

Ambition, challenge, transition

Reflections on a decade of NHS commissioning



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The independent collective voice of clinical commissioning groups

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Endorsement from NHS Clinical Commissioners

NHS Clinical Commissioners (NHSCC) welcomes this report by the NHS Confederation, and its reflections and messages from the old to the new commissioning system. As the independent membership body for clinical commissioning groups, NHSCC believes it is important to understand and learn from the previous commissioning arrangements in an open and constructive way. We must build on experience and insight from the past to have a strong and effective future.

We think that as you read the report you will find the messages are candid, clear and thought-provoking, providing a powerful narrative on some of the realities of being a local NHS commissioning organisation.

For clinical commissioning groups in particular, some of the key lessons concern the need to build constructive and mutually supportive relationships with the centre; gain system-wide support for service change and reconfiguration; and recognise and draw on the influence of local decision-makers and opinion leaders, including those in local government, the media and provider organisations.

We believe this report also marks an important point in the establishment of clinical commissioning groups: transition has ended and the baton is finally ours. It is our time to step forward and make a real difference to the health and wellbeing of our local populations.

Dr Steve Kell and Dr Amanda Doyle,
co-chairs of the NHSCC Leadership Group

NHS Clinical Commissioners

The independent collective voice
of clinical commissioning groups

NHS Clinical Commissioners

NHS Clinical Commissioners is the only independent membership organisation exclusively for clinical commissioning groups (CCGs).

Our role is to help CCGs secure the best possible healthcare and health outcomes for their communities and patients.

We're giving CCGs a strong, influencing voice from the frontline to the wider NHS, national bodies, government, parliament and the media. We're building new networks where CCGs can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.

We are driven and committed to delivering programmes that are shaped and developed by our members. Our independence means we're only accountable to our members.

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Foreword from Sir David Nicholson



This report by the NHS Confederation is essential reading for the leaders of new commissioning bodies. It examines the main challenges and achievements of primary care trusts (PCTs) with honesty and insight, reflecting and building on the experience gained, the legacy left and the lessons learned from more than a decade of PCT-led commissioning.

PCTs put commissioning centre stage in the NHS, and played a critical role in achieving better outcomes and higher standards of quality and safety for patients. They led what was often inspiring work to improve the health of the populations they served and, in particular, to improve access to care in some of our most deprived communities. But there were also things we could have done better. Most notably perhaps, they experienced tensions in balancing local and national priorities, and sometimes found it difficult to make sustained and consistent progress in tackling health inequalities and reducing the demand for acute services.

This report highlights many of the achievements of PCTs, discusses some of the pressures and challenges they faced, and looks to a future where NHS commissioners will play an even more important and valuable role in achieving the best for patients and communities.

From my perspective, two key messages from the report provide particularly valuable learning and legacy for new commissioners. The first is the recognition of the importance of clinical leadership, ambition, autonomy and determination and the value of clinical commissioners being at the centre of partnership working with local stakeholders to achieve the best overall outcomes for their populations. The second is the reflection that understanding and responding to the needs, concerns and ideas of local people and the wider clinical community is critical to the success of effective commissioners.

I hope colleagues in clinical commissioning groups, local authorities and NHS England will reflect on the messages in this report as they shape and lead the next phase of NHS commissioning.

Sir David Nicholson KCB CBE
Chief Executive
NHS England

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Introduction

This report has been produced by the NHS Confederation to mark the end of a significant period of transition for NHS commissioning. Since the publication of the NHS white paper *Equity and excellence: liberating the NHS* in July 2010, commissioning arrangements have been through a process of unprecedented change and reorganisation, culminating on 1 April 2013 with the transfer of commissioning functions from primary care trusts (PCTs) to clinical commissioning groups (CCGs), local authorities, NHS England and other national bodies.

This report explores the achievements and challenges experienced over more than a decade of commissioning through the voices of those who lived it on the ground.

The material for this report was gathered from interviews, carried out between November 2012 and February 2013, with 20 leading figures from and around PCTs. The interviewees' job titles used in the paper refer to their roles during the period they were reflecting on. A full list of interviewees is provided at the end of the report.

This report captures critical lessons from the past, and translates these into messages that are relevant to new commissioners. It is intended to be a practical and supportive tool for colleagues in the new system, with resonance for commissioners in CCGs, local authorities and NHS England, as well as an acknowledgement of the contribution and legacy of PCTs. Crucially, it asks what reflections PCT leaders would share with new commissioners.

Some of their most striking observations are summarised below.

- The potential strength of CCGs is that they not only bring local clinical leadership to the fore, but that they are founded on principles of distributed clinical leadership, ownership and membership. The value and impact of individual clinical leaders being seen to drive commissioning strategies and decisions is significant. However, to exploit the full potential of CCGs, these leaders must secure the active and constructive participation of their member practices, enabling their primary care colleagues to see themselves as part of the commissioning system, and to use their insight into the needs and experiences of patients to drive change.
- Communication and engagement with the public is not an 'add-on', but is a core function of a commissioning organisation. From the outset, new commissioning bodies need to be clear with local people and with their partners about their role: as the representative and advocate of patients; as the visible purchaser of health services on behalf of service users; and as a body that must act strategically to address the healthcare needs of a population in the best way it can given the finite resources available.
- Whatever the formal structure and nature of the relationship between NHS England and CCGs, it must be mutually supportive, enabling both shared decision-making and constructive challenge in both directions.
- If new commissioners are to be more successful in securing higher quality care and sustainable long-term improvements in health outcomes, an immediate priority is reducing the demand for and improving the efficiency of secondary care services. This will involve stimulating the primary and community care offer; emphasising prevention and early intervention; encouraging innovation; and being constructive and rigorous in the management of contracts with providers.

The evolution of NHS commissioning

1990

The internal market

- NHS organisations are separated into 'purchasers' and 'providers' to promote competition and efficiency.
- Purchasers of care assess needs, plan services and represent the interests of patients to the providers – principally hospital trusts.

From 2002

PCTs take on full devolved responsibilities

- PCTs take on full devolved responsibilities from health authorities for community health services, health improvement and integrating.
- New responsibilities follow, including overseeing the introduction of Payment by Results; managing the new general practice and dental contracts; and implementing practice-based commissioning.

2008

World Class Commissioning

- The World Class Commissioning programme aims to assure and improve PCTs' commissioning skills.
- It seeks to clarify the purpose of commissioning and the organisational features required to undertake commissioning effectively; introduce an assurance framework to judge the capabilities of PCTs; and promote ambition and improvement amongst PCT leaders.

2010

Health Select Committee report on commissioning

- A report on commissioning by the Health Select Committee is scathing (unduly and unfairly in the opinion of the NHS Confederation) in its assessment of PCTs' commissioning skills.
- It accuses commissioners of sub-standard data analysis, failing to challenge poor quality and inefficiency, and having a poor grasp of clinical issues.

2012

Health and Social Care Act

- The Health and Social Care Act 2012 formally introduces the proposed structural changes to the commissioning landscape.

2000

Primary care trusts launched

- Further market reforms see a shift in focus (and terminology) away from 'purchasing' to the broader and more strategic idea of 'commissioning'.
- 303 primary care trusts (PCTs) across England are established to purchase care from hospitals and other providers and to work with local agencies to improve public health and tackle inequalities, and are also to directly provide community health and some primary care services.

2006

PCT mergers

- PCTs are merged to form 152 (later 151) organisations with broadly the same boundaries as their local authorities.
- It is felt that consolidation of commissioning expertise will improve PCTs' effectiveness, and that aligning NHS commissioning boundaries with local authorities will help drive greater joint working across health and social care.

2009

Transforming Community Services

- PCTs are required to divest themselves of all directly provided community and primary care services.
- This is a further attempt to ensure PCTs focus on their strategic commissioning responsibilities, unencumbered by the distraction of (and potential conflicts of interest in) service delivery.

2011

PCT clusters

- The prevailing view that commissioners are still not delivering for the NHS, combined with the growing pressure on NHS finances, and the new coalition government's proposed changes to commissioning structures, result in the clustering of PCTs.
- This is intended to ensure their viability while reducing management costs and preparing for their planned abolition in 2013.

2013

PCTs abolished and new commissioning arrangements established

- On 1 April 2013, NHS England, clinical commissioning groups and health and wellbeing boards take on many of the responsibilities of PCTs.

Early organisational focus and ambitions

Getting the groundwork right and establishing firm foundations early on is critical to the success of any new organisation or system.

Emerging as they did from primary care groups and community health trusts, PCT leaders now acknowledge that in many areas the early focus of their organisations was on improving primary care and providing and developing community services. Experience and expertise in commissioning better acute and mental healthcare (now distributed between a much larger number of PCTs than the health authorities that had previously been responsible for these functions) was often less well developed.

Although the idea of PCTs acting as 'system leaders' for their local NHS was implicit from the beginning, an initial focus on their own provider role and on primary care development, rather than the more intangible task of 'strategic' or 'whole system' commissioning, was perhaps inevitable for PCTs in the early days. As the providers of often very substantial, and in some cases complex and specialist, services, PCT board members and directors were rightly concerned with ensuring first and foremost that their own services were safe, effective and efficient. As discussed from page 11, the need for the work that PCTs also embarked on to improve the quality and safety of primary care provision should not be underestimated.

'PCTs quickly developed new ambitions to engage with their partners and with their local communities to improve public health and reduce health inequalities'

While their very early priorities may have been internally focused, PCTs quickly developed new ambitions to engage with their partners and with their local communities to improve public health and reduce health inequalities. When the initial 303 PCTs were merged into 152, it was decided, after intense local government lobbying, that the new boundaries would match those of counties and single-tier local authorities, so there was a clear population with which to engage and a partner with whom to work. Former NHS Ealing chief executive, Robert Creighton, says: "The old health authorities were rarely borough based and did not see it as their job to engage with local people, [whereas] I saw it completely as our job to work as part of the leadership of the local health and welfare community, with the council and very strongly with local voluntary groups, to get people to understand the health service better and take more responsibility for the way they interacted with it."

As PCTs settled down following their initial establishment and mergers, they set themselves increasingly ambitious goals for improving access to and the quality of local health services. There was in particular a determination to finally tackle the ever-growing demand for hospital treatment by investing in prevention, identification and early intervention and by moving services into the community.

The World Class Commissioning programme legitimised system leadership and explicitly put PCTs at the forefront of this type of service change and transformation, articulating the "sexy" role envisaged for them by the new director-general for commissioning, Mark Britnell.

Sophia Christie, former chief executive of NHS Birmingham East and North, believes there were strong reasons for describing

the PCT role as system leader: “They were responsible for a huge mass of public investment and they had the population health responsibility. They were also the first time an NHS organisation had explicit responsibility for improving the health of the population rather than just securing access to services for it. You couldn’t do that without taking on a leadership role, and that put you in a very different position from traditional NHS system management. This opened up a different relationship with acute services.”

It was not until the early months of the coalition government, when it became clear that PCTs were to be abolished, that the full range of functions they had actually taken on over the years became widely understood at the Department of Health. Former NHS Newham chief executive and PCT Network director, David Stout, says: “It was evident no one had the faintest idea what the full range of responsibilities of PCTs was. The NHS Confederation did some work with the Department of Health and came up with about ten pages of dense text.”

These responsibilities were varied, ranging from: delivering the 18 weeks referral to treatment target; meeting requirements such as the European Convention on Human Rights and the Disability Discrimination Act; facilitating the redesign of care pathways; delivering the 2010 Carbon Reduction Strategy; responding to emergencies such as swine flu; ensuring providers followed mandatory NICE guidance; to awarding ophthalmology contracts.

While such responsibilities will be dispersed across different commissioning organisations in the new system, all health service commissioners will have complex, interdependent and wide-ranging functions and duties to fulfil, that go far beyond simply specifying and paying for healthcare services.

Earlier recognition and acknowledgement of the breadth and complexity of their responsibilities, and the capacity required to manage these, clearer articulation of their purpose, and stronger support for their system leadership role may all have helped PCTs hit their stride sooner.

Key points for new commissioners

- CCGs are uniquely placed to combine the expertise of clinicians and managers in a single organisation with the clear and sole responsibility of commissioning health services to improve quality and outcomes. They should make the most of this opportunity, and quickly assert themselves as the representatives and advocates of patients and communities, rather than of providers or ‘the system’.
- The scope and complexity of their responsibilities and the importance of their task mean that commissioners need to be intelligent, strategic and collaborative commissioners from the outset. They must be honest about the extent to which they understand the opportunities and challenges they face and their ability to achieve change, and must ensure they develop or gain access to the right information, skills, support and partnerships as quickly as possible.
- Clinical and professional leadership must be directed at addressing the health needs and priorities of a local population. This means working with partners and influencing across a health economy, not just focusing on particular service areas and sectors that are the most familiar or visible.

Building capacity and capability

Initially, PCT management teams were relatively small and formed largely of individuals bringing knowledge and experience from their previous posts at health authorities, primary care groups (PCGs) and community health trusts. It took time for PCTs to understand which skills they needed and to develop them, and these requirements changed as the demands on them changed.

Staff numbers increased over the first few years, reflecting an array of additional and often very operational and technical responsibilities taken on by PCTs, such as establishing the Choose and Book appointments system and implementing Payment by Results and the Quality and Outcomes Framework for general practice.

The chance later on to concentrate on strategic commissioning, as provider arms were transferred elsewhere, gave PCTs a renewed purpose and focus but again required extensive staff development, placing a premium on softer skills such as negotiating, influencing and coalition building.

“It was political and emotional intelligence – working with people across silos in health and local government – which were the skills I prized most highly in appointments,” says Robert Creighton.

David Stout suggests that PCTs attracted people with a natural inclination towards partnership working: “The command and control mentality would have been futile in a PCT because the amount of control was limited, and if you thought you could achieve your goals by shouting or just by using a contract you would have been disappointed.”

The non-executive directors on the PCT board were intended to strengthen local connections

and influence by representing the interests of local people, as well as bring in additional skills. Prized among these was commercial acumen and experience, which was difficult for PCTs to find among NHS managers.

Sheila Childerhouse, former chair of NHS Norfolk and Waveney, says the quality of non-executive directors “was often weak at the beginning, with too much emphasis on picking the local ‘great and the good’ rather than perhaps the best people with the strategic vision.” But, as with many other aspects of PCTs’ operations, the quality of boards improved substantially over time, while executive leadership teams developed a deeper understanding of their board’s role and who could provide the insights they needed to make the organisation more effective.

In common with many successful NHS organisations, the high performing PCTs tended to maintain strong and stable senior management and leadership following the initial period of establishment. With so much of the success of PCTs dependent on working with everyone from the council to local businesses to acute trusts, stability at the top provided firm foundations for the personal relationships that were essential to getting the job done.

PCTs also made commissioning an attractive career for the first time. Sophia Christie: “Being a PCT chief executive was the best job I could ever imagine in the health sector. It was stimulating, challenging,

‘The high performing PCTs tended to maintain strong and stable senior management and leadership following the initial period of establishment’

rewarding and strategic, and you saw the impact of your actions on real people.”

However, PCT leaders acknowledge that they were helped to develop their organisations, attract increasingly skilled directors and non-executive directors, and adapt to changing demands by the relatively benign financial climate in which they operated.

New commissioners, by contrast, will take on their responsibilities facing considerable financial pressures, and with most searching for savings rather than prioritising the use of growth funds. Their organisational or functional budgets are also smaller due to there being a larger number of CCGs than there were PCTs, and because previous PCT functions have now been dispersed across several different parts of the system. This may make it harder for any one part of the system to manage financial risk and uncertainty and to invest in organisational and leadership development, without effective collaboration and partnership working. Under these new arrangements and pressures, commissioners must demonstrate early maturity, readiness and leadership.

Former NHS Tower Hamlets chief executive, Alwen Williams, stresses the importance of organisational development: “CCGs have a much tougher call and they are going to really have to work on all fronts – strategy, performance delivery and organisational development.”

Andrew Donald, former chief operating officer of NHS Birmingham East and North, also says organisational development will be a key priority in his new role as chief officer of the Stafford and Surrounds CCG: “If we don’t do it, it won’t work.”

‘Shrewd partnering with councils, other CCGs and companies, as well as with their commissioning support unit, will be essential, particularly with minimal running costs’

Developing the organisation means getting skills and insights from outside. Shrewd partnering with councils, other CCGs and companies, as well as with their commissioning support unit, will be essential, particularly with minimal running costs. Andrew Donald: “The first thing we do in this CCG is not think ‘how do we do it’, but ‘who can we do it with’ or ‘who can do it for us’.”

Commissioning support service providers, as well as local authorities and NHS England’s area teams, will also need to find ways of investing in staff and leadership development if they are to secure the knowledge, skills, culture and behaviours required in the new system.

The Department of Health’s last major initiative to grow commissioning skills was World Class Commissioning. While many people winced at the hyperbole of the name, the programme pushed commissioning centre stage in NHS management. There was a clear message that commissioners were not there simply to transfer money from the Department of Health to providers; they were charged with reshaping services, driving up quality and improving local healthcare and health outcomes. The ‘system leader’ role became central to PCTs’ operations and positioning in the health service, and the range and sophistication of the skills and competencies required to perform this role became clearer.

Reflections on World Class Commissioning vary widely. For some PCTs, it helped them develop their skills and overcome significant operational shortcomings. Many saw it as a rather bureaucratic and time-consuming exercise which became something of a consultancy-driven industry, but which nonetheless helped develop their thinking and provided some useful tools. For the highest performers, it failed to give enough focus to strategic issues.

Helen Buckingham, former director of commissioning and performance for NHS Medway, reflects the views of many: "World class commissioning was a stupid phrase, but as a principle and process it was a good one. It wasn't good as a tick box exercise, but when you sat and thought about what it really meant to be a system leader, it made you think about the right things."

Despite the criticism it attracted and its ultimate rejection after a change of government, the World Class Commissioning programme arguably provided validation that commissioning was being done to a high standard in many parts of the NHS, and that PCTs had most of the skills to do what they were being asked to, albeit these needed development and refinement. It also extended understanding around the NHS of what commissioning actually was and what it was meant to achieve.

Love it or loath it, World Class Commissioning leaves an important legacy for CCGs and other new commissioners, and there may be some genuine return on the effort and resources invested in it if some of the focus, rigour and prominence it brought to the commissioning task are retained.

Key points for new commissioners

- Commissioning is rewarding, but it is also complex, difficult and not always valued or understood. Effective commissioning organisations require exceptional, resilient leaders with the ability to manage uncertainty, develop lasting relationships and secure change through influence not power. They also need access to high-quality technical and professional skills.
- New commissioners will be working in a much tougher financial climate with fewer resources at their disposal in comparison to their predecessors. As leaner organisations, they must put organisational, leadership and staff development at the heart of their operations to build strong, cohesive teams.
- Critical to this will be building capacity through partnership working and collaboration with other organisations to secure the necessary skills and resources.

Meeting local needs and reducing inequalities

Most PCTs were far more effective than their health authority predecessors at analysing the health needs of their local population and finding ways to meet these needs.

Andrew Donald says that as his PCT's focus moved from providing for illness to understanding and meeting the health needs of the local population, they "realised what we were commissioning were probably not the right things. We discovered we needed to commission at a much more granular level. The Asian populations had very different needs from white British, for example. You have to get in there and find out what people's lives are like – what they do, where they go, where they get their information. As a commissioner, people expect you to know what to commission intuitively, but the reality is that the answer comes from your local communities."

Making progress on reducing health inequalities required understanding the culture of different target groups, then using the right message and media to reach them and change behaviour. When Tower Hamlets promoted breast screening they found that Bangladeshi women wanted clear medical instructions that they should be screened and liked to attend in groups, so minibuses were arranged, while white women wanted information, choices and to attend alone. PCTs ran smoking cessation services using a variety of messages, media and settings, including mosques and working men's clubs.

Funding increases allowed PCTs to expand services in areas of high need. "We reduced the inequalities of inputs quite considerably – we improved the provision of services in the areas where we knew that health was worst," says Robert Creighton.

Every PCT had successes in addressing inequalities, often with harder to reach groups. For example, NHS Newham tackled tuberculosis; NHS Birmingham East and North improved diabetes care for South Asian communities; Hull reduced drink-related street injuries; and NHS Liverpool and Liverpool City Council led the country in establishing smoke-free public places.

As a result of this work, local understanding of the determinants of ill health is now far more sophisticated, the provision of health services in areas of high need has been increased, teenage pregnancy rates have declined, and addressing health inequalities is now embedded as a key policy objective.

'You have to get in there and find out what people's lives are like – what they do, where they go, where they get their information. As a commissioner, people expect you to know what to commission intuitively, but the reality is that the answer comes from your local communities'

Nonetheless, substantial progress in reducing health inequalities and securing longer, healthier lives for people in deprived communities has proved elusive. As Sir Neil McKay, former chief executive of East of England Strategic Health Authority, puts it: "Despite everyone's hard work there is still a hell of a long way to go... It has been quite

tough to convert all of the endeavour into real evidence that we have done much about inequalities."

It is important to reflect on and try to understand why the work, into which such energy and passion was invested by PCTs, may have had a limited impact.

Key points for new commissioners

- Reducing health inequalities is a slow and difficult process. The chances of success are likely to be improved by sustained partnership working between NHS bodies, local authorities and voluntary organisations to address the social determinants of ill health.
- Addressing health inequalities is dependent on having a deep understanding of local need, adequate capacity and resources, and being able to communicate effectively with all parts of the population.
- Success, when it comes, is likely to be through developing services which are closely tailored to the needs and draw on the resources of specific sections of the population, i.e. through more 'person and community-centred' commissioning.
- Tackling inequalities will involve making difficult decisions about priorities, resources and expenditure of effort.
- Local commissioners will need to be able to evaluate and understand the extent of their impact on health outcomes and inequalities, and be willing and able to adapt and develop new strategies if progress is not being made.

Working with providers

Improving primary care

The quality of general practice in the UK is rightly acknowledged to be extremely high, and as playing a crucial role in the overall success of the NHS model. However, as in any other sector, there are some examples of poorer quality and performance. Addressing these exceptional cases, while driving overall improvements in service quality, was one of the more difficult and under-reported aspects of the work of PCTs. It involved approaches such as encouraging single-handed GPs to work in networks and improving the coordination of general practice with other community services. But the pivotal issue was what Helen Buckingham describes as “the long and arduous struggle” of driving out the worst performing doctors, who generally worked alone.

David Stout: “There are some extraordinary stories about the frankly dangerous and appalling quality of general practice... It was incredibly time consuming taking action, to some extent against the will of the GP leadership – they certainly didn’t always get behind it even though they knew it needed doing.”

Building a case to either encourage or compel a poor performer to stop practising could often take up to two years and involve analysing data

such as the Quality and Outcomes Framework, activity reports and patient surveys. But with few effective contractual levers to force GPs to change or quit, clinical leaders and managers often had to resort to complaints, prescribing errors and peer pressure.

Former NHS Buckinghamshire GP executive member and now director of policy at the NHS Confederation, Dr Johnny Marshall, says PCTs often found it difficult to address variation in GPs’ performance: “It needed a greater partnership between local GP communities and PCTs and in some areas that simply didn’t exist... In many it was quite an adversarial, contractual relationship.”

In some areas general practice is now undoubtedly a great deal safer. Sophia Christie: “There are a small number of PCT medical directors and their commissioning manager supports who have spent ten years of their lives putting huge personal and emotional commitment into trying to protect patients from dangerous practice.”

Responsibility for continuing this work falls between CCGs and NHS England’s local area teams. While the 35,000 contracts for primary care services are now held by NHS England, CCGs are the ones who are closest to the issues, and they will need to push improvement.

Key points for new commissioners

- While formal responsibility for primary care contracting rests with the local area teams, CCGs will need to take a lead in developing local models to improve primary care quality.
- They will need to take this on despite the difficulties that will inevitably arise in judging the performance of GP colleagues and so members of the CCG.
- Effective engagement with the local medical committee representing GPs will be essential.

“There is a bit of a redundant debate going on at the moment, which is that CCGs don’t commission primary care, therefore that’s the job for NHS England. Actually, CCGs are going to be the only bit of the new structure with a deep knowledge of their local areas... Driving the transformation of GP services and integrated care has to be absolutely fundamental to the CCG’s role,” says Alwen Williams.

Improving secondary and tertiary care

Many PCTs found that effective relations with acute and mental health providers took time to evolve. Some PCTs struggled to move from contract management and monitoring to a commissioning approach which embraced redesigning pathways and promoting improvements in quality and safety, while providers took time to understand and accept that commissioners legitimately had such a role.

“In the early days they didn’t quite get us, didn’t really see us as people who would help them improve their services, but that changed,” says Helen Buckingham.

Some of the rhetoric from the Department of Health around decommissioning services to secure major improvements did not reflect the reality that change is overwhelmingly achieved through collaboration between commissioners and providers and rarely through cancelling a contract. Confrontational commissioners failed.

Sophia Christie: “There are virtually no hard levers available to commissioners to get NHS organisations to behave. Procurement

is useful when... your local provider has already failed. But as a way of getting NHS organisations to behave better it... can only ever be a marginal activity.”

From around 2010 the biggest challenge facing PCTs was controlling the growth in hospital activity. Although this was always a priority, the funding had been growing so the imperative to curtail activity was nothing like as strong as it now became. On the contrary, PCTs had been under pressure to secure the delivery of New Labour’s key promise in the 1997 general election to slash waiting lists, which created a surge in elective activity.

As it was rolled out, however, there was a growing perception that the payment by results system, while highly effective at pumping growing funding from the Treasury into acute trusts in times of plenty, was poorly suited to reining in demand.

“The tariff system meant it was almost impossible to stop the local trust racking up business, which meant we were almost always on the back foot financially... there is no incentive for hospitals not to just carry on in the way they always have,” Robert Creighton says.

He continues, “As one foundation trust chief executive reportedly put it: ‘I am not doing

‘There was a growing perception that the payment by results system, while highly effective at pumping growing funding into acute trusts in times of plenty, was poorly suited to reining in demand’

anything to reduce demand. I am employed by my board to get as many patients as possible through the door because every time they do the cash register rings.”

Substantial service reconfigurations – shutting hospital services and moving care into the community – are required to make inroads into demand. PCTs attempted to do this, but faced political and media opposition.

Prior to 2010, service reconfigurations, such as concentrating maternity services or A&E on a particular site, had been driven more by quality than efficiency considerations. As NHS spending was frozen, the ‘Nicholson Challenge’ to find £20 billion of efficiency savings (known as QIPP – Quality, Innovation, Productivity and Prevention) came to the fore. The QIPP rhetoric has often left the public and local politicians thinking that cost is the sole motivator for service changes.

Despite repeated speeches from NHS leaders stressing the need for services to change to improve quality and efficiency, health secretaries balked at supporting tough decisions. Robert Creighton: “Over ten years we tried three times to address those issues and each time we were unsuccessful. The government’s ambition for us as commissioners was to be bold and change the system, but when push came to shove those attempts got derailed because politically they were not supported.”

NHS Liverpool is one PCT which succeeded in reducing hospital beds. Former chair, Gideon Ben-Tovim, says the key to leading reconfigurations is to “hold your nerve, be supportive but robust [towards providers], drill down in an evidence-based

way about what’s essential, have strong clinical leadership and dialogue, engage systematically with the community and work with providers on solutions to their issues.”

Overall, PCTs directed funding to government priorities such as cancer, heart disease, stroke and waiting times but often struggled to direct funding towards prevention and early intervention. Hospital activity was always the focus.

Andrew Donald believes the funding increases were part of the problem: “We were very good at taking the 6 to 7 per cent growth and using that at the margins to create change. I don’t think we ever really got providers to change and that was because there was always money in the system to solve the problem. Now there is no money and small district general hospitals and other providers are going to have to work with CCGs to bring about change.”

In the light of the report by Robert Francis QC into Mid Staffordshire NHS Foundation Trust, CCGs will be looking for assurance from providers that they are meeting standards around issues such as dignity, safety and nutrition. CCGs will not have the

‘The key to leading reconfigurations is to “hold your nerve, be supportive but robust [towards providers], drill down in an evidence-based way about what’s essential, have strong clinical leadership and dialogue, engage systematically with the community and work with providers on solutions to their issues”’

capacity to gather this data for themselves. This will require negotiation, management and governance to ensure providers put in place objective and transparent systems reflecting patient experience.

The regional offices of NHS England will play a central role in pushing through service reconfigurations, and this creates risks for CCGs.

If they are not seen to be central to decisions about local services, their relationships with local partners will be undermined, while any hint of conflict between different layers of the NHS will create confusion and fear in the minds of the public and their politicians. Again, whatever the formal division of labour between NHS England and CCGs, the two have to share decision-making.

Key points for new commissioners

- To make healthcare services more sustainable, a significant priority for CCGs is to reduce local demand on acute services. The key to making progress is to reconfigure services locally to ensure the primary and community care alternatives are suitably robust.
- Support for major service reconfigurations will only be secured where there is robust evidence, clearly presented to the public by commissioners they trust. CCGs will need to build visibility and trust within their communities to do this.
- While there will inevitably be disagreements between NHS England and individual CCGs over reconfiguration, commissioners will need to weigh the benefits and costs of having a public row. Disputes conducted through the media will undermine public confidence in the NHS, distress patients and make other changes more difficult.
- NHS England could play a useful role in influencing ministers to understand and support reconfiguration plans.
- In the wake of the Francis report, CCGs will have greater responsibility for the improvement of quality and safety of health services. However, with limited resources to monitor this at a local level, they will need to build relationships with respective provider boards to ensure effective governance for quality and safety is in place and that robust, timely and transparent performance data is supplied. These discussions have the added value of being clinician to clinician.
- Contractual penalties and terminations are levers that commissioners can use to implement change if significant concerns in quality arise. CCGs must be supported and have the confidence to use these types of lever where they see fit.

Supporting clinical leadership

The coalition government argued that PCTs needed to be abolished so control of the NHS could be wrested from 'bureaucrats' and put back in the hands of clinicians. But clinicians had more profile and clout in PCTs than is often recognised.

The influence of clinicians on the work of PCTs was written into their structure through the 'three at the top' model, with joint leadership coming from the chair, chief executive and chair of the professional executive committee (PEC), which was formed of GPs and other clinicians. The PEC was seen as the champion of clinical engagement, as well as a mechanism for strengthening clinical governance.

Sophia Christie argues this model provided PCTs with the ability to check some of the 'special pleading' by providers and "brought a good generalist overview to the excessive specialisation of the acutes... That clinical paradigm was very powerful."

As well as the PEC members, medical, nursing and public health directors were involved in leading PCTs. Indeed, some PCT boards had a higher proportion of clinicians than many acute trusts.

In practice, the influence and engagement of GPs and other clinicians within PCTs varied widely. A good number of PCTs made strenuous efforts to give PECs an important role in decision-making, and some could legitimately claim it was the engine room of the operation, but in others there was considerable distance between the clinical and managerial leadership. The influence of clinicians on PCT boards also varied, but in stronger PCTs they played a key role in strategy, oversight and leadership.

It is acknowledged that one particular vehicle designed to secure more power for clinicians – practice-based commissioning – got insufficient traction. It was sporadically promoted by NHS leadership as a way to encourage clinical engagement in service redesign and improvement and there were some good small-scale examples, but there were too many other priorities and in some areas too little commitment (from both PCTs and GPs) to making it happen.

However, practice-based commissioning did point the way to putting commissioning power in the hands of GPs and, in some areas, practice-based commissioning groups have provided the foundations for the CCGs that have subsequently emerged.

While PCTs were accountable to the SHA, CCGs are accountable to very different constituents, including NHS England, Health and Wellbeing Boards and, crucially, their own GP membership.

Of these, the toughest group to manage relationships with may well be their member practices. CCG heads will need to provide leadership while convincing members that they have not crossed over to what many perceive as the 'dark side' of NHS management.

But beyond suppressing rebellion, securing the involvement of the majority of GPs is critical

'Every GP needs to think strategically, seeing themselves as part of the commissioning landscape and using their experience of working directly with patients to drive wider change'

to the success of the new system. Every GP needs to think strategically, seeing themselves as part of the commissioning landscape and using their experience of working directly with patients to drive wider change. "So, instead of just treating the diabetic patient in front of them, they need to think about the whole diabetic service, and flag up to the CCG those systems and processes that need to be in place to do that," says Dr David Paynton, former commissioning director, NHS Southampton City, and now national clinical lead for the Royal College of General Practitioners Centre for Commissioning.

However, this is no easy task. Ian Walton, former PEC chair of NHS Sandwell, predicts it will be tough for CCG leaders to persuade the mass of GPs to get involved. "Their experience is that when they've got involved it hasn't lasted and it hasn't made a difference," he says.

Nigel Watson, chief executive of Wessex Local Medical Committee, highlights the risk of conflict between CCGs and LMCs: "If they think they can sit there and cut services and make the working life of GPs harder and harder there won't be much tolerance. They won't survive very long because the GPs

'Effective and transparent governance will be essential to protect GP commissioners as well as demonstrate to the public that decisions are being taken in the interests of patients'

will be removed from the [CCG] board." The design of the new system risks GPs and commissioners being exposed repeatedly to conflicts of interest. Effective and transparent governance will be essential to protect GP commissioners as well as demonstrate to the public that decisions are being taken in the interests of patients.

David Paynton sees 'open book' contracts and a progressive approach to freedom of information as essential: "Unless we can demonstrate to our local communities that we [are] doing things for the right reasons, we are never going to get anywhere. We need to be very open and transparent about... investing in primary care."

This is difficult terrain for CCG leaders, who will have to guide their colleagues through governance issues and give firm if unwelcome advice. As the NHS Confederation and RCGP Centre for Commissioning point out,* CCGs will need clear, robust mechanisms for addressing conflicts of interest if they are to maintain confidence in the probity of commissioning.

Despite the obvious advantages of clinical leadership, Dr Helen Thomas, former associate medical director of NHS Devon, Plymouth and Torbay, fears many GPs are underestimating the range and difficulty of issues they will now oversee. These include complex cancer pathways – which they will still be involved in even though NHS England will be leading – and safeguarding. "You ought to be seriously concerned, and have damn fine managers to make sure you can deal with all this," she says.

Many CCG leaders are struggling to accept how much time they will need to

* NHS Confederation and RCGP Centre for Commissioning (2011) *Managing conflicts of interest in clinical commissioning groups*.

spend on commissioning. The risk is that they compromise both their clinical and commissioning jobs by failing to give either the attention it deserves. The consensus seems to be that commissioning will need at least two full days a week. Describing his own experience of combining clinical and non-clinical roles, Nigel Watson says: "My two days a week in practice feels about the minimum I should do to keep on top of my clinical competencies; I certainly wouldn't do one day."

He believes commissioners must not be full-time: "It is essential that clinical commissioners are real GPs."

The weakest part of PCTs' clinical engagement was with trust clinicians. David Stout: "Did the front line of clinicians feel ownership of the commissioning agenda? No, they didn't. The opportunity for the CCGs is to get genuine frontline ownership of what they do."

Key points for new commissioners

- One of the toughest jobs for CCGs will be engaging their members in their work. Every GP needs to see themselves as an influential part of the commissioning system, able to use their clinical insights to improve care and population-level outcomes.
- CCGs need a constructive relationship with the LMC, which needs to feel it is part of the commissioning infrastructure while understanding it does not have a veto.
- Conflicts of interest between a GP commissioners' role in the CCG and their role as provider of primary care services can present a risk. The best way to avoid problems is to establish robust, transparent governance procedures and encourage vigorous oversight. If mistakes are made, minimise the damage by getting all the facts into the open quickly and explain how systems are being changed to stop it happening again. The overriding principle for managing conflicts of interest must be openness.
- The aspect of commissioning where CCGs can make the biggest difference compared with PCTs is collaborating with primary and secondary care clinicians in improving and redesigning services. These clinicians must be involved from the outset, not invited to help in implementing CCG plans.

Partnering with local government

PCT leaders see partnership working with local government as one of their major achievements. “It opened up a set of collaborations that was really fruitful,” Sophia Christie says.

Time was needed for local authorities and PCTs to establish trust but, once the benefits of joint working were demonstrated, enduring partnerships took shape. Many councils and PCTs shared premises, scores of public health directors and other staff were appointed jointly, and hundreds of millions of pounds of services are now jointly commissioned. The local strategic partnership and local area agreement – the vehicles used under Labour governments to bring together public service providers in the local area – were among the ways joint working was established.

Where relationships were strong, PCTs and local authorities were able to have honest conversations about difficult issues such as reconfiguration. Robert Creighton: “We would conduct the debate in a civilised way and if we were able to persuade them, they would agree. We were able to do that with stroke care – at the end of the day stroke services did not continue [locally]. They were adopting an entirely reasonable and reasoned approach.”

Peter Hay, currently strategic director for adults and communities at Birmingham City Council, which has a £310 million joint commissioning budget with the NHS, says there have been “numerous examples of councils and PCTs working together on major service reconfigurations, using techniques such as joint scrutiny commissions to assess evidence and determine the best way forward.”

But integrating health and social care services has had its setbacks. While there are celebrated examples of much closer working, including North East Lincolnshire and Torbay, areas such as Barking and Dagenham and Herefordshire struggled to maintain momentum after early advances. And even where the structures are closely aligned, there is still a long way to go before patients experience a seamless service.

Organisational barriers such as financial and information systems play their part, but success in integration ultimately depends on relationships, trust and commitment. As the NHS itself demonstrates, being part of one funding system is no guarantee of integrated services.

Health and well-being boards strengthen and clarify the role of local government in the health system and make democratic oversight of the local NHS tangible for local people.

The key to successful partnerships between CCGs and local authorities will be understanding their complementary roles. For some clinicians, it may take time to appreciate the value of local politics and to reconcile their evidence-based approach with the negotiation and compromise inherent in political debate. GPs must recognise the key role that councils play, not least as powerful voices in debates about service change.

‘The key to successful partnerships between CCGs and local authorities will be understanding their complementary roles’

Key points for new commissioners

- PCTs have demonstrated the potential for partnership working with local government; CCGs need to ensure that joint work now delivers measurable, substantial improvements in service quality and patient experience.
- Joint commissioning is much tougher under the current financial climate. To make it work, both parties need to have a shared vision and approach, not simply cooperate. This means reaching agreement on difficult issues such as pooling risk and sharing savings.
- There are huge cultural differences between the health service and local government. Relationships work if each side understands the values and strengths of the other partner, and shows willingness to develop enduring bonds based on trust and respect.
- Commissioners need to recognise the influence councillors can have over strategic decisions such as reconfigurations, and involve them from the beginning of the decision-making process.

Communicating with the public

One of the most powerful messages from PCTs is the need to communicate with the public, patients and their representatives, and to do so relentlessly. A constant dialogue is needed with the public to identify needs and resources, change the way people manage their own health and use services, and sell the arguments for difficult decisions about reconfiguring services.

For PCTs, the role of explaining to local people what the health service does and how they could engage with it became more central in later years. For CCGs, communicating with the local population and trying to give substance to the slogan “no decision about me without me” has been a priority from the first day.

“Take communicating really seriously,” says David Stout. “The more you want to do, the more you have to be prepared for the public to resist it. There is a routine blame game that commissioners do often, which is to blame the politicians for opposing change when all they’re doing is following the public. You blame the public for blocking change when all they’re doing is listening to the clinicians, and you blame the clinicians for blocking change when you haven’t brought them on board.”

Key to securing support is to involve everyone in the decision about the best way to achieve the desired outcome, not to seek support

for a CCG strategy. “Start the conversation at the beginning, [do not] go to them with the answer, be honest about the issues and don’t go to them with questions if you have no intention of listening. It takes time, courage, planning and continuity”, says David Stout.

Clinicians must front the communications, and use their consulting room skills to explain complex issues in ways that people understand. Alison Wilson, former director of health systems development at NHS Tees, says: “They mustn’t start talking management-speak. There is no doubt that they do change the conversation. People trust them.”

Jan Hull, former director of commissioning development at NHS Somerset, agrees that CCGs must take full advantage of their clinical status: “PCTs were not good enough at getting clinicians involved in communicating with the public; it was usually the managers up on stage facing the barrage of questions. That is a mistake; the public want a doctor explaining to them.”

Jan Hull believes that failing to get communications right at the beginning causes serious problems: “You need a communications plan, do things in the right order and have the right people involved. If that goes off badly, it’s very difficult to get it back.”

Key points for new commissioners

- Communicating with and being visible to their populations are among the most important things CCGs will do. Clinical commissioners and their member practices need to provide that public interface.
- Involving the public in decisions and engagement will improve the quality of commissioning overall.
- If CCGs are to be patient-centred they need an effective patient voice at the heart of their work. This means using patient experiences to test service quality, using patients’ insights to redesign services, and being honest with patients about shortcomings and difficult decisions.

Relations with NHS leadership

Balancing national and local priorities

One of the biggest dilemmas faced by PCTs was balancing their determination to address local priorities with what often felt like overwhelming pressure to concentrate on central government priorities. Some PCT managers reflect on the way, like Kremlinologists, they picked through the wording of the Department of Health's annual operating framework to decide which of the dozens of "priorities" mattered, which could be career limiting if missed, and which could be ignored.

However, PCT leaders acknowledge that national and local priorities are not always inherently conflicting. Reflecting on achieving the right balance, John McIvor, former chief executive of NHS Lincolnshire and chair of the NHS Confederation's PCT Network says: "There have been very few national priorities which were not relevant to local populations... I think some of the differences between local and national priorities are overplayed."

Some of the biggest targets made a profound difference to patients as well as validating the Labour government's claim to be improving the NHS. "Waiting times, MRSA – would we have addressed those things as energetically and forcefully if they had not been part of the performance management system? But because that is what we were performance managed on, lots of other things didn't happen, things that mattered to us locally," argues Robert Creighton.

Perhaps more unhelpful than the long lists of priorities was the Department of Health's tendency to issue lengthy and unwieldy guidance on how they should be achieved. David Stout recalls: "The guidance that came out of the Department was almost uniformly unimplementable because it was a load of froth or thousands of pages with links to more thousands of pages on the internet – what

are you supposed to do with that? If you want guidance, make it implementable, such as practical tools [or] benchmarking data to help CCGs do their job."

Provider vs. commissioner interests

In the early years of PCTs, individuals working both in the SHAs overseeing PCT performance and the Department of Health tended to have far more experience of, and so focused on, the acute sector rather than commissioning. There was a perception that the priority of those at the top was to get NHS trusts through the foundation status process, not to develop the power of commissioners to reform local health economies. David Stout: "The Department was awash with people who were from the provider world, who articulated things in provider terms, who were responsible for holding commissioners to account but did not really understand... how commissioning works."

This focus on provider interests was also seen to have influenced the decisions of SHAs. David Stout again: "PCTs often experienced SHAs as provider focused and it was an impediment to seeing through some of their commissioning strategies. If one of your strategic objectives was moving care closer to home, and doing that destabilises the local trust on its route to foundation status, then you were severely discouraged from doing that. Some major constraints were put in the way of PCTs doing what was required."

Regional relationships to the centre

The amount of freedom or control exerted over PCTs by their SHA varied considerably and was determined by a mix of factors, including the quality of PCT leadership and PCT performance, the need for regional-level brokerage of big

strategic decisions and, to a striking degree, the approach and style of different SHA leaders.

Sheila Childerhouse believes NHS England can learn from the example of SHAs: “Control your local and regional teams because I can see already, talking to colleagues around the country, we are going to have a very different approach in different regions and some of that is exactly the same as SHAs. There is a danger that we will completely turn off some of the emerging CCGs if we behave in the way that some of the SHAs used to behave.”

Under World Class Commissioning, PCTs were working to an ‘earned autonomy’ model in which scrutiny and oversight would gradually reduce as they demonstrated improvement and increasing success. For CCGs, earned autonomy has now, in theory, been replaced by ‘assumed liberty’. In his letter to NHS England’s chair, Professor Malcolm Grant, setting out the government’s priorities, then health secretary Andrew Lansley stressed that the “overarching objective” of the new system is that it “transfers power to local organisations.”

While the sentiment of government is clear, the degree of oversight and intervention will be determined by NHS England. While it has been supporting localist messages, it also has an overriding objective to avoid service failure; the rigour of the CCG authorisation process is a clear message that it will need to intervene where it perceives weaknesses.

Sir Neil McKay stresses the need for CCGs and NHS England to take a pragmatic approach

‘Whatever the formal separation of commissioning responsibilities between the local groups and the commissioning board, in practice they need to be co-commissioners’

to autonomy, in order to reduce and manage the risk of failure: “Philosophically [assumed autonomy is] the difference between ‘Here are your powers, get on with it’ rather than ‘Here are your powers, demonstrate to me that you are able to exercise them before I let go’. Anyone would see that the former strategy is highly risky with newly formed organisations, including many people who’ve never had formal managerial positions before.

“These things are always about personal relationships. Some CCG might wave a copy of the act at the regional director, saying ‘There is assumed autonomy please let me get on with it’, but the sensible CCG and regional director will have a negotiation about how to exercise that authority.”

Nonetheless, Sir Neil believes it is crucial that NHS England sets the right tone on autonomy from the beginning: “It is showing everybody demonstrably that people are prepared to allow CCGs headroom to operate, allow them to take some reasonable risks, and recognise that mistakes are going to be made.”

This means embracing the idea of different services being provided in different places: “If you give CCGs responsibility for planning health services, you have to be prepared to accept there will be differences between them.” Whatever the formal separation of commissioning responsibilities between the local groups and the commissioning board, in practice they need to be co-commissioners.

Johnny Marshall: “If we are going to move to... where you have one commissioner who has responsibility for primary care services and tertiary specialist services and the other who has responsibilities for community, most of mental health and the general hospital services, it creates a sort of sandwich, and unless you get the primary care and specialist care integrated

around the needs of your local population, potentially you are going to have investment and services in the wrong place.”

The new system must be given time to work. Sophia Christie: “In two years’ time, most CCGs will only then have got all their teams

together, finally worked out their strategy, and only just be beginning to secure trust with local partners, because that is founded in personal relationships and that takes time. Those two years will have been completely wasted if the next government then changes it again.”

Key points for new commissioners

- If it is to fulfil its proper role and potential, NHS England will need to retrain its focus on commissioning, and avoid the risk of being ‘captured’ by provider interests.
- NHS England will need to show it is pursuing and enabling local autonomy for CCGs, as set out in the Health and Social Care Act (2012) and the Government’s mandate (2012). NHS England’s local area teams must not replicate the command and control approach often adopted by SHAs.
- CCGs need to recognise the legitimacy of NHS England’s desire to manage risk with new organisations and negotiate with regional directors about how they safeguard local autonomy whilst maintaining assurance around performance.
- CCGs require a central support system which helps them to differentiate between being at risk of failing, competent or high performing. Alongside service quality and financial stability, CCGs that can demonstrate they have strong bonds with their GP membership, health and wellbeing board, provider clinicians and local people will stand the best chance of being given the space to make their own decisions.
- The best guarantors of CCG autonomy will be individual success and mutual support. Collectively, CCGs need to show they can address their problems and develop their skills without constant reference to the centre, supporting each other and exploiting parts of the system such as clinical networks and senates.
- NHS England will increase the risk of CCGs failing in their responsibilities to their local populations if they overload them with centrally imposed objectives and impenetrable guidance. National priorities must support broader objectives to improve health outcomes and those deemed essential for the effective running of the NHS.
- CCGs need a strong collective voice in their negotiations with NHS England to ensure that the oversight of their activities is proportionate and meets the requirement of assumed autonomy.
- Whatever the formal divisions in responsibility for commissioning services between NHS England and CCGs, in practice the two need to work closely together to ensure that all services meet local needs and that there is effective integration between, for example, tertiary and primary services.
- One of the big reputational risks for the new system is accusations of a ‘postcode lottery’ as CCGs pursue different strategies. NHS England must be the public champion of this diversity.
- To give the new commissioning structures a chance of succeeding, they need a period of stability without structural reorganisation.

Conclusion

More than a decade of PCT commissioning has yielded a substantial body of achievements, relationships and experiences on which CCGs can build. There are some important lessons and messages for CCGs and their partners from 13 years of making commissioning work, outlined below.

- The strength of CCGs is that they bring clinical and managerial expertise together into one place. There is significant added value in having clinical commissioners driving commissioning intentions and improved service quality at a local level.
- CCGs are membership organisations; securing the participation of their members is critical to success. General practices need to see themselves as part of the commissioning system, using their experience with patients to drive change.
- Strong governance and transparent decision-making are key to building confidence in CCGs' work and minimising the risk of conflicts of interest.
- Communication and engagement with the public is a core function of all commissioners – as the visible purchaser of health services on their behalf and also as a body that acts on the healthcare needs of its population.
- The best guarantors of CCG autonomy will be individual success and mutual support. Alongside service quality and financial stability, CCGs who can demonstrate they have strong bonds with their GP membership, health and wellbeing board, provider clinicians and local people will have the best chance of being given the space to make their own decisions.
- Collectively, CCGs need to demonstrate they can address their own problems and develop their skills without constant reference to NHS England, supporting each other and collaborating with clinical networks and senates.
- CCGs will be seen as guardians of quality and safety. Commissioners will need to work with providers to ensure effective governance for quality and safety is in place and that robust, timely and transparent performance data is supplied to the CCG.
- Whatever the respective structures, NHS England and CCGs have to share decision-making.
- CCGs need a powerful voice to ensure that the commissioning board listens. This is the only way to ensure the new system really is led by the clinical commissioners.
- An immediate priority for commissioners is to secure high-quality, sustainable outcomes – in particular, reducing the demand on hospital services by stimulating the primary and community care offer and emphasising prevention and early intervention.

PCT leaders know better than anyone the difficult road ahead for clinical commissioners and their local partners. Compared with the professional fulfilment of directly treating patients, the satisfaction of commissioning may prove elusive.

As Helen Buckingham concludes: "You must believe you can make a difference and pursue that arduously and energetically, but not be disappointed that those ambitions don't come easily. Commissioning is more remote, more distant and more strategic, so judging your success is hard, but people who work behind the scenes still make a difference to patients."

NHS Confederation viewpoint

The recent transition to the new commissioning system has been a challenging time for many in the NHS. We believe that the expertise developed during nearly 13 years of PCT commissioning cannot be underestimated in terms of the knowledge and learning it provides to new commissioners. We hope that the information in this report helps to support the retention of organisational knowledge and the transfer of a legacy from PCTs to the new system.

We would like to take this opportunity to thank all of our PCT colleagues for their contribution to the NHS over many years, and for their professionalism and commitment to supporting a safe and well managed transition to the new system. In particular, we would like to thank the individuals who contributed to this report for the candour and constructiveness of their reflections, and for taking the time to share their thoughts during a significant period of upheaval. Their insight should give their successors a baseline from which to work – one which enables them as new commissioners to be aware of the challenges but feel determined to achieve more for the health of their local populations. We wish them well in this endeavour, and look forward to supporting them in it through our involvement in NHS Clinical Commissioners – the new independent membership body for CCGs.

If you have any questions or feedback on this report, we would be keen to hear it. Please contact julie.das@nhsconfed.org

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Ambition, challenge, transition

This report has been produced by the NHS Confederation to mark the end of a significant period of transition for NHS commissioning. It explores the achievements and challenges experienced over more than a decade of commissioning through the voices of those who lived it on the ground.

Through interviews with twenty leading figures, this report captures critical lessons from the past, and translates these into messages that are relevant to new commissioners. It is intended to be a practical and supportive product for colleagues in the new system, with resonance for commissioners in CCGs, local authorities and NHS England.

“This report by the NHS Confederation is essential reading for the leaders of new commissioning bodies.”

Sir David Nicholson, Chief Executive, NHS England

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