

Exploring the ongoing development and impact of Clinical Commissioning Groups

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List of abbreviations

CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CSU	Commissioning Support Unit
DH	Department of Health
GB	Governing Body
GP	General Practitioner
HWB	Health and Wellbeing Board
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LA	Local Authority
NHS	National Health Service
NHSE	NHS England
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PH	Public Health
SHA	Strategic Health Authority

Background

Participants in our study so far have made a number of claims about the 'added value' that clinicians (particularly GPs) bring to the commissioning process. By 'commissioning process' in this context we mean everything associated with commissioning, including pathway development, contracting with providers, the ongoing monitoring of contracts and any attempts to modify referrer behaviour. These claimed benefits have generally centred on the value of having clinicians present in negotiations with providers, and the ability of clinicians to influence their colleagues' behaviour. In addition, the NHS England has set out what they believe clinicians add to commissioning:

'As envisaged by the Government in Equity and Excellence: Liberating the NHS, the added value that clinicians bring to commissioning based on their skills, knowledge and standing in local communities is a defining feature of the new commissioning system and underpins how Clinical Commissioning Groups (CCGs) will be successful in each domain. This added value is said to include:

- *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 out-dated 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 para 3.14)*

Aims and research questions

The over-arching aim of the second phase of this project is to explore the impacts of CCGs, with a particular focus upon the potential added value that clinicians bring to the commissioning process (in its widest sense), and to elucidate the contexts and factors that enable or inhibit the delivery of these benefits.

In order to fulfil these aims, this report addresses the following research questions:

- What are the formal and informal roles and responsibilities adopted by clinicians holding leadership roles in CCGs?
- How is the CCG setting about its commissioning tasks, including: pathway development; procurement; contracting; and interactions with external stakeholders? What is the role and influence of clinicians in these processes?
- What claims are made for the 'added value' provided by clinicians in these areas, and how do these change over time?
- What evidence is there to support the claims made by the NHS Commissioning Board of clinician 'added value' in commissioning?
- What factors or contexts appear to be enabling or inhibiting the ability of clinicians to influence the commissioning process?
- How are managerial roles and managerial-clinician interactions changing as a consequence of the new system?

Theoretical framework

Overall, commissioning in the NHS is in a state of flux, with many changes occurring simultaneously. For example, in addition to the creation of CCGs, many commissioning managers have been transferred to work in larger Commissioning Support Units, Health and Wellbeing Boards have been set up and responsibility for public health has been transferred to Local Authorities. Any changes observed in commissioning processes and outcomes will have been influenced by all of these actors and organisations. It is therefore impossible to set about a conventional evaluation in which researchers evaluate the success of a new initiative and attempt to establish causality in relation to changes observed. We therefore approached the issue of outcomes associated with clinician 'added value' in commissioning by examining the roles that clinicians are taking in CCGs and the claims that are made (by both clinicians and managers) about their added value.

Methods

The findings presented here represent the second stage of a longitudinal project tracking the development and early activities of CCGs. The first stage of this project involved an intensive investigation of the early development of CCGs, using 8 case study sites alongside 2 national web-based surveys (see report (Checkland et al 2012) for detailed description of methods and case study sites). For this second stage of the research we are tracking the ongoing development of the case study CCGs, with a focus upon the 'added value' that GPs bring to commissioning. It is the initial phase of this second stage that we report here. The case study sites were selected to provide maximum variety across a number of characteristics, including

size, the homogeneity of the socio-demographic profile of the site and the complexity of the local health economy and local government institutions.

For this part of the study we undertook 42 interviews with GPs and Managers in 7 of our 8 case study sites (one site declined to participate further). Table 1 details the interviewees.

The findings presented are from the analysis of 42 interviews with GPs, managers and other clinicians in the 7 sites. The interviews took place between July 2013 and January 2014. Interviews covered topics such as their current roles and responsibilities, their understanding of the value of clinical input in commissioning (with concrete examples where possible), their workloads and their interactions with managers.

The case study sites were selected to provide maximum variety across a number of characteristics, including size, the homogeneity of the socio-demographic profile of the site and the complexity of the local health economy and local government institutions.

	Number of GPs	Number of Managers	Nurse (Clinical Lead)
Site 1	7	0	0
Site 2	7	0	0
Site 4	4	0	0
Site 5	5	1	0
Site 6	3	1	1
Site 7	2	0	0
Site 8	7	4	0
Total: 42	35	6	1

The study utilised the NVivo software package, a computer programme specifically developed to assist in the organisation and analysis of qualitative data and a valuable resource in the management of qualitative data (Basit, 2003). Minimisation of some of the administrative tasks involved in the qualitative research allows for more time to think about the content of the raw data, and this encouraged deeper analysis of the data than would have otherwise been possible. Use of NVivo helps render the process of analysis more explicit and reflective. Computer assisted analysis can strengthen the conclusions drawn, by demonstrating that the analysis has been systematic, reliable and transparent (Gibbs, 2002; Pope, Ziebland, & Mays, 2000). The focus of this analysis was to explore the opinions of clinicians and

managers about the value that GPs bring to the process. The results from this (presented here) will be used to focus a second phase of data collection, in which the claims made will be followed up in the observation of the work of 4 of our case study CCGs.

The CCG Role

How clinicians got involved in the CCG

Two main reasons were given for involvement of clinicians in the CCG: either respondents volunteered because of their interest in the role or they were asked by colleagues to undertake the position. Upon taking the position they were nearly always elected unopposed. However, some did have to go through an assessment interview. This of course raises some questions about democratic legitimacy of CCGs and rates and level of participation. These respondents discuss how they acquired the role:

'So what happened there was a lot of people contacted me, came to see me saying that there was a requirement for "a big hitter" to do the role. I'd been involved in medical politics for years here and I'm well known for doing stuff. And that they couldn't think of anybody else to do it' [GP ID 183].

'I said I put my name in because I thought that was a natural progression of event, that since I'd been part of the formation of the CCG it would make sense for me to take on the role, but again it wasn't presumed and we offered it to all the other GPs in the CCG. Again mine was the only head over the parapet to be hit...and therefore it wasn't difficult to aim at...' [GP ID 33].

'I thought, well, you know, [the position]...sounds good and I do passionately believe in the NHS and, you know, we've got to protect it, you know, there's some real dangers to it. And I think CCGs are the best way of doing that. So I went for it, and I went through an assessment process which I passed, and there were no other people interested so it didn't have to go to a vote. So I got it' [GP ID 339].

How they see their role developing

Clinicians talked about the development of their role in three ways. The most predominant of these was in relation to progression of various projects in which they were involved. Secondly, was in relation to succession planning and a recognition that they may be only in the role for a finite period of time and the importance of having someone take on the role with their departure. Finally, some respondents

discussed their role development as being largely unchanged for the foreseeable future.

These respondents illustrate their role development in relation to these areas.

'...certainly on the things we're working on, I think they will progress. For example the neurology, we've got a bit of a block on it, we're hopefully going to resolve...The pain management is very much supported by the primary care, and by secondary care, and although I chair it they've got great involvement...So, that's my role there, and I think that will deliver. The rheumatology work, as I say, is just commencing, and that's a challenge, which route we go down, whether we go down a procurement route, or a redesign route with the provider. And there's some GP expectations. This is part of the discussion we had at the network this week about, you know, they want to move things forward' [GP ID 109].

'...I think its right that it shouldn't be the same person. Even if I might want to, succession planning, I think it should be a different face sometimes, it should be someone with other ideas, and whether I'll be still involved in the CCG or I'll find some other little bit I certainly won't be involved at the really kind of high level because I don't have that time and I don't want to have that time commitment to it. I want to be a clinician' [GP ID 309].

This understanding of the nature of clinical engagement in CCGs is interesting, as it highlights potential differences between CCGs and previous commissioning organisations such as PCTs. In PCTs, the roles of Chair and Chief Executive were filled by career managers. Whilst such managers did move between organisations, there was an underlying expectation that, once appointed to a senior role, they would remain with the organisation for the foreseeable future. In CCGs, by contrast, many of the most senior roles are filled by GPs who continue to have clinical commitments and, as the quote above demonstrates, continue to identify themselves first and foremost as clinicians. Indeed, as we reported earlier (Checkland et al 2012), many CCGs have explicitly written into their constitutions a clause which mandates that clinical leaders serve for a limited time. This suggests that CCGs will face challenges in terms of stability and succession planning that PCTs did not.

The desire for stability in the role is also interesting. As this GP suggests, there is concern over workload for those with other commitments, and this is an issue that we will explore below.

'I think my role specifically, should carry on as it does now. What I'd be afraid of is that more and more would be pushed into it...' [GP ID 105].

Clinician time spent on CCG work

When asked the amount of time spent on CCG work this varied of course, dependent on role and responsibilities and not all respondents were clear about the time they spent in their role. However, as a guide, a Chair of Council Members cited half a day a month, whereas a Clinical Chair of a CCG spent 24 hours a week in the role. For locality leads (including locality chairs) the hours ranged from 4 to 20. However, as an average, locality leads would spend 11 hours a week on CCG work. These hours however, are what respondents said they were formally contracted to do but many said that they would also spend evenings and weekends engaged in CCG business, as we discuss later. These interviewees give a flavour of the work they do and the time they spend:

'So I work here or I'm based around and about here on a Thursday for two sessions. Once a month I chair [a committee]...once a month we have Governing Body, once a month with have [another committee, and]... monthly Commissioning Delivery Committee. I go to the monthly Clinical Leads Meeting. I'm also chairing the Mental Health Programme Assurance Board which is once a month. Mental Health Strategy Group. What else do I go to in terms of meetings? At the moment because each Locality Network has a quality lead and at the moment ours has resigned so I am filling...[in] until we get somebody else volunteering so it alternates, one month it will be the Quality Improvement Committee the next month it'll be the GP Quality Development Group so they alternate. That's in terms of meetings and that takes up obviously a big bulk of time' [GP ID 106].

'...I've got a day filled with meeting people. So I would say probably a day of that week. Yes; some weeks it's more, some weeks it might be less. So sometimes it'll be the whole of the Thursday when we have a Locality Executive, you know, when all the locality leads and I get together and we have a...[county] wide locality leads meeting I'll chair that and then we might have the Governing Body in the afternoon as well, so I know I can have another half day but another week it might just be half a day. So whereas today I've got, if you look at my diary and the children ask me, what are you doing today, and you say you're just having meetings, and actually a lot of it's just with one or two other people, which is more, a lot of it's about supporting people in their roles, it's about relationship building, it's about just those informal discussions you need' [GP ID 160].

Although not predominant in the discussions, in terms of personal remuneration and payment to practices, the minority with a view felt that they either lost money in doing the CCG work or the payment wasn't enough to cover the practice costs for locum payments etc. This is an important issue in terms of sustainability. Most of those engaged in significant roles in CCGs are partners in practices. When partners are absent from the practice, their colleagues have to cover the work, or they must

employ locums. Partnership tensions can arise when there are workload pressures, and it will be important for CCGs to establish sustainable ways of managing clinical workload alongside the new managerial work required.

Clinician time spent attending meetings and reading email and other documentation

A substantial proportion of clinicians CCG time is being spent responding to emails, reading documentation and attending meetings. The amount of time attending meetings varied widely according to role of the individual. For instance, a Chair of a CCG could attend a series of meetings every month such as CCG Executive, locality and commissioning meetings, Governing Body and this apart from external meetings locally, regionally or nationally. Then of course there are one to one and informal meetings. The message from study participants however was clear: too many meetings and not enough time. These respondents give a flavour of these concerns in regard to meetings:

This GP highlighted the variety of meetings which he was expected to attend:

'...the work that we're doing now doesn't compare with what we did ten years ago, we're a lot busier in that point of view. My work is not just seeing patients now it's going to committees, it's doing all of this, its meetings, practice meetings, going to prescribing meetings, and there's not a lot of time frankly' [GP ID 253].

This workload brings with it challenges, especially with regard to prioritisation:

'What would make it easier? If you could invent an extra four days in the week that would probably be the main thing...it's about spending your time most efficiently, and I think we're all learning that as time goes on, ditching meetings which everybody in the world wants you to come to meetings of theirs and everybody wants to have your ear because they think you've got the money; and it's learning which of the meetings are actually useful where decisions have got to be made, where they need clinical input, and which ones can be left at a sort of an organisational level...' [GP ID 283].

This raises interesting issues for the future of CCGs, as it highlights the question of where *clinical* input is actually required. Developing an understanding of where and in what contexts the clinical voice adds significant value will be important if CCGs are to be sustainable.

Too much paperwork and not enough time to read it all and spending a great proportion of evenings and weekends immersed in documentation was the average lot of the typical study respondent. This is a typical statement:

'...when I was on holiday, what really brought me to my senses, it took me an hour to an hour and a half every day, just to keep up to date with the reading, every day.'

So, on top of that other commitment, I will be doing between one and two sessions, outside my commitment, just to do the reading' [GP ID 348].

A similar story was in relation to responding to email and study respondents would cite spending a lot of out of hours time reading and responding to email. One GP cited spending 2 to 3 hours a day responding to CCG related email. As one Clinical Lead wryly noted: *'...I spend half of my life responding to emails...'* [GP ID 286].

In addition to formal meetings etc. there was also discussion amongst respondents of informal meetings and communication through 'water cooler' moments also taking time, although this was not to a significant degree.

Past to Present – Differences from PCT and Shadow to Operational CCG

Remembering the PCT

The main feeling amongst clinicians and managers in regard to the differences between the CCG and PCT were that now as part of the CCG clinicians made the decisions as opposed to the PCT where they had very little part of the decision making process. In addition, clinicians largely believed PCTs were too bureaucratic.

Interviewees discussed that now under the CCG there is more clinical engagement, whereas under the PCT this was under-utilised. Clinicians now have a strategic role. Respondents claimed that PCTs didn't engage with GPs and that they were felt to be very managerially led. It was believed that PCTs had too much focus on processes and structure which could result in delays in decision making or decisions not enacted. It was also believed that the clinicians voice was not heard whereas now under CCGs it is, as one GP noted there was always a strong feeling that PCTs 'do unto people'.

These interviewees encapsulate these issues:

'...it's trying to work out how to lead an organisation [CCG] and it's a real opportunity to be in a position where you realise that you say something and...often it'll go ahead. Whereas before, you know, you felt you were battering against processes and governance structures above you that just seemed completely inflexible, yes, so that's been very satisfying' [GP ID 160].

'...there's probably quite a lot of pent up frustration in commissioning organisations in the past that they couldn't, they could see what needed to be done but...couldn't get it done you know, so you'd get sort of, you know, well why won't the GPs just do this? Well because you didn't engage them from the first place, they don't really own

it and they don't see the reason to. You get things like referral management schemes set up...if you were a GP and ...some bureaucrat came along and said to you, when you refer somebody in...despite the fact that you did all those years of training and you know how to diagnose somebody, we're not going to be entirely confident that you've got it right so we'll just check it again if that's ok with you...But they were probably understandable bureaucratic responses to 'we don't know how to get a grip on the system' you know' [Manager ID 35].

This respondent was very critical about their former PCT:

'...they were hopeless, they were unspeakable. They were all the things you shouldn't be; they were remote, they were top down, they were unaware of their community, they'd fail to engage or debate things before passing them on...and we were just out of sight, out of mind. They had no culture of trusting Primary Care to innovate. They would come along and go, we've had a brilliant idea, do this. And we'd go, that doesn't work; you can't do that locally' [GP ID 309].

This CCG Chair discusses how CCGs are now much more patient focused:

'I think what's become obvious to us is that having GPs in every conversation that happens at any level makes it very patient-focused. And so one of the non-executive directors that we have used to sit on the PCT board, and I was asking her the other day and saying, Well, is this board different to how PCTs used to be or... And she said, it's just phenomenally different because there isn't an agenda item on here which isn't based around patient care. There isn't... and even the more esoteric agenda items... actually the debate becomes not about logistics of doing it, it becomes around what's best for patients always and making sure that we bottom that out'. [GP ID 231].

Although not a prevalent theme, for those with experiences of practice based commissioning, the general feeling amongst such participants was that PCTs were not as helpful as they could have been in assisting with practice based commissioning and in some aspects were more of a hindrance than a help, through bureaucracy or general lack of help and assistance.

Out of the Shadows: from Shadow to Operational CCG

Although respondents did not dwell on this issue as much as the differences between the PCT and CCG, two common aspects were apparent; firstly echoing the previous discussion about the differences between PCT and CCG, clinicians now felt more engaged and were taking a leading role and secondly that the process has been disruptive on a number of levels. Respondents discussed issues such as having to get from a sub-committee of the PCT to a fully functioning CCG and

ensuring that practices were engaged in that process. Having to navigate the shifting sands of taking on more roles and decision making and having to add to or change the priorities of the emerging CCG in the process. There was of course also the process of being authorised as a CCG and some discussed the work this entailed.

This Chair of Council of Members encapsulates many of the above themes:

'I think increasingly we're now beginning to discuss real time stuff rather than just hear some information so, you know, the first year as a shadow was, a lot of it was about how we're setting up and what we're doing. So I think at the last Council of Members meeting we discussed things like the response to the A&E situation locally, how are we going to deal with that, how that might be taken forward, we discussed how practices might bid for non-recurrent funding, we discussed how practices are going to make use of pharmacy support, so now beginning to be genuine real time decisions that have an impact' [GP ID 309].

Another common theme was the disruption caused by reorganisation from the move from a PCT to a CCG. The disruption was also discussed in terms of the wider policy landscape with the move of public health to local authorities, the creation of new bodies such as Health and Wellbeing Boards etc. This Chief Clinical Officer discusses one aspect of how the changes were disruptive to colleagues:

'We've got the locality leads... [and] I think they've suffered a lot with the changes. They are new roles understanding what's going on, not understanding the system, not understanding which meetings they need to go to, and what happens at what meetings. Things that I thought...[were] absolutely clear obviously was a mystery to them, really. We're still working with them to try and get it organised' [GP ID 266].

CCGs have significantly less money available to provide managerial support than was the case in PCTs (CCGs 'running costs' are set at £25/head of populations. In 2011/12 the national PCT average commissioning running cost was £37 per head. However, there was wide variation, with the lowest cost reported as being £21 per head and the upper quartile figure of £43 per head (Audit Commission, 2012)). Although not a major concern of study participants, there were some worries that, CCGs had insufficient management support available. In addition, clinicians in their new roles as members of the CCG, and taking on major new roles may need further training or professional development. Here two clinicians voice their concerns in these areas:

'I feel there's not the us and them that we used to have in the PCTs. But..the resources aren't there anymore. So that's where the sort of kind of difficulty and the frustrations are now. So...I'm sure the pot is now smaller...the PCT budgets were reduced by a third, so obviously, you know, that was a constraint. And...there's a

reduction in the kind of management budget, if you like, which I suppose you could say, yes, okay, fine... you know, that's fine because we had this thing about too many managers and not enough going in. But I think what's happened is, because of the current funding arrangement, even the amount of money for clinical services is just flat, isn't it? There's very little growth in that. So I think that's what's creating an issue'. [GP ID 233]

'...I still find it very, very difficult, and what's starting to happen now, is I'm starting to be rolled out as the clinician in a lot of the social care arenas. I've got a huge presentation on Monday, to the council, which will be over a hundred and something...I don't even want to think about it...and then I've got to direct the workshops. And I just have to get through it. You just have to put your head down and get through it. But I've had no training, so it's just a case of just wing it and hope. And sometimes it goes okay and sometimes it doesn't' [GP ID 349].

What 'added value' do Clinicians bring to the commissioning process?

A number of themes emerged in this respect:

- GPs have a knowledge from working on the ' front-line' and see their patients on a regular basis and thus know the problems and difficulties they encounter. They are able to feed back such experiences to managers, and the wider bodies of the CCG. Working every day with patients in a myriad of circumstances, they know the various systems and pathways and how the various elements of the NHS work. Therefore GPs have a good knowledge of what works and what will not, as opposed to managers who do not have these insights.
- GPs clinical knowledge is needed to inform service provision, pathway development and contextualise policy etc.
- GPs are more patient focused and also act as a patient advocate.
- The GP and Manager role is a symbiotic one: GPs believe their clinical contribution is needed by managers and contextualises policy and provision. However, GPs recognise managers' important role in policy formation, implementation and overall strategic development. Conversely, managers greatly appreciate the clinical input from GPs and other clinicians as this provides a firm foundation to policy and presenting business cases etc.

We will discuss each of these in turn.

Working on the front-line

Working with and seeing patients daily GPs are in the position of knowing patients' real experiences of all aspects of the services provided by the NHS. Furthermore, GPs can quickly see any common factors from patients' feedback such as the lack of service provision in any areas. GPs also understand patients' needs and wants and what services and support they require and when. As such, they can understand where service provision needs to be enhanced or pathways altered to better reflect patients' needs. Such knowledge is seen as very valuable for commissioning as GPs have a good insight as to what will work for patients. Furthermore, with this daily contact with a broad range of patients, problems or difficulties with a pathway for instance, can be alerted and dealt with promptly before becoming a major problem.

As these GPs illustrate:

'So I think GPs do have a unique view of the whole system, because of the one to one work with patients and you see the patient going through the system and I think currently our NHS is so fragmented, there aren't very many vantage points within the system that you can actually see the whole thing and how it works or not' [GP ID 267].

'We are the people on the ground, we know what's going on day to day; and as a GP you probably have about as broad an idea of what's happening to your patients day to day as anyone else, you see 50 to 60 of them a day in all states, whether they've just come out of hospital or whether you're just sending them into hospital, whether you're sectioning them into mental health services, whether they're in the last stages of life and moribund; so you have a very broad idea of what is working and not working in the system' [GP ID 283].

'This to me is the whole point of GPs being involved in commissioning...I know what it's like on the ground. I know that at the CCG meetings, people might say your district nurse will do X, Y, Z and is brilliant at A, B and C, and I know on the ground that's not true. Okay...they refuse to do A and B, sometimes they'll do C if you beg them, and X, Y and Z don't exist...I attend meetings where you get the Chief Executive of this, that and the other organisation, and they come up with all these flowery reports about how good the service is, and I can say, hang on a minute, I work on the ground, I know exactly what's happening, that does not happen in practice' [GP ID 339].

'I think a view from the shop floor really. I wouldn't have a clue when it comes to contracting and management speak and everything else is part of this role but if you're talking to me about the best way to manage a patient or a patient journey or

understanding a patient's experience and how you apply that then I'm your woman' [GP ID 106].

GPs were also seen to have a further insight in knowing the local community and what services are available, apart from NHS provision, as they have wider links with social services and other local government bodies.

The value of clinical knowledge and input

Clinical knowledge and input was seen as critical. It was argued that the clinical focus is necessary to improve services, whereas previously, under the PCT, there may have been more of a focus on such things as finance and costings by managers and not whether a service is performing to expectations or the clinical value of the service. It was claimed that the emphasis now has shifted to a more clinical focus with GPs engaging more in the CCG. This can translate as viewing pathway development from a clinical perspective, with a view to making it more efficient and less bureaucratic. Our respondents suggested that the clinical focus can inform service provision and policy development and contextualise it with the clinical input. This GP illustrates some of these issues:

'...as a manager, you're looking at figures and you're looking at a service and a specification. You can say to yourself, well, why aren't district nurses doing that, okay. And we've asked them to do that, they should be doing that. And so then there's two routes. You can either come down with the stick and then that doesn't get you anywhere, or you can actually try and understand what's going on, okay. And I understand what's going on because I work with them and I live and breathe general practice three days a week. So I can say, actually the reason that's not working is because you haven't put in this link here; if you put in that link there, it would work seamlessly and things would be much better. So yeah, I can give that ground level data. And it's hard to underestimate the value of that' [GP ID 339].

In addition, there is now more of an emphasis on services being patient-focused. This is through such things as patient quality coming more to the forefront and valuing the patients experiences as GPs hear of these concerns from patients almost daily in their practices. This GP illustrates some of these points:

'...in the past, the clinical focus hasn't been there at all, and what we do is we are able to bring this back to the patient, in a way that I don't think managers traditionally have done, and we have that window on the world, that can challenge both the clinicians in the hospital, and the managers, when they say, this happens, and your patient has been in seeing you only that week telling you it wasn't like that at all' [GP ID 348].

With GPs understanding of the clinical environment and working on the front-line they can respond and alert the CCG to any difficulties in services provided and by being on the front-line react more quickly to rectify any problems. As this GP noted:

'Suddenly we've got an avenue to say this is not acceptable we're not happy with this and actually the number of complaints, not necessarily complaints as such, but the number of examples of dissatisfaction has markedly reduced and I think that's really positive' [GP ID 284].

This Accountable Officer discusses the impact of clinicians in regard to urgent care:

'I think definitely where we are with our urgent care strategy you know we have, most systems have wrestled with urgent care for ages haven't they and whilst we still have some way to go in terms of what we're implementing, I honestly don't believe we would have got to where we've got to in terms of the ambition and the coherence and the engagement of providers if this had not been led by clinicians, I just do not see that having happened so you know I feel supremely confident that we will deliver something of real value around urgent care and that will make the difference that needs to be made and I'm even more confident that this is the result of the clinical leadership of that work...' [Manager ID 45].

This Chair of Governors discusses the value of clinical input when commissioning an Improving Access to Psychological Therapies service:

'...our viewpoint about the patient experience bit and what goes wrong for patients in the kind of pathway is really, you know, we've got so much more information now. I mean commissioners might look at evidence from complaints and things like that but we just know first-hand how, whether something works or whether it doesn't work. And an example of the IAPT [Improving Access to Psychological Therapies] service that we redesigned is a really good example about. There were four GPs on the group that helped design and commission and commissioning managers came up with the model, what we've done is we've not just commissioned an IAPT provider, we've commissioned them towards also providing psychiatric liaison services, so essentially the majority of the CMHT [Community Mental Health Team] work is now within the IAPT unit. So there's no hand off, there's no, this patient is too sick for the IAPT service but they're too well for the GP, it's all one provider, they have to sort it out. It's produced a different line that's, you know, how sick are they for admission and things like that but then that has to deal with the CMHT in most teams' [GP ID 8].

Decision making closer to patients

Although this particular aspect was not prominent, it was believed that patients' direct experience could help in identifying any problems in care provision and perhaps contribute to formulating policy to improve services, because of the close links GPs have with their patients. With GPs seeing patients daily they know when certain services are not delivering and see if certain care pathways are working correctly and patients are not being incorrectly referred for example. These GPs discuss aspects of how decision making is closer to patients:

'...it's the ability to have somebody who's sitting with patients, in your area, who knows what the local scene is, who's capable of making the challenge. Bring the heavy lifting gear in, bring the contract people in, bring the analysis people...all of that can be very helpful, but if you don't have somebody who's sitting with patients a significant part of their week, you cannot add value to the process [GP ID 348].

'...we know that all patients want is to get to the end point, to know what the problem with them is and to get it sorted really. What they don't want is multiple levels asking them five different questions and the endpoint is the same. They would rather get less amount of bureaucracy in the middle and make sure that their health is looked after and the diagnosis is done and the management is done sooner rather than multiple levels in the middle' [GP ID 33].

Summary

Thus, it is being claimed that GPs bring a *concrete* knowledge of how the NHS actually performs in practice to the commissioning process, based in the real experiences of patients. Furthermore, that knowledge is *fine-grained*, distinguishing in detail between the experiences of different categories of patients and between services. Perhaps more surprisingly, a claim is also being made that GP knowledge is *broad*, encompassing the full range of services from multiple different providers. This contrasts with the historical narrative surrounding GP-led commissioning, that GPs were too concerned with individuals, and lacked the broader understanding of population health required to commission successfully across the range of services and needs (Miller et al, 2012). Finally, it is being claimed that GPs are better able to engage with and challenge secondary care clinicians, and that they are ensuring that the work of CCGs focuses directly on benefits to patients. This latter claim is, of course, one that was also made by PCTs. For example, one PCT in the North West of England highlighted the intention of 'keep clinicians at the core of service design and commissioning' as part of its organisational development plan.

The GP and manager dynamic: a symbiotic relationship

There was a strong belief by respondents that GPs' clinical contribution is needed by managers and that it helps contextualise policy and provision. However, GPs recognise manager's important role in policy formation, implementation and overall strategic development. Conversely, managers greatly appreciate the clinical input from GPs and other clinicians as this provides a firm foundation to policy and presenting business cases etc.

There is a near universal mutual respect between the GPs and managers we interviewed, with each valuing the others' role and contribution. GPs and managers discussed how they needed each other and the various skills, insights and contributions both bring.

It was argued that managers are able to formulate policy and strategy, able to act as a steer through the policy process, write the various policy documents, business plans and present the case to various parties and government, whereas GPs can assist in clinical input and also have a good understanding, being close to patients, of using various systems and procedures and pathways on a number of levels and have a good knowledge of what will work for patients and providers and what will not. These GPs illustrates some of these themes:

'The managers find it, I think, invaluable, because the accountant understands the accounts, but he doesn't understand why we're spending too much on one procedure and not enough on another, and what the clinical...you know, the situations behind all that. So it's a partnership that works well. We couldn't work without them, and they can't work very without us' [GP ID 200].

This GP puts the GP and manager relationship in the following context:

'...if commissioning's a bicycle, just because you change who rides it, why's it going to be any different, okay? And the answer is, it isn't... so there's no point being deluded and saying, Well, GPs are in charge, therefore it's all better...But what it gave us was the potential to say, can we unlock the best of all those...people working together? And I think that's what we've been able to do, which couldn't have happened before because there was no room for the GP engagement in that process...We've got much more GP empowerment in each of those committees, and I think that's made a substantial difference, but it's not a case of, managers couldn't do... we need the managers just as much as they need us. I think what we've done is allowed... we've freed managers... managers beforehand couldn't be managers. They had to be managers and pretend at being clinicians. Now they can be managers, and they've got clinicians working with them' [GP ID 231].

There was also a view (albeit a minority one) that GPs are more willing to engage with other GPs rather than take the word of a manager, as they are now engaging with their peers and colleagues. As one manager stated, it was much easier for a GP to 'sell' a proposal to fellow GPs than a manager trying to do so as the trust is there.

However, overall there was much mutual respect of the role managers played and this was echoed by managers in relation to GPs and other clinicians.

Managers greatly valued the clinical input and the patient focus that GPs and other clinicians brought. Their clinical expertise aided such things as policy development, service provision and pathway development. In addition because GPs and other clinicians work on the front-line they have a much clearer idea of patients' needs and what is practical and deliverable. This manager echoes some of these points:

'...as managers, [we] were trying to lead the practices to do the flu plans and it did need quite a lot of clinical input about the practicalities of if you only had three GP's and things like that, whereas, now...so I think we felt quite uncomfortable, maybe a bit vulnerable, in some ways, that we may not be quite getting the answers right, whereas, now I feel it's very much a partnership and we have that mandate from them of their informally saying, ah, but have you thought of this, this and this? So actually when we roll it out, yes, we have thought of X, Y and Z and we've got the answers to that and this is why we've chosen to do that and I just feel like we have that a bit more now...' [Manager ID 130].

The GP manager dynamic was seen as greatly important and many GPs and managers spoke very highly of each other and their good working relationships and how together they established a good partnership and complimented each other in their skills and abilities. As one GP noted on the clinician manager dynamic:

'...it's having the right manager matched to the right clinician. This should almost be a dating process!' [GP ID 349].

Engaging with GP Practices

Engaging with GP practices and ensuring practices were engaged, informed and felt a valuable part of the CCG was seen as very important. Three main themes emerged in relation to engaging with GP practices:

- Quality assurance visits and sharing best practice
- Training and education

- The provision of various programmes and liaison through meetings

There were a number of ways of engaging with practices. One mechanism was through quality assurance visits or what could be termed performance management of practices. The emphasis was that these visits were not to be seen as an 'inspection' but more of an aid to practices to identify where services could be developed and where they excelled and use this to share best practice with other GP practices. One study site was conducting a 'listening exercise' with practices to hear their concerns and their views. Although not a major element of the discussions, in respect of engaging with practices in regard to training and development etc. there was a recognition that more work needed to be done in this area.

These GPs discuss such visits and the elements to them and their value:

'There's a big kerfuffle about what you call these visits but it was purported that they were quality visits but this quality has a performance element attached to it. So I've got to address each member of practice and say well your impact on the Clinical Commissioning Group and budget is well these are your referrals, these are your prescribing figures, these are all the impact that you have, these are the A&E attendances that are happening during the day. This is your patient experience survey data; these are some of the comments that are coming back. These are some of your low referrals, you know, how are you managing that? Are you referring enough? Or your reporting rate for instance is very high and I think that's a great thing, it shows a good safety of patients, safety culture. How do you do that and how can I share that good practice? Hopefully it's going to be that type of relationship' [GP ID 102].

'...the information we've got from those visits has informed the design of the access work because it became really clear that there was such a variation and some practices really understand their processes and their systems and how efficient that everything is and others haven't got a clue. So it's about trying to share good best practice as well' [GP ID 122].

The provision of education and training was also as another way of engaging with practices. This could range from half days presentations on the Health and Social Care Act and the role of the CCG to Dr Foster Training, training with data analysis etc. The provision of various programmes to practices was also seen as a method for engaging. For example, one GP discussed their role in engaging with practices on developing clinical leadership, another on the provision of a risk stratification tool with practices. A clinical lead described how they were involved in dermatology service project to have a dermatology champion in each practice. In addition there would be formal meetings where GPs from practices would meet from the governing

bodies of CCGs to GPs engaging through locality forums etc. Managers engaging with practice managers and other clinicians etc.

Commissioning Support Unit

Commissioning Support Units (CSUs) are a new feature of the reorganised NHS. Essentially, staff with responsibility for supporting commissioning work have been transferred to one of 18 CSUs although a number are looking to merge (Todd, 2013). CCGs are expected to commission CSUs to provide support services for them, and they can choose from a menu of possible levels of service, from a minimal service such as back office functions, to a more complex package of commissioning support. CSUs are currently hosted by NHS England, but it is expected that they may become standalone third sector organisations in the future. Their role and functioning are a work in progress at present, and respondents in our study were just beginning to explore their relationships with the new bodies. Many respondents noted that they knew staff from the CSU, as prior to re-organisation they had been employed by the PCT. It was felt that this helped to develop relationships. This is just as well, because respondents also commented on the need for the development of such relationships as newly constituted CSUs found their role in the new system. For those using the services of the CSU the record was mixed. Some thought the services provided by the CSU were good, however, it was also believed that there were a number of issues over the quality of information and data provided by the CSU and it was felt by some respondents that they needed to be much clearer and explicit in the future, describing to the CSU what was required. These interviewees discuss these concerns:

'...I get the feeling there's a little bit more of a mind-set at their end which is, well we can find this data, so we will provide that data, and the questions were being asked that were maybe more helpful, it's a tougher job to do, so we won't really do that, that would be perhaps a wrong assumption, but it feels that way...Certainly from a new organisation wanting to please a new client, one might have expected a few bells and whistles at the outset of this part of the equation' [GP ID 104].

'I've experienced some frustration with actually getting data, the timeliness of information being produced. I think because it's such a huge organisation looking after so many CCGs sometimes the prioritisation as a customer you start thinking well I can't move a piece of work. I've waited three and half months recently for some ultrasound data and we had to escalate it, letters coming from the network to get something happening because there just didn't seem to be any impetus and we were just being, well what I felt was fobbed off, we need to do this, we've got to do that, which doesn't help' [GP ID 132].

However, respondents said that they hoped that once the CSU had settled into its new role then matters would improve. As respondents noted, it was a work in progress. There was also some recognition that the CSUs may not have the staff required to support CCGs comprehensively.

Commissioning work

One of the focuses of our interviews was on the practical work that clinicians were doing related to commissioning. In this section, the different categories of work related to commissioning will be addressed.

Pathway development

The development of patient pathways was a key issue that emerged. Three main themes were seen in this respect:

- Issues around pathway re-design, development and new pathways, notably to ensure pathways are efficient and effective and the strategic co-ordination of pathways.
- The benefits of having clinical involvement in pathway development.
- The difficulties of working across boundaries such as local authority boundaries and working with other CCGs.

Issues around pathways in the context of development, new pathways and pathway re-design in addition to ensuring pathways were efficient and effective was one of the main themes reported. Furthermore, overarching these elements was the strategic co-ordination of pathways. Respondents discussed pathway re-design and development in a number of contexts.

Respondents were involved in pathways in a number of circumstances and in a number of arenas. One respondent discussed pathway development for the intermediate care and trying to involve secondary care in the process. Another discussed an ambulatory care pathway across four CCGs. Long-term conditions was the responsibility of one respondent in terms of ensuring that the pathway was efficient and effective. Managers were involved in ensuring that pathways were robust and that timely information was delivered, in terms of any pathway re-design and new pathways. This is in addition to getting the input from practices on improving pathways. Pathways development would be discussed in a number of fora, including network meetings, locality meetings, commissioning meetings and pathway re-design groups.

This GP discusses future pathway development and ensuring the engagement of all relevant parties and strategic co-ordination:

'So that's going to be the first session of the LCF [Local Commissioning Forum] and then we're going to plan for future sessions. And the future sessions might well include things like pathways. So for instance, DVT [Deep Vein Thrombosis] pathway, a fantastic pathway, really good. But experience has shown that the people that use it are the people that know about it. So the presentations on it were done at council of members and were emailed round to practices. But that doesn't get to every GP. That's what we've discovered is that the people that come to council of members know about it, but it's variable as to how effectively they will distribute it to their teams. And that's because of lack of time again, you know, because there is just no time, there is no time for people in practices to meet. So that's the idea of the LCF is that actually don't launch pathways at council of members because you've only got ten percent of the medical workforce there. Launch it at LCF where you've got everybody there, including practice nurses and community matrons, and then help practices take ownership of some of these pathways, rather than here's the pathway, you do it. It's kind of well, first of all, think of an idea, we'll work it up; if it makes sound patient and financial sense, we'll work up a pathway; here's the pathway that you wanted and let's start using it. And we think we'll get much better engagement that way' [GP ID 339].

Below are two projects in relation to pathway development discussed by GPs.

Case Study: Community geriatrician project

The GP was at a GP learning session. In the session they focused upon what GPs wanted to make systems better and one of the major issues was having domiciliary visits back for GPs and a consultant. In addition, there was a major problem with care homes and their A&E attendance and admission rates. At the same time, the GP was contacted by a consultant at the Foundation Trust because their readmissions were high (in which they get penalised) and the trust wanted to undertake a project looking at their readmissions and they, like the GPs at the learning session, highlighted care homes as an issue, so it was decided to collaborate in the context of the needs of the GPs, the needs of the trust and the needs of the care homes and calculated the costs for the project to reduce readmissions.

The project was established in which there was a geriatrician from the hospital who works with the community matron who is from the community trust. The matrons weren't performing well and felt unsupported and had no leadership role, so an extra matron was employed, their hours extended and had the community geriatrician supporting them. The matrons are now conducting teaching events in the care homes, drafting all care plans for patients, including anticipatory care plans. The community geriatrician, who is now partly community based working with the matrons, will come and see referrals in the care homes. As a result, A&E attendees from care homes had fallen dramatically, down by nearly 49%.

Apart from this outcome, it is believed the community matrons enjoy having the clinical leadership and support which was previously lacking. This has resulted in them being able to make more decisions because they are confident of clinical support. The matrons meet with the community geriatrician once a week to discuss their caseload and any issues. In setting up the project, KPIs (key performance indicators) were outlined and funding was sought from the SHA (Strategic Health Authority) by the CCG and the funding was given up-front to fund it. The project is now being commissioned long term and expanded slightly.

The GP was involved in setting up the project, liaising with the consultant at the trust, the community matrons and commissioning manager. The aim was devising a pathway, referral form, feedback, and service specification for the consultant because the post was funded by CCG. The GP drafted the pathway, which was circulated and amended by colleagues and then approved. The GP was also involved in amending various elements of the project at various stages. The service specification of the project was drafted by managers. The project went live and in the first few months the GP met with colleagues fortnightly to monitor the project and then the meetings continued on a monthly basis. The GP is now only responsible for drafting the annual report.

Case Study – Haematology project

A GP discussed a pathway pilot in haematology. In a haematology blood test, some blood tests are abnormal, some are normal, and some are in between. Some of the abnormal blood tests can be managed quite well in primary care, and they don't need to be referred to secondary care. However, there are some borderline blood tests which can be managed in primary care with some advice, and there's some tests that would eventually need to be referred, but can be monitored in primary care. For instance, there could be an abnormal white cell count, or an abnormal amount of protein in the blood, which isn't perhaps crossing the threshold where it needs referral.

The GP was involved in developing an e-referrals system pathway, which is used in cardiology, mental health and paediatrics. There is a CQuIN [Commissioning for Quality and Innovation] in the acute Trust which had used a way GPs could send in queries, which could look at actual advice without them being referred. However, it was 'kind of a fudged system' because it used ordinary emails. Decided to use the 'choose and book' advice and guidance, which has got a tariff system and various mechanisms, and base that as a template for the new e-referrals system. Negotiated with the acute Trust with a view that the choose and book template is going to be used. Hoped to have a suite of suggested guidelines, and one of the options would be to do an advice and guidance referral, following the template. This would be worked through and developed and possibly led by secondary care. The new system has to be effectively communicated to GPs. It is hoped it will:

'... improve the care pathway, hopefully reduce the number of secondary care referrals, reduce their 18 weeks problem, reduce everything, win, win'.

As can be seen in these examples above and the discussion on strategic co-ordination earlier, a key theme highlighted by respondents is the need for strategic

co-ordination and making sure the right linkages are in place to result in smooth pathway development. This manager discusses one method of ensuring strategic join-up:

'...recently for the [local initiative] paediatrics work [a GP] asked for feedback on I think it was bronchiolitis pathways that have been developed ready for the winter. So she liaised with the programme link in our locality...he came to the meeting, we circulated the pathways and asked for feedback and then...collated the feedback and fed them back to [the GP] and also he asked the group to share those with the practices. So it's just getting their involvement that way, it's just a different way of trying to link them in really' [Manager ID 131].

Benefits of Clinical involvement in pathway design and development

Having clinicians involved in pathways was seen as beneficial for a number of reasons. Firstly, GPs having a conversation with fellow GPs and other clinicians means they can discuss clinical aspects in-depth as opposed to managers who do not have this same level of clinical knowledge. Secondly, because of this clinical knowledge, clinicians will have a good idea of what elements may or may not work in relation to a pathway. Finally, GPs are closer to their patients and hear from them any problems they have encountered in relation to a pathway. These interviewees discuss these elements:

'So a lot of...it is around the clinical care a lot of the time but they've [GPs] got more awareness of the patients because they work a lot more closely with the patients. So when you're trying to look at services and what you're going to be commissioning they can actively say hold on a minute this isn't working for those patients because of this particular reason. We're doing a community ultrasound project...at the moment looking into putting in the community ultrasound and that came up again as a result of direct discussions... because they are saying well our patients...we're having problems with our patients because they're an older population, their transport links are not good and they're having to travel from miles to go for an ultrasound at the hospital, relying on friends, family...if we had something more local this would be much better for our patients. So they're very good...at fighting for their patients. So it's very good, you do get the patient perspective from a GP standpoint as well, and the issues that their patients are potentially facing. So I think it's very good, it's another way of hearing the patient voice through what the GPs are saying. Putting the clinical input into the pathways, the care pathways as well is invaluable' [Manager ID 132].

'...we see the patients, I think we talk to the patients, and I think the Managers, you know, bless 'em you know they're all lovely, but you know sitting in an office, it's very hard for them to understand the patient pathways. You can see what would work on

paper but I think the difference is that I see patients every day of the week and I will say to them 'how was your hospital experience?' and they will tell me, but as a Manager you would only be able to read that in a report so I think the difference is we bring the realism bit' [Nurse ID 40].

'...the current dermatology pathway we have, we have community dermatology for non-cancerous problems, so someone with eczema who doesn't need to go to the hospital are seen in the community but there are, with any qualified provider you have to have three providers providing that. Now sometimes the GP themselves do get confused as to where to send this person to and one of the plans was to have a layer on top of the referral layer saying, so the GP refers to that point and at that point will then refer to the right person. The input we had as a clinician is that why do you want to point, what you need is the knowledge given to the GPs in a simple format saying this is where it goes and then let one point straight refer to the other rather than having those layers' [GP ID 33].

'...there's a clinical pathway around treatment of heart attacks...and it was just seeing a patient who had been through the pathway and the patient thought it was fantastic the care they'd got. When I listened to that patient I thought, this isn't right, this isn't good quality care, actually that patient has been put at risk in that that they didn't need to have, and I need to look at why has this patient gone through this pathway in this way. And, I discovered it was the wrong pathway really in terms of quality, and we've changed that now and they get the right quality of care' [GP ID 282].

Difficulties working across boundaries

Although not a major theme, some respondents discussed the difficulties of working across boundaries. These boundaries may be with local authorities, other CCGs or the boundaries between health and social care for example. As these respondents illustrate:

'...the pathways for our patients are just a bit of a nightmare, because there's patients at [one local authority area], they've got different social services and all sorts, and it's difficult to get the links. They provide very different services there sometimes, and it's a question of trying to get things to link up' [GP ID 105].

'...it's slow because for something like the ambulatory care it's got to be the same across the four...CCGs. And sometimes just they all have meetings at different times, and once one disagrees with something it then has to go back, it is quite frustrating – it is slow' [GP ID 39].

Contract negotiation

In our earlier work, some respondents had suggested that contract negotiations were one area where GP clinical knowledge could be of value, (Checkland et al, 2012). We therefore explicitly asked respondents about this area of work. In practice, it was not seen as a major component of the GP role. However, those who did see it as important tended to discuss contract negotiation largely in the context of the emphasis on quality and in relation to strategy development. Some respondents were either involved in contract meetings, and / or committees involving commissioning, service development and quality with emphasis on strategy. Some interviewees were involved in drafting service specifications, and performance measurement. These respondents give a flavour of such activities:

We've brought quality to the focus in terms of our contract. The way we contract and the system that we've got, we're about to deliver...we've got a system where GPs can...inform that process...It's about [a] challenge to what's going on, to ensure we've got the right quality stuff in there' [GP ID 348].

'We'd set up a new contract for diabetes in the community, and we ran it as a pilot. We now want to continue it, and the Trust say, well, if you want to continue it, it will continue to cost you another £80,000 a year. I had to point to them that actually the results of the trial was that the number of diabetics that were going to hospital has reduced, they're better managed in the community, that they're overall workload in hospital has gone down, so it should be absorbed into the block contract that they've currently got. That's a fairly simple one. I suppose, again, going back to things like the DVT [Deep Vein Thrombosis] pathway, they would say, it's dangerous. You can't do it. This can only be done by a hospital, so we're able to say, actually, no, it's a simple four-step pathway. You don't need any training. As long as people follow this pathway, it's safe, it's absolutely safe to do so, and we're basically not giving you that contract because you charge £1,000 and we can do it for £100 in the community. It's just things like that, that we would challenge them on' [GP ID 266].

There was some discussion amongst respondents in relation to problems with contracts and these included whether a provider is delivering as set out in the contract, problems with providers dictating what they can provide as opposed to what the CCG specify and one provider discussed the issues of the conflict of interests in relation to provider and commissioning.

Procurement

In relation to procurement, again, this was not a significant theme in the context of the study. When discussing procurement the emphasis was on quality through scoring and evaluation of bids and in setting specifications. Respondents focused on

the fact that clinicians know patients' needs, and can therefore contribute effectively to these areas.

Contract Monitoring

Ensuring quality, cost-effectiveness and the needs of patients being addressed were the key drivers of contract monitoring. The monitoring gives the opportunity to flag up issues of concern, particularly for big contracts, before they become a major issue. These two respondents give a flavour of the monitoring process and procedures:

'...how are we doing with this year's contract, how are we managing this year's contract? If we are not managing it very well, what can we do to reduce it clinically, what are the new clinical ideas?...we started a community warfarin initiation project which is done by two practices. How is it going? When we're timing it to make sure that we get the information from that to develop whether it was a useful thing to do, whether we want to flow it out to the rest of the practices and to take it from there' [GP ID 33].

'...so one group will be about quality the other one will relate to service development. So okay we've got this contract but actually what we'd like to do is do less of that something and actually we'd like to provide it in a different way. And the service development group is about how you take forward those developments and the contract management board is realistically about managing what we have agreed that we will do. And so those things are in place' [GP ID 284].

Other aspects of Commissioning

No clear themes emerged when discussing other aspects of commissioning, although three minor themes were apparent. Firstly, the value of GPs clinical input and secondly, the potential for commissioner/provider conflict of interest. Finally it was contended that commissioning was not understood very well by clinicians. These respondents illustrate these issues in reference to the potential conflict of interest in regard to commissioning and provider split and GPs understanding of commissioning:

'I think it comes down to a pants question! It depends on whether I'm wearing my commissioning pants today or my providing pants. Because we are commissioners and providers aren't we? And it depends as to what sort of knickers you've got on next morning, as to how successfully you can drive this process. So, from a commissioning perspective, I should be very hands off, however, from a providing perspective, it's not going to work if I'm not hands on. So trying to find a balance between those two is very, very difficult' [GP ID 349].

'I think most of my GPs don't understand commissioning as it has become to be understood. You can [get] diplomas and degrees in commissioning, when they read about commissioning, when they look at their magazines about commissioning, when people come and talk to them about commissioning it's presented as a tremendously complicated issue. All of this CQC, all of this standards stuff which is supposed to make everything wonderful, but which I'm hinting to you does squat bugger all, means nothing to them. I try to basically break commissioning down to where, when, how and why, and I want to demystify commissioning and I want it to be very, very practical about what they do with the patients that's with them now. So I don't like a lot of the advice I get from all those people who want to give me good advice, and I hate it when it gets complicated, because if this is complicated what the hell am I doing it for? Well, it has to be simple. These huge public service provision issues do not work if they're complicated. Why is Choose and Book useless? It's complicated! I used to contact the appointment system at the local hospital!' [GP ID 183].

This Locality Support Manager discusses the value of clinical input into commissioning:

'...what would happen for example in the networks we have commissioning leads now and they're known as commissioning leads for the networks, before it was just a representative from the network came and was talked at. Whereas now they are making more...having more input into the commissioning decisions in terms of pathway developments saying they're being asked well this is what we want to do what do you think? Oh we've got the right things in this service...this is what we're thinking of putting in is this the correct information, do we need to improve anything else? What considerations do we need to make? So their voice is being heard much more in that and then we've got clinical leads for each area. We've got a lot more clinical leads than we previously did have which is quite useful to us, you need that clinical input because sometimes you just couldn't get hold of a clinical leader, you'd be waiting for a long time to get a response from them' [Manager ID 132].

Previous involvement in clinical commissioning

Although a minor theme, prior experience predominated in regard to involvement in clinical commissioning. This usually was through PCT or earlier involvement (PCGs) or through practice based commissioning.

Localities – themes and issues

Many CCGs have local GP groups which are often known as 'localities'. Localities are often built upon previous local structures such as previous practice-based commissioning groups, or local educational initiatives. Many practices now in CCG localities have worked together for many years in different ways. Our initial research in this area (Miller et al, 2012), highlighted the fact that the roles and responsibilities of CCG Localities are often unclear, perhaps because they have been built upon these pre-existing structures. The range of roles seen included the following:

- As a vehicle for maintaining GP engagement
- To collect local-level intelligence to inform the work of the CCG
- To provide representatives for the formal governance structures of the CCG
- As a forum within which to disseminate information
- As a forum for educational and quality-related activities
- To undertake commissioning-related work for the locality
- To undertake commissioning-related work on behalf of the wider CCG

In this part of the study, engagement was the major theme to emerge in the conversation about localities. Engagement was couched in terms of the lack of engagement from the CCG or other organisations such as social services, or practices not engaged. Engagement was also discussed in the context of the extent to which different localities are engaging with their CCG and other localities and are starting to challenge on issues such as finance and budgets etc.

One GP discusses the difficulty of co-ordinating primary and secondary care through localities and the difficulty of engaging social services and other providers and that it is difficult to engage with key individuals. Another GP discusses that they had a two day sabbatical per week for three months and part of their role was to change the mind-set of their locality from being a sub-committee of the PCT to functioning locality under the CCG. Here they explain the difficulties with engagement:

'I basically concentrated on getting the...locality from basically being a sub-committee of a sub-committee of a PCT, into facing up to the rather stringent reality of the Health and Social Care Act being law and the fact that we all couldn't go around pretending it wasn't. But most of the practices are still going around pretending it's not, but it's not because we haven't told them' [GP ID 183].

Another GP discusses disengagement in the localities due to the perception of not being allowed to lead on commissioning:

'I'm walking away from it, and in the other localities, they've not managed to recruit anyone to lead. And they've got an interim lead, and I think it's all...it all feels very

fragile and it feels like a lot of window dressing. And why bother? GPs have got better things to do really. And I can see the importance of it and it's completely right that it should be clinician led, but it's not being allowed to be clinician led' [GP ID 162].

This locality chair discusses how the locality was not consulted by the CCG:

'My concern at the moment is there is a bit of a disjoint in that – and I raised this recently so I'm not saying anything that I haven't actually raised my concern over – is that a lot of the time these things come out to us and they're filtered down so there was a change in our strategy in originally doing the six clinical areas and the four others and it was then changed to the seven programme areas... I specifically don't remember them coming out and discussing that with us. It was lost in the myriad of papers that come out and I think it's not [because]...our views haven't actively been sought but because it hasn't been teased out as being sort of this is the way the CCG thinks things should be going as GPs on the job what do you think? So that got missed' [GP ID 106].

However, respondents also discussed how their locality or localities were actively engaged with the CCG and each other and a variety of other organisations and would, for example, question on issues such as CCG finances, and some GPs were seen as fighting for the interests of their locality.

This Locality Chair discusses how their locality is becoming more engaged:

'I've got to say the Locality Meetings are challenging. They should be challenging. I think they're getting more challenging but I think that's a good point in that GPs are now realising that GPs are controlling their budgets, and I think challenge is becoming because of that' [GP ID 105].

One manager talked about how their locality had always been a challenge, but largely in a negative way. However, more recently, they have become more engaged and involved in the decision making process of how the CCG works. They are now challenging the CCG on a number of issues and taking a more strategic view. They are also sponsoring a piece of work around integrated care teams. Although the request for GPs to feedback issues from the locality meeting to practices has not met with unalloyed success, it is a situation that is improving. Here the Locality Support Manager discusses the locality challenging the CCG:

'They challenged whether each of the localities are being truly represented on certain committees and whether the GP voice is really being heard and whether it's clinical commissioning rather than managers making decisions, so they really challenged that' [Manager ID 131].

A GP discussed how their three localities are now working much closely together as historically they had done things very differently. The emphasis is on more joint working and avoiding duplication. However, it was stressed that each locality still had a desire to retain their identity. Furthermore, a forum was established in which the three locality leads would meet and share best practice to take back to their own locality.

Another GP talked about how they are going to hold a monthly mental health community forum which will have the mental health leads from each of the localities in attendance.

In one study site localities had delegated authority to implement schemes up to the value £100,000 and the authorisation process was reviewed annually. Such schemes included adding extra pharmaceutical support into GP Practices, GP prescribing quality etc. However, across the sites, this was the exception, not the rule.

Patient Groups

Although not a prominent feature of the discussions with study respondents, when asked about patient groups and patients attending various meetings such as the CCG governing body, the view was that in regard to patient groups there was a need overall to engage them more. Some discussed how some patient groups would have a good attendance whilst others would not and the links with patients' networks and how these were utilised. This GP who sits on a Patient and Public Engagement Reference Group discusses engaging with patient groups and gaining their views:

'...we have several mechanisms. So we have the CSU that has a patient involvement, [a] patient engagement lead...And they seek patient views on our behalf, usually for particular projects...So we're doing a review into community services to see whether they're fit for purpose really. And the CSU are leading that review and I sit on the Board there. And so we've tasked them with well, how are you going to get patient involvement in this, you know, what do patients think about the community nurses and home care and district nurses. So they've come up with a plan of how they they're going to do that, and off they'll go and seek views. And they'll do interviews, they'll do questionnaires, they'll try and reach the hard to reach groups. So, you know, for instance the over eighties who are housebound who maybe have a really good relationship with their district nurse, they're probably on first name terms, they're not going to want to say the bad things about that district nurse. So we have a way in there...there's a network of older people's groups...they will do that work for us. They will go in and speak to patients, do the home visits on a

one to one basis, to give us that information. So, of course, we're very conscious that he or she that shouts loudest is often the one that's heard, but we want to get that broad range of opinion' [GP ID 339].

In regard to patients attending meetings, such as the CCG governing body that meets in public, it was felt that there was usually a good attendance from the public. One GP noted how their patients would attend the governing body meeting. Another respondent discussed giving a presentation to a variety of patient groups about their CCG and also participated in locality 'roadshows'. It was generally believed that the public would ask insightful and interesting questions.

This GP Chair discusses the public in regard to public governing body meetings:

'Well we've got quite a lot of people coming to the governing body and particularly a consistent few from some of our patient participation groups in practices. So that's quite interesting, that thread from the governing body, to individual practices to their patients and these are unpaid, aren't they? They're often retired professional people who take their time out to come and take their own notes and then take that back and talk about it' [GP ID 101].

CCG Challenges

Difficulty engaging GPs in the CCG

Study respondents were asked about any difficulties engaging GPs in the CCG. Two major concerns were voiced here, firstly that not enough GPs were engaged with the CCG and allied to that, as alluded to earlier, were concerns that with GPs retiring or leaving the profession etc. there was no succession planning for the generation of GPs and other clinicians to take over the work of the CCG. There were concerns that GPs and other clinicians were too busy with their own practices and work to become engaged with the CCG. As such, it tended to be the same individuals who would volunteer for roles. This then led to concerns about succession planning and the lack thereof. There was also the recognition of the need to engage GPs more in relation to the work of the CCG and its role and function. Vacancies on various committees were another issue. Another feature was the concern, as alluded to earlier, of the CCG roles and responsibilities GPs had to undertake and GPs not believing they had the time to take on such responsibilities.

Here some study respondents articulate these concerns:

'...get 60 or 70 GPs together in a locality and you'll find there's one or two folks who endlessly seem to end up going to the strategic meetings and the burden and everybody else seems happy with this, and in this engagement for wider involvement you end up with people just saying well, you'll do it anyway. So that's the kind situation we're in...it's grown up over many, many years and it hasn't been helped by the fact that as new GPs have come in they have had zero interest in the wider administrative burden that used to be shouldered by a larger group of usually male fulltime GPs. But I'm afraid we have identified no young thrusting GPs with an interest in the wider strategic administration of the NHS. They're all more interested in work / life balance' [GP ID 183].

'...I don't think we should underestimate how much more development there is still to do, particularly in engaging the membership in both an understanding of what being a member is and what we are members of but also you know, how they can then use that membership to effectively change the commissioning landscape which I think for many of them at the moment they either conceptually or intellectually don't understand and if they do have an inkling, either don't have the time or don't have the inclination to get involved, if that doesn't sound too cynical' [GP ID 35].

'...I think it's getting GPs locally to understand that they are the CCG, and that they can contribute to pathway development and things...I only really have contact with the ones who come to the Council of Members but that's only a fraction of the GPs in the area. So, probably the knowledge of CCGs to the majority of working GPs is pretty small really, and we want to make sure that we're not just seen as like a PCT who tells GPs what to do, we want them to be involved in it' [GP ID 285].

CCG Funding

CCG funding and the lack of, was still a worry for some of the respondents in the study. In conjunction with this concern was the recognition to control practice costs and the need for more integration to potentially make further savings. In regard to financial concerns a whole plethora of issues were raised from the general financial climate and the 'Nicholson Challenge' (Appleby et al, 2014), of delivering £20 billion in productivity improvements by 2015, the running costs of the CCG being too high, spending going to secondary rather than primary care, the financial challenges of administering a failing trust etc.

This Commissioning Lead discusses controlling practice costs:

'...we've...got a fairly good buy in from the GPs on the healthcare budget and the understanding that there's only a finite pot of money. But again, we haven't really delivered the drivers, the incentives and the disincentives to spend money wisely. So you'll still get the odd GP who will still prescribe erratically and not worry about

the implications of that, or admit people to hospital willy nilly. And so I think that work, we can build on fairly quickly because we have got that peer pressure...' [GP ID 162].

This Clinical Lead discusses the need for integration and pooled budgets:

'This crazy system, so we want to sit down at a table with a bunch of GPs and a bunch of secondary-care physicians and social workers and everything else and say, right, this patient has X number of conditions – rather than sign them into one – what would be the best way, if you could design the system from space now how would you see their path of care, and try and ignore all these sort of self-interested systems we've built up over the years. You wouldn't design a healthcare system the way that the current one works' [GP ID 283].

CCG size and boundaries

Although not seen as a major issue, a concern of some study participants was the size of their CCG geographically, and issues relating to co-terminosity of boundaries and inter CCG working.

A number of issues were cited in relation to CCGs geographical size and these were from a CCG being too large and remote and not adequately responding to the needs and wishes of localities and practice populations and difficulties sharing information across the CCG. Conversely, there were also concerns raised in regard to CCGs being too small and the waste of resources due to the duplication of financial and human resource costs with small neighbouring CCGs. There were also concerns raised in regard to co-terminosity of boundaries being a problem for the work of integrated teams in the context of differing policy and practice of neighbouring CCGs. One respondent cited trying to deliver a Deep Vein Thrombosis pathway across four CCGs which had been signed off four months previously but was held up due to the different committee cycle of the four CCGs and therefore the CCGs had not signed off the finances for the pathway.

Policy and Practice challenges

Although not prominent concerns in the discussions, three areas predominated on issues around policy and practice: firstly, there was too much central control over policy and practice by national government, secondly, the reorganisation of the NHS due to the 2012 Act (Health and Social Care Act, 2012), had caused large scale disruption and finally, that after such an upheaval new and existing organisations were still taking time to settle down and as such clearer communication and networking between organisations were still developing.

These respondents highlight their concerns in relation to national government and centralised control over the policy process:

'It's more difficult when you're centrally restricted. So you can see something you would like to do but legislation prevents you from doing it. So I think unfortunately we've been given something on the one hand but we haven't been given the freedom or the autonomy to deliver it. And again that's frustration, which is not a good one' [GP ID 163].

'...if the government gave us just a few more tools and kept their hands off us...because we do lack the right tools to be able to commission someone properly' [GP ID 165].

'GPs just don't have time to...have long, discursive, heartfelt discussions about what they feel about the Health and Social Care Act. Most GPs will tell you what they feel about that in one phrase and it won't be printable. So we've got this deficit that really the Government, the very high politics lost our GPs almost to begin with. And we're trying to make up by saying don't look at that sort of stuff, look at the sort of stuff we're doing practically in your...locations locally' [GP ID 183].

These respondents discuss the effects of the resulting reorganisation:

'Well I think that this government reorganisation has been less than helpful to us ...because we were essentially there, and what's happened is we've lost the memory that we had within our organisations, because they've been spread to the four winds' [GP ID 348].

'...it's been very disrupted over the last eighteen months. People are having to reapply for jobs and we've been in a kind of state of paralysis for the last twelve months, eighteen months, in this transition...I think we've lost time and I think we were probably further ahead...two years ago...And we've stalled quite a bit. We're trying to get back, the amount we'd gained, in terms of engagement and developing services. And the sad thing is, every few years there seems to be a major re-organisation...And the problem is, people underestimate the cost of it, not just in real money, but actual time wasted' [GP ID 162].

In the aftermath of reorganisation it was believed that the new structures needed time to settle down within the NHS and externally and new networks needed to be formed in respect or organisations like public health and bodies such as Health and Wellbeing boards.

This locality support manager discusses how the reorganisation has affected practices:

'...with all the changes the practices don't know where to go because a lot of the people who were previously doing them are no longer there...They're not sure where the structure is and...you end up...you do a lot of firefighting and often you're chasing round trying to find bits of information...' [Manager ID 132].

CCG Successes

Despite CCGs only going live on April 1st 2013 and the year previous in shadow form, interviewees could provide examples of CCG successes. Such examples were of projects that had been initiated when the CCG had been in its shadow form, or at the latter end of the PCT.

This interviewee discusses a nurse education and support for practices project which: *'...because of the project...the practices have started to talk to one another, that they hadn't done for 30 years, to my knowledge, they've never talked to one another, and they're working together and sharing things. And recognising the advantage of working hand in hand, as opposed to doing everything separately. And I don't think that probably would have happened, I'm sure that could not have happened without the project. And the project couldn't have happened without the CCG'* [GP ID 348].

Other examples of success included:

- A scheme which involves the community monitoring of housebound patients with chronic diseases and a community ultrasound project and a cardiology one-stop shop.
- An advanced nurse/practitioner scheme which was initiated by winter pressures (and now to be continued), which will provide extra help to try and avoid people who have been discharged from hospital being re-admitted. Patients getting visits by a nurse after their release from hospital if their GP believes it is required.
- A pathway around the treatment of heart attacks being enhanced after the identification of improvements required.

This GP explains how the direct intervention of the CCG helped improve patient care:

'...I established a monthly...clinical quality working group and in each of the three localities I have a GP Clinical Quality lead and the guy in...[one] locality noticed two episodes in his practice, and he only has a small practice...two episodes of a patient who'd gone to A&E, had a blood test that would, the point of the blood test was to

give information about whether they might have had a heart attack or not, so it's one of the very early enzymes that's realised if there is cardiac damage.

So they had gone and they had had this blood test but they had been sent home before the results of the test had come through, so nobody had checked that, but the patient had got sent home and he saw this had happened once and then he saw a second example and then he thought, well this isn't right, because, you know, the people should have them looked at.

So through our group, because he had the support to be able to exercise the leadership, with our support he challenged that and to cut a long story short, the hospital then undertook an audit and they actually found a lot of people had been sent home and they didn't have a process for checking these things and because it was a hospital outside our area, we worked with that CCG and we raised the issue and then they took responsibility for making sure the audit was done and everything and it's just been concluded now, we are just getting the audit report back now that they have changed their practice and they have followed up all the patients and nobody had actually suffered any harm which is just a matter of luck really, but it's because the GP kind of noticed it, but he wouldn't have necessarily done anything or realised that he could do anything, but the fact that I both understand how the GP works and how that should be fed into the system, really it's because we kind of supported him and then he made it happen' [GP ID 267].

Engaging with external stakeholders

As part of the study, respondents were asked about the mechanisms for engaging with external stakeholders and other bodies such as local authorities and the level and scope of involvement. Here, the focus is on networking with external stakeholders, in addition to the interactions with public health, local authorities and health and wellbeing boards.

Wider networking was predominantly with local authorities, public health, social services and the voluntary and community sector. In addition, there was further networking through integrated teams, secondary care, and provider organisations for community services. Although, CCGs reached outwards they also had, for example, social services representation on a clinical body. Furthermore, projects were also discussed which featured joint working from other organisations. One such project involved joint working with social services, community services, hospital trusts and primary care within the local area.

These interviewees discuss wider social networking:

'I'm developing relationships with managers within secondary care, I'm developing relationships with management within social care, within the provider organisation for community services...so whereas most clinical leads probably work with one provider, I'm trying to work across all of them, so that's always quite a challenge, and you always have to bear in mind that your agenda is not the same as their agenda. So the politics of it is quite big' [GP ID 349].

This Clinical Nurse lead discusses how such joint working can make a practical difference on the frontline: *'...seeing the patient on the ground so you know, the patient whose parent is in the care home, and we know that care home isn't delivering what we want it to deliver, we're able to feed that in and actually can make a difference because we now have those communications, that network which we never had before'* [Nurse ID 40].

As can be seen wider networking was through joint meetings and joint projects and there was some indications of a desire to have further integration.

Joint working with the Local Authority

Work with the local authority was on a range of issues at a number of levels. Respondents reported such working as encompassing: engaging with social services at locality level and working on projects together; locality based forums that fed into health and wellbeing boards and social care; a CCG representative on the safeguarding children's board; an integrated health and social care forum that feeds into a care homes forum. Other instances of joint working included a Mental Health Commissioning forum that fed into the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing board. There was also discussion around a Transformation Integration Group with the aim of transforming services in the local authority area with representation from the local authority, mental health trust, voluntary sector etc.

There was also working on various projects together. In addition, there was of course, joint commissioning with the local authority.

This interviewee discusses the importance of the local authority link in relation to a fitness project:

'...it's important that we have a link [with the local authority]...because there's so many...the benefits of exercise are massive in terms of chronic diseases and so it's actually making sure there are things out there that we can access, and making sure

it's easy for patients to access them, and to align them to what we're doing. So if we've got a particular focus on something, so actually there's this service there. So it's communicating with them and making sure that things work well'. Joint working with the local authority was seen as very important was joint working with public health, if anybody knew where they had gone...' [GP ID 105].

Joint working with Public Health

The main theme when discussing working with public health can be surmised in four words: where did they go? Of course, under the 2012 Health & Social Care Act (ibid), public health moved from the disbanded PCTs to local authorities. This reorganisation has meant that many of the networks with public health have been lost. Respondents frequently cited that there was very good contact and relationships with public health whilst they were at the PCT but these relationships have been severed with the move to local government. Public health is now largely but not wholly seen as more remote with much less contact and not linked to localities as they used to be.

These respondents discuss the reorganisation and the impact it has had:

'They've moved to the council building down the road. So in just practical things, like they're not in the same building, changed their email numbers, changed their phone numbers...So practical things like that have been a nightmare, but that will iron out. But not having them in the building is...and there's less of them, it seems to be diluted, so watch this space...' [GP ID 165].

'I guess personal interactions in terms of just being able to go down to the office and get that, whereas, now it's trying to go through the local authority switchboard, trying to find them, they don't know who they are, you know, because they are quite new, so you're asking for a team, like, we don't have them there, as you do. So in terms of just not being able to go down and have that casual informal chat, that is where I do feel that we are lost, because I did actually know some of the team quite well anyway, just for corridor conversations of, oh, did you hear about NICE Guidance? That sort of thing and I do feel that that's been lost, I do on that' [Manager ID 130].

However, some respondents still reported good working partnerships with public health on projects, or attending meetings with the Director of Public Health or other public health officers. Nevertheless, the overriding theme was the reorganisation and the difficulties therein.

Health and Wellbeing Boards

Although not a major theme, for those who sat on, or worked with, those on Health and Wellbeing Boards (HWB), the overriding message was that it was still very early days for HWB. All upper-tier local authorities established a HWB (as a sub-committee of the local authority) in shadow form from April 2012, and these became fully operational on 1 April 2013.

Some initiatives were discussed in relation to HWB: one GP related how the HWB is developing locality based forums that will feed into the HWB at county level. A GP who is vice chair of a HWB at county level felt that issues with the HWB included the need for it to settle down and have a framework for quickly implementing ideas into workable policy and the need for policy and procedure for joint working to be put in place.

A respondent discusses the HWB in relation to it still being early days and the attend problems with that:

'It did a marvellous thing on...reducing excess winter deaths. We did actually do some different stuff. Interestingly one of the problems with it, there's nothing beneath it and ...you can't have the Health and Wellbeing Board doing, it's a board. So what lies beneath and what groups report to it and what work are they prioritising and that hasn't landed properly at all yet...' [GP ID 101].

However, as discussed, the overriding message was that HWB were still in development and had not yet had time to make a measurable impact.

Networking with other Stakeholders

Networking with a wider range of stakeholders' usually entailed formal meetings and meant links with groups such as various social services committees, secondary care, care homes forums, community, mental health and hospital trusts. Respondents participation took on a variety of forms from a GP being the vice chair of a Service Development Group of a hospital trust and GPs interacting with trusts around contracting and patient issues to meetings around more integration with secondary care. Although not as prevalent, some respondents discussed working with other CCGs in relation to a federation model, or working with providers who deliver services in a neighbouring CCG or CCGs. CCGs also worked together on such issues as the commissioning of mental health services, and A&E admission issues. A respondent discussed sitting on a clinical quality group which had clinical leads from 3 neighbouring CCGs. Very little discussion centred around the links with the voluntary and community sector, but examples of such links included working with the 3rd sector around hospices and end of life care, a GP discussed the good

working relationship with the voluntary sector in connection with a dressing clinic and a carer's day event. Another respondent discussed voluntary sector representatives on a planned mental health commissioning forum.

CCGs: impact on working/personal life and GP Practice

What makes the role easier or more difficult to fulfil?

Lack of time to do the role coupled with the need for a balance between CCG and practice work was the predominant reason cited for what makes the roles more difficult to fulfil and conversely, more time for their CCG role was given in making the role easier to fulfil. However, there was with that recognition of maintaining a balance between CCG and practice work. Another element, (although not as predominant), was that the role they had was more clearly defined for themselves and therefore for others, so there was a recognition of what their role entailed by colleagues.

This Locality Chair discusses the problems of time management and the CCG/practice balance:

'...time is always a problem, I mean it would be nice to have loads of time to do it. I think it's...the balancing of the clinical work and responsibilities with the work here [at the CCG], because you can't, I wouldn't want to cut down any more sessions, and the CCG don't have a massive budget as well, so they wouldn't want to pay me for any more sessions! So you sort of have to do as much as you can in the time you've got. And it is difficult, and sometimes you think, well am I doing as much as I should be? But then, actually, if you look at the time you're spending, it's quite a lot. And then it's trying to do the things, trying to squeeze the other things in as well. So I think time is the most difficult thing. Another difficult thing is if you need to arrange meetings, well I don't have much flexibility, because I've got clinical commitments, and so I only have...out of my two sessions a week, a lot of those are taken up with set meetings, so there's little time...so I rely on other people's flexibility to be able to do that really. So, they're probably the main things' [GP ID 105].

This respondent discusses their role development:

'I've got a more defined role now I think which helps. Whereas I didn't know what a Medical Director of the CCG did... there was just no template to this one and so I kind of got interested in certain things that went on and heard things and chased around like a Labrador puppy and kind of thought that sounds interesting, do it' [GP ID 102].

Time Pressures in the role

As mentioned previously, the time pressures that clinicians were under in their new roles in the CCG were considerable.

Reading documentation, responding to emails attending meetings outside normal CCG hours and during the evenings was common. There was a common concern that on occasions there was not enough time to fulfil their CCG role adequately and finding the balance between CCG and practice work was difficult and was having an impact on the practice. These respondents encapsulate some of these themes:

'I think what makes it more difficult is, trying to do the day job as well very well, trying to do two big jobs really well, and effectively, you know, I have to work 60-70 hours a week to do that, it is tough on a personal level' [GP ID 165].

'It is really, really tight; there's a job there for a full-time person. So I feel like I'm skirting around the edges which is a feeling shared by most of the people who work for the small CCG I think, because you only have a certain staff budget you just can't have a person working full time on respiratory for you – or cardiovascular, or diabetes, or...you know – so you land up with half an hour of me per week in each of those areas, very ad hoc. And I think that is a problem... And you're sitting answering emails at 11 o'clock at night et cetera, so the workload in the long term is just about sustainable at the moment, but it's hard' [GP ID 286].

One manager voiced concerns that GPs are nearing burnout and if the workload stayed the same it was not sustainable. One GP felt that they were continually fire-fighting and it was recognised that time pressures was a significant problem.

Study interviewees were asked with their involvement with the CCG, what impact this had on their working and personal lives and what impact it had on their GP Practice.

Impact on working and personal lives

Two main themes emerged when asked what impact the CCG had on their working and personal lives firstly were issues around excessive workload and secondly, how much respondents enjoyed the CCG work and enjoyed the challenge of working on the CCG. One less significant themes was that such a workload was unsustainable and difficult to get a work/life balance and a minor theme was that the CCG work afforded the opportunity to learn new skills.

These respondents illustrate some of these themes:

'...it's unsustainable and I've got two part time female [GP practice] partners with family. I've got a full time male partner... just started a young family and they need a quality of life and so we've just chosen to actually pay for a full seven session salary partner to ease that which is a big hit on your income but if I didn't have that I'd be having a heart attack within the next few years so it's a no brainer I think' [GP ID 102].

'And having...the CCG is not easier, but it's different. So having that variety in my working week is really helpful. It's not just, you know, 30 patients each morning followed by another 30 patients in the afternoon, you know, with just no time even for lunch in between. You know, that's mentally quite taxing when you're trying to do your best for each individual patient and they might have two or three problems each. That's quite a lot of decisions that you're making. And this is a different kind of taxing, you know, so it's more meetings and reading papers and, you know, reading emails and responding to queries, and there is time to do it, you know. So it's a different kind of stress. And I'm learning new skills as well, I think that's important to stretch yourself mentally. And I definitely am learning new skills, you know, in terms of leadership skills, presenting, standing up in front of a crowd' [GP ID 339].

'I think one of the ones is that you've got a mix, a portfolio working now; working in general practice five days a week – whatever people do – is incredibly stressful, it's hard on you emotionally, it's hard on your life and on your health, and so doing another role which is interesting and rewarding, uses those clinical skills but in a less intense fashion in some ways is good, that improves your quality of life' [GP ID 283].

This CCG Chair gave their view on the impact on staff:

'...GPs' morale's really bad, the hospital would say the same, my team would say the same, actually it's bad across the whole of the NHS. It really is and, you know, in most of my one to ones with my team people say they have never seen all parts of an organisation feeling like they can't cope anymore and stress being manifested, sickness and absence and arguments and attitude. All of the things that can manifest, I see that everywhere...' [GP ID 101].

CCG role and impact on GP Practice

Three main topics emerged in relation to this issue and they were:

- Time pressures and the difficulty of getting a CCG/practice balance
- The practice was seeing an impact because of CCG work
- Patients complaining that they cannot see their GP

A number of related and inter-related issues also stemmed from these three topics. Firstly, that the performance of the practice had declined because the GP was not there all the time or their particular skill set was not available. Some practices had got locum cover to address the cut in hours of the GP. Some GPs reported having to miss CCG meetings because of their practice commitments. This GP illustrates time pressures and the difficulty of getting a CCG/Practice balance:

'...it would be nice to have loads of time to do it. I think it's trying to balance... it's the time and the balancing of the clinical work and responsibilities with the work here [at the CCG], because you can't, I wouldn't want to cut down any more sessions, and the CCG don't have a massive budget as well, so they wouldn't want to pay me for any more sessions! So you sort of have to do as much as you can in the time you've got. And it is difficult, and sometimes you think, well am I doing as much as I should be? But then, actually, if you look at the time you're spending, it's quite a lot. And then it's trying to do the things, trying to squeeze the other things in as well. So I think time is the most difficult thing. Another difficult thing is if you need to arrange meetings, well I don't have much flexibility, because I've got clinical commitments, and so I only have...out of my two sessions a week, a lot of those are taken up with set meetings, so there's little time...so I rely on other people's flexibility to be able to do that really' [GP ID 105].

This GP relates their experience in relation to not being able to see patients:

'And, suddenly... [a patient] says, I can't get you for three weeks or two weeks...and then it starts to look silly. Then, oh, you're a hard person to get hold of. Which I don't like, you like to think you're offering a service that you have done in the past, which is people see you and feel that they can get hold of you when they need to, and that has knock-on consequences for what happens within the surgery.

The consequence of that then seems to be that people who haven't seen the person they wanted to see, seem to find the way back into the system a lot more. So, we see people, and I'll see people, I'm sitting here thinking, hang on a minute, you've been in here three times in the last month and you're not somebody that normally comes in that often. We seem to be seeing a lot more people who are re-attending, that may be just a way of describing the fact they haven't really got what they wanted in the first place. I don't know. But, that's nothing to do directly with this, it's a consequence, it's nothing to do with the CCG, it's to do with not being in the practice for one day a week' [GP ID 104].

Although not a major theme, some respondents reported conflict with their practices over their CCG work and either not allowing them to reduce their hours or doing so very begrudgingly. One GP left their practice entirely to take up a full time CCG role.

Respondents also reported that in the context of time pressures, they would work evenings and weekends on CCG work and days off.

CCGs and bureaucracy

A significant view from respondents was that systems, processes and procedures of the CCG were too bureaucratic. Such systems and process did not adhere to any particular function of the CCG or other aspects such as commissioning etc. and examples were given in a variety of settings. Respondents gave examples in relation to IT systems, the CSU, pathways being bureaucratic, referrals, and trying to acquire various data for example. These interviewees voice some of these concerns:

'...we've still got, not as much, but handwritten discharge notes and there's no electronic records up at the hospital and people go up and nobody knows a thing about them because they've lost this wodge of paper notes, and they don't prescribe electronically...there's huge frustrations with how other bits of the system don't talk to each other or they don't have the capacity to do the basics...' [GP ID 163].

'It's made difficult when people produce hundred page specifications and then you get a contract which is so wordy and full of rubbish, that people can't be bothered with this and then potential alternative providers, who are usually smaller, who would be very good, are just pushed out, because they can't cope with the bureaucracy' [GP ID 162].

However, one GP ended on an optimistic note that CCGs may be different from their PCT predecessors:

'I'm pleased for how the new structure's working. What I'm anxious about is I hope it doesn't become bureaucratic over time and we don't get evolved into an organisation with the best will in the world that is trying to get more process, because the processes have led to sort of event which has caused some complaint, so I hope we can keep our focus on outcomes rather than processes...' [GP ID 33].

Discussion

This data collection took place as newly-established CCGs emerged from the very demanding authorisation process. This was extremely labour intensive, requiring the collection and collation of hundreds of documents. It is therefore hardly surprising that our interviewees were in some ways less enthusiastic and certainly more realistic than the interviews we conducted in the early stages of CCG development. However, it is also clear from this summary that both clinicians and managers remain committed to the project on which they have embarked, and continue to believe that they can make a positive difference to the services provided in their local areas.

They remain firmly of the belief that the involvement of clinicians – and in particular GPs – is important, and that it adds value to the commissioning process. The exact nature of that value is less clear.

Essentially, the claims made by respondents highlight two aspects of GP's knowledge and experience that are important for commissioning. The first is that their knowledge is *fine-grained*. By this we mean that their knowledge is rooted in the experiences of individuals, and that their role as front-line clinicians seeing significant numbers of patients allows them to aggregate that knowledge about individuals to provide an overview of the whole system. This claim is interesting, as it carries within it two assumptions. The first is that such aggregated knowledge of individuals is sufficiently representative to illuminate the system as a whole; the second is that personalised knowledge such as this is in some way more useful than the more systematic evidence about service quality or efficiency historically gathered by PCT public health staff to support the commissioning process. These assumptions fit within the more general discourse about the importance of personalisation that is evident both within the Health and Social Care Act and within public service policy more generally, (Cribb and Owens, 2010). The second claim made by our respondents was that GP knowledge is *concrete*. By this we mean that their knowledge is based upon real experiences of particular services, not on statistical evidence. This is seen as particularly important in the NHS following the Francis report (Francis, 2013), into poor care at Mid Staffordshire NHS Trust, in which failure to act on this type of concrete knowledge was highlighted as an important issue.

Of course, clinical involvement in commissioning is not new, and PCTs had GPs and other clinicians represented on their Boards, their Professional Executive Committees and in their Practice-based Commissioning (PBC) groups. Indeed, the first phase of this study highlighted the extent to which the GPs involved in CCGs are in fact the same individuals who were previously involved in PBC, PCTs and in other commissioning forums. This early evidence therefore suggests that the next phase of this study should focus upon the extent to which the new system enables and facilitates the mobilisation of this knowledge, and on the extent to which this mobilisation impacts upon the commissioning process. Furthermore, the focus we have identified in knowledge about individuals rather than populations coupled with the move of Public Health into local government, and consequent change in the relationship between commissioners and their public health colleagues, suggests that it is important to explore the impact that this shift is having on the commissioning process. Emphasising the value of GP's personal knowledge implicitly downgrades the more systematic approach to knowledge which characterises the public health approach.

In addition, both managers and clinicians report significant concerns about the sustainability of the new system. GPs are working long hours, often in the evenings,

reading papers for meetings and responding to emails. Much of the work that they do takes place in meetings, and this requires time out of practices. Respondents highlighted both personal issues of work-life balance, and practice issues associated with their increased workload, with some saying that patients were beginning to complain about their lack of availability. There is some suggestion in our data that, post-authorisation, GPs are beginning to adopt a 'steering' approach rather than 'rowing' (Barlow and Röber, 1996), working in meetings at a strategic level, with the day to day work carried out by their manager colleagues. This is facilitated by what appears to be the development of productive and mutually supportive relationships between GPs and managers. Our own research into Practice-based Commissioning showed that the managerial-clinician relationship was one of the key determinants of the success of that scheme. We found that poor relationships were characterised by a feeling of 'them' and 'us', with GPs resentful of the lack of understanding of clinical matters by managers focussed on financial targets. However, we also found evidence of good relationships, in which highly skilled managers were pro-actively managing their GP colleagues to bring about change (Coleman et al, 2009). This new evidence from the first year of CCGs suggests that these relationships are developing one step further, with GPs and managers forming close and mutually supportive alliances. Managers report that they find the clinical expertise of the GPs very useful, giving them confidence in negotiations with providers, whilst GPs report their admiration for the skills the managers bring. The highly personal nature of these relationships was highlighted, with respondents stressing the development of trust and confidence over time.

Finally, there were some claims made about the fact that GPs now have 'ownership' of CCGs, which makes it easier to 'get things done'. To some extent this seemed to be a claim about reductions in bureaucracy, as well as some suggestion that the psychological impact of 'ownership' was empowering GPs to make changes that were needed. It was also suggested that 'ownership' made grass-roots GPs more likely to engage with change. We do not yet have any evidence about the validity of these claims. Reductions in bureaucracy seem unlikely, given the complicated accountability framework within which CCGs operate (Checkland et al, 2013), and the extent to which 'action' is now more possible and more acceptable requires further empirical exploration.

Taken together, the findings from this section of the research provide valuable evidence which will enable us to focus the next phase of the research, in which we will use observational methods to explore in more depth the claims that have been made. In these observations our focus will be upon the following over-arching questions:

- How is GPs fine-grained and concrete clinical knowledge used in the different aspects of the commissioning process?

- Whose knowledge is used/privileged?
- What evidence is there of any impact of this knowledge on commissioning or contracting processes and outcomes?
- What evidence is there of any impact of the CCG's activity on the work of front-line GPs?
- Is there any evidence that GP 'ownership' of CCGs supports or enables change?
- In what ways does the new system facilitate or inhibit the application of GP fine grained and granular knowledge?

We will do this by attending a range of different types of CCG meetings, including Governing Body meetings, locality groups, commissioning committees and (where possible) contracting meetings with providers. In each of these different forums we will pay attention to who is in the room, how they behave, the extent to which clinical knowledge is mobilised, and the end service by that mobilisation. We will continue to observe clinician-manager interactions, and explore the extent to which the wider GP body is engaged with the CCG's work. The results of this observation will then feed into a final phase of interviews, exploring claims made about impacts.

References

Appleby J, Humphries R, Thompson J and Jabbal J. How is the health and social care system performing? January 2014. Quarterly monitoring report. London: The Kings Fund.

Audit Commission, NHS financial year 2011/12, Audit Commission. September 2012.

Basit, T. N. (2003) Manual or electronic? The role of coding in qualitative data analysis, *Educational Research*, 45(2), 143-154.

Barlow, J. & Röber, M. 1996. Steering not rowing: Co-ordination and control in the management of public services in Britain and Germany. *International Journal of Public Sector Management*, 9, 73-89.

Checkland K, Coleman A, Segar J, McDermott I, Miller R, Wallace A, Petsoulas C, Peckham S and Harrison S (2012) Exploring the early workings of emerging Clinical Commissioning Groups: final report. London: Policy Research Unit in Commissioning and the Healthcare System [PRUCOMM].

Checkland K, Allen P, Coleman A, Segar J, McDermott I, Harrison S, Petsoulas C and Peckham S. Accountable to whom, for what? An exploration of the early development of Clinical Commissioning Groups in the English NHS. *BMJ Open* 2013;3:e003769. doi:10.1136/bmjopen-2013-003769

Coleman A, Checkland K, Harrison S and Dowswell, G (2009) Practice-based Commissioning: theory, implementation and outcome. Final Report. Manchester: University of Manchester.

Cribb A and Owens J (2010) Whatever suits you: unpicking personalization for the NHS . *Journal of Evaluation in Clinical Practice* 16 (2) 310-314.

Francis R. Report of the Mid Staffordshire NHS Foundation Trust public inquiry. Stationery Office, 2013.

Gibbs, G.R. (2002) *Qualitative data analysis: Explorations with NVivo*. Buckingham: Open University Press.

Health and Social Care Act (2012) London: Stationery Office.

Miller R, Peckham S, Checkland K, Coleman A, McDermott I, Harrison S and Segar J (2012) Clinical engagement in primary care-led commissioning: a review of the evidence. PRUComm: London.

NHS Commissioning Board (2012). Clinical commissioning group authorisation: Draft guide for applicants. April 2012.

Pope, C., Ziebland, S., and Mays, N. (2000) Analyzing qualitative data, *British Medical Journal*, 320, 114-116.

Todd, R (2013) Three CSUs explore 'partnership', *ehealth INSIDER*. Available from: <http://www.ehi.co.uk/news/EHI/9027/three-csus-explore-%27partnership%27> [Accessed: 14/03/2014].