagement in commissioning. It takes into account the current content of the Health & Social Care Bill and endeavours to ensure that the essence of clinical commissioning with clinicians leading and engaging in the commissioning of health care services, able to improve the health of their populations to deliver changes in care, are encouraged and maintained.

The content is being tested with GPs to ensure it represents accurately their key issues associated with maintaining local engagement in the development of services.

The paper does not cover other issues of CCG development eg collaborative management of acute contracts between CCGs as these will be part of ongoing CCG development no matter what size or configuration of CCGs.

This is very much a 'work in progress' paper and will be refined and added to over the next few weeks, in discussion with a number of CCG leaders. The small group that met in October to flush out these issues (membership on final page) is scheduled to meet again on 14 December to have further discussions. A further paper will then be distributed to CCG and PCT/SHA cluster colleagues, which we hope will be useful in the ongoing discussions about configuration on the lead up towards authorisation.

## 2. Context

The NHS Alliance (NHSA)/National Association of Primary Care (NAPC) Clinical Commissioning Coalition have received reports that a number of emerging CCGs are being 'strongly encouraged' to re-think their shape, size and fit. This is in order to fit various perceptions about what the rules indicate or is desired in the run up to the configuration gateway (end of December 2011) as a pre-cursor to the CCG authorisation process.

The concerns are perceived to come from a variety of sources including SHAs, PCT clusters / Local Authorities and neighbouring CCGs. A number of CCGs feel that their desire to find solutions that will continue to harness the innovation, efficiency, real clinical engagement and ownership that they believe flows from being small, whilst still complying with and managing the agreed minimum unavoidable costs / governance requirements, is being severely stifled.

There is also a concern that the 'ready reckoner' developed to help emerging CCGs test out their potential running costs, is perceived to 'oversell' what might be needed to cover the essential governance requirements, and as a result is pushing CCGs against their desire and what they believe will work best, to become much larger.

Those who wish to remain small are looking for support for them to be innovative and to test out different models and it is hoped that the output of this piece of work will help facilitate such a discussion and will also help to 'myth bust' where relevant and highlight real concerns where they do exist.[1]

In discussion with GPs about the size of CCGs there are several reasons as to why they wish to maintain their current size and shape. These relate to having a sense of autonomy, with the ability of 'like-minded' clinicians to take decisions locally, thus gaining more clinical buy-in to service change and health improvement. The potential solutions have therefore centred around developing ways of working that allows groups of practices within a CCG to maintain their ability to direct their own affairs (within delegated limits) but operating within a larger entity to maintain cost effective and efficient working. This is equally relevant for smaller geographies or localities set within a larger CCG as it is for smaller CCGs wishing to develop and maintain itself as a separate statutory body..

## 3. Key issues

The issues appear to relate to perceived concerns about:

- Affordability within the as yet not confirmed running costs allowance (RCA)
- Co-terminosity with LA
- Co-tiguosity with neighbours
- Differing views about merit of small and large CCGs and their ability to deliver at both ends – to scale & clout but with local ownership & engagement.
- What the 'rules' allow [1]

In discussion with several GPs from CCGs who had a particular interest in this issue, the following can be summarised as the practical questions that need to be thought through and some innovative solutions and answers found:

- What is the extent of delegation that could be achieved to enable small groupings of, say c30k population – retain their influence over local issues and still operate as part of a larger CCG?
- What are the perceived minimum 'unavoidable' costs that come with being a statutory body and what if any of those costs could be shared with other CCGs – for eg - can a CCG share a Chair, Accountable Officer and other members of the governing body as a way of reducing costs whilst still retaining effectiveness and good governance?
- What are the key timing issues to be understood when smaller aspirant CCGs might need to consider joining another CCG or share management teams in order to create a new CCG that can deliver for all of the practices and population served?
- How can a CCG that spans more than one local authority boundary and more than one PCT Cluster boundary be 'accommodated' within the perceived 'rules'?
- What are the elements of good governance that CCGs need to be mindful of when looking at sharing posts and role within and across CCGs to share costs? For eg should and could the Chair and the Accountable Officer be the same person?



[1] Julie Wood, NHSA October 2011

Critical factors / issues proposed by the CCG representatives include:

- **Flexibility**: maximum is needed, as the reasons for each CCG to collaborate varies across CCGs – no 'one size fits all' model
- **Localism:** engagement with the constituent members and maintaining this within all CCGs irrespective of size was fundamental. Those at the larger end of the population spectrum would need to give greater thought to this, but also protecting this as a key 'design principle' this for those groupings who decide they are too small to become a statutory body and therefore need to become part of a larger CCG.
- **Identity:** linked to localism, ownership of decisions, sense of control/influence and relationship between individual GPs through constituent practices to the CCG's governing body and any other CCG committee's / working groups.

To assist in the above, the following were considered helpful:

- A possible model scheme of delegation to respond to the desire for more local 'autonomy/sovereignty' which could be adapted for use locally to reflect particular circumstances
- Somewhere to go if CCGs run into difficulties persuading the local NHS managers that their proposals are workable – the NHS Alliance/ NAPC Clinical Commissioning Coalition, as the means of providing a collective voice on Clinical Commissioning would be one 'place to go' for help and indeed is already being used in this way.
- A need for an "honest broker" role to support local health communities in finding mutual acceptable solutions that are possible within the remit of the legislation.
- Stopping the contradictory messages about what is possible and what is absolutely not allowable within the legislation.
- Descriptions of what needs to be achieved supported by example options that could be selected from describing the how.

Within the governance of the CCGs it seems as though there is a need to cover a minimum number of roles including the accountable officer, director of finance, chief operating officer, clinical lead, lay representatives, audit chair, chair of the remuneration committee and chair of the governing body. Some of these roles can be combined as they do not need to be filled by individual people although good governance recommends a separation of some of these duties. This will need to be understood by CCGs so they can optimise joint roles whilst not compromising good governance.

## 4. Work to date

There have been some meetings involving Department of Health (DH) staff, NHSA/NAPC representatives, CCG representatives and NHS staff. These meetings have endeavoured to consider the various issues and propose potential resolutions for further discussion. This has included reviewing the outcome of various scenarios using the ready reckoner particularly around fitness for purpose for CCGs based on a range of population sizes and also what CCGs may need to build/share/buy in terms of accessing support for commissioning. Although there has been absolutely no determination of minimum size, as this would clearly run counter to the spirit of the White paper vision for clinical commissioning, there was an

acceptance in some of the above discussions that there was a size of CCG which was seemed as though it would be too small to operate as a statutory organisation entirely independently because of the essential and unavoidable running costs that would arise.

The scenarios detailed below cover CCG populations of 50,000, 100,000 and 300,000 at a RCA of £25 and £35 per head. The population sizes are illustrative and not absolute but they do give a good view about how much resource might be available to cover all running costs of being a statutory entity. The costs have been incorporated into three areas of:

- unavoidable costs associated with statutory functions (these include board staff costs, internal audit, external audit, counter fraud, annual report publication and public meetings (suggested 6 per annum plus AGM as a minimum to assure 'good governance'), and some support staff for the larger organisations
- absolute minimum core costs as part of running an organisation (including clinical engagement) and
- other costs which would either need to be shared or purchased as commissioning support.

Whilst costs have been kept to a minimum there is need to consider what is the minimum for an organisation to function and to satisfy minimum governance requirements. This is critical given that as a statutory body the Accountable Officer (whoever that is) will need to be able to satisfy him/herself that the organisation is fulfilling the whole range of statutory functions no matter if that commissioning support service is being delivered by its own staff (the '**build'** element of 'build, share and buy', or by others, on its behalf, on a **'shared'** basis, (for instance with other CCGs around lead commissioning arrangements) or a '**buy'** arrangement, with a Commissioning Support entity (for instance with regard to services such as procurement, HR, invoice payments etc.

All of this will require the CCG to put the systems, mechanisms and staff in post to be able to provide this high level assurance, since the responsibility and accountability cannot be delegated away from the CCG itself and its governing body will therefore play a key role.

For an organisation of less than say approximately 100,000 population at a potential RCA of £25 per head it would seem to prove difficult to cover all governance requirements, provide the required assurance and still have sufficient funds to purchase all other requirements of commissioning support.

<u>£25 per head</u>

| | 50,000 (15 practices) | | 100,000 (18 practices) | | 300,000 (46 practices) | |
|---|---|---|---|---|---|---|
| | Total cost | Cost per head | Total cost | Cost per head | Total cost | Cost per head |
| Running cost allocation | 1,250,000 | 25 | 2,500,000 | 25 | 7,500,000 | 25 |
| Unavoidable costs | 666,000 | 13.32 | 737,000 | 7.37 | 760,000 | 2.53 |
| Core costs (clinical engagement, support staff) | 217,000 | 4.34 | 617,000 | 6.17 | 1,089,000 | 3.63 |
| Numbers of staff (including chair, accountable officer, lay members, clinicians, admin and in the larger populations includes more support staff) | 4.4 wte | | 10 wte | | 14 wte | |
| Total | 883,000 | 17.66 | 1,355,000 | 13.55 | 1,849,000 | 6.16 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Balance for all other bought in costs eg commissioning support | 367,000 | 7.34 | 1,145,000 | 11.45 | 5,651,000 | 18.84 |
| What might this buy? (Equivalent to band 7 posts) | 8.6 wte | | 27 wte | | 133 wte | |

£35 per head

| | 50,000 (15 practices) | | 100,000 (18 practices) | | 300,000 (46 practices) | |
|---|---|---|---|---|---|---|
| | Total cost | Cost per head | Total cost | Cost per head | Total cost | Cost per head |
| Running cost allocation | 1,250,000 | 35 | 3,500,000 | 35 | 7,500,000 | 35 |
| Unavoidable costs | 666,000 | 13.32 | 737,000 | 7.37 | 760,000 | 2.53 |
| Core costs (clinical engagement) | 217,000 | 4.34 | 617,000 | 6.17 | 1,089,000 | 3.63 |
| Numbers of staff | 4.40wte | | 10.00 wte | | 14.00 wte | |
| Total | 883,000 | 17.66 | 1,355,000 | 13.55 | 1,849,000 | 6.16 |
| Balance for all other bought in costs eg commissioning support | 867,000 | 17.34 | 2,145,000 | 21.45 | 8,651,000 | 28.84 |
| What might this buy? (Equivalent to band 7 posts) | 20.4 wte | | 50 wte | | 204 wte | |

## 5. Potential resolutions

As noted above the testing of a 'right size' of CCG was not confirmed other than indicating that less than a approximately 100k population seemed too small to act entirely independently with an exclusive management team and be able to fulfil all statutory functions, from a RCA and good governance perspective. From the analysis of the above it would however seem feasible for a 100k(ish) population and above CCG to be statutory and develop innovative arrangements for sharing a management team with other CCGs and access shared and bought in commissioning support, as there would be sufficient funds after unavoidable costs to purchase the needed level of support whilst still ensure sufficient core staff to help support the assurance that will be needed.

It is absolutely clear however that it is not just the RCA that should determine the 'right size'. If that were the case then there would be an immediate push to only support large CCGs since they have those economies of scale. We do however know that evidence suggests that 'to maintain a sense of localness for the clinicians forming the group, whilst having a critical mass for managing clinical and financial risk, organisations will need to have a population base of at least 100,000'[2]

In addressing the issues above the following is proposed:

- With regard to size/ flexibility and localness – in order to support innovative practices or groups of practices discrete parts of CCGs could be given delegated authority to determine their use of budget, contract/commissioning intentions and service changes. There could be degrees of sovereignty developed for these discrete patches / operating areas as approved

[2] Beyond PBC: The local clinical partnership. The Nuffield Trust/NHS Alliance. Smith,Wood and Elias November 2009

by the CCG governing body. This would need to be 'pushed' as far as possible to retain the interest and innovative ideas of a number of clinicians. A menu covering differing degrees of autonomy set within a scheme of delegation could be prepared. There are a range of models that could be developed to incorporate delegated budgets (eg prescribing, community services, acute services), contract schedules can be negotiated to take into account service models reflecting local circumstances that can differ across large geographical areas. It will be important to align risk where it can be managed or mitigated. Risk sharing will need to be considered to manage budget fluctuations. In addition there will need to be incentives and penalties built in to the scheme of delegation to ensure continuous improvement.

- CCGs will need to be sufficiently flexible to allow the different patches or operating areas to develop at variable speed. The enthusiasm of practices should not be dimmed by the pace of the slowest. CCGs will need to oversee health and health care improvement across their entire populations. CCGs who use this model may want to develop an 'escalator' within which each patch/operating area functions that will give more autonomy and authority linked to specific inter practice and CCG agreements. This could be something that large CCGs might wish to consider as well as those who may have wanted to remain small and independent but who ultimately decide they need to join together to get the benefits they need from economies, efficiencies and proportionate governance but still want to retain that real local ownership.

- With regard to geography, guidance should be clarified to ensure that there is no overlap of population responsibility between CCGs. The responsible population is built up by the member practices registered populations and a set of wards that cover the unregistered populations within which the practices who have the majority of the population within the ward sit.

- This allows CCGs to be responsible for populations in more than one local authority. As part of the CCG authorisation process CCGs would need, where this is the case, to demonstrate their ability to work effectively with more than one Local Authority and associated Health & Wellbeing Boards.

- With regard to proportionate governance, it is suggested that Chairs, Accountable Officers and other Governing Body members can be shared in the same way as they are shared now between SHAs and PCTs as long as there is a clear governance framework that specifies who is responsible for what. There is a need to ensure that the minimum roles are addressed and whilst some of these may be shared there does need to be some separation of duties. It is suggested that a matrix of these roles highlighting which might be shared and which it would not be good practice to share would be helpful for CCGs.

- On grounds of good governance practice it is suggested that the Chair and Accountable Officer are not the same person.

- With regard to timing, CCGs are encouraged to find their own solutions to give the best local fit as early in the CCG development stage as possible as this will give them the greatest chance of being authorised. As their track record will be part of the authorisation process it is felt that any joining together of CCGs would need to be sooner rather than later. It would be discouraged for CCGs to go through the authorisation process where there is significant

doubt over viability, as coming through the initial configuration gateway process.. This would be considered detrimental to their populations as they would then need to seek membership of an alternative CCG where they would not have taken the opportunities that joint development would offer. However CCGs who firmly believe they have workable, affordable and effective arrangements that are allowable within the Bill, are also encouraged to put these forward to the configuration gateway in order to test out fully whether there are innovative solutions that could and would work. CCGs must not be dissuaded at this stage where they firmly believe and can demonstrate how their plans are allowable within the proposed statute, workable, affordable and effective.

- PCT Clusters have the lead for the development of CCGs so that they can become authorised by the NHS Commissioning Board. Any issues considered by CCGs as not conducive to achieving this aim should be addressed to the PCT Cluster in the first instance. This can include any contradictory messages perceived by either party. If no resolution can be found then the PCT Cluster or the CCG can engage the assistance of the SHA Cluster so that the matter is concluded. At any time the CCG could seek assistance from one of the Primary Care Organisations to act as an "honest broker" to assist in seeking resolution.

- In addressing the above any examples of good practice or options will be compiled for circulation to CCGs.

**6. Next steps**

- This paper to be shared for discussion with interested CCGs, DH, NHS staff and stakeholder bodies and views collated by the end of November 2011.
- A meeting of the small group of interested CCGs scheduled for 14 December
- A revised paper to be issued on 15 December for wider discussion with the aim of concluding this work by the end of January 2012.
- Further work needs to be undertaken to develop the menu of options for delegated authority.

Julie Wood, National Director NHS Alliance (on behalf of the NHS Alliance /NAPC Clinical Commissioning Coalition)
Cameron Ward, Director of Commissioning Development, NHS North of England

7 November 2011 revised / 14 November Version2.1

**Attendees at October session to discuss these issues**

Julie Wood National Director NHS Alliance (on behalf of the NHS Alliance /NAPC Clinical Commissioning Coalition)
Dr Shikha Pitalia, GP United League Commissioning
Dr Johnson DeSouza, GP, SHA GP lead Yorkshire & Humber
Joseph Chandy, Practice Manager/CCG Chair, Easington Durham
Cameron Ward, Director of Commissioning Development, NHS North of England
Gail Richards, DH

**Apologies**

Dr Mark Spencer, GP, Fleetwood, Lancs

Dr Jo Medhurst, Bexley
Dr Amit Bhargava GP, Crawley and NHS Alliance co-clinical lead
Dr Stewart Findlay, GP , Durham Dales

**Also invited**
Dr Peter Patel