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EIGHT

Clinically led commissioning: past, present and future?

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Introduction

One of the key elements of the Health and Social Care Act 2012 (HSCA 2012) was the transfer of responsibility for commissioning healthcare services from managerially led Primary Care Trusts (PCTs) to newly established Clinical Commissioning Groups (CCGs), led by General Practitioners (family doctors or primary care physicians, generally known as GPs). The 2010 White paper, 'Equity and Excellence' argued that:

Commissioning by GP consortia [now known as CCGs] will mean that the redesign of patient pathways and local services is always clinically led and based on more effective dialogue and partnership with hospital specialists. It will bring together responsibility for clinical decisions and for the financial consequences of these decisions (Department of Health, 2010, paragraph 4.4).

The document goes on to acknowledge that this approach is not wholly new, arguing that, 'commissioning never became a real transfer of responsibility. So we will learn from the past, and offer a clear way forward for GP consortia' (Department of Health, 2010, paragraph 4.5).

In this chapter we examine that history, and explore what can be learnt from previous attempts to involve GPs in commissioning care. We will then apply that learning to the provisions of the HSCA 2012, highlighting the correspondences and discontinuities between what we know from history and what was proposed. We will then go on to present evidence from our research on CCGs, exploring what happened in practice when CCGs were established. Finally, we will

1 discuss the continuing evolution of health policy in the UK in the
2 light of both historical evidence and our current findings. Throughout
3 this chapter, the focus is upon GP involvement in commissioning,
4 rather than the wider concern of clinician involvement. This is because
5 the explicit goal of the HSCA 2012 was to bring GPs back into the
6 forefront of commissioning.

8 **Clinically led commissioning: a brief history**

9
10 This and the subsequent section draw on a comprehensive literature
11 review carried out between 2011 and 2014 (Miller et al, 2012; Miller
12 et al, 2015), where all the relevant references can be found. Clinical
13 involvement in the commissioning of healthcare services started with
14 the introduction of the quasi-market into the NHS in 1991. The
15 function of *purchasing* services was separated out from their *provision*,
16 with Health Authorities established as purchasing bodies, responsible
17 for assessing population needs and purchasing care from semi-
18 autonomous NHS Trusts. Needs assessment within Health Authorities
19 was led by public health professionals, with managers responsible for
20 agreeing and monitoring contracts (Flynn and Williams 1997). At
21 the same time, GP practices were invited to take on budgets for some
22 aspects of services, notably elective (planned) care and prescribing. This
23 was known as GP ‘fundholding’ (GPFH), and over the next five years
24 approximately 50% of GP practices took on GPFH. From 1991–2010,
25 GP involvement in what came to be called ‘commissioning’ waxed
26 and waned, with successive reorganisations increasing, diminishing and
27 reintroducing GP involvement as governments wrestled with problems
28 of efficiency, effectiveness and engagement.

29 **Table 8.1** summarises the characteristics of the various GP-led
30 commissioning initiatives.

31 Thus, the nature of GP involvement in commissioning has varied
32 over time. In particular, the extent of GP involvement has oscillated
33 between leadership (fundholding, Total Purchasing Pilots (TPPs),
34 Primary Care Groups (PCGs), CCGs) and a more advisory role
35 (Locality Commissioning, Primary Care Trusts (PCTs), Practice-
36 based Commissioning (PBC)). Each iteration of policy was intended
37 to remedy the problems of what went before. Throughout this
38 period, however, the ‘programme theories’ underpinning clinical
39 commissioning schemes remained the same: first, that engaged GPs
40 would be more likely to be efficient and effective purchasers of services
41 for this patients as they would have greater knowledge of patient
42 needs; and second that incentivised GPs would be more likely to act

Table 8.1: History of GP-led Commissioning in England

Date	Innovation	Scope of scheme
1991–1995	Introduction of purchaser-provider split	Provision of care split from purchasing, with Health Authorities established as purchasers of care for geographical populations
	GP Fundholding (GPFH)	Volunteer GP practices provided with budgets to purchase care for their registered populations. Budgets covered elective care and prescribing
	Locality commissioning and GP commissioning	A variety of locally developed models of GP involvement, with varying degrees of power and responsibility
1995	Total purchasing pilots (TPP)	An extension of GP fundholding. Volunteer groups held a budget covering a range of services which was agreed with local Health Authority
1997	New Labour government elected – GPFH abolished, Primary Care Groups (PCGs) established	PCGs officially sub-committees of Health Authorities. Responsible for commissioning full range of services. GP majority on Board
2000	PCGs became Primary Care Trusts (PCTs)	Health Authorities abolished, PCTs given responsibility for commissioning full range of services and providing community services. GPs no longer in a majority, few GPs involved
2005	Practice-based Commissioning (PBC) introduced	Volunteer groups of GPs given indicative budgets covering variable range of services. Most covered elective services, prescribing and some also covered community and emergency services
2010–2012	Coalition government elected, announce abolition of PCTs and establishment of Clinical Commissioning Groups	GP-led organisations with full statutory responsibility for commissioning all services other than primary care and highly specialised services. Fully established by 2012.

Source: Miller, Peckham et al (2015), p 2

to constrain demand (Mannion 2008; Coleman et al, 2009b). In the next section we explore the evidence about how the various initiatives played out in practice.

Clinically led commissioning: research evidence

The largest body of evidence available focuses upon GPFH and its derivatives, including TPPs. The key research focus was on outcomes, with a tendency to focus on the easily measured – for example changes to GP prescribing. Few studies focused on how these were achieved and whether clinical engagement was an important factor,

1 or explored the relationship between clinical leaders and the wider
2 body of GPs. Only a small number of studies explore the leadership
3 positions clinicians held and the degree of influence they exerted over
4 commissioning decisions. Even fewer studies examined the influence
5 of GP fundholders on other bodies with which they interacted, for
6 example the Health Authority (HA) or provider organisations.

7 Motivations underlying GP involvement in the various types of
8 clinically led commissioning vary, depending upon the nature of the
9 scheme. Common to all, however, was a belief that GPs, as frontline
10 clinicians, bring valuable clinical and patient-specific knowledge to the
11 table, and a desire to innovate. Furthermore, evidence suggests that the
12 extent to which GPs felt able to innovate was a key determinant of the
13 extent of their engagement. Where autonomy is granted and 'success'
14 experienced, engagement grows, but where perceived autonomy
15 and control is less, GPs tend to disengage. Maintaining wider clinical
16 engagement (beyond the leaders) was agreed to be a priority, but the
17 extent to which this was achieved varied considerably. Engagement
18 was easier in smaller schemes but these tended to be limited in scope,
19 while more comprehensive schemes found it more difficult to engage
20 with a wider GP community. Engagement was, notwithstanding,
21 time-consuming and labour intensive.

22 In terms of outcomes related to clinically led commissioning, the
23 evidence is not strong. The most detailed evidence comes from GPFH
24 and TPP, focusing on easy to measure activity such as changes in referral
25 patterns, prescribing costs and waiting times. There is some evidence
26 that GPFH tended to reduce the rate of growth in both prescribing
27 costs and referral rates, although causation cannot be assumed, as those
28 practices which took up GPFH tended to differ systematically from
29 those which did not. Despite these caveats, however, it seems likely
30 that responsibility for a budget tends to make practitioners think more
31 carefully about their prescribing and referral decisions, and to focus on
32 improving quality of care within their practices, but this does depend
33 upon good relationships with frontline GPs, who need to feel that the
34 commissioning body has legitimacy and that the actions they are being
35 asked to take are reasonable. Peer review by trusted peers seems to
36 be an important mechanism underlying this (Coleman et al, 2009b).
37 This is easier to achieve in smaller schemes, and can be enabled by
38 relatively modest incentive schemes (Checkland et al, 2011). There is
39 some evidence that clinically led commissioning of various types led
40 to the establishment of a greater range of services in the community,
41 such as physiotherapy services, and to the development of better liaison
42 between primary and secondary care, via, for example, 'discharge

liaison officers'. Such services were rarely critically assessed for quality or costeffectiveness, however, with their establishment alone often being claimed as a 'success'. Priorities for service development tended to be based upon individuals' areas of interest or perceived local need, rather than a more systematic assessment of needs or service gaps. Furthermore, secondary care services tended to resist attempts at disinvestment, meaning that many such 'out of hospital' services represented duplication rather than substitution. There is very little evidence of any clinically led commissioning schemes generating significant changes to secondary care services, although where schemes made this their main focus they were able to make some short term changes to the pattern of hospital use. There is no evidence to support the contention that clinically led commissioning of any kind led to an overall improvement in quality of care.

HSCA 2012: what was intended to happen?

The White Paper, 'Equity and Excellence' (Department of Health, 2010) was published early in the life of the new Coalition Government. Its contents were generally seen as a surprise, as the Coalition agreement had specifically ruled out any significant reorganisation of the NHS (Cabinet Office 2010). As has been discussed elsewhere in this volume, the White Paper proposed a wholesale reorganisation in which Primary Care Trusts would be abolished, with commissioning responsibilities split between newly constituted 'Clinical Commissioning Groups' (CCGs) and a new arms' length body, initially known as the 'NHS Commissioning Board' (later renamed NHS England). CCGs would be responsible for commissioning secondary care, community and urgent/emergency services, while NHS England commissioned primary care services (including general practice, dentistry, pharmacy, optometry and so on) and specialised services. The 'vision' underpinning the reorganisation was of an NHS that:

- is more transparent, with clearer accountabilities for quality and results;
- gives citizens a greater say in how the NHS is run;
- is less insular and fragmented, and works much better across boundaries, including with local authorities and between hospitals and practices;
- is more efficient and dynamic, with a radically smaller national, regional and local bureaucracy; and

- is put on a more stable and sustainable footing, free from frequent and arbitrary political meddling.

(Department of Health 2010, 9)

It was argued that CCGs would ‘shift decision making as close as possible to patients’, and ‘build upon the pivotal and trusted role that primary care physicians already play’ (Department of Health 2010, 27). The document sets out the perceived shortcomings of previous clinically led commissioning initiatives, and argues that the establishment of GP-led CCGs will avoid the problems associated with these previous initiatives. Membership of a CCG was to be compulsory for all practices, and an ambitious timetable was set out with CCGs established in shadow form in 2011, taking over full responsibility in April 2013. A series of further documents set out more details about the establishment, governance and responsibilities of CCGs (Department of Health 2011a; Department of Health 2011b; Department of Health 2011c; Department of Health 2011d; Department of Health 2011e; Department of Health 2011f). It was argued that CCGs would be different from their predecessors by virtue of their status as ‘membership organisations’:

CCGs will be different from any predecessor NHS organisation. While statutory NHS bodies, they will be built on the GP practices that together make up the membership of a CCG. These member practices must decide, through developing their constitution, and within the framework of legislation, how the CCG will operate. They must ensure that they are led and governed in an open and transparent way which allows them to serve their patients and population effectively. (NHS Commissioning Board, 2012c, 4)

It was also argued that the ‘added value’ that GPs would bring to commissioning included:

- strengthened knowledge of the needs of individuals and local communities and the variation in the quality of local services, by harnessing the unique role of general practice to be in everyday contact with patients, their families, and carers;
- increased capability to lead clinical redesign and engage other clinicians based on the understanding of clinical risk and evidence of best practice;

- better involvement and engagement of local people to adopt improved services and move from familiar but outdated services based on the focus on quality and outcomes and the trusted positions held in communities;
- improved uptake of quality based referral options across practices based on greater involvement in priority setting and redesign;
- greater focus on improving the quality of primary medical care as a key part of clinically led redesign of care systems.

(NHS Commissioning Board 2012 paragraph 3.14)

It is instructive to test these claims against what is known from research. First, GPFH, TPP and PBC were all underpinned by the idea that GPs, as frontline clinicians, understood the needs of their patients. Evidence suggests that, in practice, while they were responsive to the needs of individuals, clinicians involved in commissioning were not necessarily better than their managerial counterparts in assessing wider need (Miller et al, 2012). Second, there is little evidence from previous clinically led commissioning schemes that GPs are more capable of leading large scale service redesign than PCTs. In terms of ‘engagement of local people’, those involved with PBC had aspirations to improve public engagement, but there is little evidence of significant success (Coleman et al, 2009a). The suggestion that the ‘trusted position of GPs in the community’ would enable them to persuade the public of the need to make significant changes to services such as significantly redesigning (or even shutting) hospital services is interesting, and yet the counterargument can be made that GPs’ position in the front line might make them less likely to support radical service redesign, as they would potentially be exposed to any public anger in their day to day work. It is certainly true that evidence suggests that referral patterns can be influenced by clinician-led commissioning authorities who are perceived to have local legitimacy, and that such groups can support peer-led approaches to quality improvement, but neither of these necessarily requires the clinical commissioners to hold statutory authority.

Taken together, the evidence base underlying these claims to benefits associated with the development of CCGs would seem to be weak. On the other hand, there is clear evidence from the past that clinician engagement in commissioning is more likely to be sustained if they feel themselves to have autonomy and freedom to innovate. As statutory bodies, CCGs were established with the freedom to decide what they

1 commissioned, at least in the area of secondary care and community
2 services; the extent to which they had freedom to innovate therefore
3 depended upon the accountability and management mechanisms
4 established in practice.

6 **CCGs: what do we know?**

7
8 Since 2011 the Policy Research Unit in Commissioning and the
9 Healthcare System (PRUComm) has undertaken three phases of
10 research on CCGs. The first phase, from early 2011 through to
11 December 2012, followed CCGs from their initial establishment in
12 'shadow' form, through to their preparations for 'authorisation' as full
13 statutory bodies. The second phase of the study ran from April 2013
14 until March 2015, focusing upon the claims made by participants in the
15 research about the 'added value' that GPs brought to commissioning.
16 Research methods and results from both of these phases of the study
17 have been published in academic papers (see above) and in a number
18 of reports (Checkland et al, 2012, 2014; McDermott et al, 2014;
19 Miller et al, 2012). The final phase of this research commenced in
20 April 2015, focusing upon the devolution of additional commissioning
21 responsibilities to CCGs. In autumn 2014, CCGs were invited to
22 express interest in taking on responsibility for commissioning GP
23 services. This means holding responsibility for GP practice contracts,
24 and raises issues of conflicts of interest as GP-led organisations will
25 be commissioning their own practices. Three 'levels' of involvement
26 were offered: full delegation of responsibility; joint commissioning,
27 with CCGs and NHSE (NHS England) working together; and 'greater
28 involvement', in which CCGs would advise NHSE on aspects of
29 primary care commissioning (NHS England, 2014b). There is a
30 clear expectation that those CCGs which opt for a lower level of
31 involvement will, over time, move to take on further responsibility,
32 but no firm timescale has been set for this.

33 This section is an updated version of evidence previously published
34 as a paper in the *British Journal of General Practice* (Checkland et al,
35 2013b). We are grateful to the journal for permission to reproduce
36 this here.

38 ***CCG autonomy and decision making: structures and governance***

39
40 On paper, CCGs have significantly more autonomy than any previous
41 clinical commissioning organisations, in that they are the statutory
42 body and will carry full budgetary responsibility. In this section

we discuss the development of CCGs structures and governance procedures, in order to explore how far this autonomy and associated ability to make decisions is being realised in practice.

Guidance for CCGs about structures and governance was non-prescriptive, suggesting only that CCGs should have a 'Governing Body', which is responsible for ensuring 'that CCGs have appropriate arrangements in place to ensure they exercise their functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it' (NHS Commissioning Board, 2012c, 32), and that they should set up relevant subcommittees as required. As a consequence, we found significant complexity and variety associated with emerging CCG structures and governance arrangements, with widely differing subcommittees and groups which were referred to using a bewildering variety of names. Terms used included: board or shadow board; executive or executive committee; clinical commissioning committee; council of members; forum; collaborative; locality; cluster; senate; and cabinet. Total governing body size as reported in the survey also varied considerably, as did membership, with some establishing a relatively small group, dominated by GPs, while others opened membership up to a variety of other professionals such as social service representatives and public health specialists. Smaller groups might find decision making easier to achieve, but at the expense of less engagement with the wider health community.

Over time, there was a developing consensus around use of the title of 'Governing Body' for the main statutory body, but considerable variety remained around the naming of other subcommittees. This made direct comparisons difficult, as it was not always clear how far bodies in different sites with different names corresponded to one another. In order to overcome these difficulties, we sought to identify groups by their functions rather than their names. Overall, we found the following functions represented in our study sites: an overarching 'Governing Body', holding statutory responsibility once authorisation was completed; a number of 'Operational' bodies, including a number of different committees or workstreams; a formally constituted operational group, often called an 'Executive', which undertakes day to day management of the group's activities; a 'Council of Members' (CoM), consisting of practice representatives; and 'Locality groups', consisting of smaller groups of representatives from a geographical area. Not all sites had Locality groups, and two had also convened a wider group of clinicians, managers and representatives from outside (for example, from the local authority or the local provider trust) to provide more general advice.

1 Even when it was possible to identify separate groups at each of these
 2 different levels, the distribution of functions in a given site was more
 3 fluid than this typology suggests with, for example, no clear separation
 4 between Governing Body functions and more operational work, and with
 5 considerable time spent in meetings discussing who should be responsible
 6 for which type of decisions. The extent of the complexity embodied in
 7 these different groups and subcommittees is illustrated by this quotation
 8 from a manager in one of the larger CCGs that we studied:

9
 10 *Well, because we're a large CCG, if we have everybody...the*
 11 *meeting's going to be, ah, less than, um, efficient. So what I've done*
 12 *is created a proposal for two boards. One is the statutory board ... The*
 13 *governing body. And the other is more of a... subsidiary board. So*
 14 *you have the locality chairs on one subsidiary board comprised solely*
 15 *of GPs, you have a superior board – the oversight and governance*
 16 *board – comprised of some GP representatives from the lower board,*
 17 *and all those statutory appointees. [Manager, ID 60]*

18
 19 In addition to their complex internal governance processes, CCGs are
 20 also externally accountable to NHS England and, more indirectly, to
 21 the local Health and Wellbeing Board (HWB). Thus CCGs, although
 22 they have complete budgetary control, may be significantly constrained
 23 in their ability to make rapid decisions or act autonomously in practice.

24 25 ***Engagement with members***

26
 27 In a clinical commissioning organisation with decision-making power,
 28 active engagement of GPs increases the ability to achieve goals and
 29 to innovate, albeit at a cost of significantly increased administrative
 30 overheads (Miller et al, 2012). In this section we examine evidence
 31 from our study about GP engagement and involvement.

32 33 ***CCG 'ownership'***

34
 35 Official guidance stressed the importance of GP engagement, explaining
 36 that: 'CCGs are also membership organisations, accountable to
 37 constituent GP practices' (NHS Commissioning Board, 2012b, 3), and
 38 suggesting that member practices should be actively engaged with all key
 39 decisions (NHS Commissioning Board, 2012a). This implies that CCG
 40 members should see themselves as 'owners' of the CCG and of its plans.
 41 In practice, constitutions, strategic plans and commissioning plans were
 42 generally developed by an executive group of GPs (aided by managers),

and then submitted to the wider membership for approval. It is not yet clear how far the GP members will see themselves as ‘owning’ these plans. The smaller CCGs in our study took this seriously, working hard to try to ensure that the wider body of members ‘owned’ the agenda. In one site, this issue was revisited in almost every meeting, and Council of Members meetings were actively used to engage the members. One GP described this process:

We also have a check and balance of the Council of Members.... The purpose was one, to hold us to account, but also to feed us information about what’s a problem. And you saw with the Mental Health Strategy. ‘This is wrong’. People giving both specific examples and endorsing broad feelings about how it did ... And then go back to the provider of that service, and say ‘This is what everybody is saying about it. What do you think you’re going to do to change it?’ So to be at that stage is actually really quite exciting because it’s almost showing how we’re going to operate in the future. [GP ID 283]

Thus, this GP saw the Governing body as being ‘held to account’ by the membership. A manager from a different site sees it slightly differently, however, as quoted below, arguing that the Council of Members had given the Executive the power to make decisions, upon which the wider membership could then comment, rather than the wider membership owning the decisions. In other words, the Executive would be required to give an account to their membership, without necessarily being accountable in a more direct sense:

Yes, that... I suppose that really is they have given the exec team responsibility decide, you know, that direction and the plan, so your first signoff is with the exec team, but then you take it to the wider group to say this is what we’re going to take forward so it’s just really exposing it to the wider remit as a sort of communication exercise really, but also it’s their then chance to say you’re all barking up the wrong tree. [Manager ID 42]

Engaging with members

All case study CCGs were in the process of deciding how they should engage with their members. Many different modes of communication and engagement were planned, such as circulated newsletters or briefings and intranet sites. We found three broad approaches

1 represented in our sites. In some (usually smaller) sites, the key task was
2 seen as getting grassroots members to engage with strategic planning,
3 contributing ideas and ‘owning’ the strategy. In larger groups, the
4 problem was more often formulated in terms of the need to disseminate
5 information down, so that grassroots members were aware of what
6 the CCG was doing. Finally, some fell between these two extremes,
7 seeing the strategic role as falling to the Governing Body or executive
8 group, but wishing to see a flow of ‘frontline intelligence’ up from the
9 grassroots, in addition to the flow of information down.

10 To engage with members, five out of eight of the case study sites had
11 established geographically-based ‘locality’ groups. In four of these, the
12 Localities form the main forum through which members engage with
13 the CCG, with wider membership meetings infrequent. In the fifth
14 site, there is also an active Council of Members. Respondents across
15 all these sites expressed a desire to have ‘strong Localities’; however,
16 it remained unclear what this meant or what a ‘strong Locality’
17 might do. The rationale appeared to be that ‘strong Localities’ were
18 necessary to engage the membership, but their ongoing role in the
19 wider organisation remained undefined and insecure. One of the key
20 questions was how much responsibility could reasonably be delegated
21 to Localities. In one of the larger sites it was stated categorically
22 that Localities could not work autonomously. In another site, by
23 contrast, Localities were given delegated authority to make significant
24 commissioning decisions, commit specified amounts of the overall
25 budget without Governing Body approval, and even manage contracts
26 with their local providers. This approach generated significant local
27 buy-in and enthusiasm; the downside was that it required a significant
28 commitment of managerial resources at the local level.

29 These findings suggest that what it means to ‘engage’ grassroots’
30 GPs in CCGs is yet to be clearly formulated. The meaning of
31 ‘membership’, the extent to which grassroots’ GPs are expected to
32 ‘own’ the agenda, the purpose of ‘communication’ and the role of
33 Locality groups all need to be more clearly defined. Furthermore,
34 it seems that ‘engagement’ may mean different things in groups of
35 different sizes, and that, as was seen in the Total Purchasing Pilots,
36 larger groups may find particular difficulties, unless they are able to
37 devolve meaningful power to their Localities.

38 39 *Commissioning activity*

40
41 Previous GP commissioners have tended to focus upon activity
42 based upon their direct clinical experience, leading to a focus on

such matters as hospital waiting times and the provision of additional community-based services, with limited engagement with a public health approach to population health. There is most direct evidence of GP commissioner impact on prescribing, improving services in primary care, and some limited impact on slowing the rate of increase in referrals and urgent or unscheduled care.

Commissioning responsibilities

At the time of the research, emerging CCGs were working as subcommittees of their local PCT Cluster, and were beginning to take over responsibility for leading commissioning, preparing to take over full responsibility from April 2013. Unlike all previous manifestations of clinically led commissioning, CCGs have statutory responsibility for virtually the entire commissioning budget. Respondents in our case study sites were very much aware of the implications of this, and of the challenges ahead:

There is no longer going to be a PCT to pick up the pieces. We are going to have to hold each other to account (localities and GPs) and work hard at this. Localities need to own contracts. We have to look at financial credibility... We need to be on top of things from quarter one and decided how we are going to monitor things [Extract from fieldnotes executive meeting March 2012 M30]

Some Governing Body members appeared to recognise the need to take as broad a view as possible of the commissioning task, moving away from small scale, practice-level interventions:

for me it's really amazing to watch these clinicians leading change on a really significant scale, and it's very different to, I guess, what I thought might happen, after seeing those early stages of practice based commissioning, which were, you know, doing a little bit of dermatology in your practice, for other practices, it was very small scale. [Manager ID 204]

We also found that, in general, meetings of Locality groups and Councils of Members tended to remain more focused upon more familiar topics such as small scale interventions to improve care for long term conditions in general practice.

Engaging with public health will be important if CCGs are to move beyond such small scale practice-level change. Under the new

1 architecture of the NHS, responsibility for public health has moved
2 to Local Government authorities. Our case study sites were aware
3 of the need to work closely with public health, with, for example,
4 some participants acknowledging the difference between ‘formal’
5 public health knowledge and ‘informal’ general practice knowledge
6 about health needs. Some sites were keen to ‘embed’ public health
7 at Governing Body level, whereas others saw it in terms of public
8 health offering the CCG a service. Respondents in all sites expressed
9 concerns about the ongoing relationship between CCGs and public
10 health. In the face of this uncertainty, personal experience of working
11 together was seen as important:

12
13 *...at the moment, there's still quite a good link, historical...with*
14 *the public health and the names and faces are still there, and as*
15 *a consequence what we get is based on those relationships, isn't*
16 *it; do we have a thorough understanding of what public health*
17 *information we would want contract to be provided to us, I don't*
18 *know about that, that's a difficult one. It's a relationship that,*
19 *hopefully, will just continue. [GP ID 104]*

20
21 Research suggests that interactions between CCGs and their public
22 health colleagues can take a number of different forms, with some
23 public health professionals seeing themselves as ‘co-owners’ of the
24 CCG agenda, while others act as ‘critical friends’ or ‘service providers’
25 (Warwick-Giles et al, in press). The implications of these different
26 approaches are not yet clear.

27 One of the key areas in which our case study CCGs told us that
28 they felt that CCGs would add value and ‘do things differently’ from
29 previous clinically led commissioning schemes was in the area of
30 negotiating with providers:

31
32 *We're beginning to see some successes in terms of GPs' involvement*
33 *in some of the, some of the contracting rounds, so...They actually*
34 *go along to the Contracting meetings. And, you know, and giving*
35 *clinical view and clinical input around some of those discussions*
36 *and conversations. And that can add real value in terms, for both*
37 *the providers and the commissioners, to really start driving forwards*
38 *some of those tricky conversations. [Manager ID 54]*

39
40 When we followed this up in phase two of our study, however, we
41 found that, while interactions between commissioners and providers
42 could be enhanced by the involvement of clinicians, this requires

careful orchestration, with detailed planning, proactive chairing and a selective approach as to where to focus clinicians' attention. This is important, as GPs have limited time and are under considerable pressure. This GP highlighted the stress he was facing:

And I spent yesterday, six hours in a Joint Strategic Needs Assessment on the Health and Wellbeing Board, for which I have not been paid, and I won't get paid. That's why I am still catching up on my clinical work, and I came in at 7 o'clock this morning to do all my paperwork and spent till 8 o'clock last night doing that. So I spend hours and hours of unpaid work.... doing the work that needs to be done. [GP ID 218]

Research by the Kings Fund/Nuffield Trust confirms these findings, and suggests that GP involvement in CCG Governing Bodies is declining (Holder et al, 2015). Defining clearly where GPs 'add value' will be important if CCGs are to be sustainable.

Quality of primary care

Previous manifestations of clinically led commissioning have had some success in improving care quality in general practice. The CCGs in our study had ambition in this regard. In particular, there was ambition to undertake some kind of performance management, including performance against commissioning budgets, referral behaviour and prescribing costs. While official documents refer to 'improving quality' in primary care, most of our respondents were happy to talk explicitly about 'performance management'. Box 8.1 sets out the approaches seen.

Box 8.1: Approaches to quality improvement in primary care adopted by case study sites

- Sharing of named referral performance data (all sites)
- Sharing of named prescribing performance data (all sites)
- Sharing of named data detailing performance against budgets (some sites)
- Incentive schemes designed to target and improve performance (some sites)
- Visits to individual practices to discuss performance (some sites)
- Discussions of audit data in all practice meetings (some sites)
- Creation of intranet (dashboard) where data can be shared between practices (some sites)
- Referral management centre scrutinising all GP referrals (one site)
- 'Buddying' poorly performing practices with those doing better for support and guidance (one site).

1 In all sites, performance management activities similar to these
2 had been running under previous structures such as Practice-based
3 Commissioning (Coleman et al, 2009b). Some respondents, however,
4 said that they were concerned that such performance review and
5 management would be more difficult in future as they had fewer staff
6 to do the work; in particular, visiting practices individually is very
7 labour intensive and may not be possible. In addition, there was some
8 tension identified between the desire to be a 'bottom up' organisation
9 led by members and the perceived need to performance-manage those
10 members.

11 How these tensions play out as CCGs take over responsibility
12 for commissioning primary care services will be an important
13 determinant of success. CCGs must maintain the trust and support
14 of their members, while actively managing their performance and,
15 potentially, enforcing local contract changes. The third phase of our
16 research will explore the experiences of CCGs as they take over these
17 new responsibilities.

18 19 **Conclusions**

20
21 If the split between 'commissioning' and 'providing' services is to be
22 maintained, it seems clear that GP involvement is important. GPs in
23 the UK are 'gatekeepers' to secondary care services, and, via their
24 registered lists, are closely in touch with the health needs of the public.
25 How best to involve GPs, however, is a question to which successive
26 governments have provided different answers. The HSCA 2012 sought
27 to give GP-led organisations statutory responsibility for a significant
28 proportion of the commissioning budget. The argument underlying
29 the abolition of PCTs was that they were too managerially dominated
30 and had failed to engage GPs effectively. The solution – a significant
31 reorganisation – contained some elements that seemed in keeping
32 with available evidence. In particular, the HSCA 2012 seemed to
33 promise significant autonomy to CCGs, with GPs firmly in the lead.
34 In practice, however, their room for manoeuvre has been constrained
35 by the financial challenges affecting the NHS as a whole, and it is not
36 yet clear the extent to which CCGs will be able to make the significant
37 service changes necessary to meet those challenges.

38 Since 2014, policy has moved forward rapidly. Simon Stevens took
39 over as Chief Executive of NHS England, and quickly published
40 his 'Five Year Forward View' (FYFV) (NHS England, 2014a). This
41 document set out the scale of the financial challenge facing the NHS,
42 and suggested that this challenge could only be met if the NHS did

things differently. In particular, the FYFV advocates the establishment of what have come to be called ‘vanguards’ to test out new models for services. These include: Multispeciality Community Providers, bringing together providers of a variety of types of care in community settings; Primary and Acute Care Systems, vertically integrating primary and secondary care; Urgent and Emergency Care networks, bringing together providers of different types of urgent care across a geographical area; and a variety of other models focusing upon specific care settings such as care homes, community hospitals and maternity services. In addition, as discussed earlier, Simon Stevens suggested that the commissioning of primary care services would be delegated to CCGs. Taken together, these developments suggest a future for commissioning in general and CCGs in particular that will look quite different. The new models of care under development suggest a situation in which, rather than assessing needs and procuring services, commissioners set agreed outcomes and hold large providers to account for meeting them. CCGs seem to be stimulating the development of provider ‘federations’ (Welikala, 2015), in which groups of general practices work together as providers across a larger footprint, and this brings potential conflicts of interest.

How these developments will play out in the longer term is currently unclear, with many questions remaining about the status of CCGs as membership organisations, the extent to which they can hold large providers to account and their management of conflicts of interest. The direction of travel – towards a greater focus on care provision in community settings – is supported by the evidence that we have presented here from the long history of GP involvement in commissioning.

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1 Petsoulas et al, 2014; Segar et al, 2014; Coleman et al, 2015; Coleman
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 3 previously published as an article in the *British Journal of General Practice*
 4 (Checkland et al, 2013b), and we are grateful to them for permission
 5 to reproduce it here. Table 8.1 is reproduced from Miller et al (2015)
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 17 co-authored the *British Journal of General Practice* paper on which this
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