



# EXPLORING THE 'ADDED VALUE' GPs BRING TO COMMISSIONING

## What works, in what circumstances, and how?

### BACKGROUND

The Health and Social Care Act 2012 (implemented from 2013) introduced Clinical Commissioning Groups (CCGs) to replace Primary Care Trusts (PCTs) as commissioners of healthcare for their local populations. These organisations were designed to unleash the potential of involving a broad range of clinicians in commissioning. Groups of GPs were invited to volunteer to form CCGs, initially in 'shadow' form, taking over statutory responsibility in April 2013.

PRUComm was commissioned by the Department of Health to undertake research following the development of CCGs in England since its inception in 2011. This report presents the findings from the second phase of our ongoing study.

In the first phase of this study (January 2011 to September 2012), we followed the development of CCGs from birth to 'authorisation' as statutory bodies (see Checkland et al., 2012 for full report). In the first phase we heard many claims about the 'added value' that GPs bring to commissioning. The aim of the second phase of the study was therefore to follow up those claims.

Our research used 'Realist Evaluation' (Pawson & Tilley, 1997). This approach involves: seeking out participants 'programme theories' as to how a particular policy or programme will bring about the desired outcomes; exploring the extent to which these programme theories 'work' in the real world; and examining in detail the mechanisms and contexts which underpin them. The approach is often said to be exploring 'what works, for whom, in what circumstances'? We applied this

approach to GPs roles in CCGs, using interviews to find out what CCG leaders believe are the key aspects of their contribution to commissioning. We then observed a wide range of meetings in order to explore the extent to which the claims they made were borne out in practice, and to try to elucidate the important conditions which supported their roles.

### KEY FINDINGS

#### COMPLEXITY

We found an unexpected degree of **complexity associated with CCG's internal structures and governance arrangements**, making it difficult to define which body was responsible for which type of decisions and who was a member of a particular body. Specifically we found that:

- Although all CCGs have a Governing Body, in practice they varied significantly. In particular, membership was very different between sites and Governing Bodies varied in how they saw their role.
- Many CCGs had established some kind of 'operational' or 'executive' group below the level of the Governing body. They had also established some sort of 'quality' committee. However, the name, role, remit, and membership of these groups varied considerably.
- Some of our case study sites had also established informal groups with the wider health economy, bringing in members from outside the CCG to discuss more strategic issues.

## GP 'ADDED VALUE' IN THE COMMISSIONING PROCESS

We identified 4 programme theories that were most frequently claimed by both GPs and managers we interviewed and tested these theories against activities which we observed in the meetings we attended.

- **Theory 1 (frontline knowledge about patient experience) and Theory 2 (frontline knowledge about services)** suggested that GP commissioners who work on the frontline and deal with patients daily can use their clinical knowledge to highlight what is working or not working and hence enable identification of problems, deal with them promptly, and have a better insight to the extent of available services. Our observations confirmed that GPs do add value to the commissioning process by using their frontline knowledge in this way. However, GPs expressed reluctance to rely solely on this knowledge of services, requesting 'proper data' to support and contextualise their knowledge, and relying on managers to provide a more systematic overview of the range of services available.

The mechanisms which enable successful application of GPs' 'frontline' knowledge include:

- Representation of a sufficient range of GPs in a wide variety of forums and meetings.
  - Task specific preparation for GPs attending meetings & meetings chaired in a proactive and facilitative way.
  - 'Proper data' to support and contextualise GPs' knowledge.
  - GPs also need to be proactive, volunteering and engaging
- **Theory 3 (clinician to clinician conversations)** suggested that GPs contribute significantly to commissioning because their clinical experience allows them to communicate with and challenge fellow-clinicians in a way that managers cannot. Our observations showed that the presence of GPs in commissioning meetings does add value in this way

We found the following mechanisms enable successful operation of this theory:

- Adequate preparation, good quality contextualised information, and careful chairing of meetings.
- Presence of senior level people who are able to make commitments on behalf of their

organisations and a concerted effort to keep frontline practitioners informed and engaged.

- **Theory 4 (GP-Manager symbiosis)** suggested that GPs and managers in the CCG have a symbiotic relationship which enables both parties to work much more effectively together than they would otherwise be able to do.

We found the development of these relationships was facilitated by the following mechanisms:

- History of working together or careful recruitment procedures.
- Having joint responsibility for delivery and ensuring that these close relationships remained open to a variety of views from the wider membership.
- Experience of 'success' was very important both in developing the close and supportive relationship between the two individuals and in bringing the wider membership along with the process.

## COMPARISON WITH OFFICIAL ASPIRATIONS FOR CCGS

Policy documents from NHS England set out the official aspirations for GP involvement in commissioning (NHS Commissioning Board 2012, NHS England 2013):

**Clinicians will deliver a constant clinical focus on improving quality and outcomes**

Our study suggests:

- *GPs do add value to commissioning process by bringing in their 'frontline' knowledge.* However, their clinical knowledge is an adjunct to rather than a substitute for more systematic knowledge
- For CCGs to deliver small and large scale change, there needs to be a symbiosis between GPs and managers and this relationship needs to remain open to the wider membership.
- Our study did not focus on the improvement of quality in primary care. However, we did find evidence that CCGs were somewhat less likely to engage in rigorous attempts to improve quality in practices than had been the case under Practice-based Commissioning.
- Close GP involvement in commissioning can facilitate better use of local services. However, this depends

upon good engagement with grass roots GPs and is not an automatic outcome of GP leadership of CCGs.

### **CCGs will deliver significantly improved engagement from constituent practices**

Our study suggests:

- *CCGs are keen to engage their members* and they want to have a two-way relationship with member practices.
- The status of CCGs as 'membership' organisations should make the engagement easier to achieve but our study suggests that many CCGs are struggling to ensure their local GPs feel 'ownership' of the work that is done in their name.
- We found little evidence that CCGs were better at *engaging local people* than PCTs had been and no evidence that *trusted positions in communities* were an important enabler in discussions of service redesign.

### **CCGs will enable the involvement of the wider clinical community in commissioning**

Our study suggests:

- We found that some CCGs have been proactive in developing forums to engage with the wider local health and care community
- However, it is vital that the clinicians who engage in this way are senior enough in their parent organisation to make commitments on their behalf
- Similarly, representatives from *local council, social care and third sector* need to have high level buy-in from the local health and social care economy.
- This type of forum does not necessarily have to be within the formal structures of the CCG as long as it provides a space for networking opportunities between clinicians and wider stakeholders.

## **ACTIONABLE MESSAGES**

We found that GPs can and do 'add value' to the commissioning process. However, we also found evidence of duplication of effort, wasted opportunities and failure to make best use of GPs' time and knowledge. Given the costs (both monetary and in terms of burdens placed upon GPs' practices) associated with GP involvement in commissioning, it is important efforts are made to both focus and maximize the value of the time spent. In this section, we highlight the lessons of our research for both CCGs and policy makers. These are

intended to be practical messages, of use to those with relevant responsibilities as they carry out their work.

### **FOR GPs**

- For maximum value can be derived from GP's clinical knowledge, **GPs must ensure that they understand the wider context of the issue in question, the purpose of the discussion and the desired outcomes.** GPs need to ask for task specific briefings. For issues where there will be discussion with providers or other bodies, collective rehearsal of relevant issues can be helpful.
- **Good GP-manager relationships are vital in CCGs.** The development of these is supported by: careful recruitment processes; sharing responsibility; clearly delineating tasks and roles; the establishment of GP-manager relationships throughout the organization, not just at the top; and mutual trust.

### **FOR CCGs**

- **CCGs are complex organisations, with complicated structures.** CCGs therefore need to have a clear understanding of their own structure and how it fits within the wider health and social care economy. There needs to be clarity at all levels over decision making responsibilities.
- Having GPs present at local collaborative forums with providers, commissioners and the local voluntary sector can allow wider engagement with a range of local organisations and development of health and care strategies beyond the confines of CCGs' statutory commissioning responsibilities. However, such forums require senior-level representation from all organisations and effective mechanisms to ensure that CCG members feel informed about these higher-level discussions, and have opportunities to feed in to the discussions.
- CCGs have enabled the potential involvement of a greater number of GPs in commissioning processes. However, CCGs need to actively consider the needs of their membership, and design systems to bring in as wide a variety of voices as possible. Communication needs to be context sensitive, cover multiple modes, and be proactive with senior leaders seeking out those with expertise or issues to attend relevant meetings or join working groups.
- GP's clinical knowledge about their patients and the services they receive is necessary. However, it needs to be supplemented with accessible and high quality aggregated data about service outcomes.

- It remains unclear what it really means to be a 'membership' organisation. CCGs need to develop a clear local understanding of what it means to them to have 'members'. They need to work with the membership to clarify the role members may play, the input they are required to make, the opportunities for deeper involvement, and a clear and formal role for membership forums.
- The maintenance of enthusiasm and engagement in the work of CCGs requires experience of success.
- Anything that makes the job of being a GP easier will be very effective in generating buy-in and enthusiasm amongst the membership, whilst experience of mutual achievement will cement and enhance effective manager-GP relationships.

#### FOR POLICY MAKERS

- Diversity and complexity is inherent in the new system. It is important that this is recognised and understood by those charged with overseeing CCGs. Whilst appropriate checks and balances need to be maintained via regulation and processes of assurance, trying to impose uniformity upon CCGs would be likely to undermine progress and alienate those involved.
- CCGs have been subject to significant change within their relatively short lifespan. Significant time and energy have been invested by those involved, and important new relationships have been forged within health economies. Further structural change would risk disrupting these, and would risk the loss of important clinical expertise from the commissioning process.
- GPs add value to commissioning, and we have delineated some of the contextual conditions and mechanisms by which this can be maximised. However, GP involvement is contingent upon GPs feeling that they have influence and an ability to contribute to decisions. Diluting the roles of CCGs or making GPs' roles advisory would risk rapid withdrawal and disengagement.
- GP time is expensive, and CCGs currently demonstrate some duplication with, for example, lack of clarity over how and where decisions are made. GPs are not required everywhere and in every forum, and it is not necessarily a bad thing if GPs back away from some roles or groups. However, it is important that CCGs have a clear understanding of the purpose of GP involvement so that any decisions about involvement or representation are made explicitly, based upon likely benefits to be achieved.

#### REFERENCES

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#### ABOUT PRUComm

PRUComm was established in 2011. It is one of a number of Department of Health-funded Policy Research Units. It is a collaboration between the Service Delivery and Organisation Research Group at the London School of Hygiene and Tropical Medicine (LSHTM), the Health Policy, Politics and Organisation Group (HiPPO) at the Centre for Primary Care (University of Manchester), and the Centre for Health Services Studies (CHSS) at the University of Kent.

Research projects cover a broad spectrum of healthcare commissioning and health system issues. PRUComm aims to deliver high quality, timely research to support healthcare practice and policy.

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