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The 'added value' GPs bring to commissioning:

a qualitative study in primary care

Abstract

Background
The 2012 Health and Social Care Act in England replaced primary care trusts with clinical commissioning groups (CCGs) as the main purchasing organisations. These new organisations are GP-led, and it was claimed that this increased clinical input would significantly improve commissioning practice.

Aim
To explore some of the key assumptions underpinning CCGs, and to examine the claim that GPs bring 'added value' to commissioning.

Design and setting
In-depth interviews with clinicians and managers across seven CCGs in England between April and September 2013.

Method
A total of 40 clinicians and managers were interviewed. Interviews focused on the perceived 'added value' that GPs bring to commissioning.

Results
Claims to GP 'added value' centred on their intimate knowledge of their patients. It was argued that this detailed and concrete knowledge improves service design and that a close working relationship between GPs and managers strengthens the ability of managers to negotiate. However, responders also expressed concerns about the large workload that they face and about the difficulty in engaging with the wider body of GPs.

Conclusion
GPs have been involved in commissioning in many ways since fundholding in the 1990s, and claims such as these are not new. The key question is whether these new organisations better support and enable the effective use of this knowledge. Furthermore, emphasis on experiential knowledge brings with it concerns about representativeness and the extent to which other voices are heard. Finally, the implicit privileging of GPs' personal knowledge ahead of systematic public health intelligence also requires exploration.

Keywords
clinical commissioning groups; commissioning; general practitioners; NHS; service development.

INTRODUCTION

The passing into law of the Health and Social Care Act in March 2012 marked a significant reform of the NHS in England.[1,2] The act abolished the 152 primary care trusts (PCTs) and the 10 strategic health authorities (SHAs), replacing PCTs with 211 clinical commissioning groups (CCGs). These clinically-led organisations became responsible for the care of the population within their geographic boundaries on 1 April 2013. A year prior to this they operated in shadow form.[3,4] CCGs are now responsible for 65% of the overall NHS budget, commissioning routine and emergency care. Another new body — NHS England (NHSE) — oversees CCGs and is responsible for commissioning services such as primary care and specialised services at a national level. The managerial budgets for CCGs are significantly less than those for PCTs, and they are expected to buy in support services from commissioning support units (CSUs).[5] At the heart of the new arrangements is the desire by government to increase competition, reduce bureaucracy, and, most importantly, to increase clinical leadership in the NHS.[6,7]

As envisaged by the government in the white paper *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. Published policy documents from NHSE list a number of potential types of 'added value' that clinicians bring to commissioning. These are listed in Box 1.[8]

Claims of GPs being on the 'front line' and knowing the needs of patients are not new.[3] A comprehensive literature review by Miller *et al*,[9] on clinical engagement in commissioning concludes that:

'There is strong evidence to demonstrate that more GP engagement seems to lead to more success in achieving goals and stated objectives. This finding is supported by data from Fundholding, TP [Total Purchasing] *and PbC* [Practice-based Commissioning]*. These schemes demonstrate that governance systems that engage the wider body of GPs and other clinicians provide the commissioning organisation, and those leading it, with greater legitimacy.'*

This evidence also suggests that PCTs represented a new low with regard to clinical engagement, with clinicians used merely as 'sounding boards' by managerially run PCTs, and clinicians having no real role in decision making.[10] Although PbC did give clinicians the opportunity to engage more in

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How this fits in

GPs have been involved in commissioning care in different ways since the 1990s, with evidence suggesting that in the past they have struggled to take a population-based view, and involve patients and the public. GPs and managers involved with clinical commissioning groups are optimistic that the new arrangements provide a clearer clinical focus for commissioning. Claims for the 'added value' clinicians bring centre around their experiential knowledge, implicitly downgrading more systematic public health evidence and raising concerns about the extent to which alternative voices will be heard. GPs and managers have significant concerns about workload and potential 'burnout'.

clinical commissioning, such efforts could be thwarted by an overly bureaucratic and prescriptive PCT.[11]

This study reports on empirical research exploring the impacts of CCGs, with a particular focus on the potential added value that clinicians bring to the commissioning process.

METHOD

The findings presented here represent the second phase of a longitudinal project tracking the development and early activities of CCGs. The first phase of this project involved an intensive investigation of the early development of CCGs, using eight case study sites, alongside two national web-based surveys (see Checkland *et al*[12] for detailed description). The second phase (reported here) undertook interviews with GPs (and some managers) in CCGs, exploring in more detail their perceptions of the added value that clinicians bring to commissioning. The final phase is ongoing, with more detailed study using observation as well as additional interviews to follow how these issues play out in practice over time. For this phase of the research, the guiding research questions were:

- How did clinicians become involved in the CCG and what are the perceived differences compared with PCTs?
- What claims are made for the added value clinicians bring to the commissioning process?
- What evidence is there to support the claims made by NHSE of clinician added value in commissioning?

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

For this part of the study, 40 interviews were conducted with GPs and managers in seven of the eight case study sites (one site declined to participate further). Table 1 provides a breakdown of the interviews by site and role.

The focus of the analysis was to explore the opinions of those involved with CCGs, principally among clinicians, but also some managers, about the value that GPs bring to the process. The results from this (presented here) are being used to focus a third phase of data collection, in which the claims made will be followed up in observation of the work of four of the case study CCGs.

RESULTS

Clinician involvement in CCGs

How clinicians got involved in the CCG. Two main reasons were given for involvement of clinicians in the CCG: either responders volunteered because of their interest in the role or they were asked by colleagues to undertake the position. On taking the position, they were nearly always elected unopposed, although many did have to go through an assessment interview. This, of course, raises some questions about democratic legitimacy of CCGs. This responder discusses how they acquired the role:

'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)

Box 1. NHSE claims about clinician 'added value' in commissioning[8]

- Strengthened knowledge of the needs of individuals and local communities and the variation in the quality of local services, by harnessing the unique role of general practice to be in everyday contact with patients, their families, and carers.
- Increased capability to lead clinical redesign and engage other clinicians based on the understanding of clinical risk and evidence of best practice.
- Better involvement and engagement of local people to adopt improved services and move from familiar, but outdated, services with 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 a clinically-led redesign of care systems.

Table 1. Interviewees

	Number of GPs	Number of managers	Nurse (clinical lead)
Site 1	7	0	0
Site 2	7	0	0
Site 3	4	0	0
Site 4	3	1	0
Site 5	3	1	1
Site 6	2	0	0
Site 7	7	4	0
Total: 40	**33**	**6**	**1**

Time spent by clinicians on CCG work. The amount of time clinicians spend on CCG work varies depending on their role and responsibilities. For instance, 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. Many GPs talked of working late nights and weekends to manage the workload. In addition to a heavy burden of meeting attendance, responders highlighted the large volumes of reading and email required. This GP was typical:

'… 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)

Box 2 summarises the workload concerns expressed.

Before and after: how CCGs are different from PCTs. Clinicians and managers told us that, in PCTs, clinicians had little role or responsibility in decision making. By contrast, clinicians in lead roles now feel that they have 'ownership' of the decisions made by the CCG. In addition to the perceived benefits of the clinical voice (discussed below), responders told us that this also had had benefits in terms of a reduction in bureaucracy:

'So we at the PCT … we had input, we had new ideas, but it was very much we would have the ideas, they would go to the PCT and then just disappear and then a circle of red tape and never come out the other end. Now it's very much we move it forward and they are behind us to support us … I think you do feel you actually have more influence now and have more of an effect.' (GP ID 350)

Box 2. GPs' workload concerns

- Lack of time to undertake the required work
- The impact on their practice work
- The sustainability of working at this intensity
- Fear of 'burnout'

What added value do clinicians bring to the commissioning process?

Working on the front line. The responders emphasised the experiential knowledge they bring to commissioning:

'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)

The value of clinical knowledge and input. Clinical knowledge and input are also seen as critical. In these interviews, the added value of the clinical knowledge available in CCGs was not so much in the detail about particular treatments, but in the way that the greater involvement of people with clinical knowledge changed the focus of discussions. In the PCT, there may have been more of a focus on such things as finance and costing 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 in the CCG. 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, OK. 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, OK. And I understand what's going on because I work with them and I live and breathe general practice 3 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, it was claimed there is now more of an emphasis on services being patient-focused, with GPs highlighting concerns from patients heard in their practices.

The GP and manager dynamic: a symbiotic relationship. There was a strong belief by responders that GPs' clinical contribution is needed by managers, and that it helps contextualise policy and provision. GPs also recognise the importance of managers' roles, however. These quotes encapsulate the issues, highlighting the close working that is required and the personal nature of those relationships:

'... if commissioning's a bicycle, just because you change who rides it, why's it going to be any different, OK? 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)

'... 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. Box 3 summarises some of the methods used to achieve this.

Practice visits were felt by some to be particularly valuable:

'... 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)

Study responders were asked about any difficulties engaging GPs in the CCG. Two concerns arose. First, that not enough GPs were engaged with the CCG, with a tendency for the same individuals to volunteer for roles, and persistent vacancies on committees was an issue. Secondly, there were concerns that, with GPs retiring, or with CCG clinicians potentially becoming overloaded and 'burntout', there was no succession planning for the next generation of clinicians to take over the work of the CCG.

Box 3. Methods of engaging GP practices

- Quality assurance visits, designed to help practices identify where they were doing well and where services could be developed
- A 'listening exercise' with practices to hear their concerns and their views
- The provision of education and training
- Dissemination of newsletters and briefings
- Locality and other meetings

DISCUSSION

Summary

This study provides evidence about the attitudes and beliefs of those currently undertaking formal roles within CCGs. Repeated references were made to the value of the clinical knowledge and the knowledge about service provision that GPs bring to the process. In terms of the aspirations of those responsible for implementing CCG policy highlighted in Box 1, the responders clearly shared NHSE's optimism that clinicians in CCGs will use their clinical knowledge to improve commissioning. They also believed that CCGs have the potential to improve quality in primary care, although this will depend crucially on the ability of CCGs to engage their members. The claim made by NHSE that clinicians will be able to use their position as trusted members of the community to engage with the public, and persuade them of the need for wider-scale system transformation, did not arise in these interviews, and indeed seems to lack face validity. There is no *a priori* reason as to why CCGs should be better than PCTs at engaging the public with the need to close services, and it is at least plausible that those with detailed knowledge of patients' wishes are less likely to take the risk of engaging in difficult service reconfigurations.

Strengths and limitations

This study provides a snapshot of views about the value of engaging GPs in commissioning. The study provides useful evidence about the developing picture on the ground as GPs bed into the roles they have taken on, raising issues that CCGs and NHSE may need to consider. The limitation of the study is that what is gathered here are opinions, mostly from clinicians themselves, although

the managers interviewed highlighted very similar issues. The next phase of this study will unpack these claims in more detail, exploring in depth their practical operation in the real world.

Comparison with existing literature

The claims made by the responders highlight two aspects of GPs' knowledge and experience. The first is that their knowledge about services and patient needs is 'fine-grained'. By this, it is meant 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 to provide an overview of the whole system. This claim is interesting, as it carries within it two assumptions: first, that such aggregated knowledge of individuals is sufficiently representative to illuminate the system as a whole; and, secondly, 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 within the Health and Social Care Act (2012) and within public service policy more generally.[13]

The second claim made by the responders was that GP knowledge is 'concrete'. By this it is meant that their knowledge is based on real experiences of particular services, not on statistical evidence. This is seen as particularly important in the NHS after the Francis report[14] 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.

These attributes of GPs are hardly new, and GPs have been involved in many previous incarnations of 'clinically-led commissioning', including fundholding, total purchasing pilots, and practice-based commissioning (PbC). Therefore the important ongoing issue is how far this 'fine-grained' and 'concrete' knowledge about their population is deployed in a way that was *not* possible under previous arrangements. Responders stated that, in general, they believed CCGs provided better opportunities for use of clinicians' knowledge to improve services than had been possible before. In particular, claims were made about the beneficial impact of GPs being 'in charge' and CCGs being 'less bureaucratic' than PCTs. This would certainly seem to be an explicit intention as CCGs were set up,[12] but, as highlighted elsewhere, accountability arrangements for CCGs are complex,[5] and the extent to which they manage to be more nimble and innovative is an empirical question yet to be answered.

In addition, questions arise as to whose 'fine grained' and 'concrete' knowledge is being used, and in what way? There is a danger here that CCGs will only heed voices of those directly involved in the CCG. This becomes problematic when the relatively small numbers of clinicians actively engaged are considered. A recent study by the King's Fund and the Nuffield Institute[15] also found that few GPs in leadership positions had undergone any kind of competitive process, and highlighted the difficulty of engaging more GPs in the CCG, the potential subsequent burnout of those involved, and a lack of succession planning.

There are also dangers associated with the implicit denigration of the systematic gathering of evidence associated with a public health approach. Public health is now under the auspices of local authorities, and many CCGs have yet to clarify fully the exact role that public health will play.[16] Past studies of clinically-led commissioning suggest that GPs have historically struggled to move beyond local concerns to take a wider population view.[9] The clear message received about the importance of individuals' 'fine-grained' and 'concrete' knowledge suggests that CCGs may also struggle in this regard. It is too early to draw conclusions, however, and it is to be hoped that CCGs develop good relationships with their public health colleagues and work closely with health and wellbeing boards to mitigate this risk.

Further concerns arise with respect to patient and public involvement. The strong belief that GPs 'know' about the needs and concerns of their patients could lead to a failure to consult more formally. Two studies on service improvement in the English NHS by Gridley *et al*,[17] highlight the patchy success in involving the public achieved by total purchasing pilots and PbC, noting that:

'... studies have shown consistently that GP commissioners are not good at public and patient involvement. In the total purchasing pilots, GPs saw themselves as "agents for their patients" without the need to actually involve them in decision making ... '

Finally, many of the responders (GPs and managers) raised concerns about sustainability and succession planning. Managers and GPs described

unmanageable workloads, with late night and weekend working the norm, exacerbated by the heavy administrative burden imposed by the authorisation process. This is obviously not sustainable in the longer term, and the responders were beginning to discuss ways of working more effectively. It is clear that the question of exactly where and when clinical input is most useful is important, and needs to be explored in more depth.

Implications for research and practice

Together, this evidence suggests that, although the clinicians and the managers with whom they were forging close and productive working relationships remain committed and generally enthusiastic about the potential added value that clinicians are bringing to the process, there is a need for caution. Three areas require further exploration before firm conclusions can be drawn. The first is the extent to which the structures and processes associated with CCGs better enable the effective wielding of GPs' claimed 'unique' knowledge, than in previous clinically-led commissioning and whether such knowledge can also enable system transformation. The second is the extent to which GPs are able to draw in wider voices, including their own 'rank and file' as well as public health experts and members of the public. Finally, research needs to explore in more detail the extent to which GP voices are needed in the different workstreams and processes that CCGs have developed. It is clearly unsustainable to have GPs everywhere and present on every occasion, and what might be called the 'smart use' of GP knowledge must be the aim. Managers told us that they valued the externally perceived legitimacy that close association with clinicians gave them; the prize must be to maximise this while not requiring GP attendance at every meeting, or GP comments on every document.

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Competing interests

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