



Exploring the GP 'added value' in commissioning: What works, in what circumstances, and how?

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Exploring the GP ‘added value’ in commissioning: What works, in what circumstances, and how?

Final Report

June 2015

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List of Abbreviations

AO	Accountable Officer
CCG	Clinical Commissioning Group
CFO	Chief Financial Officer
CoM	Council of Members
COO	Chief Operating Officer
CSU	Commissioning Support Unit
DH	Department of Health
GB	Governing Body
GP	General Practitioner
HSCA	Health and Social Care Act
HWB	Health and Wellbeing Board
LA	Local Authority
NHS	National Health Service
NHSE	NHS England
PBC	Practice Based Commissioning
PbR	Payment by Results
PCG	Primary Care Groups
PCT	Primary Care Trust
PEC	Professional Executive Committee
PH	Public Health
SHA	Strategic Health Authority
SMT	Senior Management Team
TPP	Total Purchasing Pilot

Executive Summary

One of the main focusses of the Health and Social Care Act 2012 (implemented from 2013) was on the development of Clinical Commissioning Groups (CCGs) to replace Primary Care Trusts (PCTs) in commissioning healthcare for their local populations. These organisations were designed to unleash the potential of involving a broad range of clinicians in commissioning of healthcare. Groups of GPs wishing to form a CCG (initially known as GP Commissioning Consortia, GPCC) could put themselves forward to be 'Pathfinders', charged with testing different design concepts and identifying areas of learning to inform the overall programme. GPCC would need to demonstrate their capability to take over commissioning to the NHS England (previously known as NHS Commissioning Board) in order to be 'authorised'.

This report presents the findings from a second phase of our ongoing study following the development of CCGs in England since 2011. In the first phase of this study (January 2011 to September 2012), we followed the development of CCGs from birth to authorisation i.e. from their involvement in the 'pathfinder' programme and officially becoming sub-committees of their local PCT Cluster until their authorisation in April 2013. One of the issues highlighted by our participants in the first phase of the study was the perception of GP 'added value'. During the authorisation process, NHS England set out what they believed clinicians would add to commissioning. Domain 1 (out of 6) of the authorisation process focused on clinical added value, requiring CCGs to show "a strong clinical and multi-professional focus which brings real added value" (NHS Commissioning Board, October 2012:11). This added value was said to include: strengthened knowledge of the needs of individual and local communities; increased capability to lead clinical redesign and engage other clinicians; and greater focus on improving quality of primary medical care. NHS England has set out further what an "excellent practice" looks like across a range of areas central to commissioning in the *Draft Framework of Excellence in Clinical Commissioning* (NHS England, November 2013).

The aim of the second phase of our study was therefore to follow up those claims made in the first phase around issues of GP 'added value'. We explored further the potential added value that clinicians, specifically GPs, bring to the commissioning process in interviews, and followed this up with observations of commissioners at work.

Methods

This report uses 'Realist Evaluation' (Pawson & Tilley, 1997) to address the following research questions:

- What value do GPs add to commissioning process (**outcome**)?
- In what ways do GPs add that value (**mechanisms**)?
- Under what conditions do GPs add value in the way described above (**context**)?

Realist evaluation is method-neutral i.e. it allows the use of any methods of data collection and analytical methods. The choice of which method(s) to use is guided by the types of data needed to formulate answers to the questions posed. We collected the data using a case study approach, semi structured interviews with clinicians and managers, and observations of various CCG meetings.

Using semi-structured interviews with clinicians and managers, we identified four 'programme theories' (Weiss, 1998) underlying the claims about GP 'added value' in the commissioning process:

1. GPs' frontline knowledge about patient experiences would enable them to identify problems and deal with them promptly.
2. GPs' frontline knowledge about services would enable them to improve service redesign.
3. GPs' clinical experience and knowledge would enable them to have the authority to speak to other clinicians in ways which improves commissioning.
4. GPs and managers have a symbiotic relationship, which together is more than the sums of its parts, and hence enhances the commissioning process.

To test whether or not the theories can be seen at work in practice, we observed a wide range of CCG meetings in 4 sites. We use our observational findings to clearly delineate the contexts in which the theories hold and the mechanisms underpinning their action.

This research was conducted between April 2013 and March 2015 and consisted of 42 interviews with both clinicians and managers, attendance at 48 meetings (approximately 111 hours of observations), and a review of various documentation associated with meetings attended and official reports.

Key findings

Complexity

In our observation of various meetings, we found a degree of *complexity associated with CCG structures and governance arrangements*. Unlike PCTs (their immediate predecessor organisations), CCGs are often quite different from one another, with different structures and distribution of responsibilities between the various committees, sub-committees etc. We were often unable to clearly 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 the make-up and role of Governing Bodies varied significantly. In particular, the number of GPs involved was very different between sites, Governing Bodies varied in the extent to which they involved themselves in operational matters, and different CCGs had interpreted the need to have meetings 'in public' differently.
- Many CCGs had established some kind of 'operational' or 'executive' group below the level of the Governing body reporting to it. 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 and focusing upon a variety of issues. Some focused on higher level long-term strategy while others had a focus on provider-specific service developments.

GPs 'added value' in commissioning processes

- Theories 1 and 2 suggested that *GPs working on the 'frontline' and dealing with patients daily are able to utilise their clinical knowledge* to highlight what is working or not working and hence enable identification of problems, deal with them promptly,

make better decisions, and have a better insight to the extent of available services. Our observations showed that GPs do add value to the commissioning process by using their 'frontline' knowledge to guide their commissioning decisions. However, GPs themselves 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 operation 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 and 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 both in person and with modes of communication such as email.
- Theory 3 suggested that GPs contribute significantly to commissioning because their clinical experience gives them the *knowledge and experience to have clinician to clinician discussions* in a way that managers cannot and allows them to view pathway development from a clinical perspective, address colleagues' behaviour, and challenge hospital clinicians. GPs' clinical knowledge and experience gives them the authority to have clinician to clinician discussions in a way that managers cannot. Our observations showed that the presence of GPs in commissioning meetings does add value in the way the theory described. However, the following mechanisms are needed to 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 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 and this is dependent on both parties having a mutual trust and clearly delineated responsibilities. In the context of individual GPs and managers working closely together, we found the development of these relationships was facilitated by the following mechanisms:
 - History of working together, although this was not a necessary condition. We saw new relationships being forged and these were facilitated by careful recruitment procedures.
 - Having joint responsibility for delivery. However, it was also necessary that these close relationships remained open to a variety of views from the wider membership.
 - Experience of 'success'. We found that this 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 previous clinically-led commissioning

We explored our findings in the light of what we know from previous initiatives involving GPs in commissioning including GP Fundholding, GP commissioning groups, Total Purchasing Pilots (TPP), Primary Care Groups (PCGs) and Primary Care Trusts (PCTs), as well as a variety of other local schemes for involving GPs and other clinicians in commissioning activity. The most direct comparison is with Practice-based Commissioning (PBC), the

immediate precursor to CCGs. PBC groups contained many similar elements to CCGs, including GP- led committees which took delegated responsibility for aspects of the commissioning budget of their PCT. The differences lay in the formal structures and in the scope of services covered. PBC groups were formally constituted as sub-committees of the PCT, with the PCT holding statutory authority, and most groups focused mainly on those services covered by the Payment by Results (PbR) tariff.

- *Processes of involving GPs* - GPs who were actively involved in PBC and those responsible for the day-to-day running of PBC were either elected or involved in smaller consortia. This is very similar to the selection and election process of GP leaders on to the formal committees of CCGs such as the Governing Body or executive group. Furthermore, in the first phase of this project (Checkland et al., 2012) we found that many of the GP leaders taking up positions in CCGs had been involved with PBC for some time, and their CCG involvement is seen as a continuation of that work.
- *Activities which GPs are able to be involved in* - CCGs enable more extensive GP involvement than was possible under PBC or other modes of clinically-led commissioning. However, the voluntary nature of initiative such as PBC meant that there was greater 'buy-in' i.e. willingness to input beyond traditional role from GPs in terms of examining their own practice.
- *Wider involvement of clinicians* – our previous study on PBC found that involving frontline GPs was the most frequently reported difficulty (Coleman et al., 2009). CCGs also found this difficult. The status of CCGs as 'membership' organisations should make the engagement of the interest of a wider range of GPs easier to achieve, but our study suggests that many CCGs are struggling to ensure that their local GPs feel 'ownership' of the work that is done in their name.
- *Perceived legitimacy and authority* - our previous study of PBC (Coleman et al., 2009) emphasised the importance of the perceived legitimacy of the PBC executive group. It might be thought that CCGs as membership organisations that are owned by the GP practices would act to enhance CCG legitimacy. However, we did not find compelling evidence of this, and some hints that the compulsory nature of membership was an issue for some GPs. The real meaning of 'membership' is not yet clear.
- *Decision making power*- those working in PBC expressed frustration at the need to obtain 'permission' from the PCT for any decisions that they made, whereas CCGs themselves hold decision making power. However, the complexity in CCG structures do not seem to bring many front line GPs any closer to the decision making process, and it was often unclear where particular decisions would be made.
- *Supportive information* - we found that GPs observed in CCG meetings repeatedly asked for what some called 'proper data' to inform their decisions. In our studies of PBC (Coleman et al., 2009), we found some issues with the way that data was obtained and used, and highlighted the importance of GPs working closely with information specialists to ensure that data was provided in a digestible and useful form.
- *Perceived authority* - PBC groups were sub-committee of PCTs, and GPs did not perceive themselves and were not perceived by others as having ultimate authority. The fact that the CCG is a statutory body gives the perception, internally and externally, of GPs' authority.

- *Opportunities to work with colleagues across the health economy* - three out of four of our case study CCGs were engaged with their provider, local authority and third sector colleagues in forums in which the wider needs of their populations could be discussed. These groups are in part a function of the increasing pressure to integrate care across organisational and professional boundaries.
- *GP-Manager symbiosis* - our previous study on PBC (Coleman et al., 2009) found that close and supportive relationships between clinicians and managers were common. We described a particular type of management approach which we called an 'animateur', by which managers were able to creatively engage with GPs to enable beneficial change (Checkland et al., 2012). The pertinent difference between CCGs and PBC is that under PBC these supportive relationships were generally limited to the middle manager level, with GPs working with managers below board level. Under PBC, the managers involved carried a dual identity, working both for the PBC group and for the PCT (McDermott et al., 2013). In CCGs, by contrast, we found these close clinician-manager relationships throughout the levels of the organisation and they are working together as part of the same organisation.

In summary, our study suggests that much of what is described under CCGs could have been achieved using PBC as a vehicle, and that CCGs are somewhat less active than PBC groups were in terms of performance management of constituent practices. However, the scope of activity under CCGs is significantly greater than was the case under PBC (or, indeed, previous clinically-led commissioning initiatives), enabling the application of GPs' knowledge to a broader range of service areas. It is certainly possible for CCGs to effectively bring the knowledge and views of front line GPs into their work, but this does not occur inevitably or by default; it requires explicit attention to processes and considerable preparatory effort. Obtaining and using effectively available aggregated data about service outcomes and usage may be more difficult under a model which sees information specialists and PH consultants employed elsewhere.

Comparison with NHSE aspirations

NHS England set out what they believed clinicians add to commissioning in 2012:

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 CCGs will be successful in each domain. (NHS Commissioning Board 2012 para 3.14).

In the *Draft Framework of Excellence in Clinical Commissioning* (NHS England, 2013), they further set out what "excellent practice" looks like. We compare these aspirations with our findings:

- *Constant clinical focus on improving quality and outcomes* - our observations showed that GPs add value to commissioning by bringing in their 'frontline' knowledge. However contextual factors, mainly how that knowledge is used and the position of the GPs in the CCGs, shaped the mechanisms which enables the outcomes expected. To enable GPs 'frontline' knowledge to be used effectively, there need to be the 'right' GP with the 'right' knowledge in the 'right' forum. This needs to be supported with 'proper data' and adequate preparation such as giving GPs task specific briefings before the meeting to ensure that maximum value is obtained from the time committed by GPs.

- *Significant engagement from constituent practices* - our study found that CCGs are keen to engage their members and they want to have a two-way relationship with member practices. However, due to the complexity of their internal structures, different CCGs should adopt different approaches to maximising the value of GP involvement. 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. One of the mechanisms enabling the 'success' of this engagement is a facilitative environment. In terms of *CCGs delivering small and large scale change*, we found that there need to be a symbiosis between GPs and managers and that this relationship remains open to a variety of views from the wider membership. One of the mechanisms to do this is by having a clear delineated responsibilities where managers formulates and writes the policy documents while GPs assist in clinical input and experience of 'success'. GPs also add value in terms of 'selling' the required changes to fellow GPs.
- *Involvement of the wider clinical community in commissioning* - we found that when considering *commissioning or de-commissioning decisions*, the presence of GPs and wider clinical community in a meeting alone is not sufficient and needs to be supported with 'proper' data. We also found that CCGs enable *clinician to clinician conversation*. However, clinicians' presence in this kind of forum needs to be senior enough in their organisations and able to make commitment on behalf of their parent organisations. Similarly, representative from *local council, social care and third sector* need to have high level buy-in from the local health and social care economy. This 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. The role of chair is also crucial in ensuring that everyone has equal opportunities to contribute to the discussion.

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 talents. Given the costs (both monetary and in terms of burdens placed upon GPs' practices) associated with GP involvement in commissioning, it is important that efforts are made to both focus and maximise the value of the time spent. Here we highlight the lessons of our research for GPs, 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

- GPs can bring useful clinical knowledge to bear in meetings. Maximum value can be derived from this by:
 - Understanding the wider context of the issue in question, the purpose of the discussion and the desired outcomes.
 - GPs being proactive in asking for task specific briefings.
 - Collective rehearsal of relevant issues before meetings.
- GPs with 'official' positions in the CCG who work closely together with managers can have a productive working relationship by:
 - Having shared responsibility for the delivery of objectives with clear delineation of tasks and roles.
 - The establishment of GP-manager relationships throughout the organisation.

- Mutual trust being developed either through historical experience of working together or careful appointment process.

For CCGs

- CCGs are complex organisations, with complicated structures; no two are exactly the same. It is therefore important that CCGs 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.
 - Complicated structures make duplication of effort more likely – it is important to be sure that participants' valuable time is not spent working on issues which will in fact be decided elsewhere.
- CCGs are an excellent vehicle for engagement across organisational boundaries throughout the local health economy. Having GPs present at strategic forums, such as Health and Wellbeing Boards and local collaborative forums, allows wider engagement with a range of local organisations. Such forums require:
 - Senior-level representation from all groups present, with those attending carrying decision-making power within their own organisations.
 - 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. 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, ensuring that the ways in which grass-roots members access information are understood and responded to.
 - Covering multiple modes, with relevant and important information disseminated in more than one format.
 - 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 but not sufficient for high quality commissioning decisions to be made. In addition they require:
 - Accessible, high quality aggregated data about service outcomes.
 - The opportunity to work with those producing the data.
 - Systematic and accessible information about available local services.
- It remains unclear what it really means to be a 'membership' organisation. The diversity of CCGs means that it is unlikely that it will necessarily mean the same thing in a small rural CCG as a large urban one. Therefore:
 - 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 and the opportunities for deeper involvement which includes developing a clear and formal role for membership forums such as locality groups and wider membership groups.
- The maintenance of enthusiasm and engagement in the work of CCGs requires experience of success:

- This does not need to be large scale change, but needs to include tangible evidence of small victories, focused upon outcomes meaningful to those involved.
- 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, taking on new responsibilities and responding to policy developments. 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.

1. Introduction

This report presents the findings from a study exploring the potential added value that clinicians, specifically GPs, bring to the commissioning process. By 'commissioning process' we mean everything associated with commissioning, including pathway development, contracting with providers, the ongoing monitoring of contracts and any attempts to modify referrer behaviour.

This report starts by situating the project in the context of ongoing PRUComm work programme following the development of Clinical Commissioning Groups (CCGs) in England since its inception in 2011. This section (Section 1) also explains why we approach our data using Realist Evaluation (Pawson and Tilley, 1997). This is then followed by a detailed description of the methods we use i.e. case study approach using interviews and observations of various CCG meetings (Section 2). The next two sections present the results by describing the degree of complexity associated with CCG structures and governance arrangements (Section 3) and unpacking the 'mechanisms' by which the claims made about GP added value work in practice as well as 'conditions' which facilitate or impede clinical input in commissioning, providing detailed evidence applicable across the full range of CCG activities (Section 4). We discuss our results in the light of what we know from previous research into clinically-led commissioning and in the context of both official aspirations for CCGs as set out in published documents and other research in this field, as well as identifying future challenges for CCGs (Section 5). Lastly, we highlight the lessons of our research for both CCGs and policy makers, which are intended to be practical messages and of use to those with relevant responsibilities as they carry out their work (Section 6).

1.1. *PRUComm work programme and Pathfinders*

In the first phase of the project (January 2011 to September 2012), we followed the development of CCGs (initially known as GP Commissioning Consortia) from birth to authorisation i.e. from when they were involved in the 'pathfinder' programme and were officially sub-committees of their local PCT Cluster until their authorisation in April 2013. We conducted an intensive investigation working with 8 case study sites alongside 2 national web-based surveys of CCGs. We explored issues that arose and were important as the CCGs developed and factors affecting their progress and development, as such we detailed the experiences of emerging CCGs being part of the 'pathfinder' programme (Department of Health, 2010a) and explored issues which were drawn thematically from the evidence we found. This included the different approaches to being a membership organisation, how the emerging CCGs were developing their external relationships (for example with the Health and Wellbeing Board, other CCGs, etc), and what approaches were being taken to commissioning and contracting. For a full report see Checkland et al. (2012).

One of the issues highlighted by our participants in the first phase of the study was the perception of GP 'added value'. Participants from many of our case study sites told us that they felt that the involvement of GPs had 'added value' in both commissioning and contracting. Managers valued certain skills that are different from their own and believed that GPs and managers' functions within CCGs are complementary. However, GPs skills needed to be utilised at the most appropriate time. GPs told us that part of the value lies in the fact that they are on the 'frontline' of patient care i.e. they see their patient population on a daily basis, hence they know and understand about patients' problems and are best placed to represent patients' interests. CCGs in our case study sites also claimed the value of having clinicians present in contract negotiations with providers in that they are able to make clinical case for commissioning or decommissioning services and can do this with authority and confidence. Peer-to-peer clinician contact was also claimed to lead to better and more constructive relationships.

In the second phase of our study (April 2013 to March 2015), we aimed to follow up those claims made about GP added value. We started by interviewing both clinicians and managers in 7 of our 8 case study sites (one site declined to participate further) to explore in more detail their understanding of the value of clinical input in commissioning (with concrete examples where possible). The findings from these interviews have been published as an interim report (see Checkland et al., 2014; Perkins et al., 2014; Section 2 below for detailed description of methods and participants). The results from these interviews were used to focus the next phase of data collection, in which the claims made were followed up in observations of the work of 4 of our case study sites. The findings from these observations will be the focus of this report.

In addition, NHS England has set out what they believe clinicians add to commissioning. Domain 1 of the authorisation process required CCGs to show “a strong clinical and multi-professional focus which brings real added value” (NHS Commissioning Board, October 2012:11). This added value is said to include; strengthened knowledge of the needs of individual and local communities, increased capability to lead clinical redesign and engage other clinicians, and greater focus on improving quality of primary medical care. In the *Draft Framework of Excellence in Clinical Commissioning* (NHS England, November 2013), NHS England set out further what “excellent practice” looks like across a range of areas central to commissioning. CCGs with “a strong clinical and multi-professional focus with significant member engagement” (p.10) is said to have the following characteristics; constant clinical focus on improving quality and outcomes, significant engagement from constituent practices, and involvement of the wider clinical community in commissioning.

1.2. Research questions

The over-arching aims of the second phase of the study was to explore the impacts of CCGs, with a particular focus upon the potential added value that clinicians bring to the commissioning process over and above what might be achieved by managers, and to elucidate the contexts and factors that enable or inhibit the delivery of these benefits.

We started by interviewing GPs and managers in 7 of our 8 original case study sites from Phase 1 of the study (one declined to participate further). The aims of the initial interviews were to explore the claims that clinicians and managers made about the value that GPs bring to the commissioning process. We addressed 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 NHS England 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?

From these interviews, we found that the claims made by the respondents highlighted two aspects of GPs' knowledge and experience (see Checkland et al, 2014 and Appendix 1 for the interim report; Perkins et al., 2014 for further detail). The first is that their knowledge about services and patient needs is *fine-grained* in that it is rooted in the experiences of individuals and that their role as frontline clinicians seeing significant number of patients allows them to aggregate that knowledge about individuals to provide an overview of the whole system. The second is that their knowledge is *concrete* in that it is based upon real experiences of particular services and not on statistical evidence. Building upon these characterisations, we went on to analyse in detail the specific examples provided of how and why it was useful to have GPs involved in commissioning, using these to develop 4 distinct 'programme theories' (Weiss, 1998) underlying the claims made about GP 'added value' (see Section 4). Our respondents suggested that:

1. GPs' frontline knowledge about patient experiences would enable them to identify problems and deal with them promptly.
2. GPs' frontline knowledge about services would enable them to improve service redesign.
3. GPs' clinical experience and knowledge would enable them to have the authority to speak to other clinicians in ways which improves commissioning.
4. GPs and managers have a symbiotic relationship, which together is more than the sums of its parts, and hence enhances the commissioning process.

To test whether or not the theories can be seen at work in practice, we observed a wide range of CCG meetings using the following questions to guide our observations:

- How is GPs' fine-grained and concrete clinical knowledge used in the different aspects of the commissioning process?
- In what ways does the new system facilitate or inhibit the application of GP fine-grained and concrete knowledge?
- What evidence is there of any impact of this knowledge on the commissioning or contracting processes and outcomes?
- Whose knowledge is used/privileged?
- 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?

Following our decision to adopt realist evaluation framework (see Section 1.3), we focussed our analysis on the following questions:

- What value do GPs add to commissioning process (**outcome**)?
- In what ways do GPs add that value (**mechanisms**)?
- Under what conditions do GPs add value in the way described above (**context**)?

1.3. Realist evaluation

Commissioning in the NHS is in a state of flux with many changes occurring simultaneously. Any changes observed in commissioning processes and outcomes will have been influenced by various actors and organisations. It is therefore impossible to set about a conventional evaluation in which researchers evaluate the 'success' of a new initiative. We started the project by approaching the issue of outcomes associated with clinician 'added value' in commissioning by examining the roles that clinicians were taking in CCGs and the claims made about GPs 'added value'. We did this by interviewing clinicians and managers and these findings have been published previously as an interim report (see Checkland et al., 2014 and Appendix 1).

Following our initial interviews, we observed a wide range of meetings to explore whether or not the claims made could be seen at work in practice. Our observations showed that CCGs are complex organisations, undertaking multiple activities simultaneously. The claims that had been made to us about the value that GPs bring to this process were quite broad and idealised: there was a clear sense that greater GP involvement was important, but participants weren't wholly clear where, in the complex network of committees, project groups and wider forums that make up the work of a CCG, that involvement could add the most value. Furthermore, we found that generalising across CCGs was difficult. Work that in one CCG was undertaken by a Governing Body, in a different CCG was delegated to a project group. This meant that it is very difficult to make any general claims about the extent to which GPs could or should be involved in different formal bodies.

In order to capture the complexity of CCGs and understand more fully how the claimed benefits of GP involvement actually operates in practice, we decided that development of programme theories (Weiss, 1998) underlying the claims needed to be supported with an additional theoretical framework which allowed us to explore in detail the local relational contexts. We decided to amend our methodology to include 'realistic evaluation' (Pawson & Tilley, 1997) as it addresses the overarching questions; what works, in what circumstances, and how?

Realist evaluation (the preferred terminology for many authors rather than the original 'realistic' evaluation) is an approach grounded in 'realist' tradition in the philosophy of science. Its key feature is its focus on the mechanics of explanation. Realist evaluation is a type of theory-based approach to evaluation. "Theory-driven" (Chen, 1990) or "theory-based" (Weiss, 1997) evaluation, as it is more commonly known, avoids the pitfalls of the now familiar 'black box' problem in evaluation research which only pays attention to whether or not the programme 'works' without regard to how and why it works (Chen & Rossi, 1987). The requirement to *explain* why programmes work or not implies an emphasis on the role of 'programme theory' (Weiss, 1997). Hence the first goal of realist evaluation is to uncover the programme theory or theories underlying the policy programme.

Programme theory involves assumptions about how the programme might or is supposed to work. What matters is not the programme activity but the way in which participants responded to the programme (Weiss, 1997). Programme theory deals with the "*mechanisms* that intervene between the delivery of programme service and the occurrences of outcomes of interest" (Weiss, 1997:46, emphasis in original). In realist evaluation, the emphasis on causal explanation also engages with the idea of 'mechanisms' at work.

Mechanisms are "underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest" (Astbury & Leeuw, 2010:368). In other words, mechanisms produce outcomes. These are made up of *individual reasoning* (choices) and *resources* available. If certain resources are provided then they will affect an actor's reasoning and generate a change in behaviour. However, whether or not mechanisms produce the outcomes expected is dependent on combinations of its contextual 'conditions' which enable or constrain the mechanisms (Tilley, 1996). Thus, for example, one of the *outcomes* expected from having clinicians in the driving seat of commissioning is that it enables clinician to clinician conversations, which ensure better commissioning decisions. The *mechanisms* which produce this outcome may include having the 'right' clinicians engaging in the conversation. The *context* which enables those mechanisms to produce that particular outcome is therefore the need to have the forum for that conversation to happen.

1.4. Broad background

1.4.1. Development of CCGs

The Health White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health 2010b) proposed the transfer of commissioning responsibility to groups of GPs, initially known as GP Commissioning Consortia and now Clinical Commissioning Groups (CCGs). In October 2010 it was announced that groups of GPs wishing to form a Commissioning Consortium could put themselves forward to be 'Pathfinders', to test the different models and identifying areas of learning to inform the overall programme. During 2011/2012, a comprehensive system of GP consortia was in place in shadow form taking on increased delegated responsibility from PCTs. GP Consortia went through a rigorous authorisation process (which was done in 4 waves) before taking on full responsibility from April 2013.

One month after CCGs took full responsibility (May 2013), it was revealed that CCGs were to co-commission primary care with the NHS England Area Teams. However it was not until a year later (April 2014), that this was made 'official' by Simon Stevens; he made it one of his priorities when he replaced Sir David Nicholson as Chief Executive of NHS England. Instead NHS England focused their effort on a national *Call to Action* which encourages patients, public, staff and partners to join a national conversation about future demand of the NHS and how to meet these challenges. The call marked the 65th anniversary of the NHS. To support local discussion about prioritisation and utilisation of resources, CCGs were given a suite of materials to support *Commissioning for Value* which is about identifying clinical priority programmes which offers best opportunities to improve value that patients and populations receive from investment in local health system. It is a partnership between NHS England, Public Health England, and NHS Right Care and works with the planning rounds for CCGs and supports vision for transformation set out in *NHS Five Year Forward View* (October 2014). To stimulate the debate with CCGs and their local partners, NHS England published a series of "thought pieces". *A Call to Action: Commissioning for Prevention* (published in November 2013) was the first in the series. This is about how commissioners can allocate greater focus and resources on helping people live healthier lives, preventing illness or diagnose illness early. CCGs were also supported with a range of data packs. The first pack called *Commissioning for Value: Data packs for CCGs and Regional Teams* (released in October 2013) was a range of data packs and online tools showing CCGs and area teams 'where to look' and compared spend and income data with their peers. This is a triangulation of nationally-held data which indicates where CCGs may gain the highest value of improvements. The second pack called *Pathways on a Page* pack (published in November 2014) provided in-depth data for 13 patient conditions, within programmes that were mostly identified as offering the greatest potential improvements in the first pack. The third pack called *Integrated Care Pathways* (published February 2015) seeks to demonstrate the extent to which complex patients utilise resources across programmes of care and the urgent care system.

In November 2013, NHS England published a *Draft Framework of Excellence in Clinical Commissioning: For CCGs* which sets out what an "excellent practice" in CCGs looks like across six key areas: clinical and member engagement, public engagement, planning, governance, collaboration, and clinical leadership. This Framework of Excellence will be continually developed and refreshed to reflect new learning and insight as it emerges. The publication of Framework of Excellence was followed by publications of CCGs 'success' stories in January and October 2014 by NHS Clinical Commissioners, telling stories of successful and innovative CCGs across the country.

One year after it was revealed that CCGs were to co-commission primary care, NHS England wrote to CCGs (in May 2014) inviting them to submit expressions of interest for co-commissioning primary care services. CCGs were asked to indicate which model they would like to choose (greater involvement, joint commissioning, or delegated arrangements) and how they would like this to evolve. Primary care co-commissioning was one of a series of changes set out in the *NHS Five Year Forward View* (October 2014). Detailed guidance around co-commissioning options, *Next steps towards primary care co-commissioning*, was published in November 2014. Conflicts of interest were thought to be one of the greatest risks, especially for CCGs opting to take on delegated budgets and functions from NHS England. In light of this, NHS England developed strengthened guidance for the management of conflicts of interest. *Managing conflicts of interest: statutory guidance for CCGs* was published as statutory guidance in December 2014. CCGs were asked to submit their full proposal by January 2015. In February/March 2015, NHS England announced that 64 CCGs have been approved to take on greater 'delegated' responsibility for commissioning GP services and 87 CCGs have been approved for 'joint' commissioning subject to constitutional amendments and the signing of terms of reference by 31 March 2015. The co-commissioning arrangements are to go-live in April 2015. The following section summarises the timeline relevant to CCG policy events and initiatives.

1.4.2. Timeline of relevant events and policy initiatives

Time	Summary of information	Source
Sept 2012	Jeremy Hunt replaced Andrew Lansley as Secretary of State for Health in a ministerial reshuffle.	
1 Oct 2012	NHS Commissioning Board was launched.	http://www.england.nhs.uk/about/
13 Nov 2012	The first NHS Commissioning Board Mandate was published. It sets out the ambitions for the health service for the next two years.	http://webarchive.nationalarchives.gov.uk/20130922140506/http://mandate.dh.gov.uk/2012/11/13/nhs-mandate-published/
	Department of Health published the <i>NHS Outcomes Frameworks 2013/14</i> .	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014
Dec 2012	NHS England published their planning guidance <i>Everyone Counts: Planning for Patients 2013/14</i> and its "supporting information" document <i>Supporting Planning 2013/14 for Clinical Commissioning Groups</i> .	http://www.england.nhs.uk/wp-content/uploads/2012/12/everyonecounts-planning.pdf http://www.england.nhs.uk/wp-content/uploads/2012/12/support-planning-ccg.pdf
	NHS England published their business plan for 2013/14-2015/16: <i>Putting Patients First</i> .	http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf
	NHS England published CCG funding allocations for 2013/14, following a decision by the NHS England Board to adopt a new funding formula.	http://www.england.nhs.uk/wp-content/uploads/2012/12/ccg-allocations-13-141.pdf
	NHS England published <i>CCG Outcomes Indicator Set</i> for 2013/14 (previously known as the Commissioning Outcomes Framework).	http://www.england.nhs.uk/wp-content/uploads/2012/12/ois-ataglance.pdf http://www.england.nhs.uk/wp-content/uploads/2012/12/ccg-ois-tech-guide.pdf
11 Mar 2013	The Government revised and re-laid Section 75 regulations before Parliament in response to concerns that it would restrict CCGs' freedom to choose not to put services out to competitive tender.	

1 Apr 2013	The main elements of the Health and Social Care Act come into force. The NHS Commissioning Board (renamed NHS England), Clinical Commissioning Groups, Health and Wellbeing Boards, and Public Health England take up their new statutory responsibilities.	
24 Apr 2013	The House of Lords peers voted against a motion to 'kill' the Section 75 regulations (254 to 146 votes), which state that CCGs must not engage in anti-competitive behaviour which is not in the patients' interest.	http://www.pulsetoday.co.uk/commissioning/commissioning-topics/ccgs/lords-rubberstamps-controversial-competition-regulations/20002711.article#.VFosUTSsWSp
May 2013	Pulse revealed NHS England's plan for CCGs to co-commission primary care with its local area teams.	http://www.pulsetoday.co.uk/news/commissioning-news/ccgs-to-jointly-commission-gps-with-local-area-teams-says-primary-care-chief/20002963.article#.U1_LG_IdV8E
June 2013	'Integration transformation fund' renamed 'Better Care Fund', and details set out. Money top sliced off CCG budgets & pooled with social care funding to 'transform' care out of hospital.	http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
July 2013	NHS England set out a national Call to Action to encourage debate about the future of the NHS in a publication <i>The NHS belongs to the people: A Call to Action</i> .	http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf
Oct 2013	NHS England working with Public Health England and NHS Right Care is providing every CCG with a suite of materials to support effective 'commissioning for value'. The first pack called <i>Commissioning for Value: Data packs for CCGs and regional teams</i> and it showed CCGs and regional teams 'where to look; as a first stage to identify opportunities to improve outcomes and increase value for local populations.	http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/ http://www.rightcare.nhs.uk/index.php/commissioning-for-value/#commissioningforvalue
Nov 2013	<i>A Call to Action: Commissioning for Prevention</i> – five step framework intended to help CCGs think about how to commission for effective prevention.	http://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf
	A refreshed mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015.	http://webarchive.nationalarchives.gov.uk/20130922140506/https://www.gov.uk/government/publications/the-nhs-mandate
	Department of Health published the <i>NHS Outcomes Framework 2014/15</i> .	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015
	NHS England published <i>Draft Framework of Excellence in Clinical Commissioning: For CCGs setting out CCGs future ambition</i> .	http://www.england.nhs.uk/wp-content/uploads/2013/11/frmwrk-excc1.pdf
Dec 2013	NHS England published their planning guidance <i>Everyone Counts: Planning for Patients 2014/15 to 2018/19</i> .	http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
	NHS England published CCG funding allocations for 2014/15-2015/16.	http://www.england.nhs.uk/wp-content/uploads/2013/12/allocation-summary.pdf
	NHS England published <i>CCG Outcomes Indicator Set for 2014/15</i> (previously known as the Commissioning Outcomes Framework).	http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-at-a-glance.pdf http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-tech-guid.pdf
Jan 2014	NHS Clinical Commissioners published 16 CCGs' "success stories" in <i>Taking the lead: How Clinical Commissioning Groups are changing the face of the NHS</i> .	http://www.nhscc.org/wp-content/uploads/2014/01/Taking-the-lead-final-pdf-for-web2.pdf

13 Mar 2014	The Department of Health laid the draft Legislative Reform Order (LRO) before Parliament. The LRO would enable CCGs to form joint committees with other CCGs if they choose (hence enable them to act collectively rather than as individual representatives of their CCGs akin to "committees in common") and with NHS England.	http://www.publications.parliament.uk/pa/cm201314/cmselect/cmdelreg/1224/1224.pdf http://www.parliament.uk/documents/DPRR/2013-14/Draft-Legislative-Reform-Payments-by-Parish-Councils-Community-Councils-and-Charter-Trustees-Order-2013/140310%20Explanatory%20Document.pdf
31 Mar 2014	NHS England published a refreshed business plan for 2014/15 – 2016/17: <i>Putting Patients First</i> .	http://www.england.nhs.uk/wp-content/uploads/2014/04/ppf-1415-1617-wa.pdf
Apr 2014	Simon Stevens replaced David Nicholson as Chief Executive of NHS England.	
Apr 2014	Better Care Fund plans submitted.	
29 Apr 2014	Simon Stevens' first appearance before the House of Commons Health Committee and gives first indication of primary care co-commissioning.	http://www.pulsetoday.co.uk/news/commissioning-news/nhs-england-chief-to-draw-up-ccg-co-commissioning-plans-this-week/20006566.article#.VEpHNWddWSr http://m.hsj.co.uk/5070378.article
9 May 2014	Letter from Barbara Hakin to CCGs setting out how CCGs can submit expressions of interest (including its scope).	http://www.hsj.co.uk/Journals/2014/05/12/o/u/q/2014-05-09-CCG-co-commissioning-letter.pdf
13 June 2014	The national tripartite (NHS England, Monitor, and Trust Development Authority) alongside the Associate Directors of Adult Social Services published a framework for <i>Operational resilience and capacity planning for 2014/15</i> . This guidance sets out best practice requirements across planned and urgent & emergency care.	http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf
20 June 2014	CCGs deadline for submitting expressions of interest to primary care co-commissioning.	
7 July 2014	NHS England commissioned Ipsos MORI to conduct <i>CCG 360° stakeholder survey</i> .	http://www.england.nhs.uk/wp-content/uploads/2014/10/ccg-360-survey.pdf
3 July 2014	NHS England's Board meeting and paper revealed the 3 categories of co-commissioning and number of expressions of interest submitted for each category.	http://www.england.nhs.uk/2014/06/27/board-meeting-3-july-2014/
19 Sept 2014	Revised Better Care Fund plans submitted, and subject to review. Review results published.	http://www.england.nhs.uk/wp-content/uploads/2014/11/bcf-ncar-results-analysis.pdf
30 Sept 2014	NHS England published <i>Commissioning Intentions 2015/16 for Prescribed Specialised Services</i> .	http://www.england.nhs.uk/wp-content/uploads/2014/10/comms-intents-2015-16.pdf
Sept 2014	NHS England primary care co-commissioning programme oversight group asked the Board to approve recommendations set out in <i>Proposed next steps towards primary care co-commissioning: An overview</i> .	http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf http://www.england.nhs.uk/wp-content/uploads/2014/10/item7b-board-1114.pdf
1 Oct 2014	A Legislative Reform Order (LRO) was passed through Parliament to enable CCGs to create joint committees with each other and with NHS England.	http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf
23 Oct 2014	Publication of <i>NHS Five Year Forward View</i> . It had been developed by NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission, and the NHS Trust Development Authority.	http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Oct 2014	NHS Clinical Commissioners published profiles of 10 CCGs driving "new and innovative" models of care in <i>Leading Local Partnerships: How CCGs are driving integration for their patients and local populations</i> .	http://www.nhscc.org/wp-content/uploads/2014/10/Leading-local-partnerships_WEB1.pdf
Nov 2014	NHS England published the data second packs to support 'commissioning for value'. It is called <i>Pathways on a Page</i> packs and it provided in-depth data for 13 patients conditions, within which those programmes that were most commonly identified as offering the greatest potential improvements in the first pack.	http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/#data
10 Nov 2014	NHS England published <i>Next steps towards primary care co-commissioning</i> .	http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf http://www.england.nhs.uk/commissioning/pc-co-comms/
Nov/Dec 2014	CCGs opted for 'joint commissioning' and 'delegated commissioning' to work with their membership and area team to consider and agree the preferred co-commissioning arrangement for 2015/16. CCGs opted for 'greater involvement' to take forward the arrangements locally.	http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf
1 Dec 2014	NHS Alliance and the Royal College of General Practitioners published a supporting document for CCGs carrying out co-commissioning <i>The Risks and opportunities for CCGs when co-commissioning primary Care: Things to consider when making your decision</i> . It outlines the benefits and drawbacks associated with taking an increased role in the provision of primary care services.	http://www.nhscc.org/wp-content/uploads/2014/12/FINAL-NHSCC_RCGP-Risks-and-opportunities-for-CCGs-in-primary-care-commissioning-1.121.pdf
Dec 2014	The conflicts of interest framework published as statutory guidance. <i>Managing conflicts of interest: statutory guidance for CCGs</i> .	https://www.england.nhs.uk/commissioning/pc-co-comms/ http://www.england.nhs.uk/wp-content/uploads/2014/12/man-conf-int-guid-1214.pdf
Jan 2015	CCGs to submit proposals for co-commissioning to their regional office.	http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf
Feb 2015	NHS England to work with CCGs to review and approve their co-commissioning submissions. Proposals to be signed off by an NHS England Committee.	http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf
Feb 15	NHS England published the data third packs to support 'commissioning for value'. It is called <i>Integrated Care Pathways</i> packs and it seek to demonstrate the extent to which complex patients utilise resources across programmes of care and the urgent care system.	http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/#data
18 Feb 2015	64 CCGs approved to take on greater 'delegated' commissioning responsibility for GP services.	http://www.england.nhs.uk/2015/02/18/commissioning-of-gp/
5 Mar 2015	87 CCGs approved for 'joint' commissioning subject to constitutional amendments and the signing of terms of reference by 31 Mar 2015.	http://www.england.nhs.uk/2015/03/05/joint-gp-services/
Mar 2015	Local implementation of co-commissioning by CCGs and their area team.	http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf
1 Apr 2015	Co-commissioning arrangements go-live.	http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf

2. Methods

Realist evaluation is method-neutral i.e. it allows the use of any methods of data collection and analytical methods. The choice of which method(s) to use is guided by the types of data needed to formulate answers to the questions posed. We collected the data using a case study approach, semi structured interviews with clinicians and managers, and observations of various CCG meetings. In this section we describe how we use these methods. We also describe how we approach the realist data analysis.

This report uses direct quotations from interviews and excerpts from meeting notes. To preserve the anonymity of our participants, quotations and meeting excerpts are either labelled with an ID number (we use the same ID numbers as used in the first phase of the project where possible) or with a generic description for example 'Director of Finance' or 'locality meeting'.

2.1. *Case study approach*

The aim of the study was to explore the way in which GPs add value to commissioning process. Case studies are recognised as the preferred method in exploratory research or when 'how' and 'why' questions are posed (Yin, 2014). This approach allows an in-depth and contextualised investigation of phenomena.

We focussed our observations on 4 case study sites (sites 1, 5, 7 and 8) from our original 8. These sites were selected based on the findings from the first phase of the study, including for example, evidence of particular innovations, examples of good practice, or examples of significant problems. We also looked at the characteristics that we know from the first phase of the study to have an impact on the way they work. These included:

- Size – small, medium and large CCGs,
- Geographical area - at least one rural and one city-based CCG,
- Relationship with LA boundaries – at least one site crosses LA boundaries.

2.2. *Programme theories derived from initial interviews*

The aim of the interviews with both clinicians and managers was to explore the claims made by both groups about the value that GPs bring to the commissioning process.

Interview topics included 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 results from the interviews were used to focus a second phase of data collection, in which the claims made were followed up in the observation of the work of 4 of our case study CCGs.

We interviewed a total of 42 individuals (mostly GPs with some managers and a nurse clinical lead) in 7 of our 8 case study sites (one site declined to participate further). Participants were chosen for interviews if they were clinicians or GPs, or managers if relevant, sitting on CCG formal committees (see Section 3 for a list of the various CCG committees). The interviews took place between July 2013 and January 2014. Details of the interviewees are shown in Table 1.

Table 1: Interview respondents by site and type

Site	Type of respondent		
	GPs	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

Interviews were audio-recorded (with consent from the participants) and fully transcribed for analysis. All interviewees were given written information sheet about the study and were asked to sign a consent form. Data were stored and managed using NVivo software package.

Interviews were analysed with the aim of developing the programme theories underlying the claims about GP ‘added value’ in the commissioning process. In developing the theories, we explored the assumptions made by GPs and managers about how GPs might or were supposed to add value to commissioning process. The theories identified were the ones most frequently espoused by both GPs and managers.

2.3. Follow up observation in selected case study sites

To test the programme theories identified from the interviews described in Section 2.2, we carried out observations of various CCG meetings, aiming to explore in more depth the claims that were made in the interviews about GP ‘added value’ in commissioning process. In other words, whether or not the claims made were borne out in practice.

We attended a wide range of different types of CCG meetings such as the Governing Body meetings, locality meetings, membership meetings, and various committees meetings across the 4 selected sites (see Section 2.4 for site descriptions). The purpose was to get a sense of where, when, how, and in what ways GPs contribute or do not contribute to commissioning discussions and what facilitates and/or hinders their involvement. Hence we are not attempting to look at whether what we observed was changing over time or whether this was evolving or more enduring. In each of these different forums we observed who was in the room, how they behaved, the extent to which clinical knowledge was mobilised, and the outcomes of mobilising that clinical knowledge. We also continued to observe clinician-manager interactions and the extent to which the wider GP members were engaged with the CCG’s work.

Observations were recorded in contemporaneous field notes and written up by the researchers. We also collected documents associated with meetings such as the agenda, minutes, and papers distributed prior or at the meetings.

The observations took place between January and September 2014. We attended a total of 48 meetings (approx. 111 hours of observations). In each site we attended a range of different types of meetings including governing body, executive group, quality and performance, and informal group meetings. Details of the number meetings attended are shown in Table 2.

Table 2: Number of meetings attended

Sites	No of meetings attended
Site 1	14
Site 5	12
Site 7	7
Site 8	15
Total	48

2.4. Site description

Site 1 was formed from two previous PBC groups which crosses a Local Authority boundary. Both groups focused upon a single Acute Trust, had worked together in the past and have similar populations. The CCG has a population size between 138,000-185,000 (quintile based on sampling size from phase one of the study; see Checkland et al. (2012).

Site 5 had a history of working together in a number of PBC groups, crossing the LA and PCT boundary. They focused upon patient flows from local Acute Trust. It has several locality groups (smaller group of representatives from a geographical area) and population size of >278,000.

Site 7 was formed based upon two previous PBC groups who came together with a footprint the same as the PCT and co-terminous with LA. They regarded co-terminosity with LA as important and they had history of working together in previous administrative groupings (for example GP multi-fund). It has a population size between 185,001-278,000.

Site 8 was formed based upon a PBC group with multiple locality groups. They had a long history of working together and focused upon a small number of Acute Trusts. It has a population size between 185,001–287,000.

2.5. Realist data analysis approach

A realist data analysis addresses questions about what works for whom, in what circumstances and in what respects, and how. The basic realist formula is: Context + Mechanisms = Outcome (CMO triads).

The first goal of realist data analysis is to uncover the programme theories underlying the policy programme. We developed our initial programme theories using the interviews with clinicians (mostly GPs) and managers about their understanding of the value of clinical input in commissioning.

We then tested the initial programme theories against data obtained from our observations from the different types of CCG meetings. We unpacked the mechanisms by which these claims can be borne out in practice and identified the conditions which enable these mechanisms to produce the outcomes expected. Our analysis is guided by the following questions:

- What value do GPs add to commissioning process (outcome)?
- In what ways do GPs add that value (mechanisms)?
- Under what conditions do GPs add value in the way described above (context)?

The analytical process is not necessarily sequential but results in a set of CMO statements i.e. in this context those mechanisms produced by that actor generated that outcome and in that context, other mechanisms would generate a different outcome. The experiences observed in different meetings in different sites are then used to refine the programme theories.

3. Complexity: what do GPs *do* in CCGs?

For this phase of the project, we started by observing a wide variety of meetings to identify what is the 'work' of CCGs and the role of GPs as commissioners. During our various data analysis meetings, we tried to identify the different typology of meetings to define what it is that CCGs do, and how do they do it. We quickly realised that, whilst different CCGs have committees and meetings given similar labels, the role and business of those committees are often quite different from one another. Thus, for example, the Governing body' in some CCGs is set up as a relatively high level forum whose main role is to 'sign off' decisions made elsewhere. In other CCGs the Governing Body fulfils a much more operational role. We also attempted to identify the different 'roles' that GPs have but this proved to be impossible as there are many different 'roles' as there are CCGs.

Due to the degree of complexity associated with CCG structures and governance arrangements, to understand what GPs do in CCGs we needed to start by describing in detail the different categories of meetings, committees or forums that CCGs had. This formed a baseline for the rest of the analysis, but we also believe that it is of wider interest, as it has significant implications for those who must interact with CCGs and those seeking to align their work across a wider area. Appreciating the variation in how CCGs have set up their structures and processes is an important first step in understanding their work.

3.1. Formal committees

3.1.1. Governing Body

All CCGs are required to have a Governing Body which is the body with statutory responsibility and whose function is to give assurance or 'sign off' on decisions. However different CCG Governing Bodies have different memberships and they vary in their role. Some Governing Bodies provide assurance, signing off decisions made elsewhere and focusing upon ensuring that correct processes have been followed, while others are involved in substantive discussions and operational decisions.

CCGs are required to hold some governing body meetings in public (Health and Social Care Act, 2012). However, 'meeting in public' does not mean that it is a public meeting. Hence the public are able to attend, observe and submit questions in advance of the meeting but they are not permitted to take part in the discussions. In all of our sites the Governing Body meets monthly in private. In Site 1, the Governing Body meets in public three times a year while in Site 7 and Site 8 they do this every two months. In Site 5 they have a monthly public meeting which is followed by a private meeting. The function of private Governing Body meetings is to discuss issues more in-depth, use time for training board members, discuss confidential issues or as one Governing Body chair in Site 7 puts it "commercially sensitive" issues such as tendering or work programmes. In Site 7 non-voting Governing Body members do not attend private Governing Body meetings while in Site 1, the "executive group", who are not themselves necessarily voting members of the Governing Body (see section 3.1.2) would attend the private Governing Body meetings.

Membership of Governing Bodies also varies. In Site 1, their membership consists only the minimum specified in the guidance (see <http://www.england.nhs.uk/wp-content/uploads/2012/09/ccg-members-roles.pdf>) i.e. GP or healthcare professionals acting on behalf of member practices, chair of the Governing Body, Accountable Officer, Chief Finance Officer, a nurse member, a consultant member, and two lay members. In Site 8, they have an additional two lay members, one of whom is the vice chair, and four elected clinical representatives of member practices and some managers at Director level for example contracts and partnership. In Site 5, they have an additional two lay members and

one of them is the vice chair. In Site 7, they include an additional one lay member, one of whom is the vice chair, GP leads, and representatives from the Local Authority and HealthWatch

3.1.2. Executive or commissioning committee

The 'operational' or 'doing' bodies in our case study sites have different names. In two of the sites, Site 1 and 7, they are called the 'executive group'. In Site 5, although they are not called an executive group, they function like one. In site 8, they are referred to as the 'commissioning committee'.

The executive group in Site 1 is the decision making body and they report their decisions to the Governing Body. According to their Constitution (dated January 2013), their remit includes setting the CCG's vision and strategy and they have responsibilities to "approve" issues relating to; strategy and planning (for e.g. approving the CCG's direction), contracting and commissioning (for e.g. approving CCG contracts in terms of commissioning support, joint working), human resources (for e.g. approving policies for employees), quality and safety (for e.g. approving arrangements for supporting NHS England), operational risk and management (for e.g. approving arrangements in respect to risk sharing and pooling), and communication (for e.g. communicating decision to all clinicians in member practices). They have a weekly meeting and their membership consists of mostly GPs, including the GP Accountable Officer, CCG GP chair, four GPs (who are not Governing Body members), Chief Operating Officer, Chief Finance Officer, Head of Quality, and Public Health. The executive group is supported by a Senior Management Team (SMT), which is the "engine room" of the CCG. The SMT is chaired by the Chief Operating Officer and only attended by managers. They work through the strategic and operational issues such as CCG performance and financial position, national policy implementation and delivery, human resources and organisational development issues or plan. They set the executive group's agenda (of which the Chief Operating Officer and Chief Finance Officers are members), to advise and support the GPs in their decision making.

Following some issues regarding decision making and focus, Site 7 decided to divide their clinical and management function. They have a separate clinical and management team, each with clearly delineated remit. According to their Terms of Reference (dated May 2014), the function of the clinical team is around clinical leadership and clinical decision making and their remit includes development and implementation of commissioning plans and pathways, while the focus of the executive team is on strategy and business management. The membership of the clinical team in Site 7 is similar to the executive group in Site 1, which are mostly GPs with attendance by the Chief Operating Officer and Chief Finance Officer. The membership of the management team in both sites is also similar, but in Site 7, these meetings are also attended by the CCG GP chair. Hence unlike the clinical team in Site 7 whose remit is specifically on clinical issues, the executive group in Site 1 does not only discuss clinical issues but also strategic and operational issues such as the 5-year strategic plan and 2-year operational plan, Better Care Fund, and new care model. In Site 7, strategic and operational issues are dealt with by the management team.

Site 8 used to have an executive group but this has now merged with a 'commissioning committee', as the CCG found that some of the work done by the two groups overlapped. The focus of this commissioning committee is on high level processes of commissioning. According to their constitution, the purpose and duties of this committee are to oversee commissioning activities and to review and deliver strategic, operational, and financial plans. It is thus very similar to the functions ascribed to the 'executive group' in site 1. It is chaired by a lay member and its members include both GPs and managers: CCG clinical chair, the four elected clinical representatives of member practices, Chief Operating Officer, Chief

Finance Officer, CCG Directors of Contracts and Performance, Delivery, Partnerships, Director of Public Health, and recently an elected Councillor.

Site 5 has an informal group which meets twice a month and brings together GP chairs and vice-chairs from the locality groups, Chief Finance Officer, Accountable Officer, and Chief Officers for Operations, Quality, and Partnerships. They are not part of the formal structure and have no delegated authority. They are a 'discursive group' that takes decision on what things to propose to the Governing Body or what the CCG's stance should be in relation to various issues. It is also a forum to update one another. This CCG also has a 'commissioning committee' whose purpose is to ensure effective commissioning and delivery of the commissioning plans. Its remit includes determining the commissioning strategy and priorities, ensuring that localities' commissioning decisions are aligned to the commissioning plan, and providing clinical leadership. Its members are mostly GPs including CCG GP chair and representatives from each locality and managers such as commissioning manager, finance manager, quality and safety manager, contract manager, and lay representative.

In summary, all of our case study CCGs have some kind of sub-committee of the Governing Body which takes responsibility for overseeing the commissioning function. However, the membership of these committees varies quite significantly, as does their role. Existing constitutional documents are generally written at a high level of abstraction (e.g. 'strategy and planning', 'overseeing commissioning' etc), making it difficult for outsider observers to clearly understand where particular issues will be discussed or decisions made. It is likely that, over time, a local embedded understanding of which group carries responsibility for which areas of work will develop. However, there is a danger that the lack of clarity that we identified could be a source of inefficiency or confusion with, for example, one or more groups discussing the same issues without a clear understanding of where responsibility lies.

3.1.3. Audit and remuneration committee

All CCGs in our sites have an audit and a remuneration committee as required by the Health & Social Care Act 2012. Both committees are accountable to the Governing Body. The Audit Committee provides the Governing Body with governance, risk management, and advice on finances and law compliance, internal control while the Remuneration Committee makes recommendations on remuneration, fees and other allowances for employees and for people who provide services to the CCG.

3.1.4. Quality committee

All CCGs in our sites have also established a quality committee, although this is not stipulated in the legislation. However they are named differently in different sites and appear to have a different remit and membership. According to NHS England (<http://www.england.nhs.uk/resources/resources-for-ccgs/ccg-tor>), the function of a quality committee is to "provide assurance on the quality of services commissioned and promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience". GPs' involvement in these committees varies.

In two of our case study sites, Site 7 and 8, their quality committee is called the Quality, Finance, and Performance committee. In Site 7 the function of this committee, according to their Terms of Reference (dated June 2014), is to oversee, understand, review and ensure that action is taken for all issues related to the quality, finance, and performance of services. The committee is chaired by a lay member and has a wide membership including CCG GP chair, some Governing Body GPs, Chief Financial Officer, Chief Pharmacist, Head of Joint Commissioning, and a representative from the Commissioning Support Unit (CSU).

In contrast in Site 8, in addition to the main committee there are sub-groups which held monthly meetings with each of the major providers locally. Each committee is chaired by a GP representative and the function of the meeting is to give assurances about quality, safety, and patient experience. They monitor various aspects of operations of the providers. Topics discussed at the sub-group meetings are provider-specific, and include issues such as pathway updates, serious incidents, activity and performance, service redesign, and office premises.

In Site 5, they have a separate Quality and Safety committee and Finance and Performance committee. The function of the Quality and Safety committee is to review and monitor all elements of quality, safety and patient experience while the Finance and Performance committee is to monitor and review finance and performance plans and achievement. The Quality and Safety committee in this site is chaired by a Governing Body GP lead who is supported by a manager. It has wide membership including a vice chair (who is a GP lead), locality chairs or vice chairs, a Chief Officer for Quality, lay members, Lead Pharmacist, and Head of Medicines Management.

In Site 1, their quality committee is called Clinical Quality and Governance and it reports to both the Governing Body and executive group. According to their Terms of Reference (dated January 2013), their remit is to provide advice and recommendations to the executive group and assurance to the governing body on quality of services, clinical effectiveness, safety, and patient experience. The information reported to the executive group is expected to be a “high enough strategic and operational level” to ensure that the committee is carrying out its responsibilities and to escalate issues of concern appropriately. This committee also receives reports on finance and performance. It is chaired by the Governing Body nurse and its members include; lay member, secondary care consultant, GP Accountable Officer, and Head of Clinical Quality and Governance. The quality committee in this site also has a service-specific sub-group. It is a joint committee with a neighbouring CCG and is chaired by a CCG GP chair. Its members including various providers of this service and a neighbouring CCG GP lead.

3.2. Informal groups

In addition to ‘formal’ committees such as the governing body, audit, remuneration and quality, some of our case study sites have developed groups which have no ‘formal’ role but with a strategic view across the local health and social care economy.

In Site 8 they decided early in to process to set up a forum to enable high level clinician to clinician discussions. Its role is to provide clinical advice to the CCG Governing Body on the impact of commissioning and development of proposals, recommend priorities for service development, facilitate progression of clinical work streams and act as a forum for engagement across the local health / care economy on clinical matters. Members of this group are primarily senior clinicians, from both primary and secondary care, with decision making capacity within their organisation. Other members include CCG managers, hospital managers, and representatives from the local council. This group is chaired by the Governing Body secondary care clinician and meets monthly.

Site 1 also have a group with a similar strategic role, however their focus is not only on clinical issues. Historically (prior to Health and Social Care Act 2012) they had established a commissioning committee working in collaboration with its providers whose role was to shape and lead on the delivery of transformation and integration of health and social care services within the district wide area. Members have delegated power to formulate the strategy and oversee its implementation. They were seen as the “integration engine room”, and when CCGs were established it was decided that this group should continue, although it has no formal role in the new system. Their function is to develop strategic plans across the

local health and social care economy, which feeds into the district wide transformational programme. It is chaired by the CCG GP Accountable Officer and meets monthly. Members of this group are seen as the leaders of the local system such as the hospital's Chief Executive and Director of Finance and representatives from the local council and voluntary sector organisations. However, there are no other GPs involved, whereas in Site 8 a number of GPs attend. In addition, Site 1 has also developed an integrated provider group. Historically, they had a provider-specific service development group. The function of the group was to discuss all aspects of service development such as pathway development. They have recently moved away from provider-specific groups into an integrated group to ensure transparency which will then enable various providers to engage in service development. The idea was to bring different stakeholders together to discuss a particular issue. This group is chaired by a GP Executive member and members vary widely from grass-roots GPs to Directors of the Care Trust and Acute Trust, Chief Executive of Community Pharmacy, and representatives from the Local Authorities. They meet once every three months. The CCG will send out a topic of discussion to a mailing list of people and the providers can decide to attend if they think the topic is of relevance to their organisation. For example, in one of meetings we observed the CCG was developing a new model of care for self-care and self-management. They wanted feedback from different stakeholders on the proposed models to feed into the development of the model.

Similarly, Site 7 has developed a forum for commissioners and local providers to exchange their views. However they are specifically focused around delivery of the Better Care Fund. The meeting is chaired on alternating meetings by either the CCG's Chief Operating Officer or a Local Authority representative. Members include: CCG managers, hospital clinicians and managers, and representatives from the local council, Commissioning Support Unit, and HealthWatch. Although it is managerially-led, in one of the meetings we attended there were some non-Governing Body GPs present at the meeting.

Site 5, historically (prior to Health and Social Care Act 2012), had developed an informal partnership group which brings together commissioners, local authorities and local providers. This group continues to exist and is now responsible for developing and implementing a major programme of service reconfiguration which is seen as shifting resources from secondary care into the community. It is a voluntary partnership set up to deliver a whole system transformation. Under this group there is an executive level which is made up of the Chief Executives of the organisation that are part of it. There is also a Programme Board which is independently chaired i.e. by non-executive appointed by the partners in the partnership and a delivery group which is chaired by the CCG Accountable Officer.

In addition, our study CCGs have a variety of other committees with varying memberships and remits. In some cases these represent the survival of legacy bodies from previous commissioning arrangements, and in other cases they were developed in response to perceived need. They are also represented on their Health and Wellbeing Board(s).

3.3. Summary

Overall, we were surprised by the degree of complexity associated with CCG structures and governance arrangements. In spite of attending meetings, interviewing staff and having access to CCG documents, we were often unable to define clearly which body was responsible for which type of decisions, and who was a member of that body. We would highlight the following as significant:

- Whilst all CCGs have a Governing Body, and there is a statutory minimum membership for Governing Bodies, in practice the make-up and role of Governing Bodies varied significantly. In particular, the number of GPs involved was very different between sites, as were the number and role of lay members. Different CCGs

had interpreted the need to have meetings 'in public' differently, and Governing Bodies varied in the extent to which they involved themselves in operational matters. In some CCGs the Governing Body was essentially an oversight role, responsible for 'signing off' decisions made elsewhere; in others the Governing Body retained an operational role. All of this is in contrast to PCTs, in which board membership and the role of the board were broadly similar, modelled upon board membership in private companies, with a built in non-executive majority, Director-level executive representation and a limited role for professional representatives.

- Many CCGs have established some kind of 'operational' or 'executive' group, below the level of the Governing Body and reporting to it. In some sites this was referred to as an executive, and in others it was called a commissioning committee. In some sites these groups have a GP majority, whilst in others they are largely made up of managers. In one site there are two such bodies, one clinical and one managerial, with little clarity about the relationship between these two sub-Governing Body level groups. These groups tend to meet frequently, and have an important role in the overall work of the CCG. However, they are non-statutory and we found some lack of clarity over the extent of their role and power. For example, some such committees have a number – or even a majority - of members who are not voting Governing Body members, but appear to be responsible for setting the overall direction of the CCG.
- All of our case study sites had established some sort of 'quality' committee, but again the role, remit and membership of these committees varied considerably.
- Some sites had also established groups with wider health economy, bringing in members from outside the CCG and focusing upon a variety of issues including some higher level longer term strategy and some provider-specific service development ideas.

This complexity is important because it highlights the fact that CCGs are more different from one another than was the case for PCTs. Thus, to say 'I am a member of the CCG's executive group' can only be understood in the context of that particular CCG, and it will not mean the same thing as being a member of the 'executive group' in a different CCG. Similarly, a Governing Body in one CCG might have a GP majority whilst another might be dominated by lay members and managers. Furthermore, a Governing Body in one CCG might have a strongly 'operational' role, whilst another might take a more hands off 'assurance' role. Whilst PCTs did have different structures below the level of their board, in general their structure was more clearly defined and they were more similar one to another, with, for example every PCT having a number of Executive Directors, who headed directorates with fairly clearly defined remits. CCGs, by contrast, can have a clinical Accountable Officer or a non-clinical one, a manager who is head of commissioning or a GP representative overseeing the commissioning function, and a Governing Body which takes operational decisions or one which signs off decisions made elsewhere. This complexity is compounded by the existence of a great variety of additional membership engagement sub-structures below Governing Body level variously called Localities, Neighbourhoods, Councils of Members etc, many of which must also sign off and agree both strategic and operational decisions. Taken together, this suggests that asking what the role of GPs is or should be in CCGs is a complex question with as many answers as there are CCGs. Furthermore, it highlights the difficulties associated with defining where expensive GP time, energy and commitment might best be focussed. Table 3 summarises the differences between CCGs and PCTs.

The realist approach adopted in this study provides one way of working with this complexity. The approach focuses upon actions and activity in context, and allows us to explore in depth

the conditions that facilitate or impede clinical input in commissioning wherever in the organisation it occurs.

Table 3: Differences between CCGs and PCTs according to different categories

CCGs	Categories	PCTs
Governing Body.	Statutory body	PCT Board.
Members involved	Mode of appointment to statutory body	Appointed by NHS hierarchy (Strategic Health Authority).
Variable – some CCGs have GPs as majority members or a GP Chair or a GP Accountable Officer on their Governing Body while others non-clinical members a non-clinical Chair or Accountable Officer.	Members of statutory body	All PCT Boards have same members. They included a team of Executive Directors, Non-Executive Directors (who formed a majority members), and the chair of the Professional Executive Committee (clinical members). The chairman of a PCT was a Non-Executive Director.
Variable and multiple – some CCGs have a separate clinical and management team while others have a GP representative and a GP majority overseeing the commissioning function.	Operational management team	Chief Executive and Executive Directors
Multiple at all levels – GPs can input in to decision making either at the Governing Body, executive, and/or locality levels.	Clinical input	Professional Executive Committee was a separate committee from the PCT Board and it functioned as an advisory body. Variable involvement at other levels
Variable – depending of the CCG's priorities.	Work streams	Generally similar between PCTs.
Variable - some CCGs have Localities, Neighbourhoods, or Councils of Members who may or may not be given devolved budget and responsibility.	Devolved responsibility and budget below statutory level	Some PBC groups had a devolved budget and responsibility.

4. Realist Evaluation

The aim of realist evaluation is to unpack the mechanisms by which the claims made in interviews ‘work’ in practice and to identify factors which enable these mechanisms. In this section we started by setting out the ‘programme theories’ about the role of GPs in commissioning that were identified in our initial interviews. Following our initial interviews with GPs and managers, we analysed the interview data to develop the programme theories underlying the claims about GP ‘added value’ in commissioning process. In developing the theories, we explored the assumptions made by GPs and managers about how GPs might or were supposed to add value to the commissioning process. We identified 4 programme theories that were most frequently claimed by both GPs and managers we interviewed:

1. GPs’ frontline knowledge about patient experiences would enable them to identify problems and deal with them promptly.
2. GPs’ frontline knowledge about services would enable them to improve service redesign.
3. GPs’ clinical experience and knowledge would enable them to have the authority to speak to other clinicians in ways which improves commissioning.
4. GPs and managers have a symbiotic relationship, which together is more than the sums of its parts, and hence able to improve ability to commission effectively.

From these theories, it is not clear how they actually ‘worked’ in practice and what could be identified as the ‘added value’ that GPs bring to the commissioning process. To do this, we tested the theories against the activities which we observed in the meetings we attended, and used our observational findings to more clearly delineate the contexts in which the theories hold and identify the mechanisms which underpin their action.

4.1. Theory 1: Frontline knowledge about patient experiences

Theory 1 derived from the initial interviews suggests that the main point of GPs being involved in commissioning is because they also work on the ‘frontline’ of the NHS and dealing with patients daily they are in a position of knowing patients’ real experiences. They would use their knowledge to pick up problems, such as knowing when certain services are not delivering or if certain care pathways are not working correctly, and deal with them promptly.

In the CMO format:

Context	Mechanisms	Outcomes
<ul style="list-style-type: none"> • GPs working on the front line and dealing with patients daily. 	<ul style="list-style-type: none"> • Ability to use their clinical knowledge to voice what is working or not working. 	<ul style="list-style-type: none"> • Identify problems and deal with them promptly. • Make better decisions.

From Phase 1 of the study, both GPs and Managers claimed that the value that GPs bring to commissioning is by virtue of GPs being on the ‘frontline’ of patient care:

The point still remains that GPs are probably the right people to do this, because the beauty of the fact that we have to sit across the table from the individual patient. And yes, we’re not the most patient responsive bunch of people, but we still have to meet Mrs Jones, and she still gets to rant at us about the fact that her hip operation isn’t

being done. And it will be our ears that get bent if we get it wrong. Whereas that's not the case if you ask anybody else to commission [GP ID 221].

It's their clinical knowledge, isn't it that's the key. So I think they add value particularly in terms of the design of services... and understanding their patient's needs [Manager ID 9].

This claim was contrasted with the role of GPs in Practice-based Commissioning (PBC), which was characterised as smaller scale and less significant:

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

In the observational phase of the current study, we tried to unpack this claim further. Our interviewees claimed that by working on the 'frontline', GPs were able to know what and when services were not delivering or when care pathways were working correctly and hence they were able to deal with these problems promptly. This also brought the decision making closer to patients:

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].

From our observations we found evidence which supports this theory. In Site 7, we observed a Quality, Finance, & Performance meeting where GP's knowledge was used to clarify what is happening 'on the ground'. At the meeting the overall performance of NHS 111 service was reported. The Head of Quality presented a summary of the report. A GP lead for this service intervened and pointed out that when the report refers to 'clinicians', it did not include GPs and only refers to 'nurse', 'paramedic', etc. He clarified that it is not a GP who was calling back but 'clinical advisor' and the term 'clinician' in the context of 111 refers to 'nurse' and 'paramedic'. This intervention was important, as it provided clarification and details to others at the meeting who would may not have understood the discussion since they do not have that 'frontline' knowledge.

However, whilst 'frontline' personal knowledge was seen to deliver some benefits, we also found instances where GPs were reluctant to rely on this knowledge, preferring to utilise more traditional aggregated formal data such as that relied upon by managers. For example, we observed a meeting where a GP was reluctant to use his 'frontline' knowledge alone, asking for '**proper**' data. In this case we observed an executive group meeting in Site 1, where the group needed to make a decision on whether or not to continue funding a particular psychological therapy service for people with mental health difficulties. They needed to decide on whether to continue grant funding the service or put it out to tender. Historically the service had received short term grant funding but this had been at a level insufficient to fully support the existing service. The current provider organisation [name of Provider A] had made up the shortfall by charging some clients for the services that they received. This service provided an alternative to the Improving Access to Psychological Therapies (IAPT) and Primary Care services provided by [name of Provider B]:

GP ID 286: The paper circulated to us is not sufficient for us to make a decision. The only result I have is from what I heard from 3 patients *so they are anecdotes and doesn't matter that much*. What I worry [about] is the relationship thing.

Head of Quality: Could [name of Provider B] offer that?

Director of Finance: This is service provision stuff so not just grant. We should have IAPT paper on the agenda for us to make decision. This needs to go out to tender.

[Director of Finance pushed for the committee to make a decision today]

GP ID 286: If it's based on me I'll say no. Just keep the patients in the system.

Chief Operating Officer: So the decision is we're not going to continue with this but just keep the patients already in the system.

GP ID 286: Yes

[GP ID 285 nodded in agreement]

[emphasis added] [Executive group meeting, June 2014, Site 1]

The two GP executives (a CCG GP chair and a non-Governing Body GP) present at this meeting had 'frontline' knowledge of the service. However, they were initially reluctant to make a decision based on this 'frontline' knowledge and a four-page summary of the report. They wanted a 'proper' or more comprehensive report before making any decision. The managers insisted that the decision needed to be made that day and the two GPs present were asked to make the final decision. Interestingly, when pushed by the managers, the two GPs decided not to pursue the need to have this 'proper' report and made a decision based on their limited 'frontline' knowledge which was in line with the recommendation made in the report summary written by the manager. It is unclear from this whether they would have continued to push for more information had their front line knowledge contradicted the short report's recommendation. It is interesting that the GPs here **acknowledged the limitations of what they called 'anecdotal' personal knowledge**. This is in contrast to the claims made in the interviews, in which such frontline knowledge was lauded as highly significant.

Similarly in Site 7, we observed a clinical executive group meeting where GPs were asked to 'think as commissioners' and develop some commissioning priorities for the CCG. However, the meeting was unproductive, with the GPs present voicing concern that they were being asked to make these recommendations without **'proper' data** to base their decisions. Furthermore, they complained of a **lack of preparation**. This was the first meeting after this group had been set up. It was attended mostly by GPs with some managers. The GP who presented this item [GP ID 10] started by asking the group to think about CCG priorities. She said that GPs need to understand and determine priorities in order to avoid doing a significant amount of work on something that is not deemed a priority. She added that the CCG needed broad strategic priorities which are aligned to the Health and Wellbeing strategy. She asked the group to harness their clinical knowledge and translate it into changes in commissioning. She gave community services as an example of a priority and whether they are poor quality, with a high patient demand, and examining different methods of service redesign. As the group was not adequately prepared for this exercise, when it started there was some confusion about what priorities they should be discussing. One of the GPs asked if they were meant to talk about financial, personal, and management priorities. GP ID 10 replied by examples of priorities such as giving poor access to diagnostics and poor diabetes performance. Another GP added that the CCG's priorities are already defined in the two year operational plan and five year strategic plan and that the group should focus on something important locally. GP ID 10 replied that those strategic priorities are high level such as keeping people out of hospital but there is nothing on how to do it. After those clarifications, the meeting was then split into groups for discussion. At the end of the exercise, everyone agreed that it is difficult to decide what CCG priorities are when they did not have the data to inform their decision, as shown in the following exchanges:

GP ID 7 noted that we need data to know where to maximise the benefits; we need data to inform it
 GP chair agreed that data is key to decide on priorities
 GP female noted that we may have specific cases in our practices that are difficult but overall we might not be spending that much money on them as a CCG; we need data to inform decision on priorities; there are going to be unsolvable cases but we need data to focus on average rather than exceptional
 GP male noted that this is the only forum available in which issues can be taken to CCG, that's why issues are voiced
 Locality Manager & GP ID 7 encouraged to send any issues to them and they will respond
 GP male suggested picking priorities out of the things they have to do anyway
 [Locality meeting, June 2014, Site 7]

Thus, once again the GPs in this site felt that their clinical knowledge, whilst useful, failed to provide the objective overview which they felt was necessary to fulfil their task. In addition, to giving the GPs adequate preparation before the meeting, it is also crucial to have a forum which enables the discussion to take place. On a positive note, this meeting demonstrates a genuine attempt to involve a wider group of GPs in the work of the CCG. Furthermore the group had a manager assigned to work with them, follow up on issues raised and pass their concerns along. However, the lack of preparation, and failure to provide the broader information required limited the role that they could play.

Taken together, these examples show that the mechanisms which enable Theory 1 (frontline knowledge about patient experiences) to work in practice include:

- For clinicians to be able to voice their concerns about whether certain services are not delivering or if certain care pathways are not working correctly, there needs to be a **forum** which enables them to do this.
- GPs need to be **prepared for meetings**, including giving them task specific information before the meeting and assigning a manager who is able to take things forward.
- Decision making or setting out priorities cannot only depend upon personal frontline knowledge; it also requires what several participants called **'proper' data**.

Refined CMO format:

Context	Mechanisms	Outcomes
<ul style="list-style-type: none"> • GPs working on the front line and dealing with patients daily • GPs clarifying what is happening 'on the ground' • GPs involved in decision making or setting out priorities 	<ul style="list-style-type: none"> • Ability to use their clinical knowledge to voice what is working or not working • Having the 'right' people with the 'right' knowledge in the 'right' forum • Meeting preparation, including giving GPs something to think about before the meeting • Having 'proper' data as well as personal knowledge 	<ul style="list-style-type: none"> • Identify problems and deal with them promptly • Improved decision making and decision making process

Observation of other meetings allowed us to further refine this theory. In the examples we have shown so far, the GPs ability to contribute to commissioning discussions was due to them having an **'official' position in the CCG**, for example, a Governing Body GP, an executive GP, or a clinical lead. However, in Phase one of the study we found that most GP leaders who are actively engaged in the CCGs are what are often called the 'usual suspects' in that they have held some sort of leadership role the past and there is difficulty in enthusing first time GP leaders (Checkland et al., 2012). Hence the majority of GPs have **no 'official' position in the CCG**. For these GPs to significantly contribute to commissioning, both the **individual GPs and/or the CCG need to adopt a proactive approach to gathering information**.

For CCGs to collate individual GPs' concrete knowledge and feed that in to their decision making process, they need to actively encourage the collation of the views and experiences of the wider GP and clinician community (those not actively involved in the CCG on a day to day basis). For example, in Site 1 we observed an executive group meeting where the CCG presented a summary of a review of the cardiology service in the local hospital which had gathered both patients' and GPs' views of the service. The review found that although the pathways looked fine and patients thought the service was very good, GP practices preferred to send their patients to a medical centre for cardiology outpatient services rather than sending them to the hospital. Reasons for this included receiving better communication and turnaround from the medical centre. The feedback from GPs was that the problem with the hospital service was issues around appointments not being on time and follow-up appointments being delayed. They decided to ask the hospital to create a defined timescale for appointments and improve the turnaround times for sending letters. The Accountable Officer was then tasked to have a meeting with the hospital Medical Director to discuss this. This demonstrates a CCG using their access to local GP knowledge before approaching the provider to have discussions. The membership structure of the CCG provided **a forum** within which this knowledge could be gathered.

For individual GPs to be able share their experience of service provision or express their concerns there needs to be a **facilitative environment** which assures people that it is safe and that they are encouraged to express their concerns, contribute to, or attend meetings. Good communication is also necessary to enable clinicians knowing which **forums** to address their concern or which meetings are happening where and what topics are covered on the agenda. In Site 8, one of the locality GPs had concerns about the re-tender of a public health service (following the move of Public Health responsibilities from PCTs to Local Authorities in April 2013). The service had previously been provided from an organisation within the CCG footprint but the contract was now been given to a different provider (outside the area). The CCG had expressed their concern to the Local Authority. However the locality GP remained concerned, arguing that the way in which the decision had been taken had implications for such processes in the future. He therefore decided to raise it again with the locality chair via a locality email. These round-robin emails go to all locality GPs, and on this occasion generated significant discussion. One GP highlighted his concerns about the process, and suggested that the wider CCG needed to use the experience as a prompt to consider in more depth their relationships with Local Authority commissioners. Another GP replied lamenting the fact that GPs with experience of local services had not been consulted in the decision. Although these GPs were not able to change the awarding of the contract, as the decision had been made and it is not a service commissioned by the CCG, they saw their concerns as important enough to raise in order to try to ensure better processes in future. The round-robin locality email provided a forum in which these concerns could be raised.

In another example in the same site, the same locality GP raised another concern, but this time regarding a CCG commissioned service. Again the concern was raised in an email to the locality mailing list. As a result, the locality chair decided to block out a ½ hour slot at the

next locality meeting to discuss this. As this is a service which is commissioned by the CCG, the GP's concerns had been taken up as an ongoing issue and input was seen as timely.

Further elaboration of the CMO:

Context	Mechanisms	Outcomes
<ul style="list-style-type: none"> • GPs working on the front line and dealing with patients daily • GPs clarifying what is happening 'on the ground' • GPs involved in decision making or setting out priorities • GPs with 'official' position in the CCG • GPs with no 'official' position in the CCG 	<ul style="list-style-type: none"> • Ability to use their clinical knowledge to voice what is working or not working • Forum for GPs to express their clinical knowledge <p>Requires:</p> <ul style="list-style-type: none"> • Having the 'right' people with the 'right' knowledge in the 'right' forum • Meeting preparation, including giving GPs something to think about before the meeting • Having 'proper' data • Facilitative environment, with clear lines of communication • Individual GP and/or CCG adopting proactive approach 	<ul style="list-style-type: none"> • Identify problems and deal with them promptly • Improved decision and decision making process

4.2. Theory 2: Frontline knowledge about services

Theory 2 suggests that GPs working on the front-line have insights into a full range of services available as they have wider links with multiple providers, social services and other government bodies.

Context	Mechanisms	Outcomes
<ul style="list-style-type: none"> • GPs working on the front line 	<ul style="list-style-type: none"> • Understanding of the whole range of services available • Forums in which to share and use this knowledge 	<ul style="list-style-type: none"> • Improved service redesign

In phase two of the interviews, GPs elaborated that their 'frontline' knowledge enables them to have a broad overview of what is working and not working in the system

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].

However, from our observations we found that GPs' knowledge was often very specific i.e. pertinent to a particular service, and they do not necessarily have insights into a full range of services, nor about how services work in general. For example, in Site 7, we observed a meeting where a representative from the community trust did a presentation about an integrated health and social care services to manage hospital discharge for older people. The service started at the end of 2013 and it was a service run jointly by the community trust and the local authority. During the discussion, we observed GPs not familiar with the service, as shown in the following exchanges:

GP female asked whether they accept referrals from GP out of hour at weekends; [name of a private company] who runs the service does not know about rehabilitation service

Community Trust's representative confirmed

GP male asked who the service is available to all living in [name of area A] or registered with GP in [name of area A]

GP male said that his referral of patient living on [name of area B] side was rejected and asked what is the service's rejection rate? There are also confusions about referral forms

Community Trust's representative answered that if you identify clearly that you require rehabilitation service it will be sent to the team

GP female noted that service is not means assessed for 6 weeks. If after 6 weeks patients are deemed to have to pay for social care input and they refuse, what do you do?

Community Trust's representative replied we start having this conversation very early if we think they need ongoing care

Community Trust's representative added they go back into hospital; it's person's choice how they choose to spend their money

GP female asked how GPs know whether at discharge hospital has involved rehabilitation team
 Community Trust's representative said if only district nurse has to be involved then the rehabilitation team is not involved
 GP female asked what is the difference between rehabilitation service and virtual community ward?
 Community Trust's representative replied rehabilitation service is designed to intervene in crisis; services serve different cohorts
 GP ID 7 noted that we have community ward, rehabilitation team, matrons, district nurses all providing continuity of care in community
 GP ID 10 noted that this is confusing and GPs don't know whom to refer to
 [Locality meeting, June 2014, Site 7]

Thus, whilst GPs do bring a frontline understanding of services to the discussion, that knowledge is partial and incomplete. The exchange above illustrates those concerned struggling to clarify exactly what service was provided, to whom and how it might be accessed. Individuals were able to contribute examples of where the service had failed to deliver, and this again illustrates the value of having a forum in which these experiences could be raised and shared. However, this exchange also illustrates the complexity of local services, and suggests that our interviewee's claims that GPs are able to 'see the whole system' is probably overly optimistic. Service re-configuration and a proliferation of providers make it very difficult for individuals to understand the full range of services available locally. Our sites recognised this, with many seeking to establish some kind of searchable database which pulled together information on the range of available services. Overall, clinical voices were valuable in providing contextual details and information as to whether services were actually being delivered as intended, but they required additional information from managers in order to understand fully the pattern of available services. We can thus elaborate the 'CMO' as follows:

Context	Mechanisms	Outcomes
<ul style="list-style-type: none"> • GPs working on the front line • Every area has a wide range of context specific services 	<ul style="list-style-type: none"> • Understanding of the whole range of services available • Forums in which to share and use this knowledge • GPs with detailed practical knowledge of the way in which particular services are delivered • Combined with a systematic overview of services available 	<ul style="list-style-type: none"> • Improved service redesign • More effective use of existing services

In common with Theory 1 (frontline knowledge about patient experiences), getting maximum value from the detailed and specific knowledge that GPs bring about how services actually are delivered in practice, as opposed to how they are supposed to be delivered, requires forums in which knowledge can be shared, mechanisms to gather the widest possible range of experiences and opinions, and willingness by individuals to engage. In addition, this theory begins to hint at the mutual dependence between clinicians (providing front line specific and detailed understanding of services) and managers (providing a systematic

overview of the range of services). This will be returned to in Theory 4 (GP-manager symbiosis).

4.3. Theory 3: Clinician to clinician conversations

Theory 3 derived from the interviews suggests that GPs contribute significantly to commissioning because their clinical experience gives them knowledge and experience which they can use to speak to other clinicians in ways which improves commissioning. According to our interviews, GPs clinical experience gives them the authority to talk about clinical issues, and to challenge providers if required, in a way that managers cannot.

In the CMO format:

Context	Mechanisms	Outcomes
Discussions requiring GPs clinical knowledge and input	<ul style="list-style-type: none"> • Willingness to contribute to discussions • Perceived authority to challenge a variety of stakeholders 	<ul style="list-style-type: none"> • View pathway development from a clinical perspective • Address colleagues' behaviour • Challenge hospital clinicians

This theory carries with it an undercurrent of 'common sense': of course it seems logical that GPs will be in a better position than their managerial colleagues to understand clinical discussions and be able to challenge providers about aspects of their performance. In Phase one of this research (Checkland, Coleman et al. 2012), one manager expressed it thus:

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

In the second phase interviews we were told:

...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].

Another manager highlighted the fact that having clinicians leading the process made provider clinicians more likely to engage:

*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].

In seeking to explore and elaborate this theory, we felt it likely that most of this type of GP involvement would occur in pathway development and contracting meetings where GPs and secondary care clinicians were present. However, in spite of attending many such meetings, we did not observe many instances in which commissioning clinicians brought their clinical knowledge to bear in challenging their provider colleagues. This does not mean that these conversations are not happening; it could be that clinician to clinician conversations are happening informally, outside of the formal meetings that we observed. The presence of clinicians in contracting meetings is not something that we commonly observed in our sites. However, in Site 8, we did observe an instance which could be seen as an example of hospital clinicians' behaviour being influenced by the presence of commissioning clinicians. Here we observed a number of Quality, Finance and Performance meetings, which also discuss contracting issues. In one such meeting it was noted that the relevant hospital's Medical Director had not been attending the meeting regularly and this was regarded as unacceptable, as there were a number of important issues on the agenda such as serious safety incidents. The group expressed their disquiet about his absence and he has since attended subsequent meetings. In Site 1, by contrast, the CCG made a conscious decision to have a manager rather than a GP attending contracting meetings, as they didn't see this as a good use of GPs' time. This suggests that the claims made by those espousing this theory – that clinicians bring a unique and important focus to meetings with providers – was not much experienced in practice.

We did, however, observe events in two of our case study sites that together provide some elaboration and explanation of the potential mechanisms which might underlie the successful operation of this theory. The GPs in Site 8 had a longstanding issue (going back to the days of the PCT) about mechanisms of communication between the hospital and the GP surgeries. Many attempts had been made to resolve this, including sending a quite sharply worded letter to the hospital. The GPs suggested the need to have a standard letter template across primary and secondary care, which ideally should have a standard format at the top of the letter which states any clinical risk or harm issues, and clearly indicates any actions which GPs might be required to take. One of the managers was copied into this correspondence. She was keen to resolve this issue, as she worried that it may lead to a deterioration in relations between GPs and consultants. She suggested bringing in some of the disgruntled GPs to voice their views face-to-face with the consultants in the provider-specific Quality, Finance, & Performance group. This meeting was held, and resulted in a satisfactory resolution, with both sides agreeing a new way forward.

In the same site we witnessed another meeting which provides some further elaboration of the mechanisms which might underlie the successful operation of this theory. This was a membership meeting, during which grass-roots GPs had a challenging discussion with a provider about a different way of commissioning mental health services. The first mechanism which appears to enable this theory to contribute to a successful outcome is **preparation prior to the meeting**. The meeting was chaired by a locality GP lead who is also the champion for mental health, and it was attended by clinicians and managers from both the CCG and the provider. The CCG decided, as a trial, to organise the meeting in a 'select committee' style approach, styling the CCG GPs as committee members, and the provider representatives as 'witnesses', asked to provide an account of their services to the assembled GPs. The chair started the meeting by setting out the overarching objectives for the way mental health was currently being commissioned. This was followed by a presentation by the hospital's programme director setting out the new service. The floor was then opened for questions. Before the meeting started, the chair had primed 5 GPs in the room with questions to ask. These GPs read out the questions when prompted to do so by

the chair and this was followed by questions from other GPs on the floor. After each question the panel was given the chance to answer. The meeting turned out to be quite a challenging session, with the panel getting fairly defensive in their answers at times. However, by the end of the meeting they came up with a list of issues (from the membership, GPs) to work on as a group (including providers, GPs and managers). The **role of the chair** was also crucial: priming grass-roots GPs with questions to ask broke the ice, and encouraged other to join in, as well as demonstrating to the provider that the wider membership supported the questions or concerns that had been raised. It also showed that these are questions and concerns of front line GPs, not just the CCG. The chair thus **created an environment in which grass-roots GPs felt empowered** to contribute, and **managed the meeting** in such a way that those who wished to had time to speak.

A similar membership meeting observed in Site 1 provided a useful contrast, reinforcing the importance of the mechanisms identified above. In this meeting, grass-roots GPs failed to have useful clinical discussions with a provider. This site had been trying to get their members to 'own' the CCG since they were authorised and inviting providers to attend the membership meeting was seen as an important means of achieving this. The grass-roots GPs in Site 1 had been unhappy with a particular provider's performance, which was failing to meet targets. The GPs had raised their concerns with CCG managers at their regular membership meetings. The executive group decided to invite the provider to attend the membership meeting to enable council members (GPs) to challenge them directly. However, when the meeting took place no such challenge occurred. The meeting was not carefully managed as it had been in Site 8. **No specific preparations** were undertaken, apart from circulating some documents, and **the organisation of the meeting** failed to empower the grass-roots GPs to contribute. The three representatives from the provider organisation started by giving a polished presentation, which was largely based upon statistics which were focused on a wider foot print, not on the CCG's catchment area. This presentation then set the tone for the meeting, and ensured that detailed questions about *local* performance could not be addressed. Although council members asked a number of questions of the service, there were not many questions of an in-depth or analytical nature in regard to the performance of the service. The grass-roots GPs did not challenge the provider in a way they had previously challenged CCG managers, and they failed to have the 'clinician to clinician' discussion that the executive group hoped they would benefit from. The GPs were too caught up by the statistics presented, and they failed to ask relevant questions. Even those GPs who had previously been most vocal apparently **did not feel empowered** to voice their concerns in the face of the confident presentation by the provider clinicians.

Taken together, these contrasting examples provide some evidence about mechanisms underlying the successful operation of Theory 3 (clinician to clinician conversations). These were:

- If CCG clinicians are to be able to successfully challenge their provider colleagues, or engage in meaningful dialogue with them, they need to be **adequately prepared**. This needs to go beyond simply circulating papers, and include **specific briefing** about important issues and if possible **collective rehearsal** of key problems or areas of concern in order to ensure that views expressed are representative of the wider membership
- Meetings need to be **carefully planned**, with a format that will **support GPs to feel empowered to contribute**
- **A strong chair** who will intervene if one party is dominating the discussion, or steer the discussion if necessary

The importance of the effective chairing of meetings was seen in many different forums, and our evidence would suggest that this is an area at which specific training for CCG members

(both managers and GPs) could be targeted. Based on these findings, we were able to further elaborate the 'CMO' configuration for this theory:

Context	Mechanisms	Outcomes
Discussions requiring GPs clinical knowledge and input	<ul style="list-style-type: none"> • Willingness to contribute to discussions • Perceived authority to challenge a variety of stakeholders <p>Requires:</p> <ul style="list-style-type: none"> • Adequate preparation, including specific briefing • Collective rehearsal of important issues • Carefully planned meeting format, encouraging contributions and preventing one party from dominating • Effective meeting chairing 	<ul style="list-style-type: none"> • View pathway development from a clinical perspective • Address colleagues' behaviour • Challenge hospital clinicians

Observation of other meetings allowed us to further elaborate this theory. One of the key tenets of the Health and Social Care Act 2012 was to give *statutory* authority for commissioning to CCGs. Practice-based Commissioning had previously involved GPs in the commissioning process (Coleman et al., 2009), but it was argued by some that their lack of statutory power had limited their effectiveness (Curry, 2008). In CCGs, by contrast, it was argued that GPs would take full responsibility (Department of Health, 2010b), and this power would 'liberate' them to contribute more fully to the commissioning process. Those we interviewed in the first stage of this research underline this change, telling us that:

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].

However, in practice we found that the formal architecture of the CCG and the operation of statutory authority was not actually necessary to enable effective clinician to clinician discussions. In Site 8, during the shadow phase the CCG made an early decision to set up a 'strategic' level group with senior members from a number of local organisations. Members of this group are primarily senior clinicians, from both primary and secondary care such as the CCG chair (who also chairs the group), GP locality leads, and senior hospital clinicians and managers, but also included representatives from the local council with high level buy-in from the local health and social care economy (as described in Section 3.2 above). These senior members all have decision making capacity within their own organisations, but the group is not part of the CCG's 'formal' structure and holds no executive power. The forum rather provides space for networking opportunities between clinicians and wider stakeholders. One of the areas of work undertaken by the group was to develop a new way for the local health and social care system to work together to respond to the challenges they faced, which included providing joined up care, responding to the financial crisis, and reducing variation in quality of care. Even though the group had no formal power, the clinician to clinician discussions within a relaxed forum allowed them to develop a new way of working together which has since been adopted across the local health economy as the default way of working. The chair argued that the presence of senior clinicians from all

organisations who felt themselves able to make commitments on behalf of their parent organisations, and the fact that these clinicians felt ownership of the new model and were prepared to take these commitments back to their own organisations both contributed to their success. A similar group was set up in another Site 1, with senior provider clinicians and managers and social care representatives sitting around a table to discuss wider strategic issues affecting the health economy. However, the only CCG clinician present was the Accountable Officer who also chairs the group. We observed this group exploring a possible new care model. They had extensive discussions and decided to roll out a particular new model of care. They secured some funding to commence this work. However, unlike in Site 8 where the GPs (who had been closely involved in the discussions) were very supportive of the new initiative, Site 1 found it difficult to 'sell' this new care model to their membership. The difference between the two groups seemed to be the failure in the second site to fully engage their GPs in the discussions.

Taken together, these examples allow a further elaboration of the CMO:

Context	Mechanisms	Outcomes
<p>Discussions requiring GPs clinical knowledge and input</p> <ul style="list-style-type: none"> • Do not need necessarily to be within the formal structures of the CCG 	<ul style="list-style-type: none"> • Willingness to contribute to discussions • Perceived authority to challenge a variety of stakeholders <p>Requires:</p> <ul style="list-style-type: none"> • Adequate preparation, including specific briefing • Collective rehearsal of important issues • Carefully planned meeting format, encouraging contributions and preventing one party from dominating • Effective meeting chairing • <i>Adequate representation from all relevant organisations</i> • <i>Those present to be sufficiently senior to answer or make commitments on behalf of their parent organisations</i> 	<ul style="list-style-type: none"> • View pathway development from a clinical perspective • Address colleagues' behaviour • Challenge hospital clinicians

4.4. Theory 4: Clinician-manager symbiosis

Theory 4 suggests that GPs and managers have a symbiotic relationship which together is more than the sum of its parts. By 'symbiosis' we mean that the relationship enables both parties to work much more effectively than they would otherwise be able to do alone. Each needs the other, and together performance is significantly improved. Managers would formulate policy and strategy, act as a steer through the policy process, write various policy documents, business plans and present the case to various parties and government. GPs, on the other hand, would assist in clinical input as they have a good understanding of various systems & procedures and pathways on a number of levels, good knowledge of what will work for patients & providers, and engage with other GPs and clinicians.

In CMO format:

Context	Mechanisms	Outcomes
GP-Manager symbiotic relationship	<ul style="list-style-type: none">• Clearly delineated responsibilities• Mutual trust	Improved ability to commission effectively

From phase one of the study, both GPs and managers claimed that, as GPs might only be working for the CCG one or two days a week, having a manager who is there all the time could act as a conduit to make sure things are co-ordinated and providing GPs with the support they needed, as described by this GP:

I think the interesting thing, from my perspective, is that I work with the network manager and I think her role, within how I function in that particular aspect of the job is quite fundamental, really, because she's at that desk all the time, and things that come through and whiz around, I'm trying to ensure [that things] go through her, not to me, so that she's not a filter, but she's aware of everything that's going on, rather than just coming as an email to me [GP ID104].

However that relationship is seen as something that needs to be built carefully over time:

And of course, from my perspective, it was a case of what I didn't want to be doing is going in there and suddenly saying, by the way, we should do this because actually it feels like a good thing. It was more about building those relationships up rather than suddenly saying, I think you should do this and I think you should do this and I think you should do the other. It was about pacing, which is what that was all about [Manager ID 34]

This deep and long-term relationship was claimed to be very beneficial, as it allowed trust to develop over time.

In the second phase of the interviews, we were told that this clinician manager dynamic is seen as:

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

This implies that, as well as shared history, mutual trust could be developed by careful matching of compatible personalities. The importance of trust was further underlined by one manager, who argued that it was much easier for a GP to 'sell' an unpopular proposal to fellow GPs than a manager trying to do so, as the trust is there between clinicians. However, others told us that this degree of mutual trust was achievable between GPs and managers.

Observations confirmed that a history of working together was very valuable in enabling the development of mutual trust. However, it is not necessarily a prerequisite. In Site 8, we observed how this symbiotic relationship could develop even if the GP and manager have limited history of working together. In this site the Chief Operating Officer was appointed after a **careful appointment process**. The CCG GP chair knew the type of person he wanted to employ and the Chief Operating Officer fitted that criteria. The Chief Operating Officer had experience in general practice commissioning role, having worked in the PCT and on PBC, and had various national roles. Throughout our observations we saw how both parties **recognised their different skills and contributions** and they felt **able to challenge one another**. This led to them becoming more confident in their roles.

Our observations in Site 7 provided further elucidation of the conditions under which close GP-manager relationships are valuable, and when they are not. In this case there had been a history of somewhat difficult relationships. The CCG had more than one locality which worked very separately, and had a relatively poor relationship with one another. As a result of these local conditions, the initial CCG configuration was strongly led by the PCT and a GP leader and a manager worked very closely together to get the CCG off the ground. Following authorisation, these two, who had a very close relationship of mutual trust, worked together to bring about a significant local service reconfiguration. However, this process failed to bring in the wider group of local GPs, and when the time came to agree the reconfiguration considerable doubts were expressed and the process was stopped. This demonstrated that close relationships between managers and leading GPs carry with them some dangers if they fail to also remain alert to the needs and wishes of the wider CCG membership. In this case it appeared that two individuals who shared common goals had failed to ensure that those goals were reflected in the wider organisation. Interestingly, it was the status of the CCG as a *membership* organisation that was crucial here: as members, the GPs felt they had the power to halt the proposed reconfiguration. In Site 1 by contrast, we observed an instance in which a GP and a manager had together worked with a group external to the CCG (including providers and the local voluntary sector) to develop a new model of care. In spite of the lack of involvement of the wider GP membership in these discussions, the manager and the GP, working together as a team, were able to 'sell' the idea to their colleagues, unlike their counterparts in Site 7. It is difficult to be sure what made this process successful, whilst that in Site 7 was not. However, our observations suggested that at least some of the explanation lay in the ground work which had been done previously to ensure that the wider GP membership felt confident that the GP-manager team were working on their behalf. This was underpinned by small successes in other areas of work, and by conscious efforts to engage the membership.

This led us to further reflect upon the ingredients of the apparently successful GP-manager dyad in Site 8. We found that **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. Thus, in Site 8, attention was paid early on to manufacturing and disseminating small successes. These included, for example, preparing carefully for and subsequently widely publicising a successful 'assurance' meeting with the local NHS England team. At these meeting the CCG had to demonstrate to the Area Team that they were successfully meeting the many 'check point' indicators. Rather than just seeing this as a routine part of the business of the CCG, those involved presented it to the membership as an example of their local success, reinforcing the notion that things were going well.

In terms of size of the CCG, our observation does not support the theory that collegiality is less obvious in larger CCGs. In Site 5, which is a large CCG with multiple locality groups, we observed clinicians and managers having a good relationship at both the individual and organisational level. The CCG decided to give each locality a responsibility for a variety of clinical work programmes. This arrangement was initially set up as the locality groups and the wider membership felt disengaged with the whole process and felt that the CCG approach was top down driven decision making. By giving each locality group a work programme, they have an agreed level of authority which enable them to make local commissioning decisions and approve business cases within the agreed thresholds. Each locality group is assigned a commissioning manager. The GPs and managers in each locality groups are working closely together on a day-to-day basis. They have a **joint responsibility** to work on their plan for programme delivery. This structure is repeated throughout the organisation, with each major working group or committee having a lead GP and a lead manager who take joint responsibility for the work that is done.

Refined CMO format:

Context	Mechanisms	Outcomes
<ul style="list-style-type: none"> • GP-Manager working closely together • Wider attempts to engage membership 	<ul style="list-style-type: none"> • Clearly delineated responsibilities • Mutual trust and confidence, helped by: <ul style="list-style-type: none"> ○ History of working together ○ Careful appointment procedures ○ Good interpersonal dynamic, including recognition of individual skills • Confidence to challenge one another • Joint responsibility for delivery • Relationship not mutually exclusive – openness to needs and desires of wider membership • Organisational level – experience of ‘success’ and ability to unite against external pressure 	<ul style="list-style-type: none"> • Improved ability to commission effectively • Better commissioning decisions • Increased confidence in both managers and GPs • Better use of GP time, with clear understanding of who needs to do what • Ability to ‘sell’ required changes to fellow GPs

5. Discussion

In this report we have explored the claims made about of the value that GPs bring to the commissioning process. We started by exploring further the claim made in the first phase of the project (see Checkland et al., 2012) that GPs added value in both commissioning and contracting. GPs in our case study sites claimed that part of that value lies in the fact that they are working on the 'frontline' of patient care hence they know and understand about patients' problems. They also claimed that having clinicians present in contract negotiations with providers means that they are able to make the clinical case for commissioning or decommissioning services. Managers also claimed that they value GPs' skills that are different from their own and believe that their functions within CCGs are complementary. We followed these claims up in the second phase of the project and started by interviewing both clinicians and managers in our original case study sites to explore further their understanding of the value of clinical input in commissioning (see Checkland et al., 2014). We used the findings from these interviews to focus our observations in 4 case study sites.

We found that CCGs are complex organisations, seeking to undertake many different activities simultaneously. Unlike PCTs (their immediate predecessor organisations), CCGs are often quite different from one another, with different structures and different distributions of responsibilities between the various sub-committees etc. Work done by a Governing Body in one CCG was delegated to a project group in another CCG. This makes it difficult to be sure where responsibilities lie within any particular CCG without detailed investigation, and difficult to compare CCGs with one another. The claims made about the value that GPs bring to these processes were broad and idealised. There was a consensus that greater GP involvement were important but it was not clear where and how GPs could add most value in the complex myriad of committees, groups, and forums existing in each CCG. Hence it is very difficult to make unambiguous claims about the extent to which GPs could or should be involved either in formal bodies or informal groups. We therefore used the Realist Evaluation (Pawson & Tilley, 1997) approach, as this addresses the questions of what works, in what circumstances, and how. It allowed us to explore in-depth the 'mechanisms' and conditions which facilitate or impede clinical input in commissioning, providing detailed evidence applicable across the full range of CCG activities.

There are both strengths and limitations of the methods used and chosen framework. The main strength was being able to develop programme theories (from the initial interviews) about what GPs and managers claimed about GP involvement and test how the theories 'worked' in the complex and evolving CCG context. Whilst we did this in only 4 of the original sites, the theories identified were developed from data gathered across 7 sites and tested. It allowed us to spend time in the sites and gain a deep understanding of how the commissioning process was being operated and how added clinical value was perceived and what it was in reality via the observations. Given the limited resources (researchers and a timescale) we had, these were effective methods and framework to build on previous phases of the research. They allowed us to compare our findings with other research to suggest some actionable messages for various interested parties (GPs, CCGs and policy makers) to consider as the system further develops.

5.1. Comparison of CCGs with previous clinically-led commissioning initiatives

In this section we explore our findings in the light of what we know from previous research into clinically-led commissioning and use our own (Checkland et al. 2008; Coleman et al. 2009; Coleman et al. 2010; Checkland et al. 2011; Checkland et al. 2012) and other's (Goodwin et al. 1998; Mays et al. 1998; Mays et al. 1998; Myles et al. 1998; Abbott et al. 1999; Lee et al. 2002; Abbott et al. 2008; Curry et al. 2008; Miller et al. 2012) research into

previous clinically-led commissioning initiatives. This includes fundholding, GP commissioning groups, Total Purchasing Pilots (TPP), Primary Care Groups (PCGs) and Primary Care Trusts (PCTs), as well as a variety of other local schemes for involving GPs and other clinicians in commissioning activity. For a full description see Miller et al (Miller, Peckham et al. 2012). The most direct comparison is with Practice-based Commissioning (PBC), the immediate precursor to CCGs. PBC groups contained many similar elements to CCGs, including GP- led committees which took delegated responsibility for aspects of the commissioning budget of their PCT. The differences lay in the formal structures and in the scope of services covered. PBC groups were formally constituted as sub-committees of the PCT, with the PCT holding statutory authority, and most groups focused mainly on those services covered by the Payment by Results (PbR) tariff. In the following sections we explore our elaborated theories in the light of what is known from research. These discussions are based upon the sources listed above, which, for clarity, we have refrained from repeatedly citing in the following text.

5.1.1. Theory 1 and Theory 2

Theories 1 and 2 both suggest that GPs working on the 'frontline' and dealing with patients daily are able to utilise their clinical knowledge to highlight what is working or not working and hence enable identification of problems, deal with them promptly, make better decisions, and have a better insight to the extent of available services. Our observations showed that GPs do 'add value' to the commissioning process by using their 'frontline' knowledge to guide their commissioning decisions. However, GPs themselves 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. We have identified the mechanisms which enable successful operation of GPs' 'frontline' knowledge. These include having representation of a sufficient range of GPs in a wide variety of forums and meetings, with the CCG being proactive in facilitating the involvement of a wide variety of GPs. GPs also need to be proactive, volunteering and engaging both in person and with modes of communication such as email. Furthermore, those GPs attending meetings needed to be properly and specifically prepared beforehand, and meetings needed to be chaired in a proactive and facilitative way.

Comparing this with experiences of PBC, it was clear that the mechanisms we have highlighted also operated under PBC. GPs involved with PBC were able to bring their 'frontline' experiences to the table, and this was facilitated by managers taking a pro-active approach to preparing GPs for meetings and by skilful chairing of those meetings (Checkland, Snow et al. 2012). In addition, we would highlight the following:

- *Processes of involving GPs* - GPs who were actively involved in PBC and those responsible for the day-to-day running of PBC were either elected (whereby GPs were voted onto some kind of executive group by their peers) or involved in smaller consortia (whereby each practice that joined the consortium was represented on the executive group). This is very similar to the selection and election process of GP leaders on to the formal committees of CCGs such as the Governing Body or executive group. Furthermore, in the first phase of this project (Checkland et al., 2012) we found that many of the GP leaders taking up positions in CCGs had been involved with PBC for some time, and their CCG involvement is seen as a continuation of that work. Involvement of grass-roots GPs was encouraged in CCGs in very similar ways to those seen under PBC, including newsletters, all-practice meetings, locality groups etc. Each practice is obliged to nominate a member with responsibility for engaging with the CCG, but such arrangements were also common under PBC.

- *Activities which GPs are able to be involved in* - CCGs enable more extensive GP involvement than was possible under PBC or other modes of clinically-led commissioning. Much of the activity in the name of PBC involved micro-level activities designed to change GP behaviour by changing referral behaviour, altering prescribing and encouraging openness for peer review of decision making (Coleman et al., 2009). This was very similar to activity under the Total Purchasing Pilots (TPPs), in which evaluators found that TPPs were more inclined to focus on services provided in primary care than on wider service redesign. CCGs, by contrast, have statutory responsibility for the full range of commissioning activity (excluding specialised services and, at present, primary care services) and have engaged with significant service redesign projects. This means that there is the potential for GP knowledge and experience to be applied more widely in CCGs. The CCGs in our study worked hard to make this a reality, and we witnessed extensive attempts to engage with constituent practices. However, the corollary of this is that the voluntary nature of PBC meant that there was greater 'buy-in' i.e. willingness to input beyond traditional role from GPs in terms of examining their own practice. CCGs were created via the contentious Health and Social Care Act (2012), and were explicitly discouraged from appearing to performance manage their constituent practices. As a result we found them to be more cautious than PBC groups had been in, for example, explicitly challenging practices about their referral behaviour.
- *Perceived legitimacy* - our previous study of PBC (Coleman et al., 2009) emphasised the importance of the perceived legitimacy of the PBC executive group. The voluntary sign up process for PBC allowed the executive to take decisions in the name of their member practices and appeared to legitimate quite extensive efforts at performance management by the PBC group. Technically, CCGs are membership organisations that are owned by the GP practices, and it might be thought that this membership model would act to enhance CCG legitimacy. However, we did not find compelling evidence of this, and some hints that the compulsory nature of membership was an issue for some GPs. The real meaning of 'membership' is not yet clear.
- *Decision making power* - those working in PBC expressed frustration at the need to obtain 'permission' from the PCT for any decisions that they made, whereas CCGs themselves hold decision making power. However, the complex CCG structures that we observed do not seem to bring many front line GPs any closer to the decision making process, and it was often unclear where particular decisions would be made. The role of locality groups (which are the main vehicles by which front line GPs can engage) was also often unclear. On the other hand, we observed particular examples of proactive CCG executive groups making an effort bring a wider range of GPs voices into their decisions, and the examples we have given show that careful management can enable this process.
- *Supportive information* - we found that GPs observed in meetings repeatedly asked for what some called 'proper data' to inform their decisions. Modern healthcare commissioning increasingly relies on detailed analysis of aggregated data. In our studies of PBC we found some issues with the way that data was obtained and used, and highlighted the importance of GPs working closely with information specialists to ensure that data was provided in a digestible and useful form. CCGs have smaller management budgets than PCTs did and most information management support is now provided under contract from Commissioning Support Units (CSUs). There are some issues associated with this model (Petsoulas et al. 2014), and the arm's length nature of CSUs does not necessarily make it easy for CCGs to build the required relationships in order to make best use of available data. Under PBC, Public Health (PH) consultants provided clinical interpretation of aggregated data; under the Health and Social Care

Act the PH function has moved to the Local Authority. This means that CCGs need to actively engage with their PH colleagues to ensure that they are able to understand the data they are given.

In summary, this study suggests that much of what is described under CCGs could have been achieved using PBC as a vehicle, and that CCGs are somewhat less active than PBC groups were in terms of performance management of constituent practices. However, the scope of activity under CCGs is significantly greater than was the case under PBC (or, indeed, previous clinically-led commissioning initiatives), enabling the application of GPs' knowledge to a broader range of service areas. It is certainly possible for CCGs to effectively bring the knowledge and views of front line GPs into their work, but this does not occur inevitably or by default; it requires explicit attention to processes and considerable preparatory effort. Obtaining and using effectively available aggregated data about service outcomes and usage may be more difficult under a model which sees information specialists and PH consultants employed elsewhere.

5.1.2. Theory 3

Theory 3 suggests that GPs contribute significantly to commissioning because their clinical experience gives them the knowledge and experience to speak to other clinicians in ways which allow them to view pathway development from a clinical perspective, address colleagues' behaviour, and challenge hospital clinicians. GPs clinical knowledge and experience gives them the authority to have clinician to clinician discussions in a way that managers cannot. In the context of discussions requiring clinical knowledge and input, our observations showed that the presence of GPs in commissioning meetings do add value in the way the theory described. However, the mechanisms needed to enable successful operation of this include: adequate preparation for meetings, good quality contextualised information, and careful chairing of meetings. Furthermore, we found that CCGs could be a vehicle for senior clinicians and managers from a wide range of organisations within the local health economy to work together on issues that transcended the concerns and responsibilities of individual organisations. The mechanisms needed to achieve this outcome include: the presence of members who were senior enough to be able to make commitments on behalf of their organisations and to make a concerted effort to keep front-line practitioners informed and engaged.

Comparing this with the operation of PBC, it is clear that the greater authority invested in the GPs working in CCGs acted to enable and enhance this kind of activity. Whereas in PBC clinicians involved in discussions with providers or with other actors in the health economy were always subject to the authority of the PCT board, CCG Governing Body members carry ultimate statutory authority. To summarise:

- *Perceived authority* - PBC groups were sub-committee of PCTs, and GPs did not perceive themselves and were not perceived by others as having ultimate authority. The fact that the CCG is a statutory body gives the perception, internally and externally, of GPs' authority.
- *Opportunities to work with colleagues across the health economy* - three out of four of our case study CCGs were engaged with their provider, local authority and third sector colleagues in forums in which the wider needs of their populations could be discussed, over and above the narrow considerations of commissioning care. These groups are in part a function of the increasing pressure to integrate care across organisational and professional boundaries. However, it is probably also true that the status of CCGs as statutory bodies has both given those involved authority, and given them a greater sense of responsibility for working collaboratively to meet population health needs.

- *Wider involvement of clinicians* – our previous study on PBC found that involving frontline GPs was the most frequently reported difficulty (Coleman et al., 2009). CCGs also found this difficult. Most had adopted a variety of mechanisms to involve their member practices, including regular meetings of practice representatives, devolution of responsibility to geographically based ‘locality groups’ and communication using newsletters, emails etc. We found that they had varying degrees of success in this, and it wasn’t clear what the ingredients of ‘success’ might be. The status of CCGs as ‘membership’ organisations should make the engagement of the interest of a wider range of GPs easier to achieve, but our study suggests that many CCGs are struggling to ensure that their local GPs feel ‘ownership’ of the work that is done in their name. The successful initiatives that we saw were those where there had been active attempts to engage local GPs in the process of decision making; lack of success seemed to occur when GPs felt that their colleagues had not consulted or involved member practices.

5.1.3. Theory 4

Theory 4 suggests that GPs and managers have a symbiotic relationship which enables both parties to work much more effectively together than they would otherwise be able to do and this is dependent on both parties having a mutual trust and clearly delineated responsibilities. In the context of individual GP and manager working closely together, the development of these relationships was facilitated by a history of working together. However this was not a necessary condition; we saw new relationships being forged, and these were facilitated by careful recruitment procedures. In the early stages of CCGs GPs welcomed the opportunity to be involved with the appointment of managers to support them, and were wary of any attempts to limit their freedom to recruit who they chose. We found that managers and clinicians appeared to work most effectively together where they took joint responsibility for delivery, and where they developed a mutually supportive relationship within which each felt able to challenge the other. By working closely together and having a clear understanding of each other’s skills and responsibilities, individual GP and manager becoming more confident in their roles and GP time can be better utilised. The additional added value of having that close relationship is the ability of GPs to ‘sell’ required changes to fellow GPs. However, it was also necessary that these close relationships remained open to a variety of views from the wider membership.

Our previous study on PBC (Coleman et al., 2009) found that close and supportive relationships between clinicians and managers were common. We described a particular type of management approach which we called an ‘animateur’, by which managers were able to creatively engage with GPs to enable beneficial change (Checkland et al., 2012). The pertinent difference between CCGs and PBC is that under PBC these supportive relationships were generally limited to the middle manager level, with GPs working with managers below board level. In CCGs, by contrast, we found these close clinician-manager relationships throughout the levels of the organisation, at Governing Body level, in working groups and in Localities. Moreover, under PBC, the managers involved carried a dual identity, working both for the PBC group and for the PCT (McDermott et al., 2013). Whilst much of the time the interests of these two groups coincided, this was not inevitably the case, particularly if the PBC groups wished to take action which was not supported by the PCT. In CCGs, GPs and managers are working together as part of the same organisation, enabling more effective collaboration and providing an opportunity to embed this throughout the organisation. We saw different approaches to achieving this, with one CCG, for example, having clinician-manager pairs heading all significant committees and working groups throughout the CCG. Others were less successful, with one of our study CCGs separating out managerial and clinical management in an arrangement which looked fairly similar to a PCT board and a Professional Executive Committee (PEC). Similar close manager-professional ‘dyads’ have been described in other types of professional organisation, with

evidence highlighting the extent to which effective examples of such partnerships can facilitate organisational change (Empson et al. 2013).

5.2. Our findings in context

In this section we will examine our findings in the context of both official aspirations for CCGs as set out in published documents and other research in this field.

5.2.1. Comparison with official aspirations

NHS England set out what they believed clinicians add to commissioning in 2012:

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 CCGs will be successful in each domain. This added value includes:

- *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).

Our study suggests that, whilst GPs can and do *lead clinical redesign*, their clinical knowledge is an adjunct to rather than a substitute for more systematic knowledge based on aggregated data and research evidence. This is important, as it cannot be assumed that GPs automatically have the knowledge required. In fact, our study suggest that improving the quality of commissioning requires GPs and managers working closely together using high quality data supplied by trusted collaborators with whom they work regularly. 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. We found that, whilst close GP involvement in commissioning can facilitate *better use of local services*, this depends upon good engagement with grass roots GPs and is not an automatic outcome of GP leadership of CCGs. Finally, 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, in part because of fears that being seen to performance manage practices would undermine the perceived legitimacy of the CCG as a membership organisation.

NHS England further explored the role of clinical leaders in the *Draft Framework of Excellence in Clinical Commissioning* (NHS England, 2013) by identifying what “excellent practice” looks like. In the following table (Table 4) we draw conclusions on the extent to which the official aspirations of clinician ‘added value’ have been realised in practice.

Table 4: Comparison between official aspirations and our findings

Official aspirations	Our findings
<p>Constant clinical focus on improving quality and outcomes</p> <p>Outcomes:</p> <ul style="list-style-type: none"> • Patient care and outcomes will measurably improve • The CCG is able to provide confidence to its local population that it is commissioning clinically safe, high quality, compassionate services <p>Enablers:</p> <ul style="list-style-type: none"> • Health outcomes are viewed as a key factor in all commissioning decisions • Reducing health inequalities with particular regard for the nine protected characteristics as outlined in the Equality Act 2010 is viewed as a key factor in all commissioning decisions • The CCG proactively builds clinical consensus for commissioning decisions • Quality is a standing item on the governing body's agenda • The CCG uses peer-to-peer reviews in working with member practices to understand variations in clinical practice and outcomes, and shares good practice 	<p>Our observations showed that <i>GPs add value to commissioning by bringing in their 'frontline' knowledge</i>. However contextual factors, mainly how that knowledge is used and the position of the GPs in the CCGs, shaped the mechanisms which enables the outcomes expected.</p> <p>There are two different uses of 'frontline' knowledge we observed – for clarifying what is happening 'on the ground' and for decision making and priority setting. To enable GPs 'frontline' knowledge to be used effectively, there need to be the 'right' GP with the 'right' knowledge in the 'right' forum. There also need to be adequate preparation such as giving GPs task specific briefings before the meeting to ensure that maximum value is obtained from the time committed by GPs. However for GPs involved in decision making process, they also need to be supported with an additional mechanisms such as access to 'proper' data.</p>
<p>Significant engagement from constituent practices.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> • The CCG enables the delivery of both small and large scale change • All CCG members including GPs, nurses, allied health professionals and administrative staff feel engaged, listened to and involved <p>Enablers:</p> <ul style="list-style-type: none"> • CCG members develop a clear shared purpose, values and priorities together • The CCG has a clear understanding of the value of member engagement in shaping and setting the vision, objectives and priorities of the CCG and are committed to delivering them • The CCG spends significant time listening to and engaging with all staff groups within member practices 	<p>Our study found that <i>CCGs are keen to engage their members</i> and they want to have a two-way relationship with member practices. However, due to the complexity of their internal structures, different CCGs should adopt different approaches to maximising the value of GP involvement. Each CCGs need decide and be clear about where and when clinical input is needed. We observed CCGs adopting a variety of mechanisms to involve member practices and they had varying degrees of 'success' in this. 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. One of the mechanisms enabling the 'success' of this engagement is a facilitative environment which assures people that they are encouraged to express their concerns, contribute to, or attend</p>

<ul style="list-style-type: none"> • The CCG draws upon the insights of GPs as patient advocates in order to further understand the needs of the patient and to ensure that care being delivered is safe and high quality • The CCG adopts a communication style tailored to the preference of its members • The CCG governing body listens to the concerns of its member practices and systematically addresses items on their 'worry list' to demonstrate the two way benefits of membership. Where issues cannot be addressed, the CCG is open and honest with practices. • The governing body does not shy away from rigorous debate and conflicting viewpoints • CCG leaders act with honesty and integrity and strive to build consensus and allegiance 	<p>meetings and good communication which enable clinicians knowing which forums to address their concerns.</p> <p>In terms of <i>CCGs delivering small and large scale change</i>, we found that there need to be a symbiosis between GPs and managers and that this relationship remains open to a variety of views from the wider membership. One of the mechanisms to do this is by having a clear delineated responsibilities where managers formulates and writes the policy documents while GPs assist in clinical input. GPs also add value in terms of 'selling' the required changes to fellow GPs. Another mechanism is experience of 'success'. This is important both in developing that close and supportive relationship between the two individuals and in bringing the wider membership along with the process.</p>
<p>Involvement of the wider clinical community in commissioning.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> • The CCG is better placed to consult on and implement commissioning decisions including de-commissioning decisions • Clinicians from across the health and care system are committed to delivering service redesign and transformation • There is a greater likelihood of early detection and rapid response to a declining or failing service <p>Enablers:</p> <ul style="list-style-type: none"> • There is an active, on-going dialogue between clinicians in commissioning and clinicians in all provider organisations to improve the quality of care, with regular meetings to discuss service quality • The CCG effectively collaborates with clinical colleagues from across the health and care system to redesign and integrate services • The CCG effectively collaborates with social care colleagues to improve joint services • The CCG meaningfully engages with the third sector in the commissioning of services 	<p>In our study we found that when considering <i>commissioning or de-commissioning decisions</i>, the presence of GPs and wider clinical community in meeting alone is not a sufficient mechanism. 'Frontline' knowledge need to be supported with 'proper' data.</p> <p>We also found that CCGs enable <i>clinician to clinician conversation</i>. However, clinicians' presence in this kind of forum need to be senior enough in their organisations and able to make commitment on behalf of their parent organisations. Similarly, representative from <i>local council, social care and third sector</i> need to have high level buy-in from the local health and social care economy. This 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. The role of chair is also crucial in ensuring that everyone has equal opportunities to contribute to the discussion.</p>

In summary, many of the official attributes resonate with the findings of our study. However, we have highlighted the complexities of membership, particularly the difficulty associated with articulating what membership means and how it can be made meaningful to all those involved. The importance of achieving small victories in areas seen as important by members was articulated to us by both GPs and managers, and we observed a number of CCGs seeking to involve their members actively in setting strategy. However, this was not always straightforward, and we have highlighted the contexts and mechanisms which can facilitate this.

5.2.2. Comparison with other research

There has, as yet, been little published research about CCGs. This is unsurprising, as they were only formally established in April 2013. A three year study (2012-2015) was undertaken jointly by the King's Fund and the Nuffield Trust, studying the development of six CCGs. The first King's Fund/Nuffield report (Naylor et al., 2013) analysed the emerging CCGs as they take up their new responsibilities. The second King's Fund/Nuffield report (Holder et al., 2015) focused on CCGs as membership organisations, exploring GP involvement and perceptions of 'engagement'. Methods used in the second year were largely similar to the first year; semi-structured interviews, observation of meetings, and an online survey of member practices. In this section we explore our findings in the light of the King's Fund/Nuffield's report.

- *Members' engagement* - the King's Fund/Nuffield (2015) survey found that two years after their establishment, CCGs' overall levels of members' engagement (defined as interest, enthusiasm, involvement & support of CCGs) had been broadly maintained, with a majority of GPs surveyed reporting being at least somewhat engaged in the work of their CCG. GPs who felt that they were able to influence CCG's decision had done so through informal contact i.e. they were able to have a clinician to clinician conversation with GPs on the Governing Body. CCG leaders were clear that they do not need all members to be actively engaged however it is important to have high levels 'buy-in'. The report suggests that, two years on from establishment, CCGs still face difficulty in getting grass roots' members to effectively feed in to CCG decision making. In most CCGs, council members' meetings are mainly one-way information-giving sessions (Checkland et al., 2012; Holder et al., 2015). Our study concurs, finding that that CCGs are keen to engage their members and they want to have a two-way relationship with member practices. However, we have highlighted the need for appropriate mechanisms in place to do this, and suggested that these will vary between CCGs due to the complexity of their internal structures. In this report we have identified some of the mechanisms which might enable GPs' engagement (see Section 4).
- *Ownership* – the King's Fund/Nuffield (2013, 2015) study found that there remains disparity between GP leaders' and GP member's sense of ownership of the CCG. GP leaders were more likely to report ownership of and engagement with their CCG than GP members. The authors suggest that one major factor affecting this is the size of the CCG, with smaller CCGs having a greater sense of ownership from members than larger CCGs. In large CCGs, GP members felt greater sense of identification with smaller locality groupings than with the CCG as a whole. In some of our case study sites, we observed GPs being involved in CCG decision-making and priority-setting activities, but these were not straightforward and required pro-active management. However, it remains unclear what 'ownership' really means. The diversity of CCGs make it unlikely that it will be mean the same thing in different CCGs.

- *Maximising the value of clinical involvement* – the King's Fund/Nuffield study (2015) found that CCGs do not always maximise the value of clinical involvement and some of their case study CCGs have started making changes to their internal governance structure such as setting up a governance committee to take away day-to-day procedural items away from the Governing Body. They also found that initial enthusiasm among some GP leaders has started to wane and there is a drop-off in engagement among GP leaders. They highlight this as a problem. However, our study suggests that it may be appropriate to reduce GPs' involvement in some forums depending on the function of that forum. The complexity of CCG's structures and the fact that different CCGs may have committees and meetings with similar labels but with roles and business which are different from one another suggests that different CCGs should adopt different approaches to maximise the value of their clinicians' involvement. For CCGs where their Governing Body is set up as a relatively high level forum whose main role is to 'sign off', it may be more valuable to reduce GPs' time in that Governing Body and put GPs' time on a more strategic or operational forum such as executive groups or local collaborative forums. The Kings Fund/Nuffield report highlight the issue of CCG sustainability, pointing to the need to nurture the next generation of CCG leaders. Our evidence suggests that an important element of this will be ensuring that GPs are engaged in the work of the CCG in ways which are effective and efficient. Experience of meetings for which they have been well prepared and which have a successful outcome will stimulate interest and enthusiasm; experience of meetings in which little appears to have been achieved will put people off.
- *Wider involvement of clinicians* – one of the aspects of the added value of having clinicians involved in commissioning processes that is often cited is the ability to have clinician to clinician discussions. Some of the enablers for this as identified in the *Draft Framework of Excellence* (NHSE, 2013) include; active and on-going dialogue between clinicians in commissioning and in provider organisations and effective collaboration not only with clinical colleagues from across the health and social care but also with social care colleagues to improve joint services and the third sector. Our study found that to engage with the wider clinical community, the formal architecture of the CCG and the operation of statutory authority was not actually necessary. Two of our four case study sites have established informal groups with wider health economy which focus on a variety of issues including high level strategy and service development ideas. However members of these groups should be senior enough to make commitments on behalf of their organisations.

5.3. Future challenges

CCGs face a very challenging future in the context of an aging population and ever tightening financial constraints. Three of the main challenges include:

- *Greater integration* – this is being encouraged through pooling of resources with their local authority via the Better Care Fund (BCF). Whilst the BCF offers a substantial opportunity to bring resources together to address immediate pressures on services and lay foundations for a much more integrated system of health and care delivered at scale and pace, there are also risks (Bennett and Humphries, 2014). In particular, there is a risk that, if the services put in place under the BCF fail to reduce secondary care activity, there will be severe pressure on CCG's budgets.
- *Working effectively across health and social care economies at a local level* – CCGs are beginning to build working relationships with other organisations in their local health economies. Three of our case study sites have established high level strategic fora to

aid this process and have started the discussions and negotiations required for this to operate. There is growing policy momentum in favour of place-based budgets, which will require commissioners and providers to work closely together. The most significant example of this is in Manchester, where a recent announcement has suggested that the entire local health and social care budgets will be combined and devolved to a local strategic board bringing together commissioners and local politicians (see http://www.agma.gov.uk/cms_media/files/mou.pdf). This has been enabled by a longstanding history of joint working across the local health and care economy. The work of commissioning is changing, and CCGs will need to adapt to these changes.

- *Primary Care co-commissioning* - under the Health and Social Care Act 2012, responsibility for commissioning primary care services was given to NHS England. Part of the rationale for having primary care commissioning outside CCGs was to move towards a more standardised model of primary care commissioning. However, it has become clear that local flexibility and understanding is required in order to properly match primary care provision to the needs of an aging population. In addition, the separation of funding streams between primary and community care means that CCGs lack the flexibility to shift funding to most effectively support patients at home. It is therefore proposed that CCGs will take over commissioning of primary care services. There are three 'levels' of co-commissioning available: influencing; becoming part of a joint commissioning committee; or taking over delegated responsibility and these are currently being signed off to start in April 2015. This shift of responsibilities brings with it significant challenges for the 'membership' model of CCGs. CCGs will be commissioning care from their own members, raising issues of conflicts of interest. Furthermore, CCGs taking on the highest level of co-commissioning responsibility will be required to performance manage their members, potentially threatening buy in and engagement with wider commissioning activity.

Taken together, these challenges point to a need for CCGs to be: adaptable and flexible; alert to the changing environment; and deeply engaged with their colleagues across organisational boundaries. Co-operative service redesign across a health and care economy is likely to occupy much managerial and clinical time and effort. Our evidence suggests that maximising the value of clinical input into this will require CCGs to invest time and effort in adequately preparing those involved, to ensure that they systematically gather evidence about service gaps and problems from their members, and to engage members in debate about the future shape of services. Doing this whilst simultaneously performance managing those members will be a complex and difficult task.

6. 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 talents. Given the costs (both monetary and in terms of burdens placed upon GPs' practices) associated with GP involvement in commissioning, it is important that efforts are made to both focus and maximise 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.

6.1. For GPs

- GPs can bring useful clinical knowledge to bear in meetings. Maximum value can be derived from this by:
 - Understanding the wider context of the issue in question, the purpose of the discussion and the desired outcomes. Simply reading the papers before the meeting is not sufficient. GPs need to be proactive in asking for task specific briefings. Having clear objectives for GP involvement, with senior managers and GP leaders being clear about where and when the clinical voice is most needed.
 - For important issues, and those where there will be discussion with providers or other bodies, collective rehearsal of relevant issues can be helpful, including, for example, pooling information and having specific roles and responsibilities.
- GPs with 'official' position in the CCG who work closely together with managers can have a productive working relationship by:
 - Having shared responsibility for the delivery of objectives.
 - Within this, clear delineation of tasks and roles.
 - The establishment of GP-manager relationships throughout the organisation, from Governing Body to locality groups, ensuring that all GPs have access to managerial expertise, whilst ensuring that all managers have clinicians to support them.
 - Developing mutual trust. Where this has not had the chance to develop based upon historical experience of working together, it can be facilitated by involving GPs in recruitment processes and ensuring that job specifications and role definitions are transparent to all.

6.2. For CCGs

- CCGs are complex organisations, with complicated structures; no two are exactly the same. It is therefore important that CCGs 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, with all groups and sub-committees clear about their own and others' responsibilities.
 - Responsibility for decision making needs to be explicitly delegated to appropriate levels within the organisation.
 - Complicated structures make duplication of effort more likely – it is important to be sure that participants' valuable time is not spent working on issues which will in fact be decided elsewhere.
- CCGs are an excellent vehicle for engagement across organisational boundaries throughout the local health economy. Having GPs present at strategic fora, such as Health and Wellbeing Boards, allows wider engagement with a range of local

organisations. Local collaborative forums in which commissioners come together with commissioning colleagues, providers and the local voluntary sector can allow CCGs to contribute to the development of health and care strategies beyond the confines of their statutory commissioning responsibilities. Such forums require:

- Senior-level representation from all groups present, with those attending carrying decision-making power within their own organisations.
 - Effective mechanisms to ensure that CCG members feel informed about these higher-level discussions, and have opportunities to feed in to the discussions, either in person or via established communication mechanisms.
- CCGs have enabled the potential involvement of a greater number of GPs in commissioning processes. However, simply being a member of a CCG is not sufficient to ensure useful involvement. 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, ensuring that the ways in which grass-roots members access information are understood and responded to.
 - Covering multiple modes, with relevant and important information disseminated in more than one format.
 - 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 but not sufficient for high quality commissioning decisions to be made. In addition they require:
 - Accessible, high quality aggregated data about service outcomes.
 - The opportunity to work with those producing the data in order to ensure that it is in a form that can be readily understood and applied.
 - Systematic and accessible information about available local services to supplement their own local knowledge.
 - It remains unclear what it really means to be a 'membership' organisation. The diversity of CCGs means that it is unlikely that it will necessarily mean the same thing in a small rural CCG, for example, as it does in an inner city or major conurbation. Therefore:
 - 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 and the opportunities for deeper involvement.
 - This should include developing a clear and formal role for membership forums such as locality groups and wider membership groups such as Councils of Members.
 - The maintenance of enthusiasm and engagement in the work of CCGs requires experience of success:
 - This does not need to be large scale change, but needs to include tangible evidence of small victories, focused upon outcomes meaningful to those involved, such as evidence of improved patient experience, improved outcomes or removing obstacles to efficient working.
 - 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.

6.3. 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, taking on new responsibilities and responding to policy developments. 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 at all levels of their organisations, so that any decisions about involvement or representation are made explicitly, based upon likely benefits to be achieved.

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8. Appendix 1



POLICY RESEARCH UNIT IN
COMMISSIONING AND THE
HEALTHCARE SYSTEM

Exploring the ongoing development and impact of Clinical Commissioning Groups: Interim Report

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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.

Table 1: Interviews			
	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 (Basis, 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 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 manger, as they are now engaging with their peers and colleagues. As one manger stated, it was much easier for a GP to 'sell' a proposal to fellow GPs than a manger trying to do so as the trust is there.

However, overall there was much mutual respect of the role mangers 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 manger 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 manger 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 buggger 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 of 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 theme 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.

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