

Kath Checkland, Anna Coleman, Imelda McDermott, Julia Segar, Rosalind Miller, Christina Petsoulas, Andrew Wallace, Stephen Harrison and Stephen Peckham

Primary care-led commissioning:

applying lessons from the past to the early development of clinical commissioning groups in England

Abstract

Background

The current reorganisation of the English NHS is one of the most comprehensive ever seen. This study reports early evidence from the development of clinical commissioning groups (CCGs), a key element in the new structures.

Aim

To explore the development of CCGs in the context of what is known from previous studies of GP involvement in commissioning.

Design and setting

Case study analysis from sites chosen to provide maximum variety across a number of dimensions, from September 2011 to June 2012.

Method

A case study analysis was conducted using eight detailed qualitative case studies supplemented by descriptive information from web surveys at two points in time. Data collection involved observation of a variety of meetings, and interviews with key participants.

Results

Previous research shows that clinical involvement in commissioning is most effective when GPs feel able to act autonomously. Complicated internal structures, alongside developing external accountability relationships mean that CCGs' freedom to act may be subject to considerable constraint. Effective GP engagement is also important in determining outcomes of clinical commissioning, and there are a number of outstanding issues for CCGs, including: who feels 'ownership' of the CCG; how internal communication is conceptualised and realised; and the role and remit of locality groups. Previous incarnations of GP-led commissioning have tended to focus on local and primary care services. CCGs are keen to act to improve quality in their constituent practices, using approaches that many developed under practice-based commissioning. Constrained managerial support and the need to maintain GP engagement may have an impact.

Conclusion

CCGs are new organisations, faced with significant new responsibilities. This study provides early evidence of issues that CCGs and those responsible for CCG development may wish to address.

Keywords

commissioning; case study; primary care; qualitative.

INTRODUCTION

Having initially promised that there would be 'no more top-down reorganisations of the NHS',¹ one of the first actions of the newly elected Coalition government in the UK was to propose what has been described as a reorganisation so large it is 'visible from space'.² Box 1 sets out the main proposals contained in the white paper *Equity and Excellence*.³

Together, these changes represent a significant redistribution of responsibilities within the English NHS. For GPs, membership of what came to be called clinical commissioning groups (CCGs) will be compulsory via their practices, with some kind of quality payment available for those who fulfil their commissioning responsibilities successfully. The policy was deliberately permissive, with, for example, the size and composition of CCGs not centrally specified. In a letter to GPs in September 2010, Sir David Nicholson stated that:⁴

'We would want to enable new organisations, and particularly [CCGs], to have the maximum possible choice of how they operate and who works for them. It is important that GP practices be given time and space to develop their plans to form commissioning consortia. PCTs should provide support for this process and empower consortia to take

on new responsibilities quickly when they are ready to do so, but it is important that solutions develop from the bottom up and are not imposed from above.'

In October 2010 groups of GPs wishing to move ahead with setting up their local CCG were invited to come forward to join a 'Pathfinder programme'. The objective of this was to allow aspiring CCGs to begin to work out the best way to organise themselves, facilitated by their local strategic health authorities. The process gained momentum quickly, and by June 2011 more than 90% of England was covered by a Pathfinder CCG. The study presented here was commissioned by the Department of Health Policy Research Programme to evaluate the Pathfinder programme. This article presents some of the findings from this study, and provides some of the first detailed evidence about the early development of CCGs as they were set up and moved towards application to be fully 'authorised'. ('Authorisation' is the process by which CCGs are assessed for fitness to take over commissioning responsibilities. The process took place in four 'waves' in late 2012.)

Background

Equity and Excellence sets out the rationale behind the proposed changes, arguing

K Checkland, MBBS, PhD, reader in health policy and primary care; **A Coleman**, PhD, research fellow; **I McDermott**, PhD, research associate; **J Segar**, PhD, research associate; **S Harrison**, PhD, professor of social policy, Centre for Primary Care, University of Manchester, Manchester. **R Miller**, MSc, MPharm, research associate; **C Petsoulas**, PhD, research fellow; Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine, London. **A Wallace**, BA, MA, PhD, senior lecturer, School of Social Sciences, University of Lincoln, Lincoln. **S Peckham**, MA(Econ), BSc, HMFPH, professor of health policy, Centre for Health Services Studies,

University of Kent, Canterbury.

Address for correspondence

Kath Checkland, University of Manchester, Centre for Primary Care, 5th Floor Williamson Building, Oxford Road, Manchester, M13 9PL.

E-mail: kath.checkland@manchester.ac.uk

Submitted: 11 February 2013; **Editor's response:**

10 March 2013; **final acceptance:** 10 April 2013.

©British Journal of General Practice

This is the full-length article (published online 27 Aug 2013) of an abridged version published in print. Cite this article as: **Br J Gen Pract 2013; DOI:10.3399/bjgp13X671597**

Box 1. Main proposals in the 2010 white paper *Equity and Excellence*³

- Primary care trusts to be abolished, with responsibility for commissioning (purchasing) services handed over to groups of GPs.
- The abolition of regional strategic health authorities.
- The creation of a new 'arm's length' body to oversee the NHS called the NHS Commissioning Board.
- The transfer of responsibility for public health to local authorities and the creation of a new national body, Public Health England.
- The establishment of local authority-based Health and Wellbeing Boards, responsible for the development of strategic assessment of local health and wellbeing needs.
- Changes to the role of Monitor (previously the body responsible for regulating foundation trusts) and its establishment as an 'economic regulator'.
- All NHS trusts to become foundation trusts.

(Note: these proposals only apply in England)

How this fits in

Primary care-led commissioning depends on active engagement by GPs and such engagement is most likely to occur if GPs feel able to act autonomously. Rank and file GP engagement depends on the perceived legitimacy of the commissioning group. Such engagement is easier for smaller groups than for larger, and comes at a cost. Previous GP commissioners have tended to focus most on areas of care directly related to primary care. CCGs are developing complex internal structures, and are subject to complex external relationships, which may constrain their freedom to act autonomously. What it means to be 'a member' of a CCG has not yet been clarified. CCGs have ambition to move beyond locally-focused commissioning, and are in the early stages of developing the links to public health that this will require. CCGs are keen to improve the quality of primary care services, but this requires significant managerial resources. There may be some tension between the need for GP 'ownership' of the CCG and a desire to improve practice performance.

that the closer involvement of GPs in the commissioning of care would ensure more effective dialogue between primary and secondary care; decision making 'closer to the patient'; and increased efficiency.³ Furthermore, it was argued explicitly that 'we will learn from the past',³ claiming to have built on lessons learned from previous clinically-led commissioning initiatives, including GP fundholding and total purchasing pilots from the 1990s.^{5,6} The reforms proved controversial, and in April 2011 a 'pause' was announced, during which further consultation took place, culminating in a number of changes to the proposals.⁷ During this time, CCGs signed up as 'Pathfinders' continued to develop, beginning to work out how they would organise themselves. Following the 'pause', additional guidance was published by the Department of Health, and subsequently by the shadow NHS Commissioning Board (renamed NHS England from 1 April 2013). There are too many documents to list individually, but they can be found at www.england.nhs.uk/resources/resources-for-ccgs/. A timetable was set out for CCGs to apply for full authorisation as statutory bodies from July 2012, with the first CCGs taking full responsibility for commissioning the majority of care for their registered populations from April 2013.

Learning from the past: what is known about GP commissioning?

The authors undertook a systematic review of the evidence relating to clinically-led commissioning.⁸ The key findings that are relevant to this article are shown in Box 2.

METHOD

The research followed a case study design, with eight detailed qualitative case studies supplemented by descriptive information from web surveys at two points in time. The research took place from September 2011 to June 2012. More details of the methods are set out in the project report.⁹

Case study sites were selected to provide a maximum variety sample across a number of domains, including:

- size;
- sociodemographic profile
- (heterogeneous for deprivation versus homogeneous);
- presence/absence of some kind of formal federation between a number of CCGs; the number of main providers with which the CCG interacted (single main trust

Box 2. Lessons from the past relating to clinically-led commissioning⁸

- GPs engage most and achieve most where they have most direct autonomy and feel that they can make substantive changes. Success feeds in to increase enthusiasm; lack of success or feelings of lack of influence act to diminish enthusiasm.
- Engagement of rank and file GPs depends on perceived legitimacy of the commissioning group. Smaller groups find this easier than larger ones. Where legitimacy is high, there is potential to improve primary care quality via peer review and performance management. However, engagement reduces if GPs feel themselves to be distant from the wider organisation or without influence. Increased engagement comes with higher transaction costs.
- Previous GP commissioners have tended to focus on areas of activity based on their direct experiences as clinicians: leading to a focus on such things as waiting times. There is evidence of limited engagement with a public health approach which focuses on a local population. There is little evidence of GP commissioners actively 'shopping around', and most change was achieved in things closely related to primary care or under the direct control of primary care, such as prescribing, improving services in primary care, and community services. It proved difficult to move resources out of secondary care.

Table 1. Site characteristics⁹

Site	Size (quintile)	Pathfinder in federation?	Sociodemographic profile	Major providers	Local authorities	Pathfinder wave
Site 1	3	No	Mixed	1	2	2
Site 2	5	Yes	Relatively homogeneous, pockets of deprivation	>1	1	1
Site 3	5	No	Relatively homogeneous, affluent, pockets of deprivation	>1	1	2
Site 4	2	Yes	Relatively homogeneous, deprived	>1	1	1
Site 5	3	No	Relatively homogeneous, deprived	1	2	3
Site 6	2	No	Relatively homogeneous, affluent	1	1	5
Site 7	4	No	Mixed	>1	1	3
Site 8	4	No	Mixed	1	1	1

versus more than one);

- the number of local authorities with which the CCG interacted (one versus more than one); and
- how far the CCG represented the recreation of a previous administrative grouping such as primary care group, practice-based commissioning group.

Data collection in the sites involved observation of a variety of meetings, and interviews with key participants.

Interviews were recorded and transcribed with consent. Researchers recorded detailed field notes during meetings and these were analysed alongside the interview data. This spread of data sources provided further triangulation, moving beyond the (often well-constructed) stories provided by those involved to also observe what actually happened in practice as the developing groups wrestled with the complex situation that they faced. Data were stored and managed with the assistance of ATLAS.ti software, enabling the secure storage of data (on a university server) and providing a medium through which research team

Table 2. Interviews undertaken⁹

Type of responder	Number interviewed	Number of interviews
Managers (NHS)	47	49
GPs	33	36
Lay members	5	5
Practice managers	3	3
Nurse (clinical lead)	1	1
Others (for example, trust manager)	1	1
Local authority representatives	1	1
Total	91	96

members are able to work together on the analysis.

More details about the collection and analysis of the data are available in the project report.⁹

This article focuses on those aspects of the results that are relevant to the literature review, exploring how what is known from past experience of clinically-led commissioning is playing out in practice in the new situation. It draws largely on the case study data, but contextual data from the surveys are included where relevant.

RESULTS

Site characteristics are shown in Table 1.

There were 96 interviews undertaken with a variety of CCG staff, as shown in Table 2. In addition, 146 meetings were observed (a total of approximately 439 hours), including governing body meetings, executive or operational group meetings, meetings of GP members, locality meetings, and meetings of local Health and Wellbeing Boards.

Quotes from interviews or extracts from field notes are provided below where these are typical of responses across the sites, or where they illustrate a particular issue well.

CCG autonomy and decision making: structures and governance

On paper, CCGs have significantly more autonomy than any previous clinical commissioning organisations, in that they will be the statutory body and will carry full budgetary responsibility. Evidence relating to the development of CCG structures and governance procedures are presented below, to explore how far this autonomy and associated ability to make decisions will be realised in practice.

Guidance for CCGs relating to their structures and governance was non-prescriptive, suggesting only that CCGs should have a 'governing body', which is responsible for ensuring 'that CCGs have appropriate arrangements in place to ensure they exercise their functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it',¹⁰ and that they should set up relevant subcommittees as they saw fit. As a consequence, this study found significant complexity and variety associated with emerging CCG structures and governance arrangements, with widely differing subcommittees and groups, which were referred to using a wide variety of names. Terms used in study sites included board or shadow

board, executive or executive committee, clinical commissioning committee, council of members, forum, collaborative, locality, cluster, senate, and cabinet. Total governing body size as reported in the survey also varied considerably, as did membership, with some establishing a relatively small group, dominated by GPs, while others opened membership up to a variety of other professionals and representatives, such as social service representatives and public health specialists. Smaller groups may find decision making easier to achieve, but at the expense of less engagement with the wider health community.

Towards the end of the study period, there was a developing consensus around use of the title of 'governing body' for the main statutory body, but considerable variety remained around the naming of other subcommittees or membership groups. This made direct comparisons difficult, as it was not always clear how far bodies in different sites with different names corresponded with each other. To overcome these difficulties, it was decided to identify groups by their functions rather than their names. In general, the following functions were found to be represented in these study sites:⁹ an over-arching governing body, planning to take over the statutory responsibility once authorisation is completed; a number of 'operational' bodies, including a number of different committees or workstreams, and in some sites a formally constituted operational group, often called an 'Executive', which undertakes the day-to-day management of the group's activities; a 'Council of Members', consisting of representatives from each practice; and 'locality groups', consisting of smaller groups of representatives from a geographical area within the CCG. Not all sites had locality groups, and two had also convened a wider group of clinicians, managers, and representatives from outside (such as the local authority or the local provider trust) to provide advice about a range of issues.

Even when it was possible to identify separate groups at each of these different levels, the distribution of functions in a given site was much more fluid than this typology suggests with, for example, no clear separation between governing body functions and more operational work, and considerable time was spent in meetings discussing who should be responsible for which type of decisions. It was clear that part of the explanation for this developing complexity lay in the participants' growing awareness of the significance of the decisions they would be called on to make.

The extent of the complexity embodied in these different groups and subcommittees is illustrated by this quote from a manager in one of the larger CCGs studied:

'Well, because we're a large CCG, if we have everybody ... so we have all of our locality chairs, and the two lay members, and the nurse representative, and the acute, um, clinician representative, all around a table, the meeting's going to be, ah, less than, um, efficient. So what I've done is created a proposal for two boards. One is the statutory board that ... What do they call it? The governing body. And the other is more of a ... It's still, to an extent, determining strategic priorities, but a subsidiary board. So you have the locality chairs on one subsidiary board comprised solely of GPs, you have a superior board — the oversight and governance board — comprised of some GP representatives from the lower board, and all those statutory appointees.' [Manager, ID 60]

Further complexities arise for CCGs, in that in addition to their internal governance processes, they will also be externally accountable to the NHS Commissioning Board (NHS England) and, more indirectly, to the local Health and Wellbeing Board, in ways that are not yet clear. Together, these factors would seem to add together to generate organisations that, although they have complete budgetary control, may be significantly constrained in their ability to make rapid decisions or act autonomously in practice.

Engagement with members

Previous research shows that, in a clinical commissioning organisation with decision-making power, active engagement of GPs increases the ability to achieve goals and to innovate, albeit at a cost of significantly increased administrative overheads.⁸ The empirical evidence from this study about GP engagement and involvement is examined below.

CCG 'ownership': Official guidance stresses the importance of GP engagement, explaining that: 'CCGs are also membership organisations, accountable to constituent GP practices',¹¹ and suggesting that member practices should be actively engaged with all key decisions in setting up the CCG.¹⁰ This implies that CCG members should see themselves as 'owners' of the CCG and of its plans. In practice, constitutions, strategic plans and commissioning plans were generally developed by an executive

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

'We also have a check and balance of the Council of Members, and my feeling initially, was that meeting was far too large ... there were 34 people sitting around. But in actual fact, if we watched how the conversation flowed at the last meeting, I actually felt it was really quite useful. The purpose was one, to hold us to account, but also to feed us information about what's a problem. ... People giving both specific examples and endorsing broad feelings about how it did, and take all that in. And then go back to the provider of that service, and say "This is what everybody is saying about it. What do you think you're going to do to change it?" So to be at that stage, is actually really quite exciting because it's almost showing how we're going to operate in the future.'
[GP ID 283]

It is clear from this quote that this GP saw the governing body as being 'held to account' by the membership. However, in the quote below, a manager from a different site sees it slightly differently, arguing that the Council of Members had given the Executive the power to make decisions, on which the wider membership could then comment, rather than the wider membership owning the decisions. In other words, the Executive would be required to give an account to their membership, without necessarily being accountable in a more direct sense:

'Yes, that ... I suppose that really is they have given the exec team responsibility to decide, you know, that direction and the plan, so your first signoff is with the exec team, but then you take it to the wider group to say this is what we're going to take forward to see what we can develop, you know, what do you want to do, so it's just really exposing it to the wider remit as a sort of communication exercise really, but also it's their then chance to say "you're all barking up the wrong tree"; "this is not right", that sort of thing.'
[Manager ID 42]

Engaging with members. All case study

CCGs were in the process of deciding how they should engage with their members in the longer term. Many different modes of communication and engagement were planned, such as newsletters or briefings sent round to all GPs and intranet sites. Across all of these different ways of working three broad approaches were found to be represented.

First, in some (usually smaller) sites, the key task was seen as getting grassroots members to engage with the strategic direction of the group, contributing ideas and 'owning' the strategy. Secondly, in larger groups the problem was more often formulated in terms of the need to disseminate information down, so that grassroots members were aware of what the group was doing.

Finally, some groups fell between these two extremes, apparently visualising the strategic role as falling to the governing body or executive group, but wishing to see a flow of 'front line intelligence' up from the grassroots, in addition to the flow of information down.

As part of their drive to engage with members, five out of eight of the case study sites had set themselves up with geographically based 'locality' groups. In four of these, the localities form the main forum through which members engage with the CCG, with meetings of the wider membership infrequent or only called to discuss specific issues. In the fifth site, there is also an active council of members. Responders across all these sites expressed a desire to have 'strong localities'; however, it remained unclear what this meant or what a 'strong locality' may do. The rationale appeared to be that 'strong localities' were necessary to engage the membership, but the ongoing role of localities in the wider organisation remained undefined and insecure.

One of the key questions was how much responsibility was felt to be reasonable to delegate to localities. In one of the larger sites it was stated categorically that localities would not be able to work autonomously. In another site, by contrast, localities were given delegated authority to make significant commissioning decisions, commit significant amounts of the overall budget (up to an agreed limit) without asking for permission from the governing body, and even manage the contracts with their local providers.

This approach generated significant local buy in and enthusiasm; the downside was that it required a significant commitment of managerial resources at the local level.

Summary. These findings suggest that what it means to 'engage' grassroots' GPs in CCGs is yet to be clearly formulated by those in positions of responsibility. The meaning of 'membership', the extent to which grassroots' GPs are expected to 'own' the agenda, the purpose of 'communication' and the role of locality groups all need to be carefully thought through and defined. Furthermore, it seems that 'engagement' may mean different things in groups of different sizes, and that, as was seen in the total purchasing pilots, larger groups may find particular difficulties in this regard, unless they are able to devolve meaningful power to their localities.

Commissioning activity

Previous GP commissioners have tended to focus on areas of activity based on their direct clinical experience, leading to a focus on such matters as hospital waiting times and the provision of additional services in general practices, with limited engagement with a public health approach to the assessment of population needs. There is most direct evidence of GP commissioner impact on prescribing, improving services in primary care, and some limited impact on slowing the rate of increase in referrals and urgent or unscheduled care.

Commissioning responsibilities. At the time of the research, emerging CCGs were working as subcommittees of their local primary care trust (PCT) cluster, and are beginning to take over responsibility for leading the commissioning process, getting ready to take over full responsibility from April 2013.

Unlike all previous manifestations of clinically-led commissioning, CCGs will have full responsibility for virtually the entire commissioning budget. Responders in these case study sites were very much aware of the implications of this, and of the challenges ahead:

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

Some governing body members in these case study CCGs appeared to recognise the

need to take as broad a view as possible of the commissioning task, moving away from small scale, practice-level interventions:

'For me it's really amazing to watch these clinicians leading change on a really significant scale, and it's very different to, I guess, what I thought may 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].

However, it was also found that, in general, meetings of locality groups and councils of members tended to remain more focused on more familiar topics such as small-scale interventions to improve care for long-term conditions in general practice.

Engaging with public health will be a key aspect of the process if CCGs are to move beyond such small-scale practice-level change. Under the new architecture of the NHS, responsibility for public health is in the process of moving from the NHS to multi-function local government authorities. The system remains in transition, with many public health employees as yet not sure where their final employment destination will be. At the same time, a national public health service is in the process of being set up, and local Health and Wellbeing Boards, responsible for undertaking the local joint strategic needs assessment and developing the local health and wellbeing strategies, are developing at different rates. Thus, public health in England is in a state of flux and transition.

An awareness was found in these case study sites of the need to work closely with public health, with, for example, some participants acknowledging the difference between 'formal' public health and 'informal' general practice knowledge about health needs. In some sites there was a clear desire to 'embed' public health at governing body level, whereas others saw it more in terms of public health offering a service to the CCG. Responders in all of the sites expressed concerns about the ongoing relationship between CCGs and public health once the planned changes take place. In the face of this uncertainty, personal relationships and experience of working together in the past were seen as important:

'At the moment, there's still quite a good link, historical, on the PCTs with the public health and the names and faces are still there, and as a consequence what we get is based on those relationships, isn't it; do we have

a thorough understanding of what public health information we would want contract to be provided to us, I don't know about that, that's a difficult one. It's a relationship that, hopefully, will just continue. [GP ID 104]

One of the key areas in which these case study CCGs told the study that they felt that CCGs would add value and 'do things differently' from previous clinically-led commissioning schemes was in the area of negotiating with providers:

'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].

There is as yet no available evidence to assess whether or not these perceptions of significant 'added value' from the involvement of GPs at this level is actually forthcoming. Such a level of involvement is both resource and time-intensive, and it remains to be seen if it is sustainable over the longer term. This GP described the pressures they were facing:

'And I spent yesterday, 6 hours in a joint strategic needs assessment on the Health and Wellbeing Board, for which I have not been paid, and I won't get paid. That's why I am still catching up on my clinical work, and I came in at 7 o'clock this morning to do all my paperwork and spent till 8 o'clock last night doing that. So I spend hours and hours of unpaid work. So I maybe do 2 days a week, and this is sometimes in my own time or my free time — doing the work that needs to be done.' [GP ID 218]

Box 3. Approaches to performance management of practices seen in the study CCGs

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

Quality of primary care

Previous manifestations of clinically-led commissioning have had some success in improving quality of care in general practice. The CCGs in this study had ambition in this regard. In particular, there was ambition to undertake some kind of performance management, including performance against commissioning budgets, referral behaviour and prescribing costs. While official documents refer to 'improving quality' in primary care, most of these responders were happy to talk explicitly about 'performance management'. Box 3 sets out the approaches seen in the CCGs in this study.

In all sites, performance management activities similar to these had been running under previous structures such as practice-based commissioning.¹² However, some responders said that they were concerned that such performance review and management would be more difficult in future as they had fewer staff to do the work; in particular, visiting practices individually is very labour intensive and may not be possible. In addition, there was some tension felt between the desire to be a 'bottom up' organisation led by its members and the perceived need to performance manage those members.

DISCUSSION

Summary and comparison with existing literature

This article attempts to relate these findings from detailed case studies of currently developing CCGs to what is known from research findings related to earlier manifestations of clinical commissioning. This exposes a number of tensions associated with the current direction of policy.

First, experience from the past indicates that GPs engage and maintain their enthusiasm most where they can see a direct relationship between their efforts and tangible outcomes. Furthermore, such a direct relationship generates a 'virtuous cycle' of engagement and enthusiasm, while feelings of constraint and inability to make change happen generate a 'vicious cycle' of disengagement.⁸ Early evidence suggests that aspiring CCGs are developing quite complex and multi-layered structures. In addition, the establishment of CCGs as statutory bodies without any 'parent body' means that there is a need for robust governance and accountability frameworks. Together, these two factors would seem to generate a risk that CCGs will not necessarily be nimble in their decision

Box 4. Key ongoing questions arising from this research

- How can the need for autonomy and efficient decision making be reconciled with the need for robust internal governance processes?
- How tightly will the NHS Commissioning Board (renamed NHS England from 1 April 2013) seek to monitor and performance manage CCGs, and what will be the impact of this?
- What will it mean for practices in the longer term to be a 'member' of a CCG?
- Will CCGs have the legitimacy required to intervene in their members' practices to improve quality?
- Will CCGs continue to be seen as legitimate by their members, once they assume responsibility for making difficult decisions?
- What is the role and function of locality groups in the longer term?
- How will CCGs work with the new public health system, and will they make the transition to focusing on wider issues of population health?
- Will concerns about conflicts of interest hamper the development of new services in practices (traditionally a strength of clinically-led commissioning)?

Funding

The study was funded by the Department of Health via its Policy Research Programme. The study formed part of the programme of the Policy Research Unit in Commissioning and the Healthcare System. The views expressed here are those of the researchers and do not reflect the position of the Department of Health.

Ethical approval

The study received ethical approval from NRES NW ref 0375.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

Acknowledgements

We are grateful to our participants who were very generous in allowing us access to their organisations at a time of considerable turmoil and change. A project advisory group provided valuable advice and support in the development and management of the study. We are also grateful to Dorota Osipovic and Ben Ritchie, who provided support for the surveys, and to Pauline Allen who provided invaluable advice and support throughout.

Discuss this article

Contribute and read comments about this article on the Discussion Forum: <http://www.rcgp.org.uk/bjgp-discuss>

making, and that the link between effort and outcome may be difficult to observe for those involved. The ongoing role of the NHS Commissioning Board (NHS England) in overseeing CCGs will be crucial in their future ability to act autonomously and in a timely fashion, with over-regulation or curbs on autonomy likely to limit enthusiasm and ongoing engagement.

Secondly, it is known that this ongoing engagement and associated willingness of GPs to make changes desired by their commissioning organisation also depends on their acceptance of the legitimacy of that organisation. In past clinically-led commissioning organisations and arrangements (such as practice-based commissioning) such legitimacy was enhanced by voluntarism and by formal sign-up procedures.¹² Membership of CCGs is compulsory, and it remains to be seen whether or how this impacts on engagement in the longer term. Recent suggestions that even if practices decline to sign the CCG constitution they will still be bound by it,¹³ raise further questions about engagement and perceived legitimacy. The evidence from this study suggests that what it means to be a 'member' of a CCG has yet to be fully established, and it is at least possible that the trend towards mergers to form larger organisations,⁹ may adversely affect this engagement. The establishment of smaller locality groups may act to alleviate this danger, but the evidence suggests that the role, remit and function of these has yet to be clarified by many CCGs.

Finally, past experience of clinically-led commissioning suggests that such organisations have in the past struggled to move beyond commissioning focused on the immediate needs of the registered patients of practices.⁶ CCGs have ambitions in this regard, but the ongoing uncertainty about the role of public health in the new

system means that there is little concrete evidence of any new approaches as yet. The one area in which these case study sites indicated that they felt GPs could really make an impact was in engagement with providers around service development and contracting; it remains to be seen whether this involvement yields positive impacts in the longer term that go beyond the needs and concerns of practices. Past impacts of clinically-led commissioning have generally centred on service development, performance management, and quality improvement in general practices. CCGs appear to have ambition in this regard, but their ability to develop services will depend on the resolution of concerns about conflicts of interest, while success in improving quality in primary care will depend on developing legitimacy and having the capacity to monitor and intervene in practices. The meaning of 'membership' will be crucial in how this plays out in the longer term.

Strengths and limitations

This study took place in the early stages of development of CCGs. It represents a snapshot of a developing situation, and this must be borne in mind in interpreting the results. However, the data collected were both wide in scope and deep, going beyond sanitised accounts of CCG development to explore in detail the issues that arose in real time. Therefore this study provides valuable early evidence that will be of use both to CCGs and to those responsible for overseeing their development.

Implications for research and practice

The key ongoing questions that arise from this research are summarised in Box 4. Issues have been highlighted that CCGs will need to consider as they continue to develop, and it is important that future research also addresses these areas.

REFERENCES

1. Cabinet Office. *The Coalition: our programme for government. Freedom, fairness, responsibility*. London: Cabinet Office, 2010.
2. Timmins N. *Never again? The story of the Health and Social Care Act 2012. A study in coalition government and policy making*. London: The King's Fund, 2012.
3. Department of Health. *Equity and excellence: liberating the NHS*. London: The Stationery Office, 2010.
4. Nicholson D. *Letter to all Chief Executives and Arm's Length Bodies: Equity and excellence: liberating the NHS — managing the transition*. Gateway ref 14795, 2010. <https://www.gov.uk/government/publications/liberating-the-nhs-managing-the-transition--5> (accessed 26 July 2013).
5. Glennerster H, Matsaganis M, Owens P, Hancock S. *Implementing GP fundholding. Wild card or winning hand?* Buckingham: Open University Press, 1994.
6. Mays N, Goodwin N, Killoran A, Malbon G. *Total purchasing: a step towards primary care groups. National evaluation of total purchasing pilot projects*. London: King's Fund, 1998.
7. Field S. *NHS Future Forum: summary report on proposed changes to the NHS*. London: The Stationery Office, 2011.
8. Miller R, Peckham S, Checkland K, et al. *Clinical engagement in primary care-led commissioning: a review of the evidence*. London: Policy Research Unit in Commissioning and the Healthcare System (PRUComm), 2012.
9. Checkland K, Coleman A, Segar J, et al. *Exploring the early workings of emerging Clinical Commissioning Groups: final report*. London: Policy Research Unit in Commissioning and the Healthcare System (PRUComm), 2012.
10. NHS Commissioning Board. *Towards establishment: creating responsive and accountable clinical commissioning groups*. London: The Stationery Office, 2012.
11. NHS Commissioning Board. *Clinical Commissioning Groups: HR guide*. London: The Stationery Office, 2012.
12. Coleman A, Checkland K, Harrison S, Dowsell G. *Practice-based commissioning: theory, implementation and outcome. Final report*. Manchester: University of Manchester, National Primary Care Research and Development Centre, 2009.
13. Lind S. CCG constitutions legally binding whether signed or not. *Pulse* 2012; **Nov 14**: <http://www.pulsetoday.co.uk/commissioning/commissioning-topics/ccgs/ccg-constitutions-legally-binding-whether-signed-or-not/20000871.article#UgoFd1MmRBQ> (accessed 13 Aug 2013).