DO GOVERNING BODY AND CSU NURSES ON CLINICAL COMMISSIONING GROUPS REALLY LEAD A NURSING AGENDA?

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1 Abstract

Aims

This paper presents findings from a 2015 survey of the Commissioning Nurse Leaders' Network (CNLN) aiming to understand how governing body nurses (GBNs), perceive their influence and leadership on clinical commissioning groups (CCGs)

Methods

An online survey method was used with a census sample of 238 GBNs and nurses working in CSUs, who were members of the CNLN. The response rate was 40.7% (n=97).

Results

While most GBNs felt confident in their leadership role, this was less so for non-executive GBNs and nurses in CSUs were much less positive than GBNs about their influence on CCGs.

Conclusions

Despite GBNs' satisfaction with their impact on CCGs, there is no reliable evidence of this impact. The purpose of such roles to "represent nursing, and ensure the patient voice is heard" (NHSCC 2016:9) may be a flawed aspiration, conflating nursing leadership and patient voice.

Implications for Nursing Management

This is the first study to explicitly explore differences between executive and non-executive GBNs and CSUs. Achieving CCG goals, including developing and embedding nursing leadership roles in CCGs, may be threatened if the contributions of GBNs, and other nurses supporting, CCGS, go unrecognised or if GPs or other CCG executive members dominate decision-making.

KEYWORDS: Clinical commissioning groups, Governing body nurses, nurses in commissioning support units, nurse leadership

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2   Introduction

The Commissioning Nurse Leaders' Network (CNLN) was set up in partnership between NHS England and the RCN to support nurses working in senior commissioning roles. The CNLN has undertaken two online surveys of governing body nurses (GBNs) since 2013 (McCann et al. 2014). Through the survey the CNLN aims to report the experiences of nurses who work in commissioning in a variety of roles including GBNs (executive GBNs and non-executive GBNs) and nurses who work on CSUs. While Clinical Commissioning Groups (CCGs) are relatively new, National Health Service England (NHSE) and other nurse leaders, the Royal College of Nursing (RCN 2012a) and NHS Clinical Commissioning (NHSCC 2016), believe it is important to understand how the GBN role is developing in terms of leading and influencing patient-centred commissioning as envisaged by NHSE (2014) and the RCN (2012a, 2012b), whether this nursing voice influences the commissioning agenda and what kind of support GBNs might need to strengthen patient-centred commissioning. This paper reports the results from the CNLN annual survey which was distributed through the CNLN as in two previous years but amended by researchers at XXXXX University following pilot work in South East England by Allan et al. (2016a; 2016b). The data from the 2015 survey were analysed independently by the XXXX University research team. We focus on the roles of executive and non-executive GBNs and their perceived impact [1] on CCG purpose and outcomes to discuss the implications of these results for patient-centred commissioning.

> **Comment [MO1]:** Name of university removed for purposes of anonymisation

3   Background and literature review

Following the Health & Social Care Act (DH 2012a) in the United Kingdom (UK), and major restructuring of the National Health Service (NHS) in England, the National Health Commissioning Board (since 2013, NHS England) was created as a national commissioning board, devolving responsibility for local commissioning to local CCGs which plan, agree and monitor health and social care services.[2] CCGs took over the design and commissioning of most health services in England on the assumption that commissioning by clinicians would lead to improved decision-making, improved outcomes for patients and more effective use of resources (DH 2011). Indeed CCGs have a legal duty to assure quality across commissioned services in secondary care and, from 2015-16, have additional optional responsibilities including general practice performance management and reviewing GP contracts (Holder et al. 2015).

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[1] 'Impact' is used in the colloquial sense of a significant effect on something (OED 2016)

[2] National Health Service England defines commissioning as 'not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment' (NHS England 2015).

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The Governing Body of each CCG includes a number of statutory roles: a Chair, an accountable officer, a finance officer, two lay members, a clinical member, and a clinical member registered nurse, subsequently known as a GBN. In order to meet the needs of the local population, the commissioning cycle comprises the processes of assessment and planning, implementation and monitoring services, and evaluation (Leach and Burton Shepherd 2014). The RCN successfully argued that nurses could bring unique perspectives and skills to the work of CCGs, and that, to promote excellence in healthcare: "Every CCG must have a nurse on their Governing Body" (RCN 2012a)[3]. Such nurses were expected to have significant experience in leadership and management (RCN, 2012a). Their role as a Governing Body board member is different to nurses reporting to the CCG Governing Body members, such as nurses working in Commissioning Support Units (CSUs)[4], and nurses working in primary care, in GP practices, e.g. practice nurses, who might be well known to clinicians sitting on local CCGs[5]. The commissioning *and* leadership components of the GBN role were highlighted at a very early point in the introduction of these new nursing roles on CCGs. The GBN's role is to bring a nursing perspective or leadership, an understanding of nursing (DH 2011, 3), and to "Promote nursing involvement at every level in the new commissioning structure" (RCN 2012a, 6). However, as with other senior nursing roles (Burdett Trust for Nursing 2006), concerns have been raised about whether senior nurses, including GBNs, can be effective in advancing a nursing perspective; what such a perspective might be; what the demands of the role might be; and what support may be needed. Furthermore, despite the RCN (2012a) advocating strongly that nursing leadership was essential to CCGs in achieving their targets in terms of "Quality, safety, effectiveness and efficiency…successful authorisation and continuing improvement" (2012a, 1), it is unclear what they mean by nurse leadership (Allan et al. in press).

CSUs support CCGs through providing services related to commissioning that enable clinical commissioners to achieve the health goals for their local population. Nurses work in CSUs in various capacities to support the CCG itself rather than the GBN. While many of these nurses might have a nursing background, few of them work as nurses in their CSU capacity (Allan et al. in press).

There has been relatively little research published on GBN roles (Allan et al.2016a; 2016b; Trevithick 2014) although there are a number of opinion pieces (e.g. West 2013; Parr 2012; Olpert 2014).

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[3] The RCN is the main professional organisation in the UK for nurses and health support workers.
[4] CSUs are intended to provide support to CCGs by providing business intelligence, health and clinical procurement services and other back-office administrative functions, including contract management. Nurses working in CSUs often call themselves commissioning nurses.
[5] Practice nurses were widely considered early in 2013 to have been the nurses most likely to be appointed as GBNs. But the requirements for these senior roles mean that they cannot work for the same services the CCG commissions from, i.e. the Governing Body nurse has to have some distance from the service s/he commissions.

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Recently NHS Clinical Commissioning (NHSCC 2016) published findings of a survey of its membership which is based on 41 responses[6], including that:

''There are now two distinct groups of nurses, those who act as the registered independent nurse on the CCG governing body, and executive nurses who are fully imbedded in the daily CCG activity with specific responsibilities. Together both groups can be described as commissioning nurses'' (3:2016).

The NHSCC raise several issues around GBNs' roles and their effectiveness which we explore in this paper, especially whether executive or non-executive GBNs are comparatively more or less "impactful" (9:2016); the effectiveness of nurses who sit on CCGs as lay members and those non-executive part-time. Lastly, the NHSCC point out that the dilemma for executive GBNs is that they wear two hats: that of independent nurse who scrutinises CCG activity and that of CCG executive nurse who is involved in CCG decision-making and activities. They suggest that the executive GBN "recognise that this conflict exists and therefore take steps to ensure they can wear both 'hats' effectively" (NHSCC 9:2016).

Much of this (albeit thin) literature is uncritical of CCGs and commissioning as such and approaches CCGs and the GBN roles as opportunities to assert nursing leadership for patient benefit. In a literature review, Allan et al. (2016b; Allan et al. in review) argue that that nurses are involved uncritically in new public management; that GBNs in contrast to GPs, lack authority, although both medicine and nursing claim to advocate patient-centred commissioning. The NHSCC are quite clear on this point "They [GBNs] provide a unique patient viewpoint while also bringing strategic clinical and practical insight into board-level decision-making about how services can work better together for the benefit of their local people" (9:2016a). We argue in this paper that nursing (and perhaps medicine) wrongly conflate their professional voice with that of patients'..

4 Methods

An online survey method was used. The questionnaire was developed in collaboration with NHSE to reflect literature review findings (Allan et al. 2016b), ethnographic work with two CCGs in the London area (Allan et al. in review) and a pilot study (Allan et al.2016a).

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[6] The NHSCC (2016) states that ''The NHSCC Nurses Forum is the independent voice for the commissioning nurse, those that sit on CCG governing bodies. The purpose of the Nurses Forum can broadly be divided into three areas; supporting members and sharing best practice, strategic influencing, and strategic leadership''. The report does not mention the total number of members, the sample size or what sampling strategy was used which makes it hard to judge the validity of the findings.

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4.1 Sample / data collection

All cases in the sampling frame supplied by NHSE (n=238, all CNLN members) were invited to participate and a response rate of 40.7% was achieved. Data collection was carried out in July 2015 by the xxxxx research team (previous waves had been carried out by NHSE).

4.2 Analysis

The quantitative data were analysed in SPSS v.20. Descriptive statistics were examined for all questions and those which were considered most relevant to the focus of this paper (concerning influencing and leadership on CCGs) were cross tabulated on the basis of GBNs in executive and non-executive roles and these were also compared with results for CSU respondents where possible (CSU respondents were given a much shorter questionnaire than those in CCGs). Non-parametric inferential statistics (Mann Whitney and Chi square tests) were used to test whether differences on the basis of role were statistically significant. The open-ended survey responses were analysed and reported in depth elsewhere (Allan and O'Driscoll 2016).

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5 Findings

An overview of the main findings from the survey is presented below.

5.1 Respondent characteristics

5.1.1 Gender, ethnicity and age

89.3% of respondents are female and 10.7% are male.

59.2% of respondents described themselves as White British and a further 36.8% described themselves as 'White', making a total of 96% White British or White. Two respondents (2.6%) were White Irish and one respondent (1.3%) was Black African.

More than half of respondents (55.3%) were aged 50-59 and a further 3.9% were aged 60-65.

Fig 1:   Age of respondents (n=76)

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5.1.2 Respondents' employers

The vast majority of respondents (92.8%) were employed by a CCG; 7.2% of respondents were employed by a CSU.

5.1.3 Working patterns

A majority of GBNs (60%) worked as full-time statutory and executive nurses (i.e. they combined these two roles) and a further 5% worked in part-time executive roles.

Fig 2:   Respondents by job / role (n=83)

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5.1.3.1 Hours worked per week in CCG role

79.7% of respondents said that they worked 37.5 hours a week or more in their CCG role. The remaining 20% of respondents were fairly evenly distributed across the remaining categories, although no respondents said that they worked 25 to 28 hours a week. This suggests that most respondents to the survey were in full-time posts in their CCG or CSU role.

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5   Table 1: Hours per week spent in CCG role (n=74)
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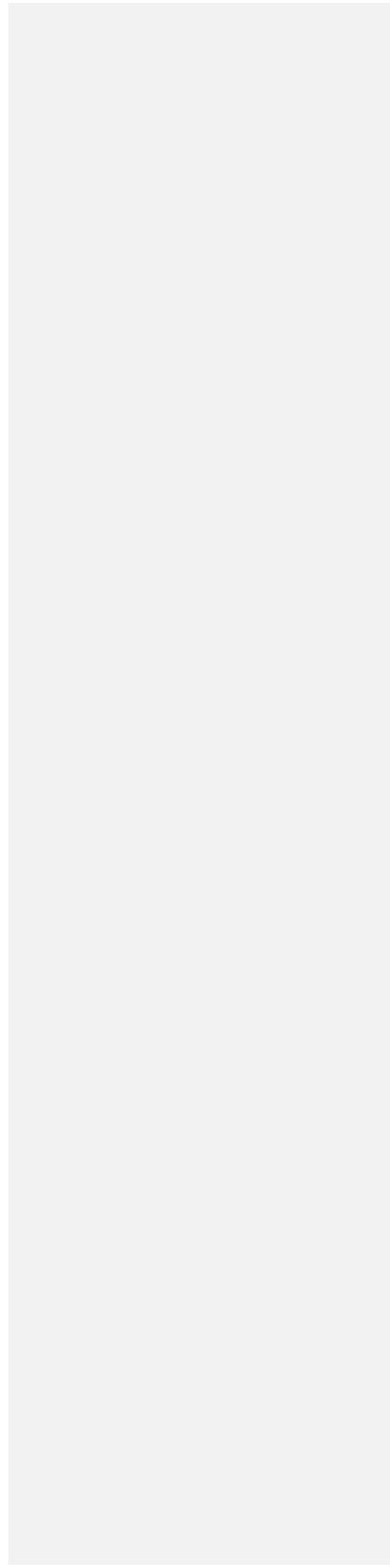
5.1.4   How long have you worked as a nurse on a CCG or CSU?

More than three-quarters of respondents had worked as a nurse in a CCG or CSU for more than two years; a further 9.1% had been in post for between 19 and 24 months and 5.2% had been in post for 13 to 18 months. Just 7.8% of respondents had been in post for less than a year.

Fig 3: Length of service as a nurse on a CCG or CSU (n=77)

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5.2   Comparing executive and non-executive nurses on CCGs

Although there is complexity and ambiguity around nursing roles in CCGs, and considerable variability across CCGs, and although structures are new and evolving (even more so at the time of our data collection), the findings suggested two very distinct roles within CCGs, which can be termed 'executive' and 'non-executive'. The former is usually a full time member of staff at the CCG and may typically be the Director of Nursing. The latter is typically a board member, fulfilling the statutory nurse's role on the board, and may attend the CCG only for particular meetings. This is consistent with the findings of NHSCC (2016) as referred to earlier.

The question on role (as shown in 5.1.3, above) captured four categories. These were recoded into two categories so that part-time statutory GBN and full-time statutory GBN were merged into a category termed 'non-executive'. The categories of 'part-time executive' and 'FT statutory and executive' were merged into a category called 'executive'. Analysing responses on this basis, using descriptive and inferential statistics, shows some interesting and significant differences between the two groups, as described below.

5.2.1   Types of previous experience and number of years worked in CCG

As this particular query involved a multiple choice question inferential statistics were not used. With that caveat, the findings suggest that executive GBNs are more experienced, with the exception of 'third sector 'experience. Those in executive roles were more likely to have had acute experience (92.6% compared to 71.4% of non-executives), secondary experience (74.1% compared to 50% of non-executives) and tertiary experience. Executive GBN were far more likely to have had previous NHS Board experience than non-executives (59.3% compared to 46.4%) but the two groups showed similar results in terms of previous board experience more generally.

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Fig 4:   Previous experience of GBNs (executive and non-executive). N=82.

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It was not surprising that the vast majority (88.6%) of those in executive roles worked 37.5 hours a week or more since this is normally a full-time role but it was unexpected that around two-thirds of those in non-executive roles were also working full-time, given that this role is understood as being centred around attending particular board meetings rather than being a permanent presence in a CCG. This finding may partly be explained by the fact that six of the 23 non-executives (26%) who answered this question were working for either two or three CCGs (as were 15% of those in executive roles).

Those in executive roles tended to have been working longer on a CCG, although a proportion of those in executive roles (12.2%) were relatively new to CCGs (less than a year) while none of the non-executives had worked for a CCG for less than a year.

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Fig 5:   Length of experience in CCG role (executive and non-executive GBNS) n=71

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In summary, it would appear that executive GBNs have a wider range of previous experience (perhaps most notably in relation to acute care and NHS Board experience) have served longer on a CCG and work longer hours. This is important, as full-time executive GBNs may well build on their greater experience to develop a stronger role in CCGs.

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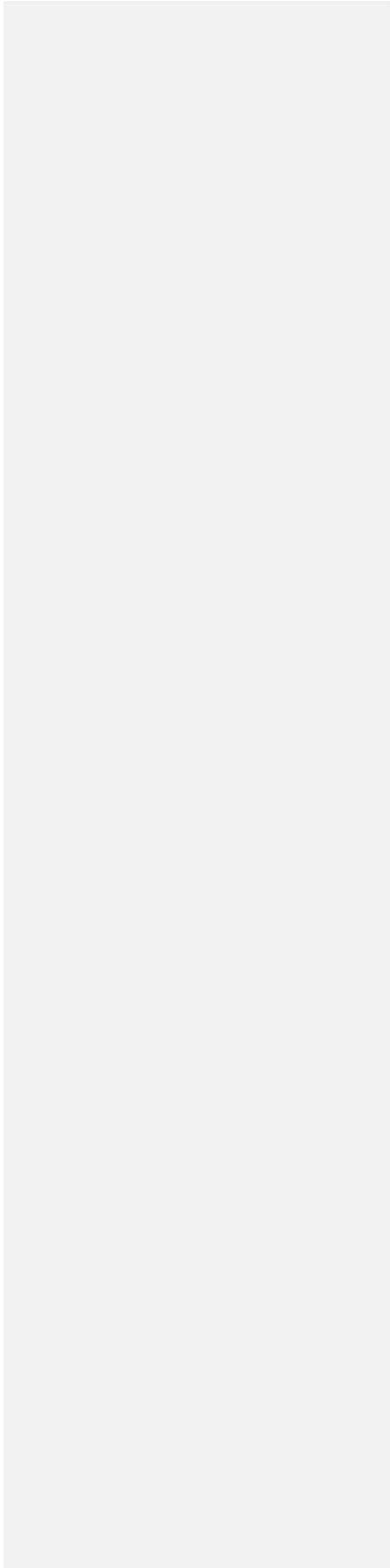
5.2.2   GBNs' views of the perceived goals (purpose) of CCGs,

Improving the population's heath was considered to be the most important goal of their CCG by a significant majority of all respondents (61.6%); 19.2% felt commissioning was the most important goal of CCG work and 9.6% of respondents believed service redesign and meeting financial targets were the most important goals of their CCG. The most striking aspect of these findings is perhaps that less than 20% of GBNs considered the commissioning process (which is the supposed purpose of CCGs) as the top priority.

Fig 6: Top CCG goal - executive and non-executive GBNs (n=73)

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5.2.3   Reasons for wanting to be a nurse on a CCG

The reasons why respondents wanted to be nurses on a CCG provide useful context in understanding the aspects of the CCG which they prioritise. This was an open-ended question (respondents write in their response in their own words) and the following are typical responses:

- o   "To have an impact on population health"
- o   "Influence commissioning of services"
- o   "Bringing clinical input to decisions"
- o   "Ensure nursing is part of commissioning decisions"
- o   "Be the voice of the patient, voice of the staff"
- o   "To bring a non-medical perspective. To lead on patient experience. To bring a focus on quality"

Overall it was clear that two of the most frequent motivations for being on a CCG related to wanting to represent the patient voice or to represent a clinical or nursing voice. This perhaps suggests a lack of critical awareness about the extent to which nurses could or should attempt to represent the patient voice as well as their own.

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5.2.4   GBNs' perceptions of leadership, influence and overall impact on CCGs.

It is relevant to assess the extent to which nurses involved in the commissioning process felt able to influence or lead, which is supposedly a key aspect of the nursing role in CCGs. Executive GBNs were significantly more likely than non-executive GBNs to say that they were influential in CCG decision making, that they led the professional nursing agenda in the CCG's locality and that they felt confident in carrying out a leadership role as a CCG nurse.

All executive GBNs considered that they had an executive role as did nearly all non-executive GBNs (87%) but the difference was statistically significant (X2 6.669; *df*=1, *p*<.05). In fact, there were statistically significant mean differences on nine of 11 scale items relating to influence and leadership between executive and non-executive GBNs. On all 11 items the mean score for executive GBNs was higher than non-executive GBNs although both groups scored relatively highly on these Likert scale items (which ran from one at the negative end to five at the positive end). The two items which showed no significant differences on the basis of executive / non-executive role related to respect from other senior nurses and support from NHSE.

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Table 2: Comparing executive and non-executive GBNs on leadership and influencing. Statistically significant items (Mann Whitney test) are asterisked.

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These results strongly suggest that while both executive and non-executive GBNs nurses feel that they are able to lead, influence and have an 'impact' on CCGs, executive GBNs are significantly more likely to feel this.

5.2.5 Differences in perceived overall impact on CCG by executive / non-executive role and comparing CCG and CSU/ tensions between CCG and CSU

As Fig 7 (below) shows, there are important differences between nursing roles within CCGs. Non-executive GBNs are positive regarding their overall impact on CCGs (78.6 % were fairly satisfied or extremely satisfied) but their satisfaction is significantly less than that of executive GBNs (86.7%). CSU nurses have the lowest satisfaction with their impact on CCGs (42.9%) but based on a very small n (n=7) [7].

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[7] CSUs were asked '' How satisfied or dissatisfied are you with the impact your role in the CSU has on the CCG?'' CCG (executive and non-executive) were asked ''Overall, how satisfied or dissatisfied are you with the impact you have on the work of the CCG?''

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Fig 7:   Satisfaction with overall impact on CCG, by job / role and location (CCG or CSU)

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Difference between roles within CCGs are striking, but differences between GBNs inside CCGs and those in roles supporting commissioning outside CCGs (in CSUs) were even greater. More than half of nurses in CSUs (57.2%) were fairly or extremely dissatisfied with the impact of their work on CCGs and just 42.9% were fairly satisfied (compared to 84% of all CCG nurses). Comments in open-ended questions suggested that nurses in CSUs do not feel respected or valued by CCGs, and that there are some tensions between these bodies.

"CCGs do not appear to value the wealth of knowledge and skills that each CSU has in terms of nursing experience and do not trust the recommendations based on that knowledge" 4059966353 (CSU nurse).

"The relationship between the CSUs and CCGs is not fully matured" 4053077258 (CSU nurse).

 "My role - i.e. supporting CCGs limits my ability to influence patient and population outcomes. Most CCG nurses are less experienced and seen as junior within CCGs and the operational side of CCG responsibilities often overrides the clinical outcome responsibilities. CCGs often see us as back office rather than expert advisors and frequently fail to follow advice of CSUs". 4024118696 (CSU nurse).

5.2.6   Support needed to fulfil CCG role

Responses to this open-ended question gave a number of suggestions for support including:

- o Mentorship, both internally to the CCG and externally; including mentorship with or from other senior nurses in the CCG locality.
- o Coaching
- o Peer support from within the commissioning network and from the NHS England regional and sub-regional groups.
- o Support from NHS England including their Leadership Academy
- o Networking
- o Good administrative [Personal Assistant] support

When asked which organisations this support should come from, responses included:

- o Professional organisations i.e. The Royal College of Nursing
- o NHS England and the Chief Nursing Officer for England
- o Health Education England
- o The respondent's own CCG

There did not appear to be any patterns of differences in the responses of executive and non-executive nurses.

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6 Discussion

These are positive, albeit self-reported, findings regarding the nursing role in CCGs. Confidence in influencing and leadership of CCGs is high amongst all GBNs although significantly more so amongst executive GBNs. CSU nurses, while a very small sample, seem the least positive of all nurses involved in commissioning, regarding their impact on CCGs.

The survey results illuminate the GBN role within CCGs and that of nurses working in CSUs through the perceptions of those working in these new roles. The results suggest that GBNs are a body of highly experienced and qualified nurses, apparently fully engaged with the challenges and opportunities of the nursing role within the newly formed CCGs.

However, some reservations about how the nursing role within CCGs is developing are justified. Firstly, our research found, as did NHSCC (2016), that it was difficult to determine precisely what nursing roles were in place in each CCG. Secondly, it has been asserted that a key advantage of the CCG 'model' over other forms of commissioning is that it places the clinician at the forefront of commissioning decisions but there is very little evidence for this claim which Allan et al. (2016b) argue conflates clinician and patient voices. Unfortunately the result of this conflation is that nursing (including GBNs themselves and nursing leaders in NHSE) may sometimes appear to uncritically accept CCGs and the unchecked growth of new public management. GBNs and senior nurses within CSUs are motivated to ensure a nursing dimension in CCG decision- making and to advocate for patient interests. Respondents may well be correct about the influence or impact which they have in relation to CCGs but obviously we cannot tell from survey research alone whether nurses' perceptions of their influence or impact on CCGs, or ultimately, on the nature and standard of care commissioned by the CCG, is justified. That is partly because a survey methodology (which is restricted to nurses in CCGs/CSUs) is not suited to such a research question, but also because of the relative immaturity of CCGs, and the roles within them.. Oates et al. (2014:59) acknowledge that CCGs are still at a formative stage, and it is unclear what leverage they may eventually have in ensuring that commissioned services are delivered, as contractually agreed, but they highlight the importance of the nursing role in developing the effectiveness of CCGs:

''Nurse input is vital to the success of any healthcare commissioning approach, given that nursing incorporates such a diverse workforce with a breadth of experience and expertise. Nursing is the largest profession in health care, with a membership well versed in multiprofessional and integrated working. Nurses also traditionally championed the patient voice and patient experience. Therefore, there is scope for collaboration and consensus between nurses in CCGs and public members within patient forums, representative groups and governing bodies''.

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Although there were only a small number CSU respondents (n=7), it seemed that, in contrast with GBNs, the majority were dissatisfied with the impact that they had on CCGs and seemed to feel undervalued or marginalised. Clearly the reasons underlying this must be understood and addressed.

Thirdly, although both executive and non-executive GBNs on CCGs are largely positive about most aspects of their roles, there were significantly less positive attitudes from non-executive GBNs. This may mean that non-executive GBNs find it much harder to influence or lead the commissioning process. Some open-ended findings suggested that, in certain CCGs, 'clinician' tends to refer to GPs or other AHPs, rather than nurses, and that this is a challenge for GBNS and nurses in CSUs. This may indicate that CCGs which do not have an executive GBN are more likely to be dominated by a GP culture which may hinder patient-centred commissioning.

It is unclear from our data whether an executive GBN is more likely to achieve patient-centred commissioning or indeed what such commissioning might look like because of the conflation of nursing voice/leadership and patient need in the NHSE survey and among GBNs' narratives (Allan 2016a, in review). Allan et al. (in review) found that CCGs' agendas are contested by patients, nurses, GPs and finance officers; with very little clarity regarding how a patient-centred commissioning might emerge from the introduction of CCGs.

7   Implications for Nurse Managers

Achieving the goals of CCGs, including developing and embedding a nursing leadership role in the new commissioning structures, i.e. CCGs, may be threatened if the contributions of GBNs and other nurses working for, or supporting, CCGS, go unrecognised or are under-utilised, or if GPs or other CCG executive members dominate decision making.

The implications of these results for both GBNs and nurse managers are intertwined and raise questions more generally for the profession and its aspirations to leadership at commissioning level: how can nurse managers working in local NHS trusts develop good working relationships with GBNs and executive nurses on CCGs to effectively push forward a nursing agenda in commissioning to promote and advance person-centred services? How can GBNs effectively work with local nurse managers to develop a nursing vision in commissioning? How can GBNs and executive nurses in commissioning work with practice nurses to build local knowledge and skills harnessed to shape local commissioning and service delivery? Can local service delivery be shaped across acute and community nursing services through effective nurse-led commissioning?

Statistically significant differences between executive and non-executive GBNs emerged across a range of questions dealing with leadership, influence, overall contribution and impact. This raises

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questions about whether the nursing perspective merely influences (as opposed to leading) the commissioning process in CCGs without nurses in executive roles and whether non-executive roles might need extra support:

As one respondent said:

"Yes it's a practically impossible task on 2.5 days per month. The nursing workforce are as many in number as GPs – it should be fairly represented. The CCG nurse is expected to be involved in all aspects of nursing leadership which is far more than the initial expectation." (CCG nurse, non-executive role ID 4051497494

The findings regarding the demographic profile of respondents are in line with those of Mc Cann et al. (2014:17) who argue for careful succession planning so that future nurse leaders are more representative of the nursing workforce and the range of populations served by CCGs.

8   Limitations

The sampling frame supplied by NHSE had contact details for 238 CNLN members, 14 of whom were indicated as 'CSU'. Although 100% (n=238) of the CNLN were sampled, achieving a relatively high response rate (40.7%, n=97), non-response bias may have operated. Furthermore, the proportion of the population of GBNs or nurses in CSUs which was represented in the CNLN sample was unknown.

Two questions (one for GBNs and one for CSU nurses) asked about overall satisfaction with impact in CCGs. We used 'impact', colloquially meaning 'having a significant effect on something' (OED 2016) but in evaluation terms impact usually refers to a long term embedded change (which in the case of a new organisations such as CCGs might not be a meaningful concept). This ambiguity may have made the question unreliable (interpreted in an inconsistent way across respondents).

9   Ethical approval

Ethical approval was obtained from the Middlesex University school of health and education ethics sub-committee.

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References

Allan, H. and O'Driscoll, M. (2016) Survey of the Commissioning Nurse Leaders' Network Membership 2015: Summary of Results Centre for the Critical Research in Nursing & Midwifery School of Health and Education. Middlesex University.

Allan H, O'Driscoll M, Savage J, Lee G, and Dixon R. (2016a) Nurses' experiences of clinical commissioning group boards. Nurs Stand. 2016 Jun 15;30 (42):46-55. doi: 10.7748/ns.2016.e9633.

Allan H, Dixon R. Lee, G., O'Driscoll M, Savage J. and Tapson, C. (2016b) Are senior nurses on Clinical Commissioning Groups in England inadvertently supporting the devaluation of their profession?: A critical integrative review of the literature. Nursing Inquiry Volume 23, Issue 2, pages 178–187, June 2016

Allan H T, Tapson C, Dixon R, Savage J, Lee G (in review) Governing Body Nurses' experiences of commissioning in England: an observational study of two clinical commissioning groups. Journal of Clinical Nursing.

Burdett Trust for Nursing. 2006. Who Cares wins. Leadership and the business of caring. http://www.nursingleadership.org.uk/pubs/5719_burdett_trust_who_cares_wins_031006.pdf (accessed 30.12.16).

Department of Health. (2011). *Government response to the NHS Future Forum Report*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/216361/dh_127719.pdf (accessed 30.12.16).

DH (2012) Health and Social Care Act
http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (accessed 30.12.16).

Holder, H., R. Robertson., S. Ross., L. Bennet., J. Gosling. and N. Curry. (2015). *Risk or Reward: The changing role of CCGs in general practice. Research Report*. London: The Kings Fund and Nuffield Trust.

Leach, K. and Burton Shepherd, A. (2013). The role of nurses in commissioning services within primary care. British Journal of Community Nursing 18(4): 187-92

Marsh, T. (2016) The Role of the Nurses on the CCG Governing Body. NHSSS
http://445oon4dhpii7gjvs2jih81q.wpengine.netdna-cdn.com/wp-content/uploads/2016/05/Final-Role-of-the-nurse.pdf (accessed 30.12.16)

McCann S., Olphert, A.M. and Minogue, V. (2014) Role of the CCG nurse in commissioning services. Nursing Times 110: 48, 15-17.

National Health Service England (2014) 6Cs live communication hub. Transforming Nursing for Community and Primary Care <http://www.tinyurl.com/communicationHubTransform> . Available at:http://www.6cs.england.nhs.uk/pg/groups/129853/ (accessed 30.12.16)

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National Health Service England (2015) Health and high quality care for all, now and for future generations https://www.england.nhs.uk/commissioning/ (accessed 30.12.16).

NHSSC (2016) The role of the nurse on the CCG governing body http://445oon4dhpii7gjvs2jih81q.wpengine.netdna-cdn.com/wp-content/uploads/2016/05/Final-Role-of-the-nurse.pdf (accessed 30.12.16)

Oates J, Jerram S. and Wilson I. (2014), 'Clinical commissioning: the nurse's role', Nursing Standard, 29, 6, 52-59.

Olphert A-M. (2014) Nurses' role in clinical commissioning, British Journal of Nursing, 23, 8, 409-410

Oxford English Dictionary (2016) https://en.oxforddictionaries.com/definition/impact (accessed 30.12.16)

Parr C (2012) Nurses left in the dark http://www.independentnurse.co.uk/news/nurses-left-in-the-dark-by-local-clinical-commissioning-groups/74338 (accessed 30.12.16)

Royal College of Nursing (RCN) (2012a) Clinical Commissioning Groups – the statutory nurse role on the governing body

http://www.rcn.org.uk/__data/assets/pdf_file/0008/465956/19.12_Authorisation_process_FINAL.pdf (accessed 30.12.16)

Royal College of Nursing (2012b) Nurse membership on clinical commissioning group governing bodies. Royal College of Nursing http://www.rcn.org.uk/__data/assets/pdf_file/0007/467611/ccgs_2.pdf (accessed 30.12.16)

Trevithick C. (2014) A research study to analyse the perceived leadership development needs of Board nurses in Clinical Commissioning Groups in light of the Health and Social Care Act 2012, in order to develop the Board nurse role. MA Thesis De Montfort University.

West, D. (2013) Nurses having limited impact on new CCG boards. NursingTimes.Net. http://tinyurl.com/ n8ffulc (accessed 30.12.16)

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Fig 1: Age of respondents (n=76)

Age of respondents (n=76)

- 30-39: 6.60%
- 40-49: 34.20%
- 50-59: 55.30%
- 60-65: 3.90%

Fig 2: Respondents by job / role (n=83)

Role / title of nurses in CCGs (n=83)

- part-time statutory nurse / GBN: 14.50%
- part-time nurse in executive role: 4.80%
- full-time statutory nurse / GBN, non-executive nurse: 20.50%
- full-time statutory and executive nurse: 60.20%
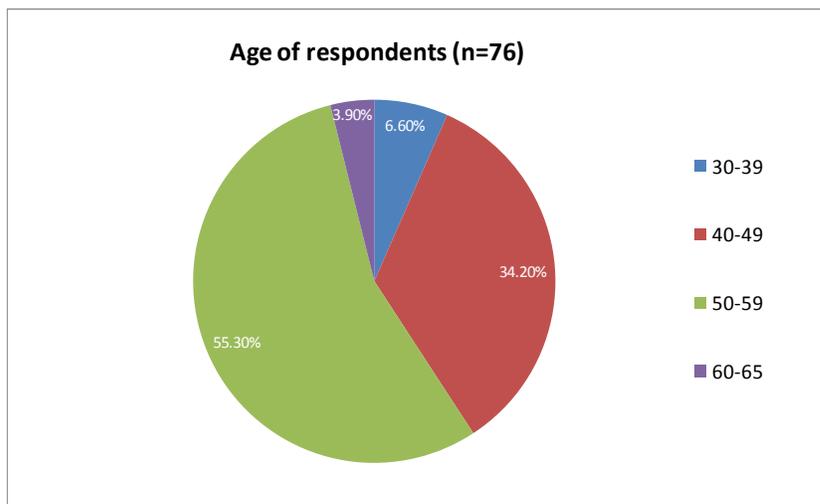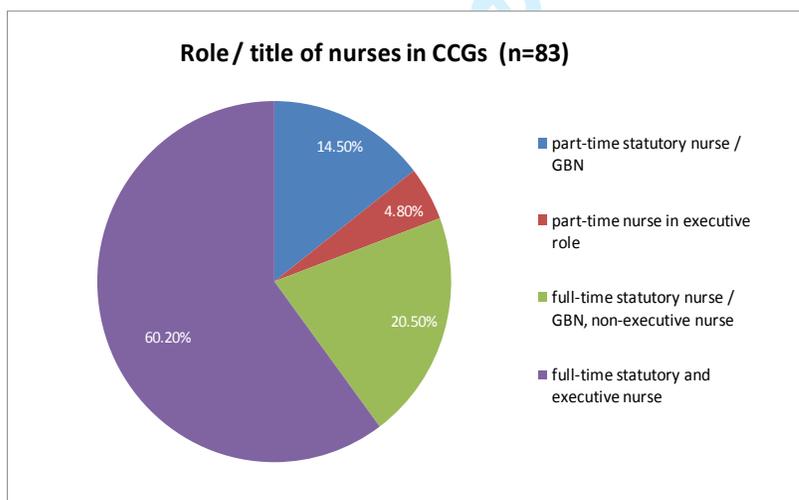
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Table 1: Hours per week spent in CCG role (n=74)

Hours per week spent in CCG role	Frequency	Percent
Fewer than 5 hours a week	1	1.4
5 to 8 hours a week	4	5.4
9 to 12 hours a week	3	4.1
13 to 16 hours a week	1	1.4
17 to 20 hours a week	1	1.4
21 to 24 hours a week	1	1.4
29 to 32 hours a week	2	2.7
33 to 37 hours a week	2	2.7
37.5 hours a week or more	59	79.7
Total	74	100

Fig 3: Length of service as a nurse on a CCG or CSU (n=77)

How long have you worked as a nurse on a CCG or CSU? (n=77)

- 6 -12 months — 7.80%
- 13-18 months — 5.20%
- 19-24 months — 9.10%
- more than 24 months — 77.90%

Fig 4:   Previous experience of GBNs (executive and non-executive). N=82.

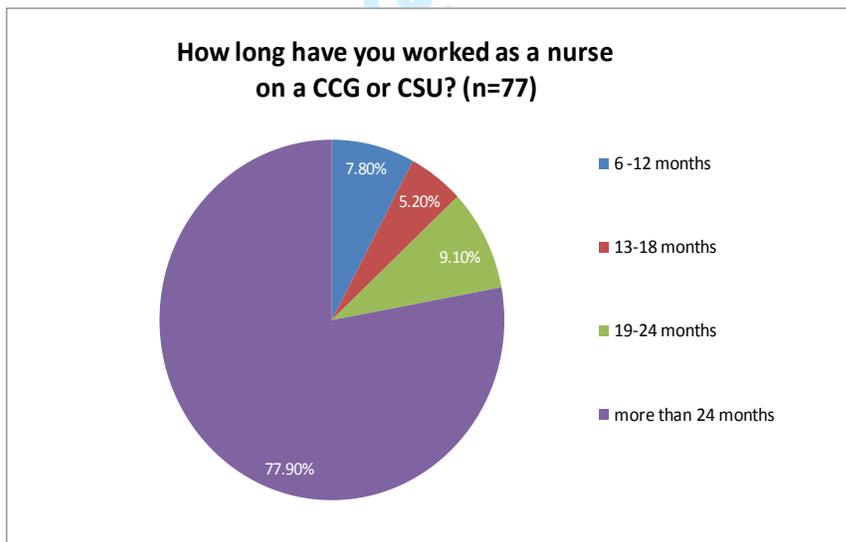**Previous experience of GBNs
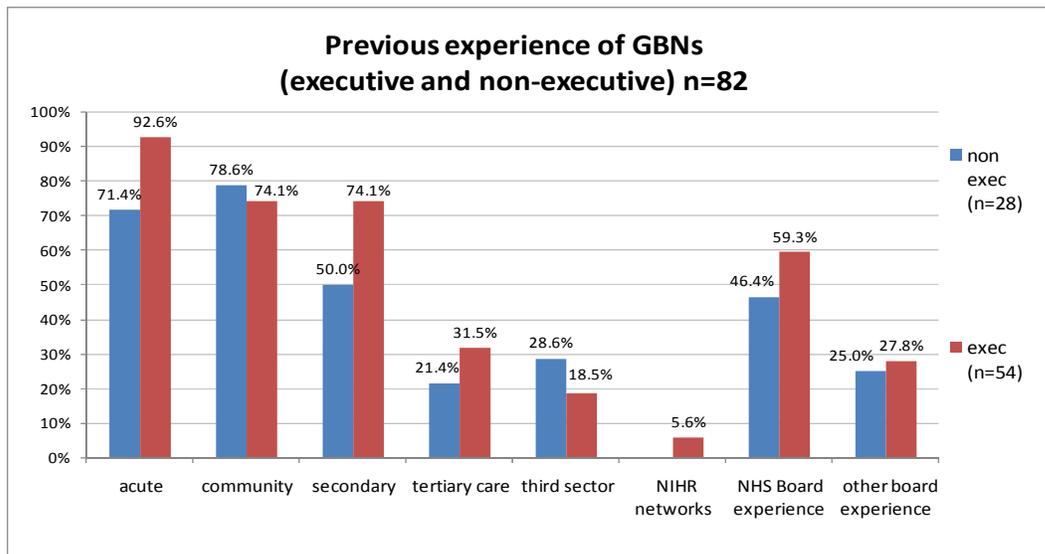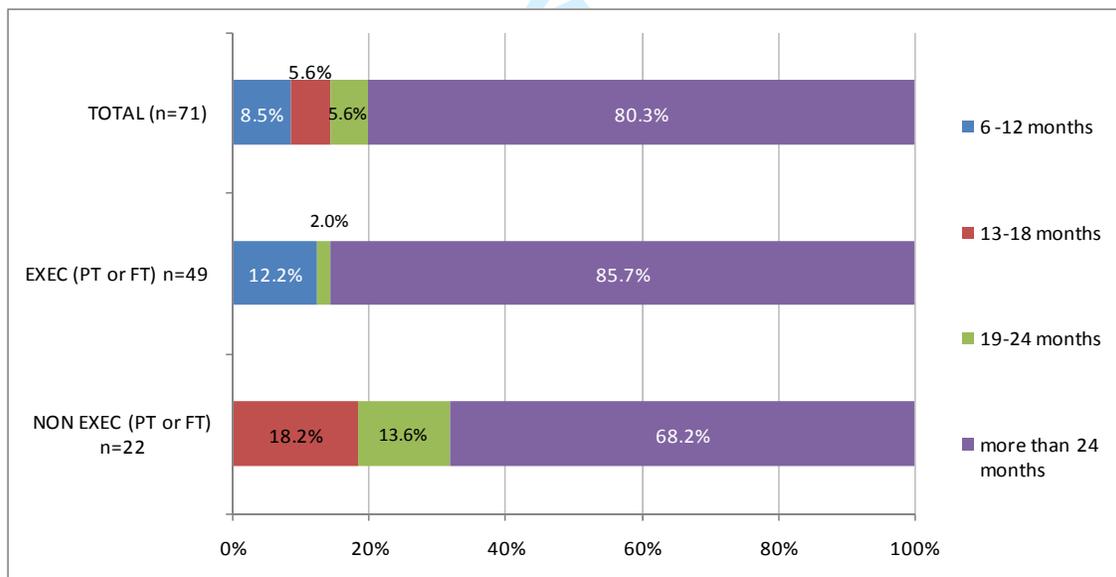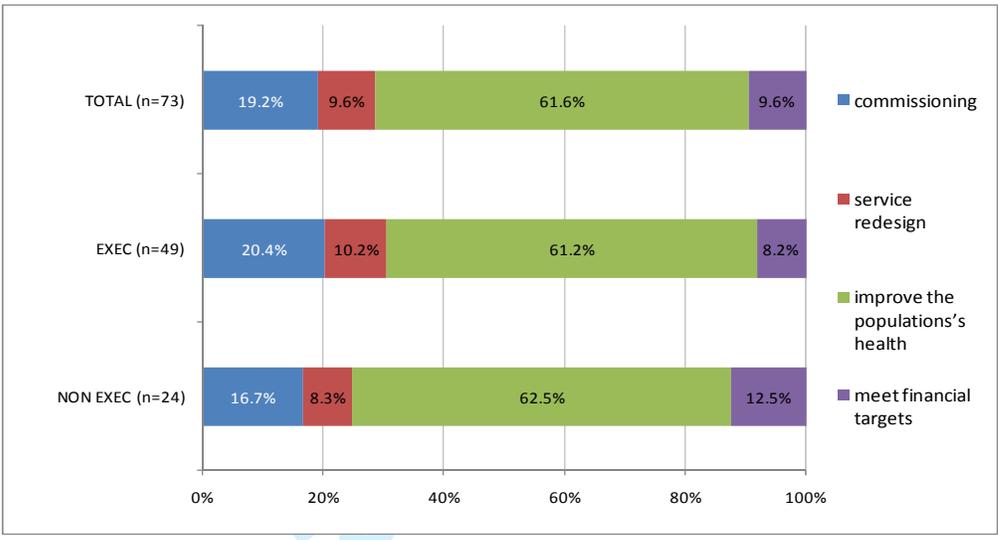(executive and non-executive) n=82**

Fig 5:   Length of experience in CCG role (executive and non-executive GBNS) n=71

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Fig 6: Top CCG goal - executive and non-executive GBNs (n=73)

Table 2: Comparing executive and non-executive GBNs on leadership and influencing. Statistically significant items (Mann Whitney test) are asterisked.

Theme' of question	question text	Mean EXECUTIVE GBN	Mean NON EXECUTIVE GBN	mean difference	Total	N	p value (Mann Whitney test)
influence	* To what extent, if any, do you feel that you are influential in CCG decision making?	4.50	3.74	-0.76	4.24	67	p=.002
influence	To what extent, if any, do you feel that you are influential in executive board decision making?	4.37	4.00	-0.37	4.31	55	p=.301
Leading	* I lead the professional nursing agenda in the CCG's locality	4.33	3.04	-1.29	3.92	72	p=.000
Leading	* How confident or unconfident do you feel in carrying out a leadership role as a CCG nurse?	4.49	4.00	-0.49	4.35	68	p=.024
senior collaboration . Networking	* I work closely with senior nurses in local provider trusts	4.63	3.74	-0.89	4.35	72	p=.000
senior collaboration . Networking	* I work closely with practice nurses in the locality	3.57	2.91	-0.66	3.36	72	p =.033
senior collaboration . Networking	* I have regular meetings with local Directors of Nursing	4.49	3.87	-0.62	4.29	72	p =.003
feel respected	CCG nurses are respected by other senior nurses (e.g. providers)	3.65	3.26	-0.39	3.53	72	p =0.138
feel supported	NHS England provides effective support for me in the CCG	3.45	3.17	-0.28	3.36	72	p =0.18
overall contribution	* Overall, how satisfied or dissatisfied are you with the contribution you make to the work of the CCG?	4.49	3.96	-0.53	4.32	73	p =.029

Fig 7: Satisfaction with overall impact on CCG, by job / role and location (CCG or CSU)

Satisfaction with overall impact on CCG - by role / job