The King's Fund> nuffieldtrust

Clinical commissioning groups
Supporting improvement in general practice?

Authors
Chris Naylor
Natasha Curry
Holly Holder
Shilpa Ross
Louise Marshall
Ellie Tait

Contents

List of figures and tables

About the authors

Chris Naylor is a Fellow in Health Policy at The King's Fund. He leads the Fund's research on clinical commissioning and also conducts research and policy analysis on a range of other areas, including mental health and integrated care. He has published widely on a number of topics, including a recent report exploring the role of volunteers in health and social care, and an evaluation of practice-based commissioning published in 2008. Before joining The King's Fund, Chris worked in research teams at the Sainsbury Centre for Mental Health and the Institute of Psychiatry. He has an MSc in public health from the London School of Hygiene and Tropical Medicine.

Natasha Curry is a Senior Fellow in Health Policy at the Nuffield Trust. Her research interests include clinical commissioning, integrated care, National Health Service reform, and governance and accountability. Natasha joined the Nuffield Trust in July 2011 from The King's Fund, where she was a Fellow in Health Policy. During her six years at The King's Fund, Natasha published widely on a number of subjects, including practice-based commissioning, the management of long-term conditions, and approaches to clinical and service integration. Prior to joining The King's Fund, Natasha worked as a consultant in health at Matrix Research and Consultancy Ltd.

Holly Holder is a Fellow in Health Policy at the Nuffield Trust. She is trained in a variety of research methods and specialises in qualitative research. Her current projects at the trust include exploring models of primary care, comparative analysis of international health and social care systems, and tracking national policy developments. Previously, Holly worked for the Centre for Analysis of Social Exclusion at the London School of Economics, focusing on the measurement of equality and human rights in the United Kingdom, including inequalities in the outcomes, provision and receipt of health and social care.

Shilpa Ross is a Researcher at The King's Fund. She has extensive experience in carrying out qualitative social research at various organisations. Since joining The King's Fund, Shilpa has co-authored reports covering various topics, including the quality of care in general practice, case management and end-of-life care. Shilpa is currently researching the lessons emerging from clinical commissioning, and the implementation of an integrated care programme.

Louise Marshall is a Specialty Registrar in Public Health currently working at the Nuffield Trust. Her previous training positions have included a primary care trust and health protection units. Prior to starting specialty training, Louise worked as a research scientist at the Medical Research Council, investigating primary care referral to a commercial slimming organisation.

Ellie Tait was an intern at The King's Fund, where she conducted research within the policy directorate. Prior to this, she graduated from Durham University with an MSc in medical anthropology. While at The King's Fund, Ellie worked on various projects including clinical commissioning and the transfer of public health responsibilities to local authorities. She currently works at Ipsos MORI carrying out market research within its health care team.

Acknowledgements

Summary

Introduction

Clinical commissioning groups (CCGs) are one of the main components of the government's reforms to the health and social care system. In April 2013, these newly established, clinically led organisations replaced primary care trusts as the commissioners of most services funded by the National Health Service (NHS) in England, and now control around two-thirds of the NHS budget. All general practices in England are now legally obliged to be a member of a CCG. The intention is to encourage clinicians to play a greater role in deciding how funds are spent in order to shape services to meet local needs.

CCGs have two important, but distinct, roles: they are responsible for commissioning secondary and community care services for their local populations; and they have a legal duty to support quality improvement in general practice. This second role has received less attention to date, but is vitally important if CCGs are to achieve their wider objectives and deliver more integrated forms of care. It will, however, be a challenging role for them to fulfil, particularly as general practitioner (GP) services are commissioned by NHS England.

About this research

The King's Fund and the Nuffield Trust are working together over a three-year period to assess the implementation and impact of CCGs. We are examining clinical commissioning in six case study sites between 2012 and 2015, focusing on:

- the nature of relationships being built inside CCGs, particularly the interface with member practices and the extent of GP involvement in CCG activities

- the role of CCGs in supporting quality improvement in general practice

- the structures and processes through which these relationships and improvement activities are conducted.

These areas are critical to the success of CCGs, as it is clinical involvement and the relationship with local GP practices that potentially distinguish CCGs from primary care trusts, and which will underpin their ability to support improvements in general practice.

We will publish our research findings annually. This first report is based on fieldwork conducted before CCGs had become fully authorised, and so provides an overview of developments up until March 2013, plus an assessment of the opportunities and challenges ahead, rather than a definitive evaluation.

The research is based on 74 in-depth interviews, 18 direct observations and a survey of all general practices in our case study sites, to which there were 232 responses.

Governance arrangements in CCGs

CCGs have developed complex governance arrangements that vary significantly. The majority have some form of locality structure to support GP engagement and local priority-setting. Partnership arrangements and alliances of varying degrees of formality are also common between CCGs, often including the sharing of senior management posts and development of joint commissioning plans. These partnerships are necessary so that smaller CCGs can operate at scale, but they do further complicate governance arrangements and can create additional barriers to engagement if decision-making at partnership level is seen as remote from local GPs.

A key issue for our research is the role and power of member GPs relative to CCG leaders. Bodies designed to represent member practices within the CCG were often expected to play an instrumental role in setting the direction taken by the organisation, although we found that these bodies were sometimes underdeveloped and failed to demonstrate significant influence. Furthermore, local GPs often had a limited understanding of the governance arrangements inside the CCG and of the constitution that describes them.

Engaging general practices

We encountered a sense of energy in the CCGs we studied and an impressive level of commitment from those leading them. The engagement of general practices was variable but generally felt to be better than in the previous practice-based commissioning arrangements. CCGs were credited with having brought local clinicians together in new ways and built more structure around existing collaborative activities between practices.

However, we also found considerable differences of perspective between GPs leading CCGs and those who had not taken an active role:

- 66 per cent of those who led CCGs felt that their CCG was 'owned' by its members, compared with 35 per cent of those without a formal role in the CCG

- 81 per cent of CCG leaders felt that decisions made by their CCG reflected their views and those of colleagues, compared with 38 per cent of those without a formal role in the CCG

- 78 per cent of CCG leaders felt that the formation of the CCG had improved clinical relationships between GPs, compared with 34 per cent of those without a formal role in the CCG.

These gaps between the views of active participants and those of other local GPs may reflect the time needed for CCGs to build connections with their members. However, if the disparity grows wider over time, CCGs risk losing their connection with grassroots GPs and repeating the history of diminishing clinical involvement that characterised many primary care trusts.

Attitudes towards the CCG varied widely among individuals: although some GPs expressed a sense of ownership of their CCG and feelings of solidarity with fellow members, others were highly sceptical of the notion of the CCG being owned by local GPs and saw the CCG as an administrative structure sitting above practices rather than something that is composed of and led by its members.

The strength of the relationships with member practices also varied considerably among CCGs. Our survey indicated a trend for the sense of ownership to be greater in smaller

CCGs, whereas members of larger CCGs commonly reported feeling more involved with their local sub-group than with the CCG itself.

Those leading CCGs are in no doubt about the scale of the challenge they face in maintaining engagement among local GPs. The environment in which CCGs are beginning their work is not a favourable one: a lack of time and capacity in general practice were often identified by our interviewees as barriers to engagement, as was the current financial climate. In the case of the latter, some GPs feared that the main responsibility would be to perform a rationing function, which, they felt, could damage their relationship with patients, although others felt that this risk was overstated.

In spite of these challenges, one encouraging finding was that, overall, those responding to our survey felt that they have more influence over their CCG than they had over the former primary care trust. Similarly, most interviewees felt that the GP voice was better represented within CCGs than it had been within primary care trusts.

Supporting change in general practice

To support the development of more integrated services, new models of primary care are needed that allow GPs and other practice staff to take greater responsibility for the co-ordination of care, to adopt more proactive approaches to population health management and to support an expansion in the range of services available in the community. CCGs could be pivotal in encouraging these kinds of improvements.

Most of the CCG leaders involved in our research accepted that CCGs need to play an active part in supporting improvement in general practice, but several expressed a degree of unease about performing this role. Clinical leaders, in particular, were keen to avoid a direct performance management relationship with their peers and strongly favoured taking a supportive or facilitative approach. Reconciling the need to challenge poor performance with the need to maintain clinical engagement and member ownership will be a delicate balance for CCG leaders to strike.

It was notable that more than 80 per cent of the GPs who responded to our survey believed that CCGs do have a legitimate role in influencing their members in terms of their referrals, prescribing and other issues. Our qualitative work suggests that this view is partly due to a feeling that 'somebody' needs to take responsibility for these issues and that, under the new system, it would be better for it to be clinically led CCGs that do this than the managerially led area teams of NHS England. However, we also found that many GPs were unclear about exactly what authority their CCG has over them in respect of their role as primary care providers.

CCGs will need to work closely with NHS England area teams, which are responsible for commissioning primary care. The division of responsibilities between the two organisations is a critical issue about which there is still considerable uncertainty. There is a widespread expectation that area teams will not have sufficient capacity to monitor or manage GPs' contracts closely and will need to delegate some of these responsibilities to CCGs. CCG leaders might therefore find it difficult to distance themselves entirely from more robust performance management activities in cases where persistent performance problems exist.

Of the tools available to them, CCG leaders placed most emphasis on providing comparative performance data to member practices, and facilitating various forms of peer-to-peer dialogue.

The ability of CCGs to do this was frequently seen as being their single greatest strength relative to primary care trusts, with 48 per cent of survey respondents agreeing that CCGs are better placed than primary care trusts to support improvements in general practice; 16 per cent disagreed. Some CCG leaders, however, felt that the mechanisms at their disposal might not provide sufficient leverage over member practices or that the resources available to perform this function are not adequate.

The perceived impact of CCGs

Although our fieldwork took place before April 2013, we found some evidence that CCGs were already having an impact on members' clinical practice. More than half of those who responded to our survey reported that being a CCG member had changed their clinical practice in terms of prescribing patterns, referral pathways and volume of referrals, although the majority of these said that the scale of the change had so far been small.

Overall, however, the majority of survey respondents were unsure what effect these changes to clinical practices would have on patients, and almost one-fifth predicted there would be a negative effect. This suggests that CCG leaders have some distance to go before they are able to give member practices confidence that being part of a CCG will benefit their patients.

A window of opportunity

If CCGs are to succeed in engaging local clinicians and building a new clinically led approach to commissioning, they will need to prove their value to their members. The history of primary care-led commissioning illustrates that a limited window of opportunity can exist within which leaders must be able to demonstrate tangible improvements for patients. This will not be easy in the current and projected financial conditions, and there is a clear danger of history being repeated if CCGs fail to bring about service changes that win the support of the local clinical community.

Our research suggests that, for the moment at least, there is a foundation of goodwill upon which CCG leaders can build. Converting this into active support and engagement is one of the most pressing challenges ahead for CCG leaders.

Key messages

- Primary care needs to grow and evolve if it is to continue to meet the needs of society; CCGs have an important role to play in facilitating this.

- Most GPs believe that CCGs have a legitimate role to play in trying to influence the clinical behaviour of local GPs, but there is some wariness about the form that this involvement could take.

- Developing greater clarity on how responsibility for primary care development is to be shared between CCGs and NHS England area teams should be a priority. In the absence of this there is a risk that neither organisation will provide the necessary leadership.

- Area teams will not have sufficient capacity to monitor or manage GPs' contracts closely and will need to delegate some of their responsibilities, relying on CCGs for their soft intelligence and their ability to influence.

- CCGs will need to strike a careful balance if they are to perform this function without alienating their GP members, on whom they depend for their legitimacy. Supporting peer review may be the most powerful tool at their disposal in doing so.

■ There are significant disparities between the views of those involved in leading CCGs and member GPs, with the latter being less likely to say that their CCG is 'owned' by its members, that its decisions reflect their views or that it has had a positive impact to date.

■ There is also significant variation in views from one CCG to another, with levels of member ownership and involvement much higher in some areas than others. Larger CCGs may face a particular challenge in engaging member practices and creating a culture of collective ownership.

■ There is a widespread desire in the GP community for CCGs to succeed, but CCG leaders have yet to persuade all GPs that commissioning can bring about improvements or that CCGs represent a departure from previous commissioning structures.

1 Introduction

Clinical commissioning groups (CCGs) are one of the main components of the government's reforms to the health and social care system. These newly established groups now control around two-thirds of the National Health Service (NHS) budget in England and commission most health services apart from primary care and specialised services. The intention is to encourage clinicians to play a greater role in shaping local services and deciding how NHS funds are spent. This has been a longstanding policy goal, but CCGs represent the most radical attempt yet to place commissioning responsibilities in the hands of clinicians.

The King's Fund and the Nuffield Trust have come together to follow the evolution of clinical commissioning in six case study sites over the three-year period from 2012 until 2015, focusing on three connected issues:

- the nature of internal relationships being built inside CCGs, particularly the interface between CCG leaders and their local general practices, and the extent of general practitioner involvement in CCG activities
- the role of CCGs in supporting quality improvement in general practice, and how they are harnessing the relationships with and between practices to facilitate development
- the structures and processes through which these internal relationships and primary care development activities are conducted.

We concentrate on these issues because they will be of critical importance if CCGs are to succeed as commissioners. In this first report, we analyse the emerging situation as CCGs take up their new responsibilities, and describe the nature of the challenges ahead. In subsequent years, we will assess what progress CCGs have made in these areas, and the implications for the populations they serve.

What is clinical commissioning?

Commissioning is the process of measuring the health needs of a population, assessing which services are needed to meet these needs and then purchasing the appropriate services on behalf of patients. The term refers to multiple activities performed by a number of professionals.

Clinical commissioning refers to a range of attempts to give clinicians a central role in some or all of these activities.

The dual role of CCGs

In understanding the focus of this research, it is important to recognise that CCGs have two distinct roles.

- They are responsible for commissioning secondary and community care services for their local population.

- They also have a role in supporting quality improvement in general practice.

These two roles are closely connected – it is not possible to commission secondary care effectively without also considering how patients are supported in primary care, for several related reasons.

- Referral and prescribing decisions made in primary care determine a significant proportion of secondary care activity and commissioning expenditure.

- Commissioners are dependent on effective management of long-term conditions in primary care if they are to improve quality and control costs.

- New models of general practice are needed in order to support better integration of primary, community and secondary care.

Although necessary, the role of CCGs in supporting change in general practice is a contentious issue, and policy about this has lacked clarity. CCGs do not commission primary care services, and CCG leaders do not have direct legal authority over the clinical behaviour of member practices. Nevertheless, the legislation is clear that CCGs do have a responsibility to support improvements in the quality of primary care. In this report, we explore how CCGs are discharging this responsibility and ask how well placed they will be to help bring about change.

Report structure

In the next two sections we set out the context for our research, outline our approach, describe our case study sites and chart the history of clinical commissioning in England.

In sections 4–7 we describe our research findings to date.

- Section 4 describes the governance structures and processes developed in our case study sites and relates these to our main research questions.

- Section 5 presents evidence on internal relationships within CCGs, discussing power dynamics and the extent to which CCGs function as membership organisations.

- Section 6 focuses on the role of the CCG in supporting improvement in general practice, the mechanisms used for this and their impact so far.

- Section 7 examines the perceived impact of CCGs.

In Section 8, we discuss our findings and relate them to our core research questions, asking whether CCGs will be able to operate as membership organisations and how well placed they are to support quality improvement in primary care.

In the final section, we consider the future and detail our key messages.

2 About this research

This project seeks to answer three sets of questions.

- How involved are clinical commissioning group (CCG) members in the activities of the CCG, and what relationships are being built between them and CCG leaders?

- How are CCGs discharging or planning to discharge their responsibility to support quality improvement in general practice, and how well placed will they be to do so?

- What structures and processes are CCGs developing in order to facilitate the above?

Approach

Six case study sites were selected at random, using a stratified approach to ensure that we included CCGs of various sizes and from all four regions of NHS England. We ensured that the sites represented a wide range in terms of levels of deprivation, and included both urban and rural areas. We will follow the development of CCGs in these sites over three years, from 2012 to 2015.

In year one, fieldwork was conducted between October 2012 and March 2013, which was the six-month period before CCGs took on full statutory responsibilities. We collected information through:

- examination of key documents relating to the CCG, particularly the constitution

- semi-structured interviews with key individuals

- observations of CCG board meetings, locality meetings or CCG-wide engagement events

- an online survey of member practices.

In both the interviews and the survey, particular efforts were made to reach general practitioners (GPs) who had no formal role within the CCG.

Interviews

Semi-structured interviews were carried out with a total of 74 individuals (Table 1). These included:

- CCG leaders (clinical and non-clinical), including the chair and accountable officer of each site

- GP members and practice managers

- senior managers from NHS England area teams and commissioning support units

- representatives of local medical committees.

The interviews covered:

- engagement with the CCG
- the role of the CCG in primary care development
- the impact of the CCG on clinical relationships.

Interview transcripts were coded thematically using qualitative data analysis software.

Table 1 Interview type

CCG leaders		CCG members		Senior PCT/ area team manager	Senior CSU manager	LMC representative
Clinical	Non-clinical	With a formal role in the CCG	No formal role in the CCG			
12	13	16	16	6	5	6

Notes: CCG, clinical commissioning group; CSU, commissioning support unit; LMC, local medical committee; PCT, primary care trust

Observations

We conducted observations of governing body, member council and locality meetings (where applicable) in each of the six sites (18 in total). Observation notes were coded thematically using qualitative data analysis software alongside the interview transcripts.

Survey of member practices

In each site, all local GPs were invited to complete an online survey. The survey was distributed directly to all member practices by email and CCG intranet systems. Practice managers and other personnel were also permitted to complete this survey.

A total of 232 responses were received across the six case study sites. Around three-quarters of the responses received were from GPs, with the remainder being mainly from practice managers. These responses represented approximately 20 per cent of all GPs across the case study sites, and a similar proportion of practice managers. Respondents were asked a number of questions on the following issues:

- their levels of engagement with the work of the CCG
- the role of the CCG in supporting improvement in general practice
- authority and accountability within the CCG
- the impact of CCGs on professional relationships, clinical practice and patients.

The survey was conducted between February and March 2013. A full summary of survey results can be downloaded from The King's Fund or Nuffield Trust websites.

Site profiles

CCGs across England are highly diverse in terms of population size and profile, and our case study sites reflect this. Table 2 provides a summary of the key characteristics. (Approximate values are given to protect anonymity.)

The box gives brief profiles of each site, capturing relevant points from the history of each CCG, its structure and any important contextual details.

Table 2 Case study site characteristics

Site	Population (thousands)	Number of practices	Approximate budget (millions)	Deprivation	Location
A	200–300	20–30	£200	Medium to low	Mainly rural
B	500+	60–70	£600	Low	Mixed urban/rural
C	100–200	30–40	£300	Very high	Urban
D	200–300	40–50	£300	High	Urban
E	100–200	10–20	£200	High	Urban
F	200–300	30–40	£300	Low	Rural

Selected details of our case study sites

Site A

Site A is a mid-sized CCG serving a mixed population that is largely affluent but with some significant pockets of deprivation. The population is older than the national average and has high rates of dementia.

The CCG was formed out of two practice-based commissioning groups. It has a partnership agreement with neighbouring CCGs and shares its accountable officer and chief finance offer with one of these. The CCG does not have a formal locality structure but does divide members into local groupings for the purposes of undertaking peer review and other activities. The main secondary care providers are located outside the CCG boundaries, making the CCG a minority commissioner in most cases.

Site B

Site B is the largest CCG in our research. It has a strong history of GP commissioning and had one of the highest take-up rates of GP fundholding in England. Overall, deprivation is low, although the population profile varies significantly across the site. Some areas report quality issues in primary care, and patient experience scores for GP services are significantly below the national average.

It has a locality structure with groupings based largely on former practice-based commissioning groups. More powers are delegated to locality level than in our other sites – each locality is allocated an annual commissioning budget by the governing body, and localities are allowed to keep a proportion of any underspend for reinvestment in local priorities.

Selected details of our case study sites *continued*

Site C

Site C is a small, urban CCG with the highest level of deprivation of our case study sites. Mortality rates from cancer and cardiovascular and respiratory diseases are very high, and measures of quality of life for people with long-term conditions are among the poorest in the country. Challenges for the CCG include high emergency admission rates and prescribing costs.

The CCG was formed on the basis of previous practice-based commissioning groups. It was originally conceived as two separate CCGs, but concerns around sustainability led to a merger, with some local leaders reporting a high degree of external pressure on this issue.

The CCG shares a key post with two other CCGs and collaborates with neighbouring CCGs through a regional network. It does not operate with localities and has a relatively large number of small and single-handed practices.

Site D

Site D is a mid-sized CCG formed out of a single practice-based commissioning group, with significant continuity in terms of personnel and projects. It operates in an urban environment serving a young, deprived population with high levels of mental health and substance abuse problems. Significant performance issues exist in local hospital trusts.

The CCG has close relationships with neighbouring CCGs and local authorities, including joint strategy and performance committees with neighbouring CCGs. However, there are no formal partnerships. The CCG operates with a number of localities that pre-date the CCG.

Site E

Site E is the smallest CCG among our case studies and consists of a highly cohesive group of practices with a strong local identity and history of collaborative working. It serves a deprived urban population with high mortality rates, particularly from conditions related to smoking and alcohol.

The CCG is part of a formal partnership with two neighbouring CCGs. The partnership has an overarching management team with a shared accountable officer and chief finance officer, and some shared committees. GPs in the CCG report historically poor relationships with the former primary care trust.

Site F

Site F covers a mid-sized population that is spread over a wide and largely rural area. It is one of the least deprived CCGs in England and has a population that is significantly older than the national average. Health care outcomes are generally good, although there have been high rates of health care-acquired infections in some providers.

There is a long history of GP commissioning and collaboration in the area. The CCG is part of a formal partnership with two neighbouring CCGs, through which an integrated commissioning plan and risk-sharing scheme has been jointly developed.

3 The evolution of clinical commissioning

Commissioning was introduced into the National Health Service (NHS) in England in the early 1990s, but has largely failed to bring about the expected benefits for patients (House of Commons Health Committee 2010; Smith and Curry 2011). This has been attributed in part to the lack of successful clinical involvement, as well as to periodic structural reorganisation. There is widespread agreement that active participation from clinicians is necessary for effective commissioning (Smith *et al* 2010). Without this, commissioners are unable to challenge providers effectively and are limited in their ability to make changes to services.

Clinical commissioning groups (CCGs) are the most recent policy initiative aimed at addressing this problem. In this section, we provide a brief account of previous attempts to expand the role of clinicians in commissioning, and describe what sets CCGs apart from these precursors. We also describe the process of establishing CCGs and how they relate to the other organisations introduced by the Health and Social Care Act 2012.

The history of primary care commissioning

For more than 20 years, attempts have been made to involve clinicians – particularly general practitioners (GPs) – in the commissioning of health services in England (*see* below). Similar developments have taken place elsewhere, for example, in the United States and New Zealand. The research conducted in a number of countries over this period points to some modest successes, but is by no means unequivocal. For a recent summary of the UK evidence, *see* Miller *et al* 2012. The following findings are of particular relevance to this report.

■ The most widely cited achievements have related to improvements in primary and community care, with less evidence of change in secondary care. GP commissioners have focused on those areas where they are most expert, such as widening the range of services available in primary care and developing community-based intermediate care services (Smith *et al* 2004; Smith and Curry 2011).

■ Primary care commissioners have been particularly successful in reducing the rate of growth in prescribing costs, although often only for a certain period of time, after which costs continue to rise at the same rate (Smith *et al* 2004).

■ GP engagement has typically been higher in schemes in which primary care commissioners have a greater degree of control and autonomy, such as GP fundholding in the United Kingdom or independent practitioner associations in the United States (Casalino 2011; Thorlby *et al* 2011) and New Zealand (Thorlby *et al* 2012).

■ Larger commissioning organisations have found it more challenging to engage local clinicians. For example, large total purchasing project sites in the 1990s had to invest considerable resources in managing internal relationships, and smaller projects made more rapid progress in achieving their objectives (Mays *et al* 2001). Similar results were reported for primary care groups and early primary care trusts (Regen 2002).

■ Overall, there is evidence that primary care commissioning has achieved most when there is effective clinical involvement (Miller *et al* 2012).

The box provides further detail on the history of clinical commissioning in England and the research evidence regarding it.

Primary care commissioning in England, 1991–2010

The earliest and most long-lived form of primary care commissioning, GP fundholding, was introduced in 1991, shortly after the creation of a purchasing role separate from service provision. Through this scheme, GPs could opt to control the budget for a defined range of elective care, outpatient and community health services, either on a single practice basis or through multi-fund groups composed of several practices. Participation was voluntary and uptake gradual, but by 1997 approximately half of all practices in England had become fundholders.

Throughout this period a number of other approaches were also developed. Most notably, 88 total purchasing pilots (TPPs) were established in two waves during 1995 and 1996. In TPP sites, GP-led groups were able to manage the budget for a wider range of services than was possible under GP fundholding. TPP sites varied widely in terms of their size and their scope. In principle, sites were able to take responsibility for the entire budget for hospital and community care, although none did so in practice, instead choosing to focus on specific areas of local concern or interest (Mays *et al* 2001).

In 1997, the new Labour government abolished both GP fundholding and total purchasing, highlighting concerns that the uptake of fundholding had been greater in more affluent areas and that it led to inequity of access to services for patients. In their place, primary care groups were established from 1999. These groups, composed of GPs and other professionals including managerial staff from health authorities, were originally intended as a 10-year project, over which time they would progressively take over more responsibilities from health authorities, ultimately becoming fully autonomous primary care trusts. However, in 2001, the government decided that all primary care groups would move straight to full primary care trust status from 2002, assuming full commissioning and public health responsibilities, as well as directly providing community and sometimes other (for example, mental health) services.

The shift from primary care groups to primary care trusts was often associated with a reduction in the level of influence wielded by clinicians within these organisations (Regen 2002; Smith and Walshe 2004; Bate *et al* 2007). Clinicians did, however, retain some influence through professional executive committees, although the power of these committees was variable and often less than had originally been envisaged in policy guidance. A national tracker survey of primary care groups/trusts suggested that most had failed to win the support of their local GPs (Wilkin and Coleman 2001).

In response to limited clinical involvement in primary care trusts, in 2004 the government announced the reintroduction of an adapted form of primary care commissioning known as practice-based commissioning (Department of Health 2004). From 2005 onwards, GPs across England formed themselves into practice-based commissioning groups, and were given an indicative budget by their local primary care trust. The extent of delegation of responsibilities varied, with some areas (for example, Cumbria and North East Lincolnshire) going further than others, but formal powers and accountabilities remained with the primary care trust in all sites. In many areas, this arrangement performed poorly due to difficult working relationships between practice-based commissioning groups and the primary care trust (Curry *et al* 2008).

A new approach: clinical commissioning groups

Clinical commissioning groups were first announced in 2010 (initially termed GP commissioning consortia) and began operating in shadow form before taking on their full legal responsibilities in April 2013. They represent a new departure from previous forms of clinical commissioning in a number of important respects.

- Membership of a CCG is mandatory for all general practices in England.

- CCGs are established as statutory bodies, and as such must fulfil a considerable number of legal responsibilities and structural requirements designed to ensure good governance and accountability to the public.

- CCGs control real rather than notional budgets, unlike practice-based commissioning (but like GP fundholding).

- In previous approaches, legal accountability remained with a managerially led structure sitting above the clinical group – health authorities in the case of fundholding, and total purchasing or primary care trusts in the case of practice-based commissioning. These organisations provided a safety net in case clinical commissioners were unable to control their costs or perform their duties adequately. CCGs, by contrast, are autonomous organisations exposed to full financial risk.

- CCGs must involve other clinicians besides GPs in their governing body, although the legal requirements for this are minimal (one nurse and one secondary care clinician in each CCG).

The wider commissioning environment in which CCGs are set is also different in a number of respects. First, the commissioning functions previously performed by primary care trusts are now split across three organisations – CCGs, local authorities (which control the public health budget) and the 27 area teams of NHS England (responsible for commissioning primary care and specialist services). These area teams also have a role in holding CCGs to account and providing them with developmental support.

Second, the nature of manager–clinician collaboration is intended to be radically different in the new system. In previous forms of clinical commissioning, particularly practice-based commissioning, this collaboration was characterised by a hierarchical relationship that often created significant tensions (Curry *et al* 2008). In contrast, CCGs are supported by commissioning support units, which are intended to have a commercial rather than managerial relationship with their CCG customers.

Third, CCGs also have an important relationship with the new health and wellbeing boards that have been established in local authorities. These boards are intended as a forum for strategic co-ordination and as a means of enhancing the accountability of the health system to the local population. CCGs have a legal obligation to consider the local needs and priorities identified by these boards, as laid out in their health and wellbeing strategies.

The complexity of this new commissioning system means that, despite their greater legal autonomy, CCGs may find themselves more strongly constrained than their predecessors were. Although accountability upwards to NHS England is intended to be less prescriptive, this is accompanied by accountability outwards to health and wellbeing boards, and inwards to the CCG's membership (Figure 1).

It is important to recognise, however, that there is some continuity alongside these changes. CCGs are not starting with a blank canvas. All the sites in our research were influenced by previous forms of clinical commissioning, often basing their boundaries on former practice-based commissioning groups and with many of the same individuals involved in leadership positions. This fits with other recently published research, which

Figure 1 The new commissioning system
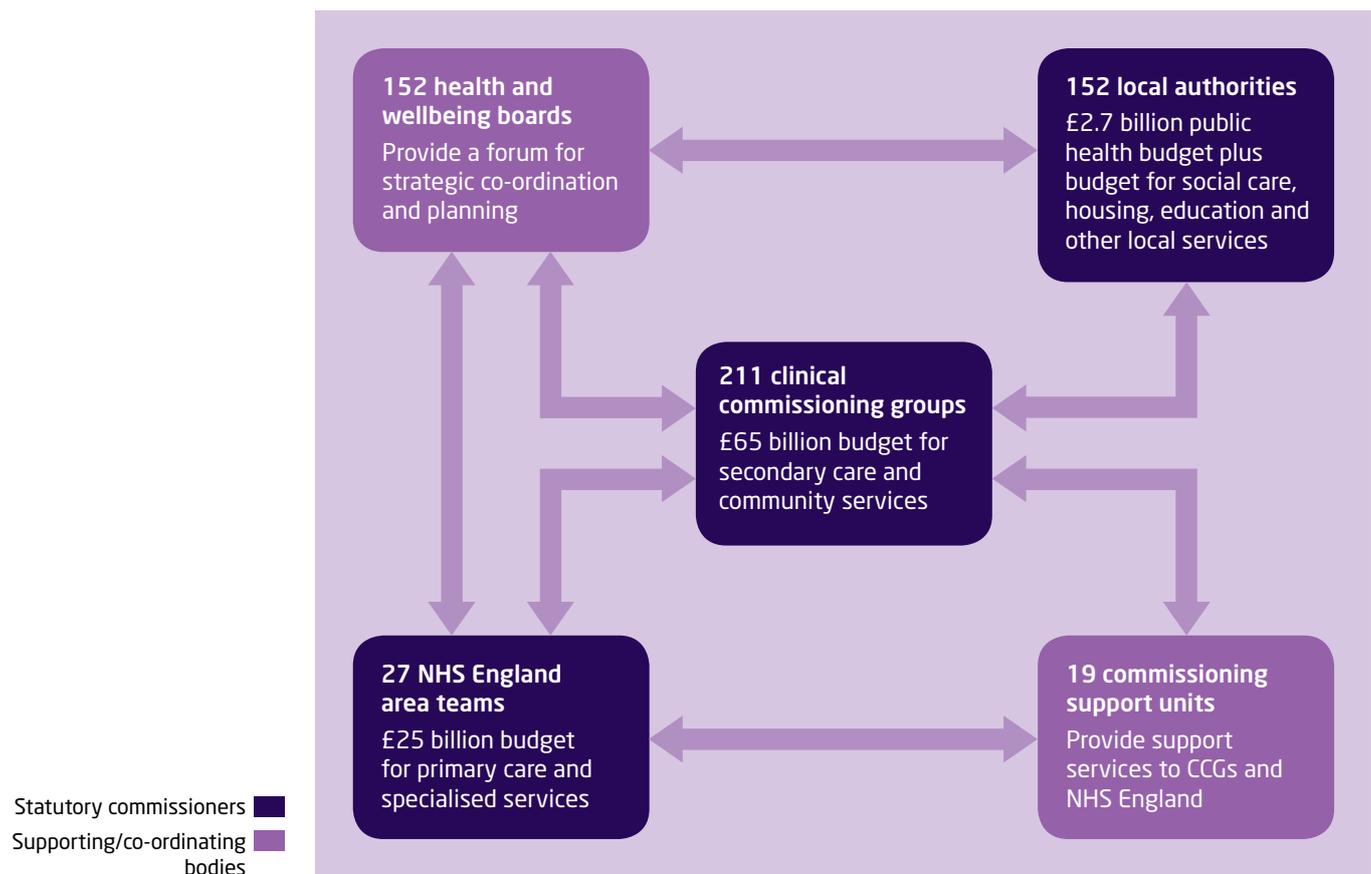
Source: Naylor *et al* (2013)

found that 80 per cent of CCGs across England were based entirely or substantially on former practice-based commissioning groups (Checkland *et al* 2012). This gives CCGs a foundation to build on, but does also heighten the challenge they face in distinguishing themselves from their predecessors.

The road to authorisation

Prior to taking on their full responsibilities in April 2013, CCGs had to complete an authorisation process designed to test their core competencies. All 211 CCGs were authorised, although 80 per cent failed to meet at least some of the assessment criteria. NHS England imposed significant restrictions on a small number of CCGs, limiting their ability to function autonomously until certain conditions have been met. Overall, CCGs in the south, the Midlands and the east of England were subject to more conditions than those in the north (Naylor 2013).

Echoing the findings of Checkland *et al* (2012), our research showed that the authorisation process had been highly demanding on the CCG leaders in our case study sites, and some interviewees reported that it had diverted energy from other core responsibilities, such as building relationships with local GP practices. This gave some practices the impression that the CCG was more preoccupied with 'jumping through hoops' than with improving patient care.

Our case study sites performed marginally better than average in the authorisation process. Two sites were fully authorised without any conditions, and others received between one and five conditions. (Across England, CCGs received a median of three

conditions, although some of these were removed prior to full authorisation in April 2013.) These results should be interpreted with some caution, however, as it is clear that even sites authorised with no conditions still face considerable developmental challenges.

It is evident that getting CCGs to the position where they are ready to take over responsibility for £65 billion of public money has been a significant undertaking – not only because of the requirements of the authorisation process, but because of the scale of the task and the demanding timeframe within which it has been completed. Although CCGs have now formally taken on their new responsibilities, the developmental challenge ahead remains daunting.

CCGs will be subject to an ongoing assurance process overseen by NHS England area teams, which will also provide developmental support to CCGs as required. Draft proposals for this assurance process indicate that it will consist of quarterly checkpoint meetings and an annual 'health check', assessing organisational capabilities, delivery and support needs. It might also include measures of quality in primary as well as secondary care (NHS England 2013a).

4 Governance arrangements and structures

In this section, we summarise how the clinical commissioning groups (CCGs) in our case study sites have been constituted, outlining the statutory requirements and describing the range of forms developed. The intention is not to give a detailed account of the governance arrangements in each site, but to highlight general themes before returning to our key research themes in sections 5 and 6.

The core structure of CCGs

CCGs have developed complex governance structures comprising multiple bodies and layers. The box summarises the main roles and structures found in most CCGs. Readers should note that the terminology used to describe these structures varies widely between CCGs.

Roles and structures within CCGs

The building blocks of a CCG are its member general practitioner (GP) practices. Each member practice typically has a nominated practice representative who attends meetings on behalf of the practice. The representative could be a GP or other health care professional, or, in some cases, the practice manager.

In CCGs with locality structures, some practice representatives will also become locality representatives (often selected through an election process). Locality representatives meet with other member representatives from their area for locality meetings, as well as coming together with other locality representatives to work across the CCG.

Every CCG is required to have a governing body. These are chaired by an elected GP chair and include a combination of member representatives (most commonly GPs), members of the executive team, lay members and representatives from other local partners. The exact composition differs, as some CCGs allow non-GPs to fill the member representative role while others require the role to be filled by a health care professional. A number of committees report to the governing body including, as a minimum, an audit committee and a remuneration committee.

continued opposite

Roles and structures within CCGs *continued*

CCGs are managed by an executive team and wider support team, who are employees of the CCG. Many of these roles have been filled by individuals previously working for primary care trusts. The number of employees depends partly on which functions the CCG decides to perform in-house and which to outsource to the commissioning support unit. CCG executives are led by an accountable officer who is legally accountable for the CCG's activities. Accountable officers may be clinicians, but in practice are more often professional managers.

Most CCGs have some form of member council that comprises either all practice representatives (in smaller CCGs) or locality representatives (in larger CCGs). The name and role of member councils varies by CCG, but in general terms is responsible for representing the membership and liaising with the governing body and executive team.

The wider structures that CCGs sit within also vary significantly, with some CCGs entering into partnerships or alliances with neighbouring CCGs. This can result, for example, in joint commissioning or risk-sharing protocols. Some also share senior executive posts across neighbouring CCGs.

Governance arrangements

CCGs are legally obliged to set out their agreed governance arrangements in a publicly available constitution. The constitution sets the 'ground rules' for the relationship between the CCG governing body and its members, as well as outlining the functions of the CCG and its constituent groups. Member representatives – on behalf of local GP practices – and all other members of the governing body must sign a copy of the constitution, confirming their commitment to agreed principles.

Roles and responsibilities

The constitution outlines the roles and responsibilities of the CCG as a whole, explaining the purpose of the organisation. These responsibilities include the duty to support NHS England in securing continuous improvement in the quality of primary medical services, in line with the requirements of the Health and Social Care Act 2012.

The constitution also outlines the responsibilities of the governing body towards its members, and the expectations placed on members. As an example, some of the principles in the constitution of site F are shown in the box overleaf. These illustrate how members are expected to work together and have joint responsibilities. Other constitutions include similar expectations, stating that member practices are accountable to each other and have mutual responsibility for ensuring the success of the CCG.

Responsibilities between members and governing bodies: example principles from a CCG's constitution

Governing body's responsibilities towards its members:

- to ensure that they are familiar with relevant policy and guidance

- to promote involvement of all members in the work of the CCG in securing improvements in commissioning of care and services

- to listen to the views of members in making decisions.

Members' responsibilities to the CCG:

- to work collaboratively and co-operatively with the CCG to achieve its aims as set out in the commissioning strategy and annual business plan

- to adhere to commissioning decisions made by the CCG

- to manage patient care within the budget delegated to practice level

- to seek to improve the quality of patient care and address areas of poor practice performance or care

- to be responsible collectively and severally for the delivery of the duties and functions of the CCG.

The Health and Social Care Act 2012 gives CCGs the power to apply to NHS England to have a member practice expelled from the group in extreme circumstances. Only one of the six constitutions reviewed went into any significant detail about what those circumstances might be. These included:

- refusal to engage or participate with CCG activities

- failure to demonstrate active effort to address agreed practice/clinical behaviours

- failure to support local plans

- no commitment to supporting other practices or the CCG by sharing expertise and/or delivery where capacity and resources allow.

Member representation

Local GP practices are represented at various levels in a CCG's governance structure. Most of the engagement and decision-making is conducted through practice representatives, who are expected to act on behalf of their practice and are responsible for disseminating information back to members. Some constitutions indicate that practice representatives will be held partially accountable for the behaviour of their practice colleagues, stating that it is their responsibility to 'ensure that their practice… adopts good practice as agreed by the group'.

Practice representatives come together to form the members' council, the fundamental purpose of which is to ensure a strong clinical voice in the CCG. The precise responsibilities delegated to the members' council differ, but often include:

- approving changes made to the constitution

- agreeing the vision and values of the CCG

- approving the commissioning plan and annual reports and budget

- approving arrangements for supporting NHS England to improve general medical services.

Some CCGs specify that member representatives must be GPs or other health care professionals from the practice, while others also include practice managers or administrators. The constitution for CCG F states that practice managers are encouraged to attend and contribute towards members' council meetings but do not have voting rights. The varying composition of member representatives, and therefore members' councils and governing bodies, means that some CCGs do not have a GP majority on the board or indeed a broader clinical majority.

Managing conflicts of interest

All constitutions must contain details about the management of conflicts of interest, defining what constitutes a conflict and how the CCG will respond. There was very little variation in these provisions between the six constitutions in our sites, and those there were related to which individual or committee was designated to manage conflicts of interest. Typical arrangements for the management of conflicts included the following.

- The CCG will create and publish a register of members' interests.

- The accountable officer will ensure that for every interest declared, arrangements are in place to manage potential conflicts, and that these arrangements are agreed in writing.

- These arrangements may, for example, describe when an individual should withdraw from a specified activity, and how the individual's engagement in that activity will be monitored.

- Conflicted individuals will be excluded from the relevant parts of meetings; when more than half of the members of a meeting are required to withdraw, the chair will determine whether or not the discussion can proceed.

- When insufficient individuals remain unconflicted, the decision in question will be made either by a different sub-committee or group within the CCG, or by an ad hoc group that could include members from another CCG or the health and wellbeing board.

- When it considers it prudent, the governing body can seek additional scrutiny of commissioning decisions, by either the CCG's own audit committee or external individuals.

The interviews conducted in this research identified a degree of awareness of and, at times, anxiety about potential financial conflicts of interest. As one CCG leader commented, it was of great importance that they avoid being seen as 'feathering our own nests'. However, one area team manager suggested that some GPs may not yet have understood how far conflicts of interest are likely to be a constraining factor in the future, and our research suggested that some GPs (albeit a minority) remain sceptical about the intentions of the GPs on the governing body.

Knowledge of the constitution

Given that the constitution is legally binding and includes important agreements about expected behaviours, it is worth noting that across all the sites, in-depth knowledge of the constitution was scarce, both in the governing body and the membership. Despite the fact that sites had held workshops and debates with GPs, often over several months, many GPs who were, nominally, signatories to the constitution expressed little knowledge of its contents.

> *I think there's a constitution went round and we signed it, can't remember what it said.*
>
> GP, site D

> *I feel when I'm asked to make decisions, I mean, for example, recently on the constitution, I'm not that interested in it and I don't have that much understanding in terms of the legal implications and all of that.*
>
> Practice representative, site E

Variations in structure

Despite tight controls over some aspects of CCG design, the internal structure of individual CCGs and the nature of their relationships with others vary between sites.

As shown in Table 3, the greatest predictor of how a CCG is organised is its size. The two largest CCGs in our research do not have formal alliance or partnership agreements with other CCGs, whereas the smaller sites do have such arrangements in place. The largest three CCGs operate with a locality structure, while the remaining – smaller – CCGs do not. The proportion of the management allowance spent on internal staff versus external support is not related to the size of the CCG.

Table 3 Summary of CCG structures by size of CCG

CCG	Population (thousands)	Alliance/partnership arrangement	Shared posts	Use of localities	Management spend on CSU (out of £25)
B	500+	No	Yes	Yes	£12.50
D	200–300	No	No	Yes	£9
F	200–300	Yes	No	Yes	£17
A	200–300	Yes	Yes	No	£7
C	100–200	Yes	Yes	No	£10
E	100–200	Yes	Yes	No	£10

Notes: CCG, clinical commissioning group; CSU, commissioning support unit.

Locality structures have been put in place in approximately 70 per cent of CCGs across England (Checkland *et al* 2012). Three of our case study CCGs operate with a locality structure. In all three, the boundaries of these locality groups are a continuation of practice-based commissioning groups or less formal neighbourhood planning groups. The purpose of locality groups is broadly similar across the sites, serving as an

engagement mechanism by which information can be passed between practices and the governing body, and as a means of identifying local priorities. One practice representative described how each locality group was prioritising slightly different issues.

> *In our locality our priority is access… but in another locality I know for a fact that they're worried about their long-term condition patients… The CCG at the moment is encouraging the localities to explore this and they're showing us that they have some funds which we can use.*
>
> Practice representative, site B

In our largest CCG (site B), localities are given a greater degree of autonomy and play a very important role in the organisation. In this site, localities are allocated an annual commissioning budget and allowed to keep a proportion of any underspend for reinvestment in local priorities.

An early evaluation of CCGs found that the precise responsibilities of locality groups had not been agreed in many CCGs. In some areas – particularly larger CCGs – there was an aspiration to develop 'strong localities' to retain the engagement of practices, but leaders were struggling to define what this would mean, and exactly which powers would be delegated to locality level (and what the resource implications would be in terms of staffing). There was some concern that locality groups were not as powerful as originally envisaged (Checkland *et al* 2012).

Partnerships with neighbouring CCGs

Four of the sites in this research have a formal partnership with their neighbouring CCGs (over and above meetings to keep one another updated on their work programme, which all of the CCGs had established). For example, CCG F has signed a three-year integrated commissioning plan as part of its partnership arrangements with two other CCGs. All the providers in the region have one of the three CCGs designated as the lead commissioner in an effort to reduce the procurement burden and co-ordinate the management of the providers. This partnership has also set up a financial risk-sharing scheme in which the cost of resource-intensive cases (for example, continuing health care) are distributed among the sites on the basis of each CCG's population size.

Similarly, CCG C is a member of a regional network with eight neighbouring CCGs. The network has established an element of financial risk-sharing as well as a joint safeguarding service.

The benefits and challenges of these partnership arrangements will become evident over time. At present, there is enthusiasm and optimism from CCG leaders about the advantages, particularly for small CCGs. As one CCG leader described, it would be a 'crowded field' to have three different commissioners interacting with a single acute provider.

> *We're getting to the point where individual CCGs are content to see leadership on certain service areas taken by a clinician operating out of a different CCG.*
>
> Governing body member, site A

However, there are some signs that CCGs involved in collaborative arrangements may find it difficult to work as part of a formal partnership while also retaining buy-in from local GPs and an individual identity.

Management support

Each CCG has been given an allowance of £25 per head to spend on management. CCGs can decide how much they want to spend internally and how much they want to outsource to commissioning support units (CSUs) or other external organisations (*see* Table 3). The types of support they can receive include:

- health needs assessment

- business intelligence services

- support for service redesign

- agreeing and monitoring contracts

- communications and engagement

- back office functions (NHS England 2013d).

The use of commissioning support varies significantly among CCGs. Leaders from site F described wanting an internal management team that was 'small and agile' and so made the decision to buy in a large amount from the CSU, spending £17 of the £25 on commissioning support. This scaled-back structure was also felt to avoid replicating the previous primary care trusts and therefore to be more in the 'spirit of the reforms'. However, as another leader from the same CCG commented, it does leave them exposed to risk and reliant on the CSU performing well.

> *I hope our confidence is not misplaced. But there's a huge risk around this, huge.*
>
> Governing body member, site F

Both CCGs and CSUs are being asked to introduce significant cultural change. The new commissioning system requires that CSUs adopt a commercial mind-set focused on serving the needs of their customers, while CCGs, in turn, need to become 'intelligent clients' of commissioning support. Previous research has shown that primary care trusts often struggled to procure and use commissioning support services effectively (Naylor and Goodwin 2010) and it is to be expected that CCGs will encounter similar difficulties, particularly at first while they attempt to define with greater clarity what their support needs are.

Other sites indicated the need for relationship-building between the CCG and CSU. Participants noted that they had not yet developed trust in their CSU and that they hoped the CSU would be able to match their expectations. One CSU lead suggested that CCGs might outsource more functions to CSUs once they had proved themselves trustworthy, arguing that CCGs might not currently have got the balance between internal investment and outsourcing right.

> *I would question whether some of them have delivered maximum efficiency… I think that over time they will come to realise that actually it is safe, it is working… and so we'll see a drift.*
>
> CSU lead

Working with other local partners

Arrangements for involving other local partners in the governance of CCGs had been developed in all of our case study sites and are cited in their constitutions. However, at the time of conducting this research, the nature of these relationships in practice varied greatly, partly because many of the partners were also new, emerging organisations. Some initial findings from the interviews and observations are outlined below.

NHS England area teams

NHS England area teams have a complex relationship with CCGs, involving three very different roles (NHS England 2013a):

- a developmental role – providing CCGs with support

- an assurance role – holding CCGs to account

- a co-commissioning role – working as a partner in commissioning local services.

As described earlier, CCGs also have a responsibility to support NHS England in its duty to improve primary care services.

Many of the NHS England area team staff had previously worked at primary care trusts and often had existing relationships with colleagues in some CCGs. However, area teams cover wider areas than did the primary care trusts that preceded them, and many staff were shed in their creation. The level of familiarity with each CCG therefore varies, with area teams having stronger relationships with some local CCGs than with others.

Because CCGs and area teams had both been heavily focused on becoming established as new organisations, considerable uncertainty about how they would work together remained at the time of our fieldwork. Half of the sites reported that relatively late appointments in the area teams meant that there was ambiguity about relationships, roles and responsibilities. Trust between the organisations was acknowledged as being very important because of the need to work closely together and the partial overlapping of roles (*see* Section 6).

Health and wellbeing boards

Health and wellbeing boards have been established as a forum for strategic co-ordination and to support CCGs and local authorities in developing a joint strategic needs assessment. As with the NHS England area teams, there was uncertainty in our research sites about precisely how they would work with health and wellbeing boards. Several sites were optimistic about the early development of these relationships based on their experience of working with the shadow health and wellbeing boards. However, one site voiced concern about a lack of clarity on how the CCG and the health and wellbeing board would work together, feeling that there were not enough places on the board for all of the CCG chairs in the local area, resulting in a perceived imbalance in favour of the council.

GP provider organisations

A growing number of practices across the country belong to organisations or networks of various kinds that provide extended primary care services (Smith *et al* 2013). These pre-date the formation of CCGs and will be an important partner as CCGs attempt to stimulate the growth of innovative models of care in the community. The interactions

between the two sets of organisations will vary depending on the configuration of local provider organisations and existing relationships with CCG leaders. In the case of super-partnerships, for example, the practices in the group are geographically connected and are likely to be located within the boundaries of a single CCG. In contrast, federations or networks can be based on a dispersed group of practices that may span a number of CCGs.

While CCGs will need to work closely with GP provider organisations, this also has the potential to create conflicts of interest. We observed this balance being struck in one of our case study sites, where GP leaders sought to promote membership of a local provider organisation without leaving the CCG leadership heavily conflicted.

Local medical committees

All sites reported constructive relationships between the CCG and their local medical committee (LMC). CCG leaders had often been members of the LMC and so had pre-existing personal relationships.

There was, however, an expectation that relationships would not always be entirely cordial in future – as one LMC representative commented: 'there are going to be some clashes' and therefore it was 'important to keep a little bit of a distance'.

The LMC representatives were clear that their role was to support the GP membership and were conscious that their relationship with the governing body could become fractious if there are instances of CCG performance management leading to sanctions on practices. For this reason, many sites felt that an individual could not be a member representative for the CCG as well as working for the LMC.

Public and patient involvement

CCGs have a legal duty to engage patients and the wider public in their commissioning activities, but there is considerable flexibility in how this can be interpreted. One CCG had agreed their priorities with members of the public, while others intended to discuss commissioning plans with members of the public in future and to consult when making changes to clinical pathways.

Discussions were observed at governing body meetings about strengthening the role of the public and patients in the procurement process, and the involvement of advocacy groups. The rationale was partly that CCGs will inevitably have to take difficult decisions and that these might be more acceptable if the public is engaged and aware of them from an early stage.

> We're doing a lot of work at the minute to engage the public so that it's their organisation… We need to have the population on board and as partners because if we need to take some difficult decisions in the future it will be easier to do that.
>
> Governing body member

Mechanisms described for communicating with the public included patient discussion groups, online surveys, and groups set up by the local authority for their consultations. However, exactly how CCGs will engage with and use information from the public and patients remained largely undetermined.

CCGs were perceived by some to have an in-built advantage over primary care trusts when it came to engaging the public because of the direct patient contact and high level of trust that exists between doctors and their patients. Some suggested that

public acceptance of controversial decisions led by GPs may increase as a result of this trust. However, research indicates that there is little evidence that primary care-led commissioning promoted increased patient and public involvement in the past (Dowling and Glendinning 2003; Smith and Curry 2011; Miller *et al* 2012).

NHS England has indicated that the assurance process being developed for CCGs will 'focus heavily on the role of CCGs in securing patient and public engagement' (NHS England 2013a, p 6). This may encourage CCGs to give further thought to the issue of how they will draw on information from these sources in their commissioning processes.

Summary

The constitutions of our sites had many similarities, but there were also some significant differences, such as in relation to the sanctioning of underperforming member practices, or which professionals are permitted to become member representatives. Despite the importance of the constitution in outlining these arrangements, there was limited knowledge of its contents in all sites.

The use of localities and formal arrangements with neighbouring sites appears to be dependent on the size of the CCG, with smaller CCGs more likely to be sharing posts and part of a risk-sharing scheme with another CCG. The use of CSUs and connections with other local partners varied slightly, and relationship-building with external organisations in the new system continues.

Despite there being a legal duty for CCGs to engage patients and the wider public in their commissioning activities, exactly how CCGs will engage with and use information from these groups remained largely undecided.

5 The role of members within clinical commissioning groups

Considerable value has been placed on the role of general practice members of clinical commissioning groups (CCGs). The authorisation process, for example, required that each CCG demonstrate 'significant engagement from its constituent practices' (Department of Health 2011, p 13). The previous section showed how this is reflected in CCGs' constitutional arrangements, which require general practitioner (GP) practices, particularly practice representatives, to participate in the CCG and work collectively to meet its aims. Similarly, governing bodies are required to engage with member practices in a number of ways. The following section sheds light on how effective these arrangements are in practice, focusing specifically on the levels of ownership and influence members feel they have, and how engaged they are in the work of the CCG.

Ownership

As a membership organisation, CCGs are generally understood to be 'owned' by their members: clinical leaders are elected to the governing body by member practices, and practices agree to the basic rules governing the CCG through ratification of its constitution.

In our case study sites, we found a great variance of opinion about the concept of ownership. Overall, 45 per cent of survey respondents agreed or strongly agreed that 'the CCG is owned by its members and feels like "our organisation"'. However, the figures varied considerably among sites and by respondent type. Members without a formal role in the CCG were considerably less positive on this issue than were members with a formal role, particularly those on the governing body (Figure 2).

Comparing responses across sites, the results suggested a trend for the sense of membership to be greater in smaller CCGs – with the percentage agreeing or strongly agreeing rising from around 37 per cent of respondents in our largest CCG to 56 per cent in the smallest (Figure 3).

This variation was also revealed in interviews with CCG members. Although some interviewees expressed feelings of solidarity with fellow members and a sense that 'we're all in it together', others were highly sceptical of the notion of the CCG being owned by its members. It is clear that some GPs see the CCG as an administrative structure sitting above practices, rather than something that is composed of and led by its members.

It's more like a partnership between the practices than a top-down relationship.

Practice representative, site B

The concept of it being something I'm a member of feels completely alien. It feels like it's just the [primary care trust] with the same characters, doing the same stuff that I don't like, carrying on, but notionally called a clinical commissioning group, rather than a [primary care trust].

GP, site B

Figure 2 The CCG is owned by its members and feels like 'our organisation'

Disagree or strongly disagree ■
Neither agree nor disagree ■
Agree or strongly agree ■
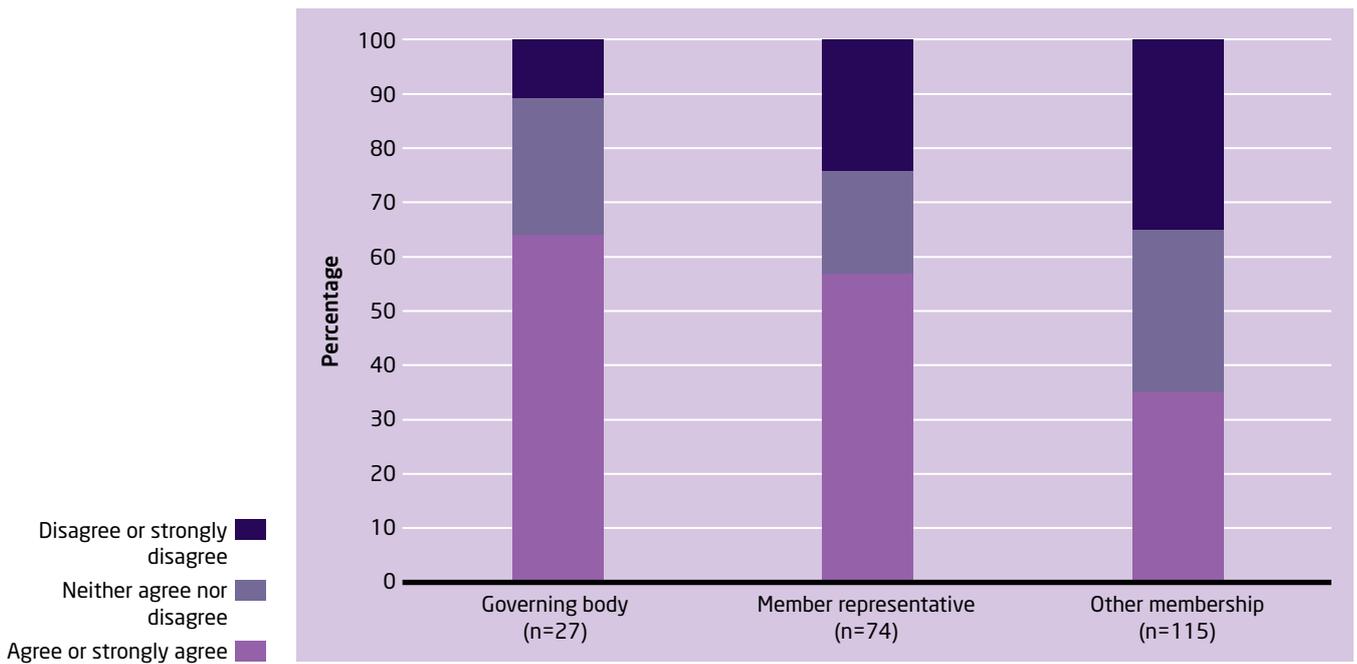
Figure 3 The CCG is owned by its members and feels like 'our organisation': percentage of all respondents agreeing or strongly agreeing, by site

> > > **Increasing CCG population size** > > >
(Scale removed to preserve site anonymity)
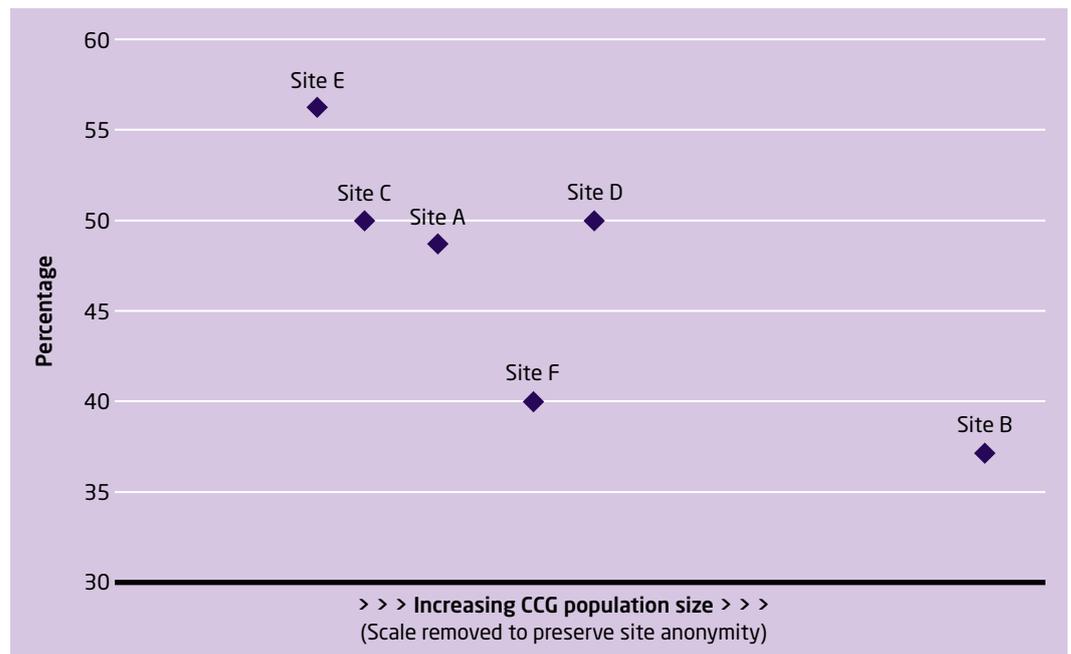
In larger CCGs such as site B, members commonly reported feeling more a part of their locality than of the CCG itself. This was often due to closer historical relationships or shared local issues, such as having a common secondary care provider or a similar patient profile. Some saw the CCG as a remote structure built on top of the more familiar locality groupings inherited from previous initiatives.

I feel much more a member of the locality… I feel the locality comes first.

Practice representative, site B

Influence

An important aspect of the relationship between member practices and the governing body is whether members feel that the influence they have over decisions is in line with the national rhetoric of CCGs being bottom-up, clinician-led organisations.

Overall, almost half of all respondents to our survey indicated that the decisions made by the CCG reflect their views and those of colleagues, with less than one-fifth (18 per cent) disagreeing. One-third remain neutral or uncertain, perhaps reflecting the newness of the organisations.

As previously, there is some variation between respondent groups: those not involved in decision-making processes were less certain about how well their views were being represented (with 61 per cent being unsure or disagreeing; Figure 4).

Figure 4 Decisions made by the CCG reflect the views of me and my colleagues
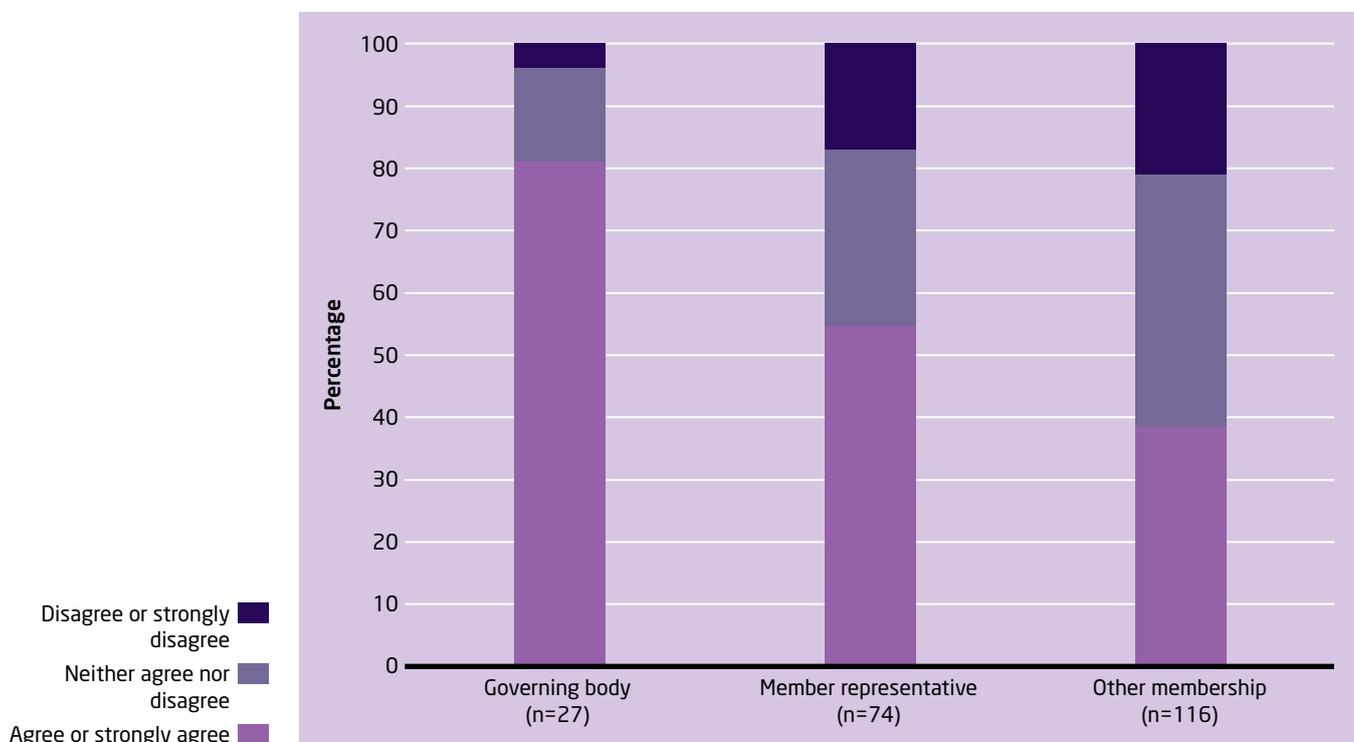
Nonetheless, participants were significantly more positive about the influence they wielded over their CCG than that they had over the former primary care trust (PCT). Forty-two per cent of respondents agreed that they could influence the work of the CCG if they wanted to (compared with 31 per cent who disagreed), with only 12 per cent feeling as though they could have influenced PCTs in the past.

These results can be compared with those of surveys conducted in 1999 and 2000, in which three-quarters of GPs indicated that they had little or no involvement in the decision-making processes in primary care groups and PCTs (Regen 2002). Many interviewee participants in our research felt that the GP voice was better represented in CCGs than it had been in PCTs.

> *I think that's the first time I've ever felt as a GP that actually I could have some input into changes and having a voice.*

> GP, site C

One important issue is the relative roles and powers of members' councils compared with those of governing bodies. Often there was an understanding that members' councils would play an instrumental role in setting the direction taken by the CCG.

However, our research highlighted that these boards were sometimes underdeveloped and failed to wield significant power in practice. When one GP practice representative in site F was asked whether they had witnessed the membership strongly influencing the CCG, the reply was: 'not yet, but I think it will happen, I hope so and I would be very disappointed if it didn't'. In another site, the accountable officer was very clear that the 'powerhouse' of the CCG was the members' board and that the governing body was not in charge and did not have authority over member practices.

However, when one of these meetings was observed, there was very little challenge from GP representatives to the plans being proposed by the executive, despite the fact that we were told that previous agreements had been reneged on.

Some noted that even where there was a formal decision-making process to involve member GPs, the necessary information was not always easily accessible, usually due to the volume of documentation. This had resulted in decisions being made without comprehension of all the information, and had left one practice manager feeling: 'we've made some decisions based on pretty shaky foundations'. A GP from the same CCG commented: 'I had very little knowledge and my vote, I don't know how useful that was'. Without adequate administrative support for member representative bodies within the CCG, there was a suggestion that practices may be 'getting a little bit disillusioned'.

The election of clinical representatives is an important way in which members are able to influence the governance of the CCG. However, some participants raised concerns about the processes for appointing clinical members to leadership roles in the CCG. Although all sites had at least nominally gone through an election process, few interview participants recalled this being a competitive process, and in several CCGs it was reported that many key posts were uncontested. In some sites, local medical committees were used to oversee the elections and were seen to add legitimacy to the process.

Similar concerns were raised about single-person shortlists for accountable officer posts and other non-clinical roles, with one participant recalling a particularly negative process.

> *The rhetoric was they would be able to choose their management support. What actually happened in practice, like everywhere else, is [the accountable officer] was interviewed as one person, on a one-person shortlist, and appointed, and heavy, heavy, heavy pressure was put on the chairs and everything, so they really didn't have an alternative.*
>
> Governing body member

Levels of engagement

In addition to assessing the level of ownership and influence members feel that they have over the CCG, our research also explored levels of 'engagement' among members. This refers to the extent to which members are aware of, involved with or supportive of the activities of the CCG.

In order to understand engagement in CCGs, it is useful to consider the findings of previous research on practice-based commissioning. A national evaluation by Curry *et al* (2008) described four main groups with differing attitudes towards practice-based commissioning:

- highly engaged leaders

- passive supporters agreeing with the principle of GP commissioning but wanting others to take the lead

- largely disengaged followers complying with basic requirements but doing little beyond this

- dissenters objecting to the principle of GP commissioning.

The research by Curry and colleagues found that the majority of GPs fell into the second or third categories, with relatively few highly engaged leaders or active dissenters. Our research showed a similar spectrum of engagement, with levels varying widely among members.

The reasons GPs gave to account for their levels of engagement or disengagement (Table 4) highlight how divided they are with regard to clinical commissioning: factors that motivate some GPs to get involved act as a disincentive to others.

Table 4 Typical reasons for engagement and non-engagement

I am engaged because:	I am not engaged because:
I want to have some influence over which services are commissioned locally and how the CCG is run, as I believe this will be in the interests of my patients.	I am sceptical about the concept of CCGs and do not believe they will deliver improved services for patients. I can serve my patients best by concentrating on my core clinical duties.
It is my responsibility to get involved in the CCG's activities and to find out what is happening within the CCG.	There is a lack of communication from CCG leaders to the membership and I don't feel informed about what is going on.
As a clinician, I have a responsibility to be resource conscious and to consider how we can do the most good with finite resources.	Clinicians should not be responsible for decisions around resource allocation as this is in conflict with being the advocate for individual patients.
The CCG creates a sense of collective ownership because the governing body is made up of local GPs who represent local practices.	My potential contribution to the CCG is being overlooked because I am a practice nurse/practice manager/health care assistant and all the attention is focused on GPs.
The CCG is a continuation of the local collaborative work that general practices were already involved in through practice-based commissioning.	The leaders of the CCG are the same individuals who were involved with the PCT – not much has changed. I am still being told what to do by a group of people.
I am familiar with and respect the clinical members of the governing body. The clinical leaders are approachable and engaging.	I do not respect the clinical members of the governing body and do not feel they represent my point of view.

Overall, nearly three-quarters (73 per cent) of survey respondents reported feeling engaged with the work of the CCG to some extent, but, as Figure 5 shows, only one-quarter of those without a formal role in the CCG said that they feel highly or moderately engaged, with 43 per cent reporting feeling disengaged (including 14 per cent who feel 'completely' disengaged).

Furthermore, the figures may overestimate actual levels of engagement, as engaged members might have been more likely to respond to the survey. It is also interesting that only half of practice representatives felt either highly or moderately engaged in the work of the CCG.

There was also some evidence of a relationship between the size of the CCG and the levels of engagement, with a slight trend for higher levels of disengagement in larger CCGs (31 per cent of GPs being moderately or completely disengaged in our largest site, versus 19 per cent in the smallest). This trend is consistent with earlier research on total purchasing pilots (Mays *et al* 2001) and primary care groups and trusts (Regen 2002) (*see* p 7).

Figure 5 How engaged do you feel with the work of the CCG?
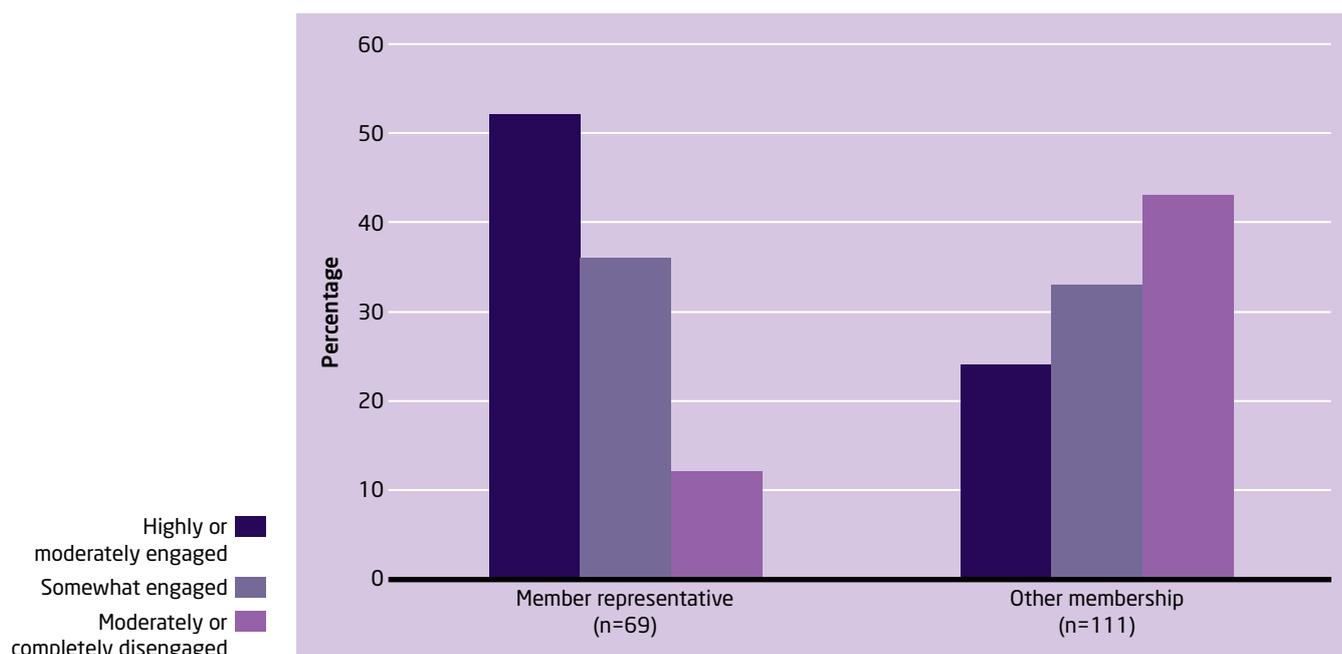
However, participants in several sites argued that, overall, engagement is currently significantly better than it was under practice-based commissioning. Furthermore the creation of CCGs with control of real budgets has injected a new energy that was previously lacking, particularly in the later years of practice-based commissioning.

> *I was entirely cynical about these reforms… But I do have to say, in terms of the GP commitment to it, I've had to eat my words. And that's what will make the difference, is that they want this to work.*
>
> Accountable officer

CCG leaders were clear that while it is not necessary for all members to be actively involved in the work of the CCG, it is important to have high levels of 'buy-in', so that members feel a sense of collective ownership and responsibility towards decisions taken. Some CCG leaders were pragmatic about how this could be achieved, with one non-clinician governing body member stating that too many meetings with GPs could saturate their interest:

> *…the system will fall apart, the GPs will lose interest, we'll waste time and we won't get anything done… [clinical engagement is] an expensive input and we need to use it well.*
>
> Governing body member (commissioning lead)

A distinction can be made here between the two functions of the CCG outlined in Section 1. The first function of CCGs – commissioning secondary care services – does not necessarily require the active involvement of a large proportion of GP members: it requires only what is sufficient to ensure that enough clinical expertise is available to support decision-making. However, the second function – primary care development – is dependent on all members engaging with this agenda and accepting the role of the CCG in supporting improvements in general practice.

> *More than anything, you need buy-in to the difficult decisions because, if they [GPs] decide not to do it, it's going to be very difficult to deliver it.*
>
> Accountable officer

Facilitators and barriers to engagement

As we have seen, levels of GP engagement in CCGs are highly variable. Different CCGs have employed different mechanisms to encourage member participation, and these have met with varying success.

CCG-wide engagement and educational events were particularly valued by CCG leaders and members alike. These generally took the form of a regular half-day event at which members of the governing body could address the membership, ideas could be exchanged and developed, information could be shared, representatives from other services could be invited to speak and educational sessions could be delivered. Participants noted, however, that these events come at a cost, as the CCG has to provide funding to allow GPs to arrange cover for their absence from their practices.

We found that early successes had played a critical role in engaging GPs in some CCGs. Some of these were from the perspective of patients (for example, a new care pathway seen to improve the quality of care), while others were from that of clinicians (for example, mechanisms to improve communication channels and processes between general practice and secondary care). One site had initiated an innovative visiting service that was seen to provide patients with a valuable service while also relieving pressure on general practices. Tangible achievements such as this were often cited by GPs as influencing their decision to engage with the work of the CCG – echoing findings from earlier research that emphasised the importance of 'early wins' in securing GP engagement in primary care groups and practice-based commissioning (Smith and Goodwin 2006).

In addition, a number of communication mechanisms had been developed in our case study sites to support member engagement further, including the following.

■ A telephone 'hotline' gave GPs direct access to members of the governing body on an ad hoc basis.

■ CCG websites or intranets provided ready access to information, as well as a means of communicating with other individuals within the CCG. For example, one site had introduced a notification system so that GPs could feed back any concerns about commissioned services.

■ Practice visits were reported by some to be a good opportunity for CCG leaders to meet GPs on their own territory and exchange information, seek volunteers and gain an idea of what services needed to be commissioned.

However, engaging members with the work of the CCG was not always easy. The most commonly cited barrier was a lack of time and capacity in general practice. The workload in primary care was described as being 'horrendous' and increasing as a result of rising demand, tighter contractual settlements and wider policy measures such as the new requirement for general practices to register with the Care Quality Commission for licensing and inspection. This climate places significant constraints on the ability of many GPs to become involved in their CCG, as described in other recent research (Smith *et al* 2013).

The financial environment was also identified as being likely to make it more difficult for CCGs to sustain member engagement. Some GPs were less attracted by involvement in commissioning at a time of budgetary stringency, fearing that their main responsibility would be to perform a rationing function, which over time could damage their relationship with patients and risk eroding public trust in the profession.

> *The idea that it's GP commissioning, it just doesn't seem plausible. It seems to be about GPs taking the responsibility for horrible rationing decisions.*
>
> GP, site B

Other GPs argued that this concern was overstated and that balancing the concerns of the individual patient against a responsibility towards the wider system has always been a central part of a GP's role.

Communication issues within the CCG were another barrier to engagement cited by some GPs involved in our research. For example, these included:

- a reliance on one individual to disseminate information from CCG meetings or distribute news bulletins, resulting in a delay before all members of staff had received an update

- the volume of information coming from the CCG or being requested by it being such as to overwhelm

- 'gaps' in the information provided by the CCG, or information being provided in a format that was not meaningful to GPs

- no response being received to queries submitted by members to the governing body.

This combination of practical constraints and principled objections mirrors the barriers described by research into earlier forms of primary care commissioning, which identified limited capacity and anxieties about the impact on GP–patient relationships as being among the most significant concerns (Regen 2002).

Summary

The majority of respondents to our survey did not feel that their CCG was 'owned' by its members, despite CCGs being intended to be membership organisations that represent the views of their GP practices. Interview data provided a mixed picture, with some interviewees expressing solidarity with other members, while others felt entirely disengaged from the CCG, both as an organisation and as a collective identity.

CCG members had similarly mixed feelings on the question of the degree of influence they wielded over decisions made by the CCG. However, it was clear that most felt they had more opportunity to influence the CCG than they had the former PCT. The strength and effectiveness of the member council was identified as important in securing this influence.

Predictably, levels of engagement varied widely, as did the reasons for not being involved. A small number of GPs chose not to be involved because they were opposed in principle to the notion of clinical commissioning, whereas others simply wanted to focus on their clinical role. Sustaining the interest of currently engaged GPs, as well as securing more engagement from others, will continue to be a crucial issue for CCGs if they are to maintain their 'bottom-up' ethos.

It should be acknowledged that our survey represents perceptions at one moment in time, and there was some suggestion that CCG leaders may be able to invest more resources into building relationships with members and creating a sense of shared ownership now that the authorisation process is complete. Our research will continue to track attitudes and levels of engagement over time.

6 Supporting primary care development

At the start of this report, we argued that clinical commissioning groups (CCGs) have an important role to play in supporting quality improvement in general practice. This role goes to the heart of the relationship between CCG leaders and members, and has been the subject of considerable debate in our case study sites and nationally. In both our qualitative work and our survey, most general practitioners (GPs) felt that there is a legitimate role for CCGs to play. The more difficult question is defining what exactly that role should be, and where it should begin and end.

In this section we discuss how the CCGs in our research are interpreting this responsibility, explore what leaders and members consider to be the proper role of CCGs in supporting changes in general practice, and consider the mechanisms at their disposal to do so. We conclude by asking whether CCGs will be more or less able to support improvements than were the primary care trusts (PCTs) that preceded them.

Understanding the role of CCGs in primary care development

Most CCG leaders involved in our research accepted that CCGs need to play an active role in primary care development, but several expressed some degree of unease about the difficulties involved in performing this role appropriately. Clinical leaders, in particular, were keen to avoid entering into any form of direct performance management relationship with their peers.

Referral and prescribing behaviours have the most direct connection to CCG business, and some interviewees felt that CCGs should limit their involvement to these aspects of general practice. Others, however, felt that CCGs do need to take an interest in other elements, such as access, workforce planning and the quality of facilities.

> If you go back to the basic rationale of what we're trying to do, how on earth are we supposed to shift care closer to patients if we can't develop the infrastructure and workforce that's out there?
>
> Governing body member, site E

It was striking that a large majority of the GPs who responded to our survey believed that CCGs have a legitimate role in influencing member practices in terms of their referrals, prescribing, access issues and patient experience (between two-thirds and three-quarters of respondents, with only 10–20 per cent disagreeing). A smaller majority (55 per cent) also agreed that CCGs have a legitimate role in influencing the quality of care provided by practices, such as through oversight of scores achieved in the Quality and Outcomes Framework (Figure 6).

Across all areas, GPs without a formal role in the CCG were less likely to agree that the CCG should be involved (for example, 85 per cent of governing body members felt they had a legitimate role to play in influencing referrals compared with 63 per cent of GPs without any formal role). However, even in the case of GPs with no involvement with the

Figure 6 To what extent do you agree or disagree that the CCG has a legitimate role in trying to influence the following aspects of your clinical practice?*
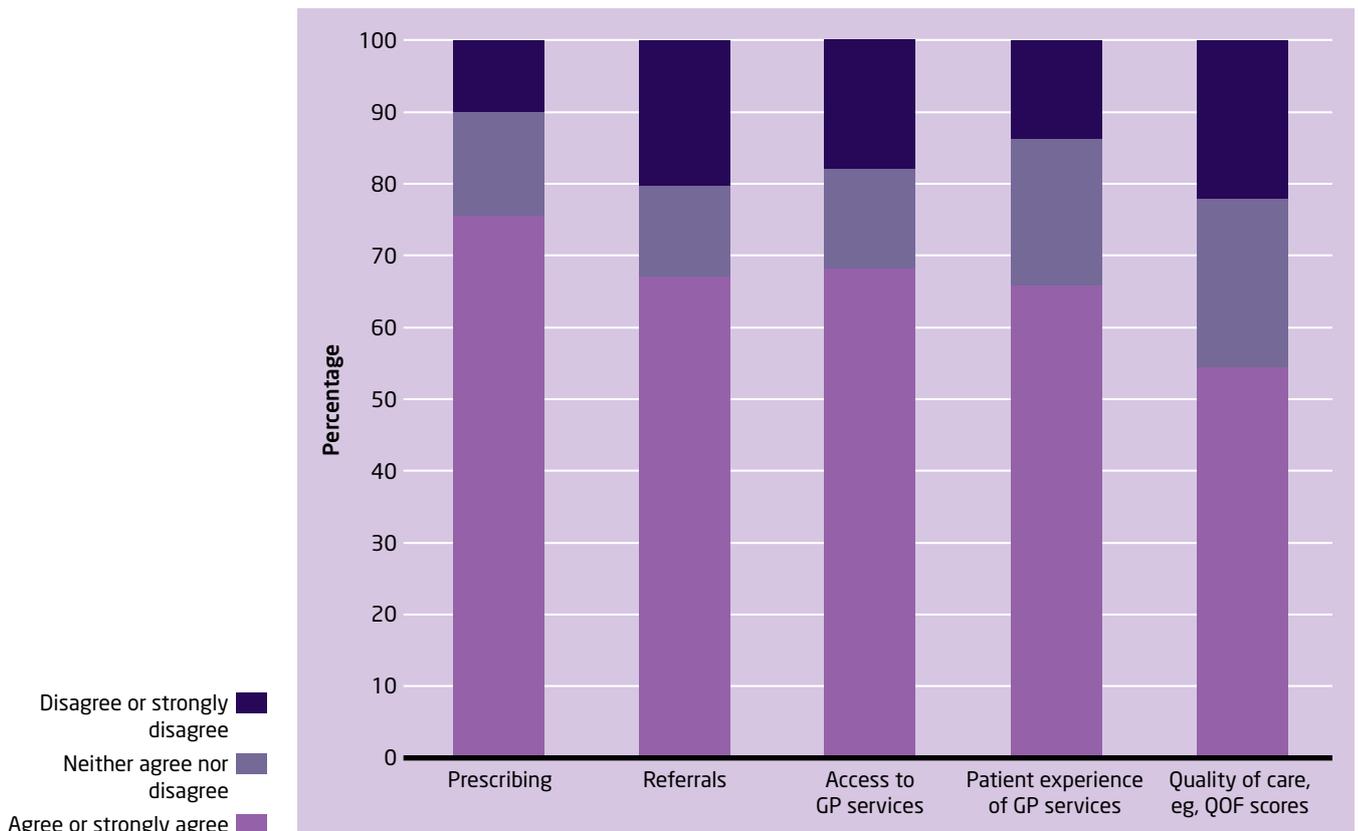
Notes: * all respondents; GP, general practitioner; QOF, Quality and Outcomes Framework

CCG at all, a majority indicated that they thought the CCG did have a role in trying to influence the clinical practice of local GPs.

Our qualitative work suggests that this view is partly due to a feeling that 'somebody' needs to take responsibility for these issues and that, under the new system, it would be better for it to be clinically led CCGs that do this than the managerially led area teams of NHS England (*see* below).

We also found that many GPs were unclear about exactly what authority their CCG has over them. Some framed the relationship in terms of members being accountable for their performance to the CCG as a collective, rather than to the governing body or the executive team. Others thought that the authority of the governing body to take an active role in primary care development is based on the fact that, in the process of signing the CCG constitution, member practices have endorsed shared agreements, such as to use agreed referral pathways.

Either way, it is clear that the role of CCGs in primary care development does not rest on a formal, hierarchical relationship between CCG leaders and member practices, but depends instead on influence, persuasion and professional credibility. In this respect, it is similar to early conceptualisations of the relationship between GPs and leaders of primary care groups, or between GPs and the professional executive committee of primary care trusts (*see* p 8). These were described by Sheaff *et al* (2004) as a form of 'soft governance', distinct from contractual relationships of the kind that NHS England now has with GPs.

Working with NHS England area teams

The issue of the division of responsibilities between CCGs and NHS England area teams is a critical one. There was widespread agreement among those who took part in our research that area teams will not have sufficient capacity or local relationships to monitor or manage GPs' contracts closely. For instance, in site A, the number of contract managers is being reduced by one-third, while the number of practices covered increases by 50 per cent. There is therefore an expectation that area teams will need to delegate some of their responsibilities and will be reliant on CCGs for their soft intelligence and their ability to influence. As the area team commissioning lead from another site commented:

I think our focus will be on applying the contract, not because we wouldn't want to do whatever is possible to improve the quality, but because the CCGs will have that shared responsibility and because we will have so few staff, we are going to be very constrained [in] what we can actually do.

NHS England area team (commissioning lead)

This implies that CCGs and area teams will be jointly responsible for quality in general practice. A strong message from our research was that close working between the two will be essential. Successful collaboration may not be easy, particularly in areas where relationships between GPs and PCT managers have historically been poor, and will require mutual trust, shared objectives and a common view of the performance problems in primary care.

It's very important that we work closely together. I don't know how co-operative they're going to be with us, we don't have a good local track record… but the principle is there.

CCG chair

We need to make sure that all the levers are pointing in the same direction and we don't have [the area team] doing stuff that then counteracts what we're trying to do, and likewise we don't then prop up a failing GP practice that actually needs to be got rid of by the NHS Commissioning Board.

Accountable officer

One of the biggest areas of uncertainty raised by CCG and area team leaders in our research was the respective roles of the two organisations and the nature of the relationship between them. Some issues are unambiguously the responsibility of area teams (for example, clear failure to deliver contractual obligations), but many felt it was not clear who would lead on 'grey areas', such as where there is persistent underperformance but no obvious contractual transgressions.

We're clear that we think we have a role in the development of quality of primary care services, and we're clear that the [area team] has a role in monitoring the performance delivery of quality of primary care, but where the two things come together we need to have a conversation with the people in the [area team] about exactly where we're going to draw the line or how we're going to work together across that line.

Accountable officer

Figure 7 depicts the distinct but overlapping responsibilities of CCGs and area teams as described by interview participants. Although this provides a framework for understanding the continuum of support and intervention that will be delivered to member practices, there is still considerable uncertainty about where the two 'thresholds' indicated should lie, and how collaboration will work for those issues that are shared responsibilities.

Figure 7 The distinct but overlapping responsibilities of CCGs and NHS England area teams

	CCG		Area team and CCG collaboration		NHS England area team
Areas of responsibility	■ Practices not performing as well as their peers, but still within the bounds of contractual requirements ■ Looking in detail at variation, eg, in referral rates	**Threshold**	■ Persistent underperformance, eg, indicated by poor QOF scores ■ Potentially including some contract compliance issues	**Threshold**	■ Clear failure to deliver contract ■ Fitness-to-practise issues

> > > > **Increasing intervention** > > > >

Note: QOF, Quality and Outcomes Framework

It is to be hoped that the division of responsibility will become clearer as the new system beds in. However, there is a clear potential for tensions and disputes to arise while these issues are being resolved. In at least one of our sites there are signs of this occurring already, with some CCG leaders fearing that the area team will attempt to devolve more responsibilities to CCG level than the CCG is prepared to accept as a way of 'abdicating responsibility and passing the buck over' (governing body member).

Carrots and sticks

CCGs and NHS England area teams will employ very different mechanisms to support quality improvement in general practice. In general, CCG leaders in our research saw their primary role as being to encourage quality improvement through the provision of support and incentives ('carrots'). Area teams, on the other hand, will be responsible for harder-edged performance management using contractual sanctions or other 'sticks'.

As membership organisations, it would be difficult for CCGs to use tough sanctions against member practices without jeopardising the close relationship on which they will depend. Recognising this, the chair of one of our sites suggested that they would not want to lead the CCG if it developed in this direction. Similarly, member practices were strongly of the opinion that the role of the CCG is to support rather than to police.

> *I don't think the CCG wants to have a formal policing role because I think that would undermine the concept of collaboration. I think the CCG would see itself as having an educational role, a persuasive role, you know, and a facilitative one.*
>
> GP, site D

> *I believe that in most cases support, training and collaboration with other high-performing practices will work better to achieve results than using sanctions against underperforming practices.*
>
> Practice manager, site A

Although the language of support was used consistently across our case study sites, this shared language concealed some differences in emphasis from one individual to another. Some CCG leaders felt that support needed to be backed up by more robust measures, whereas others feared this could undermine other activities. One area team director suggested that although CCGs will not be expected to use sanctions themselves, it will be important for CCG leaders to be able to back up the 'stick-based' work of area teams by explaining to their members the point beyond which an intervention from the area team might be expected.

If it comes to it then the stick has to come out… There is more to it than just being very supportive and soft.

<div align="right">CCG chair</div>

A number of GPs felt that the balance struck in their area was wrong and that local leaders had been too directive, punitive or critical of their performance to date – although it was not always clear whether this was attributable to the CCG leadership, the remaining PCT leadership or both. Again, other GPs disputed this and there was no site with a clear consensus view.

In contrast to the supportive approach called for from CCGs, there was some expectation that area teams would be taking a much more assertive role in GP performance management than was often the case under PCTs. As area teams cover larger areas than PCTs, and with fewer staff, they will not be able to support practices as closely as PCTs did, resulting in a more formal, arm's-length relationship focusing largely on performance management as per the contract.

Mechanisms available to CCGs

CCGs have a number of mechanisms available to help support quality improvement in general practice, some of which are more controversial than others. These mechanisms include:

- providing education and information
- facilitating peer pressure
- sharing comparative data
- providing financial incentives
- agreeing referral pathways and protocols
- establishing referral management centres
- setting performance targets
- using sanctions against underperforming practices
- organising practice visits to discuss performance problems
- expelling practices from the CCG.

The majority of survey respondents agreed that CCGs should support quality improvement through provision of education and training, comparative performance data, and, in some cases, financial incentives, while only a minority supported the use of performance targets or sanctions (Figure 8). Although the graph indicates similar trends in opinions between the respondent groups, support for the use of all mechanisms (particularly financial incentives or comparative data) was less strong among those without a formal role in the CCG.

Education and peer review

In common with previous forms of primary care commissioning, CCGs in our case study sites supported various forms of education and professional development for member practices. Most funded regular educational events, with a range of inputs for GPs and other practice staff (*see* Section 5). These were generally considered to be valuable and were popular with members.

Figure 8 In your view, which, if any, of the following mechanisms should the CCG use in order to support improvement in general practice?

Governing body
(n=29)
Member representative
(n=77)
Other membership
(n=124)
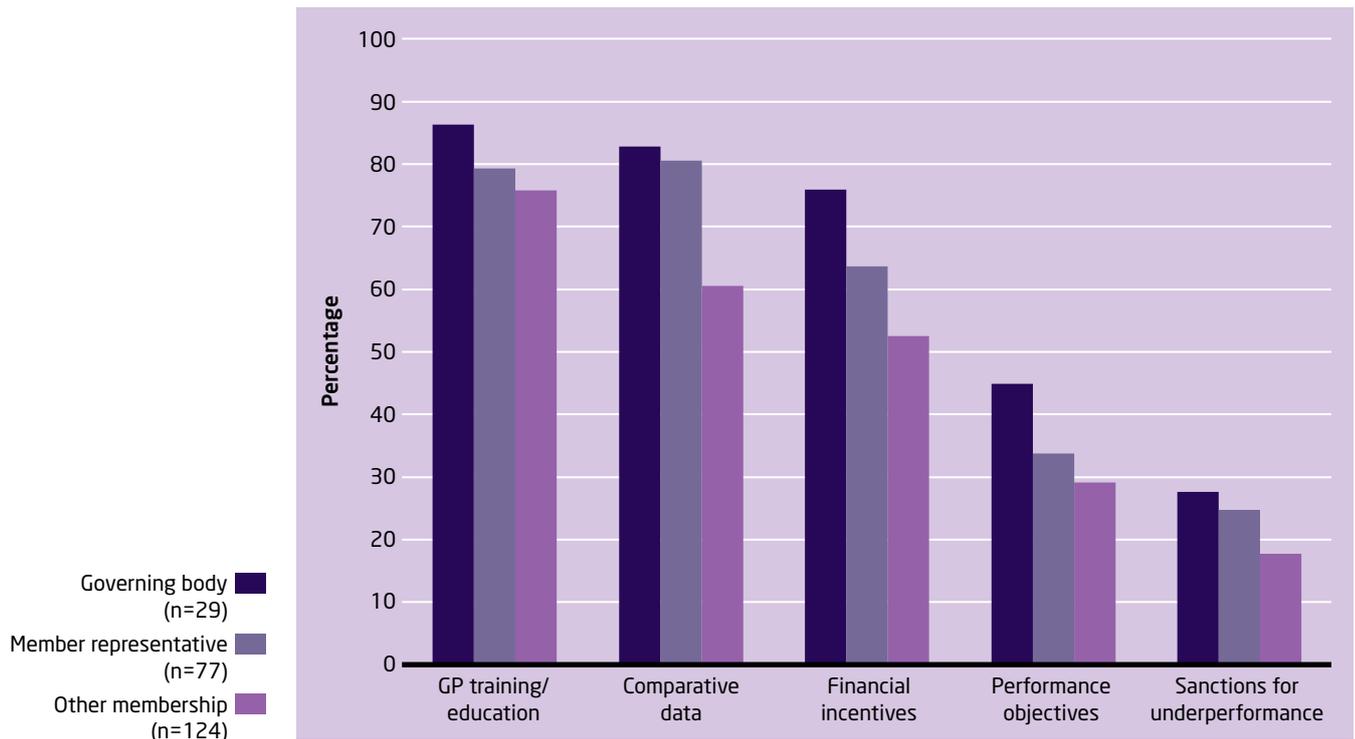
Particular importance was placed on providing comparative performance data to member practices and facilitating various forms of peer-to-peer dialogue to explore the possible reasons for variations. Peer review has been a core part of primary care commissioning since the inception of GP fundholding (Smith and Goodwin 2006), with most GPs demonstrating a willingness to engage in peer review by the time of practice-based commissioning or earlier (Coleman *et al* 2009).

The ability of CCGs to support this was often seen as being their single biggest strength relative to primary care trusts. Many felt that peer pressure was potentially a very powerful lever and that this could operate more effectively within a system based on clinical leadership and collective responsibility than one involving top-down direction.

> *With the CCG it feels a little bit more like, well, these are your colleagues or your peers saying this is what we're doing, why aren't you doing the same sort of thing, so I think that does mean it puts a little bit more pressure on you to change things if you're not doing what everyone else is doing.*
>
> GP, site F

All of our sites distributed comparative data on referral rates and prescribing costs to member practices – often continuing or building on processes already developed under previous forms of primary care commissioning – and had formal structures in place to facilitate peer-to-peer conversations. In one site, two local GPs have been recruited by the CCG to take on a specific responsibility for peer review activities, visiting practices on an 'opt in' basis.

In most sites, locality group meetings or other forums are used to encourage peer-to-peer conversations, and data is distributed to members using regular newsletters. Peer comparison was seen to be most effective if done face to face in relatively small groups.

Some sites have created smaller clusters of three to six neighbouring practices beneath locality level for the purposes of regular peer review.

There's something about looking your peers in the face and discussing difficult things in a way that among eight practices has some meaning [but among] 80 practices doesn't have so much meaning. I feel that sort of localism does feel a bit more real than a slightly more abstract, larger organisation.

GP, site B

This emphasis on encouraging peer-to-peer comparison and education with regular review of benchmarking data is supported by the findings of previous research that showed that these kinds of approaches are more likely to be clinically and cost-effective than more interventionist strategies that create new steps in the referral pathway (Imison and Naylor 2010).

Financial incentives

Financial incentives were also seen as potentially important, although there was often considerable nervousness about using them appropriately when trying to influence the performance of practices.

One important means by which CCGs can influence GPs to modify their practice is by commissioning enhanced primary care services beyond the scope of the GP contract. Recent guidance gives CCGs the power to do this provided that they meet the requirements of procurement regulations (NHS England 2013b).

Most of our sites are already managing existing 'local enhanced service' contracts, such as to reimburse member practices for engaging with the CCG or to encourage them to monitor referral patterns and engage in other CCG activities. These incentive schemes have often been continued, with some modification, from comparable schemes under practice-based commissioning. Existing prescribing incentive schemes have also been continued.

However, many GPs were uncomfortable with the idea of financial rewards to practices being linked to a reduction in access. Previous research has highlighted the risk that financial incentives could reduce appropriate as well as inappropriate referrals (Roland *et al* 2006). These concerns led site F to rule out the development of new financial incentives for practices at present on the grounds that they can be too blunt and not sufficiently sensitive to clinically warranted variation. Other sites also raised similar concerns.

Any sort of financial incentive which is linked to potentially blocking access to patients' appropriate care makes me feel deeply, deeply uncomfortable. And yet, I think there is acknowledgement that, actually, if we're going to do more within the practice, you need to somehow find a way of rewarding the practice for doing that – the extra manpower, the extra hours that are involved in that.

GP, site B

From 2014/15, the 'quality premium' paid by NHS England to CCGs will provide an additional means of creating incentives for member practices, with a value of up to £5 per head of population covered by the CCG. Guidance requires that the premium must be used in ways that improve patient care or health outcomes, and can only be handed directly to member practices as part of a targeted incentive scheme to bring about such improvements (NHS England 2013c). This leaves room for CCGs to use the quality premium as a mechanism to influence and support member practices.

Referral pathways and protocols

Referral pathways and protocols are a commonly used tool for changing referral practices. They were often seen as being helpful, although in two sites there has been considerable controversy over guidelines introduced to limit referrals for hip and knee surgery in the case of people who are overweight or who smoke. Some GPs in these sites said they had been reassured that the guidelines were based on sound clinical evidence, but a minority remained unconvinced and expressed concern about the power of the CCG to make rationing decisions that members are expected to enact.

> *There is one issue which makes me very uneasy. This is the decision to ration hip and knee replacements by deferring or declining surgery for patients who are obese or who smoke.*
>
> GP

None of our sites had an external referral management centre in place, and some had explicitly ruled out this option because it had proved unpopular with members.

Addressing underperformance

Where peer pressure and incentives fail to have the desired effect, there are limited levers available to CCGs, particularly as the GP contract is held by NHS England. Several sites set performance targets for member practices in terms of their use of resources and use structured recovery plans as a way of encouraging underperforming practices to take remedial action. In some cases, underperformance triggers a practice visit from the CCG leadership. The nature of these visits varies, with some discussions being described as 'challenging' and others as more supportive. Several GP members emphasised the value of including clinical leaders in these performance conversations and avoiding a paternalistic tone or manner.

> *The chair of the CCG turned up in our patch and, on the first day, basically told us that we were overspending, we were regarded as moaners and not liked within the patch and you thought, 'Fine. If that's the way you want to kick it off, then you're going to have complete lack of engagement.' It was a very destructive opening gambit.*
>
> GP

The ultimate lever available to CCGs is to apply to NHS England to have a member practice removed from the CCG. There was considerable scepticism, however, about whether this would be a realistic option. Some felt it could be used in exceptional circumstances, but that there was a high risk that 'if you do expel them they'll probably come straight back again because there's nowhere else to go' (practice representative, site F). The general feeling was that any move to expel a member practice would have to come from the membership itself and would need a high level of support. As described in Section 4, only one of our case study sites had explicitly outlined the circumstances that would lead to a practice being expelled.

Summary

It is clear that CCGs have a role in supporting quality improvement in general practice – this is written both into the legislation and their constitutions. CCG leaders and the majority of members recognise this, but the issue remains a sensitive one, and there are differences of opinion on the question of how exactly CCGs should undertake this role.

CCG leaders and members alike placed considerable emphasis on CCGs playing a supportive role, facilitating change rather than imposing it. However, NHS England area

teams will be reliant on close assistance from CCG leaders to perform the area teams' role as contract manager adequately. CCG leaders may therefore find it difficult to distance themselves entirely from more robust performance management activities in cases where persistent performance problems exist in general practice.

The most powerful tool available to CCGs is their ability to encourage and support peer review and comparison between member practices. Many participants felt that the relationship between clinical leaders and member practices means that CCGs are better placed to harness the power of peer-to-peer influence than were PCTs. Whether this and the other mechanisms available to CCGs give them sufficient power to be able to support quality improvement effectively remains unproven, as we shall see in the next section.

7 The perceived impact of clinical commissioning groups

This section presents the evidence on the perceived impact of clinical commissioning groups (CCGs) in their early history prior to formal authorisation, and the impact they are expected to have over the first year of full operation. It is not a comprehensive account of the impact of CCGs, but rather focuses on issues of core concern to our research, specifically the effect on clinical relationships and on member general practitioners (GPs) as providers of primary care. The findings reported here must be treated as provisional given the early stage at which the fieldwork was conducted, and will be returned to in greater depth in subsequent stages of the research.

Effects observed to date

Impact on relationships between GPs

In general, interview participants were very enthusiastic about the CCG having brought individuals and practices together in a forum that had not existed before.

> *In terms of their attempts to talk to the average GP [the CCGs] are one of the better things that's happened [in] the past 20 years.*
>
> LMC representative

Survey data also suggested that the impact of CCGs on clinical relationships in primary care is perceived to be largely positive so far – although unsurprisingly greater benefits have come to those who have taken an active role within the CCG. Overall, 45 per cent indicated that relationships had improved, compared with 13 per cent who reported a deterioration (Figure 9). One-third of all respondents said that there had been no impact on relationships.

Impact on relationships with secondary care clinicians

Many interviewees also saw the formation of CCGs as an opportunity to improve relationships between primary and secondary care, with increased clinician-to-clinician dialogue. There were a few examples of this happening already, such as through buddy groups linking GPs with secondary care clinicians. Building on these clinical links will be important if CCGs are to realise the potential added value of clinical engagement in commissioning.

There is also, however, the potential for the commissioning role to complicate the clinical relationships between GPs and secondary care colleagues. Negative effects were reported in three of our sites, largely as a consequence of efforts made by CCGs to reduce referrals and admissions or to introduce unpopular pathway changes. In general, personal relationships between primary and secondary care clinicians remained good, but organisational relationships had at times become antagonistic and adversarial, and some feared that this might in time affect personal relationships.

Figure 9 What impact has the formation of the CCG had on clinical relationships between GPs?
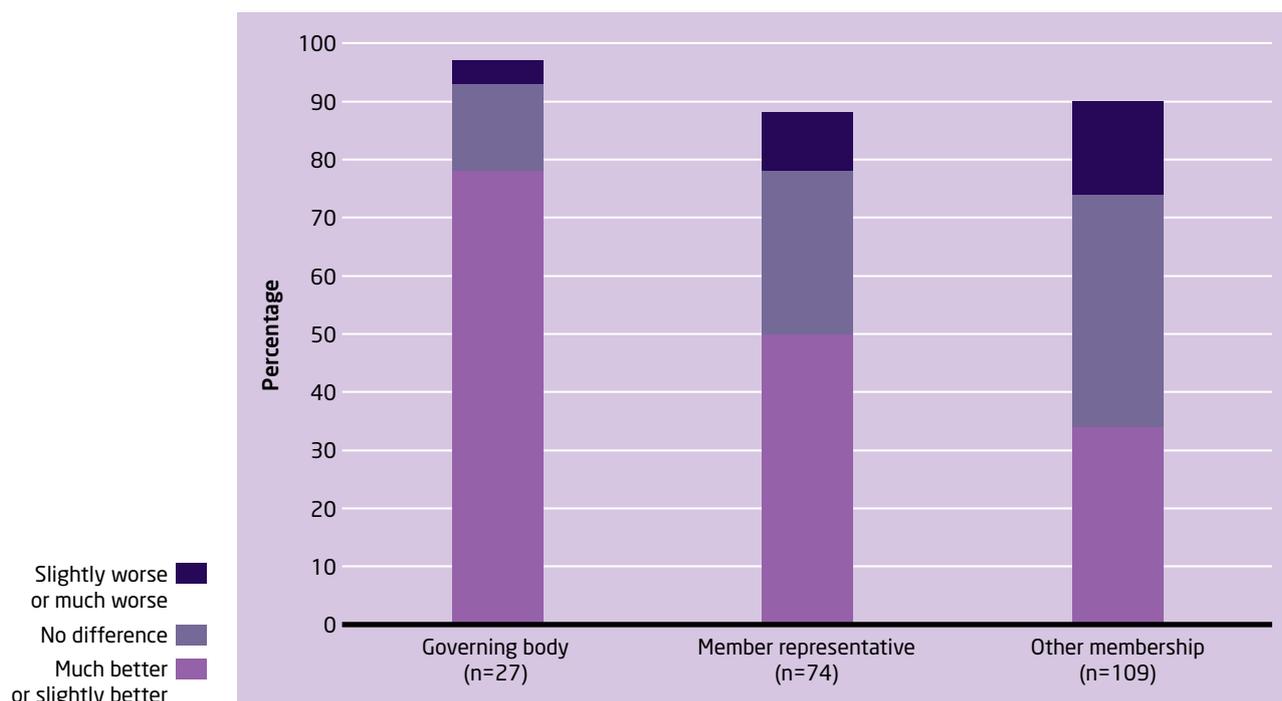
Note: percentages do not round up to 100 as the graph does not present those who selected 'Don't know'

Links with community care and social care providers were generally less well developed in our case study sites. CCG leaders in several sites expressed a desire to develop these further, recognising that these services will need to play an important part in efforts to develop more integrated forms of care. Two sites reported that relationships with community care were improving since the introduction of the CCG and that the new commissioning arrangements were breaking down barriers and making communication easier.

## Impact on clinical behaviour in general practice

Despite the early timing of our fieldwork, we found some evidence that CCGs were already having an impact on members' clinical practice. More than 50 per cent of practices in our survey reported that being a CCG member had changed their clinical practice in terms of prescribing patterns, referral pathways and volume of referrals, albeit that the scale of change had so far mostly been small (Figure 10).

The most commonly cited effect of CCGs was that peer-to-peer dialogue had heightened GPs' awareness of their referral and prescribing patterns and how they compare with those of others. In most sites, at least some practices or localities reported that this had led to their succeeding in reducing their referral rates or prescribing costs. Others, however, reported that their clinical practice remained entirely unaffected so far.

I think my referral patterns have changed because I'm much [more] aware of more cost-effective ways of prescribing as a result of CCG feedback, and I think our commitment to it has definitely increased because I feel passionate about seeing better health care provision for my patients.

GP, site C

Most GPs reported using new referral pathways, although in some cases these represented the culmination of work that was already under way before the creation of the CCG.

Figure 10 Has being part of a CCG changed your clinical practice in the following way?*
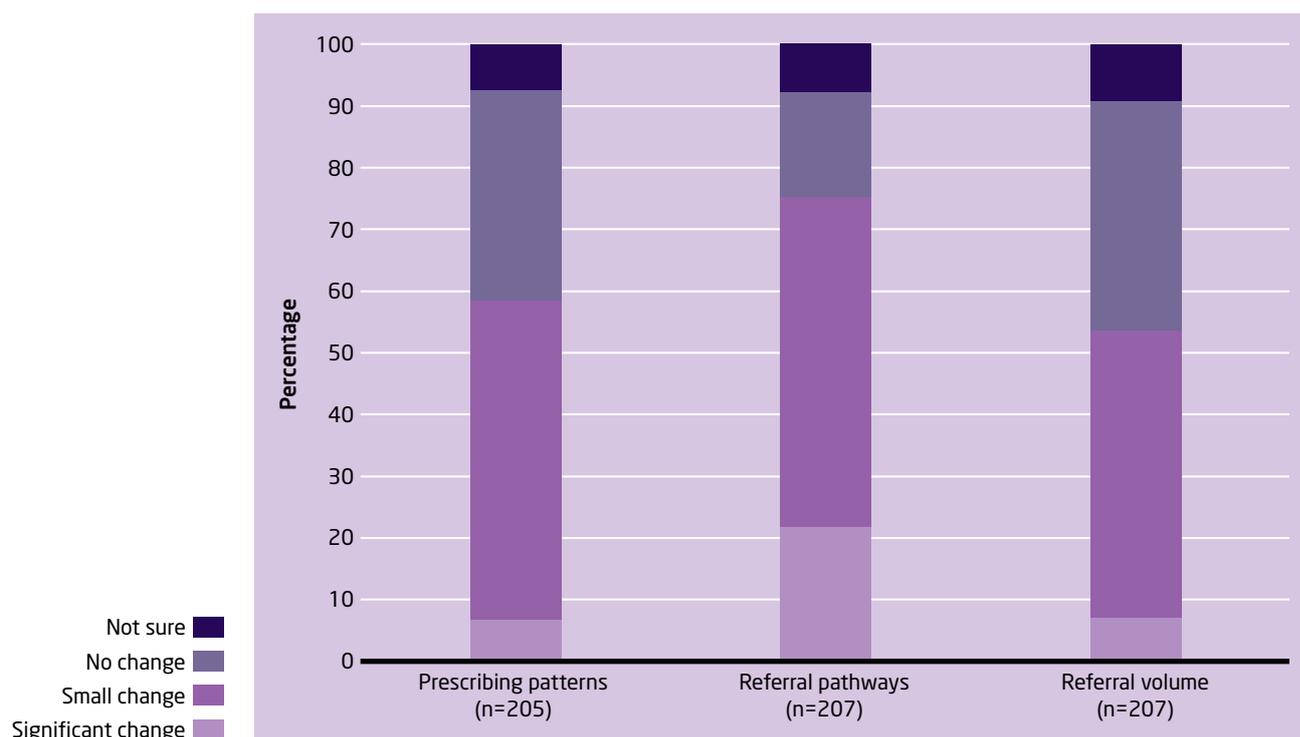
Note: * all respondents

The new pathways were mainly seen as a positive development, although some had caused controversy (*see* p 37). In site D, a reduction in the expenditure on acute services for people with chronic obstructive pulmonary disease was attributed to a new care pathway.

A small number of tangible service changes were credited to CCGs. Again, some of these had already been initiated before the CCG was set up, but had been pursued and implemented by the CCG leadership over the past two years. As often seen under practice-based commissioning, the emphasis in these initiatives was on strengthening primary care and developing new services in community settings. Examples include the following.

■ In site A, more patients with diabetes are reported to be being managed in general practice rather than in secondary care, with support from specialist diabetic nurses.

■ Physiotherapy input to general practice has been increased in site E in an attempt to reduce musculoskeletal referrals.

■ A new visiting service in site B allows GPs to have patients visited by another GP, enabling them to continue with practice work, and has proved very popular with local GPs.

Expectations of the future

The impact that CCGs will have on general practice in the future is still uncertain, and we encountered a wide range of views about this in our case study sites. Nonetheless, there was a prevailing feeling that, although success is by no means assured, CCGs are better placed to oversee improvements in general practice than primary care trusts were. A total of 48 per cent of all survey respondents agreed with this statement, with governing body members being by far the most confident in the potential of their CCG (Figure 11).

Figure 11 The CCG will be more effective than the primary care trust at helping GPs to improve the services they provide to their patients
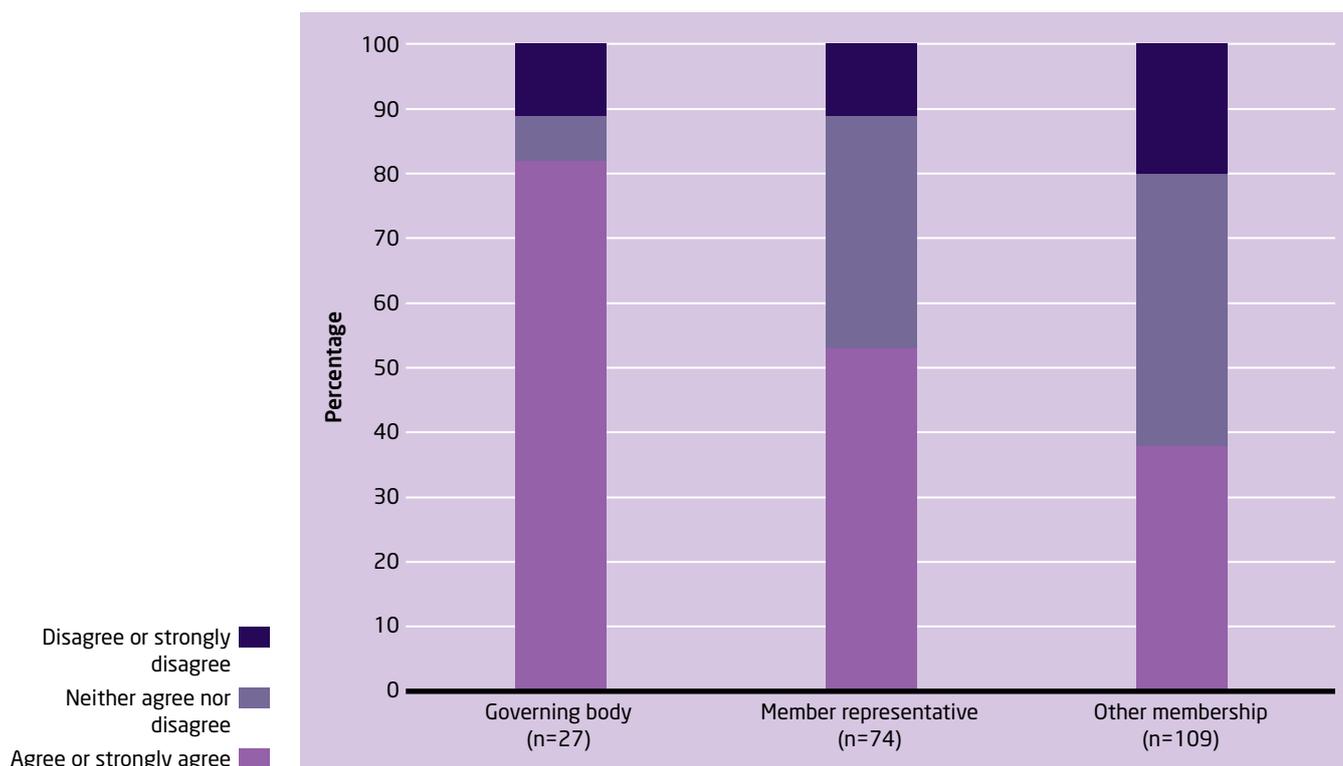
This belief was generally justified by reference to the potential strength CCGs derive from being clinically led, member-owned organisations. This view stood out from our interviews with CCG members and leaders alike, many of whom argued that primary care trusts were not capable of harnessing peer pressure in the same way. The belief that this will make CCGs more effective at supporting improvements in primary care was widely held.

> *I think CCGs… are much more likely to be able to use peer pressure and influence their peers to deliver than PCTs ever could, and I think if they don't they'll fail, I think it's as stark as that.*
>
> CSU lead, site A

However, these views were by no means universal, and some were either uncertain or pessimistic about the likely impact their CCG would have on the quality of general practice. Several participants, including CCG leaders, felt that the mechanisms at CCGs' disposal will not provide sufficient leverage over member practices, or that the resources available for management are inadequate. Some raised the question of whether primary care trusts with added clinical involvement could have achieved as much or more than CCGs.

> *These changes were already happening locally with GP involvement in commissioning before CCGs, and would have continued to happen even if CCGs had not been created.*
>
> GP, site D

Some GPs raised the prospect of actions taken by CCGs having a negative effect on the quality of general practice. As reported in Section 5, a number were highly concerned that involvement in financial decision-making would damage the relationship between GPs and patients. There was also some anxiety that CCGs would create new burdens for GPs that would then reduce the amount of time available for patient care.

The majority (59 per cent) of survey respondents were unsure about the effect on patients that would result from changes to their referral rate, referral pathways, prescribing patterns or other clinical practices deriving from their being members of a CCG (Figure 12). It is of some concern that a slightly greater proportion predicted a negative impact than a positive one over the next 12 months (19 per cent compared with 16 per cent of all responses). Furthermore, these responses are more negative among those who are not actively involved with the CCG. This suggests that CCG leaders have some distance to go before they are able to give member practices confidence that being part of a CCG will benefit their patients.

Figure 12 Overall, what impact will any changes to your clinical practice have on patients over the next 12 months?
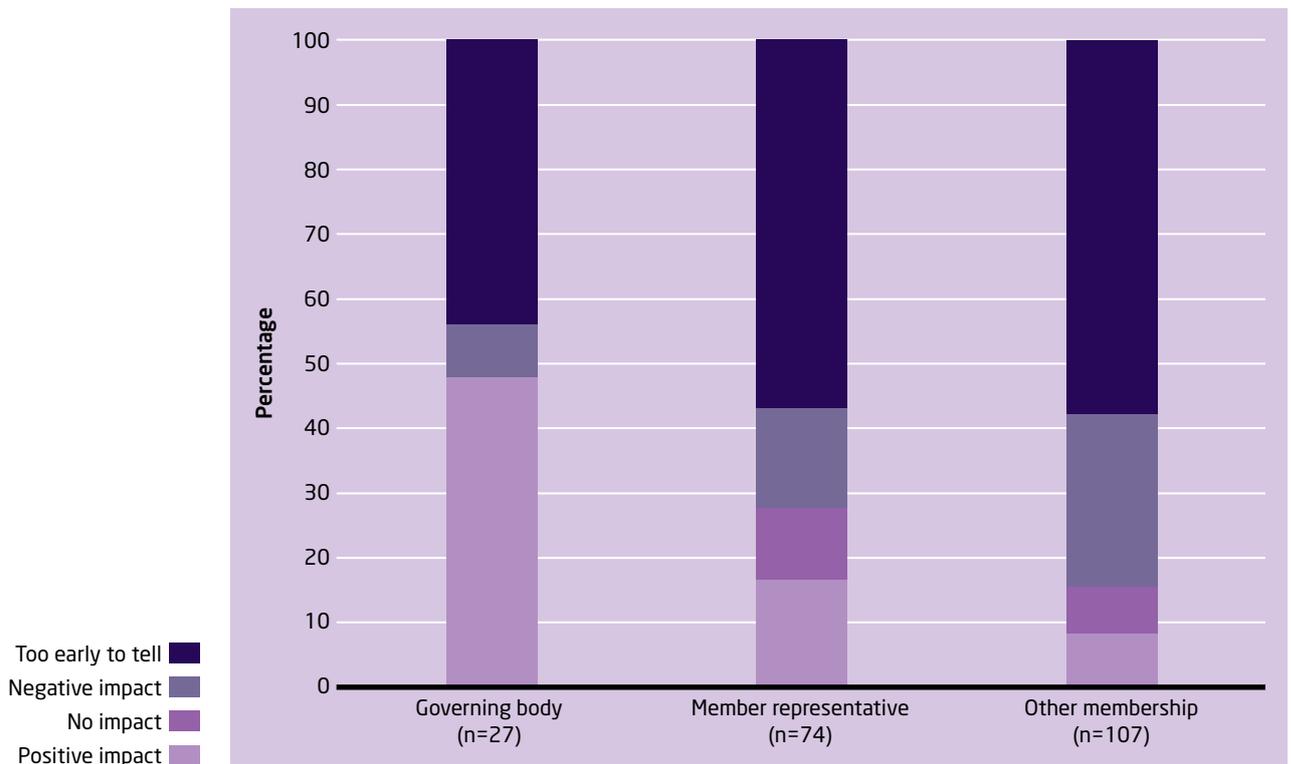
8 Discussion

Supporting improvement in general practice

Strong primary care is widely recognised as being the foundation of high-performing health systems, and general practice in the United Kingdom is internationally regarded as providing highly accessible, well-co-ordinated care (Starfield 1998; Schoen *et al* 2011). Nonetheless, there is a growing recognition both inside and outside the profession that primary care will need to grow and evolve if it is to continue to meet the needs of a changing society (Lakhani *et al* 2007; The King's Fund 2011).

We have argued elsewhere that more integrated forms of care are needed to support the growing number of people with long-term conditions, particularly frail older people and those with multiple conditions (Curry and Ham 2010; Goodwin *et al* 2012; Ham *et al* 2012). To facilitate these changes, new models of primary care are needed that allow general practitioners (GPs) and other practice staff to take greater responsibility for the co-ordination of care, to adopt more proactive approaches based on a population health perspective, and to support an expansion in the range of services available in the community (The King's Fund 2011; Smith *et al* 2013; Thorlby 2013). Clinical commissioning groups (CCGs) could be pivotal in bringing about these innovative approaches to primary care.

Recent policy developments have heightened the pressure for change in general practice. The announcement of plans for a new chief inspector of primary care adds to strengthened regulatory oversight by the Care Quality Commission, which now requires all general practices to be registered with it and monitored through periodic inspection. This raised level of expectation comes at a time when some practices are facing a falling income and there is the potential of a shortage of GPs in some parts of the country over the coming decade (Raleigh *et al* 2012).

In this challenging environment, GPs will need to work increasingly closely with their peers in local practices and other providers, and CCGs have an important role in supporting this kind of collaborative activity. We have argued throughout this report that if they are to achieve their goals, CCGs will need to play an active part in facilitating change in primary care. This is a contentious issue but our research suggests that most GPs acknowledge that this does fall within the remit of CCGs, and it is enshrined in the constitutions on which CCGs are founded. The debate is not about *whether* CCGs have a role in primary care development but about *which parts* of the agenda they take on, and how they go about it.

Given the importance of quality improvement in general practice, it is a matter of concern that so much confusion remains about how the responsibility for achieving it will be shared between CCGs and NHS England area teams. It is clear that area teams will be reliant on CCGs and will not be able to performance manage GPs effectively without their support. It is equally clear that CCG leaders will need to strike a delicate balance between

engaging local practices and challenging them when appropriate. The risk is that, in some areas, neither organisation will perform the role effectively nor provide the necessary leadership, and that the partnership between them will fail to create the much-needed stimulus for change.

Our research suggests that peer-to-peer relationships between member practices are likely to be the most powerful tool at CCGs' disposal. The power that CCGs have to harness these relationships is what could potentially set them apart from primary care trusts and, encouragingly, survey respondents were optimistic that CCGs would be better placed than their predecessors to support improvement in general practice – although those not actively involved in CCGs were less optimistic about this than CCG leaders were. The challenge will be to act as a catalyst for change without damaging the relationship with member practices on which CCGs depend for their legitimacy.

CCGs can support the development of new forms of primary care by using their commissioning powers to stimulate the growth of GP provider organisations and networks. International evidence and historical precedent both suggest that being involved in an organisation that has extended primary care provision as its focus will have a greater appeal for many GPs than involvement in commissioning (Thorlby *et al* 2012).

If CCGs are to help foster this kind of innovation, the issue of conflicts of interest will inevitably come to the fore. For CCGs to commission enhanced primary care services from local GP-led provider organisations without risking incurring reputational damage to GPs, it will be important that conflicts of interest are managed robustly. The extent to which this becomes a constraining factor that limits the development of new forms of general practice remains to be seen.

Sustaining engagement and enthusiasm

The rationale for creating CCGs was to give clinicians responsibility for making commissioning decisions and to harness their expertise more effectively. In order to bring about the changes to primary care described above, CCGs will need to build and sustain engagement in their work across the local GP community.

Those leading CCGs are in no doubt about the scale of the challenge they face in maintaining and improving engagement among member GPs. The environment in which CCGs have been created is not a favourable one. Ongoing financial strictures threaten to deter some GPs, who fear that in this context the core tasks of commissioners will be rationing and disinvestment rather than service improvement. Wider pressures on primary care place limits on GPs' capacity to engage in the work of their CCG.

Despite this, we encountered a sense of energy in our case study sites and an impressive level of commitment from those leading them. The engagement of local GPs was generally felt to be better than with practice-based commissioning, and CCGs were credited with having brought people together in new ways and built more structure around existing collaborative activities between practices. Although far from universal, we often found a degree of goodwill among local GPs and a desire to see clinical commissioning succeed.

However, we also found a considerable difference of perspective between GPs involved in leading CCGs and those who had not taken an active role. The latter felt less sense of ownership over their CCG and were significantly less likely to say that the decisions taken reflected their views and those of their colleagues. It was encouraging that a wider group of GPs beyond those on the governing body had become involved in a number of

ways (for example, as practice representatives) and reported feeling more engaged in the work of the CCG as a result. However, if the gap between active participants and other local GPs grows wider over time, there is a clear risk of CCGs losing their connection with grassroots GPs and repeating the history of diminishing clinical involvement that characterised many primary care trusts.

Our findings suggest that larger CCGs may face a particular challenge in engaging member practices and creating a culture of collective ownership. This mirrors findings from research on earlier forms of primary care commissioning (Malbon and Mays 1998; Smith and Goodwin 2006) and resonates with other evidence on CCGs (Checkland *et al* 2012). However, smaller CCGs also face an equivalent challenge, albeit at a different level. These groups are often working as part of a formal partnership with neighbouring CCGs, and our research suggests that the distance between partnership structures and member practices in small CCGs can create just as great a barrier to engagement as the distance between governing bodies and members in larger CCGs.

The fundamental challenge is, therefore, similar for all CCGs, regardless of size or structure – being able to operate at scale without losing local roots and engagement. Locality structures (in larger CCGs) and inter-CCG partnerships (in smaller CCGs) represent two different ways of attempting to secure the advantages of both localism and scale. It remains to be seen which approach will be most effective.

The status of CCGs as membership organisations could help support a culture in which GPs and other clinicians view themselves as collectively accountable for the quality of health care in their local area and for using the available resources in the best interests of patients and the public. However, as membership is mandatory and most GPs have a limited choice over which CCG they belong to, it is far from clear what being a membership organisation will mean in practice.

If CCGs are to succeed in engaging their members, they will need to prove the value of commissioning. Leaders will need to be able to demonstrate to their members tangible improvements for local patients within a short timeframe. Again, this will not be easy in the current financial conditions.

The risk of recreating the past

A recurring theme throughout our research was the strong desire for CCGs to be different from primary care trusts (PCTs). The fear of 'recreating the PCT' was a prevailing concern for CCG leaders and members alike, particularly in sites that had a history of poor relationships between clinicians and primary care trust managers. Some of the less engaged members were highly sceptical about the CCG being anything more than the primary care trust 'rebranded'. Whether or not this accusation is fair, these perceptions matter and finding ways of differentiating themselves from their predecessors is one of the main challenges CCGs face.

Similarly, there is substantial concern among CCG leaders that other parts of the system will revert to hierarchical relationships based on top-down control. Many saw actions taken by NHS England area teams, the Department of Health and others as illustrating that there would be a significant amount of central control in the new system and that the political narrative around local freedom and autonomy would fail to manifest itself in reality.

In terms of their composition and structure, there are important differences between CCGs and primary care trusts. The question is whether these translate into differences in function. In some sites, CCG leaders have attempted to identify precisely how they intend to use their relationship with local practices to work innovatively in the new system. This included concerted engagement and communication with members; making decisions in a more bottom-up way, with greater input from local GPs; and enhanced clinician-to-clinician interaction between primary and secondary care. These ideas express a vision for CCGs that would be genuinely different from that of previous commissioning bodies.

9 Conclusion: a window of opportunity

The history of clinical commissioning illustrates that a limited window of opportunity can exist within which progress must be made. Engagement with practice-based commissioning moved through a curve during its lifetime, with initial enthusiasm being replaced by scepticism and disillusionment once general practitioners (GPs) had begun to lose confidence in its ability to deliver tangible improvements for patients. Previous research has described how a vicious circle emerged over time, one 'in which GPs were holding back until practice-based commissioning had proved itself, but without GP involvement this being unlikely to happen' (Curry *et al* 2008, p 21).

There is a clear danger of history repeating itself if clinical commissioning groups (CCGs) fail to bring about service changes that win the support of the local clinical community within an acceptable timeframe.

To avoid this risk, CCGs must build on the positive steps that many have already made. In particular, CCG leaders must harness the support of local GPs by:

■ prioritising member relationships and cultivating a sense of collective ownership of the CCG

■ creating a governance structure that supports the involvement of local clinicians in decision-making and delegates power where appropriate

■ clarifying the relative roles of member councils, locality groups and the governing body, and ensuring that those involved understand what authority and responsibilities sit at each level

■ articulating the role of the CCG in supporting quality improvement in primary care, explaining where this role begins and ends, and how the CCG will work with the NHS England area team

■ supporting peer-to-peer dialogue and performance review in small groups, particularly through face-to-face meetings

■ ensuring that members understand the most important elements of the CCG's constitution

■ communicating a vision for the CCG that describes how it is distinct from previous commissioning organisations.

If they are to succeed in the above, CCG leaders will need to operate within a supportive environment. The scale of the upheaval in the wider commissioning system has created considerable instability, and greater clarity is now needed regarding how CCGs, area teams and other local partners will interact. In particular, NHS England has a duty to promote autonomy in CCGs, and it is important that its area teams are held to account for doing so.

Many of the GPs involved in our research expressed a strong desire for clinical commissioning to succeed, irrespective of whether they were personally involved in their CCG. It is this commitment that could, in the end, determine whether CCGs surpass the achievements made by their predecessors and bring about improvements for patients.

Key messages from our research

- Primary care needs to grow and evolve if it is to continue to meet the needs of society; CCGs have an important facilitative role to play in making this happen.

- Most GPs believe that CCGs have a legitimate role to play in trying to influence the clinical behaviour of local GPs, but there is some wariness about the form that this involvement could take.

- Developing greater clarity on how responsibilities for primary care development are to be shared between CCGs and NHS England area teams should be a priority. In the absence of this there is a risk that neither organisation will provide the necessary leadership.

- Area teams will not have sufficient capacity to monitor or manage GPs' contracts closely and will need to delegate some of their responsibilities, relying on CCGs for their soft intelligence and their ability to wield influence.

- CCGs will need to strike a careful balance if they are to perform this function without alienating their GP members, on whom they depend for their legitimacy. Supporting peer review may be the most powerful tool at their disposal in doing so.

- There are significant disparities between the views of those involved in leading CCGs and member GPs, with the latter being less likely to say that their CCG is 'owned' by its members, that its decisions reflect their views or that it has had a positive impact to date.

- There is also significant variation in views from one CCG to another, with levels of member ownership and involvement much higher in some areas than others. Larger CCGs may face a particular challenge in engaging member practices and creating a culture of collective ownership.

- There is a widespread desire in the GP community for CCGs to succeed, but CCG leaders have yet to persuade all GPs that commissioning can bring about improvements or that CCGs represent a departure from previous commissioning structures.

Next stages of this research

This report is the first in a research programme that will continue until 2015. The findings presented reflect the situation in our case study sites at one stage in an ongoing process, and will be subject to change as CCGs develop and other system reforms take hold. In subsequent stages we will return to the themes covered in this report, examining developments in the study sites after they assumed their full statutory responsibilities and powers. Themes for ongoing exploration will include:

- how CCGs implement their responsibility to support improvement in general practice, and the effectiveness of mechanisms available to support and influence member practices

- how the governance structures and processes developed by CCGs are working in practice, and whether these support the involvement of member GPs in commissioning activities and enable clinical expertise to be harnessed effectively

- how internal relationships develop over time as CCGs balance the need to engage local GPs with their responsibilities to support quality improvement

- the evolving interface between CCGs and other organisations, including NHS England area teams, commissioning support units and GP provider organisations.

References

Bate A, Donaldson C, Murtagh MJ (2007). 'Managing to manage healthcare resources in the English NHS? What can health economics teach? What can health economics learn?' *Health Policy*, vol 84, no 2–3, pp 249–61.

Casalino LP (2011). *GP Commissioning in the NHS in England: Ten suggestions from the United States.* London: Nuffield Trust. Available at: www.nuffieldtrust.org.uk/sites/files/nuffield/publication/gp-commissioning-in-the-nhs-in-england-ten-suggestions.pdf (accessed on 14 June 2013).

Checkland K, Coleman A, Segar J, McDermott I, Miller R, Wallace A, Petsoulas C, Peckham S, Harrison S (2012). *Exploring the Early Workings of Emerging Clinical Commissioning Groups: Final report.* London: Policy Research Unit in Commissioning and the Healthcare System. Available at: www.prucomm.ac.uk (accessed on 14 June 2013).

Coleman A, Checkland K, Harrison S, Dowswell G (2009). *Practice-Based Commissioning: Theory, implementation and outcome: Final report.* Manchester: University of Manchester National Primary Care Research and Development Centre.

Curry N, Goodwin N, Naylor C, Robertson R (2008). *Practice-Based Commissioning: Reinvigorate, replace or abandon?* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/practice-based-commissioning (accessed on 14 June 2013).

Curry N, Ham C (2010). *Clinical and Service Integration: The route to improved outcomes.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/clinical-and-service-integration (accessed on 14 June 2013).

Department of Health (2011). *Developing Clinical Commissioning Groups: Towards authorisation* [online]. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/134863/dh_130318.pdf.pdf (accessed on 14 June 2013).

Department of Health (2004). *The NHS Improvement Plan: Putting people at the heart of public services.* Cm 6268. London: The Stationery Office. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118572.pdf (accessed on 14 June 2013).

Dowling B, Glendinning C (2003). *The New Primary Care: Modern, dependable, successful?* Maidenhead: Open University Press.

Goodwin N, Smith J, Davies A, Perry C, Rosen R, Dixon A, Dixon J, Ham C (2012). *A Report to the Department of Health and the NHS Future Forum. Integrated care for patients and populations: improving outcomes by working together.* London: The King's Fund and Nuffield Trust. Available at: www.nuffieldtrust.org.uk/sites/files/nuffield/publication/integrated_care_for_patients_and_populations_-_improving_outcomes_by_working_together_jan12_0.pdf (accessed on 14 June 2013).

Ham C, Dixon A, Brooke B (2012). *Transforming the Delivery of Health and Social Care. The case for fundamental change.* London: The King's Fund. Available at: www.kingsfund. org.uk/publications/transforming-delivery-health-and-social-care (accessed on 14 June 2013).

House of Commons Health Committee (2010). *Commissioning. Fourth report of session 2009–10. Volume 1.* HC 268-1. London: The Stationery Office. Available at: www. publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/268i.pdf (accessed on 14 June 2013).

Imison C, Naylor C (2010). *Referral Management: Lessons for success.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/referral-management (accessed on 14 June 2013).

The King's Fund (2011). *Improving the Quality of Care in General Practice. Report of an independent inquiry commissioned by The King's Fund.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/improving-quality-care-general-practice (accessed on 14 June 2013).

Lakhani M, Baker M, Field S (2007). *The Future Direction of General Practice: A roadmap.* London: Royal College of General Practitioners. Available at: www.rcgp.org.uk/policy/ rcgp-policy-areas/~/media/Files/Policy/A-Z%20policy/the_future_direction_rcgp_ roadmap.ashx (accessed on 14 June 2013).

Malbon G, Mays N (1998). 'Total recall: what can total purchasing pilots teach PCGs?' *British Journal of Health Care Management*, vol 4, no 9, pp 428–30.

Mays N, Wkye S, Malbon G, Goodwin N (eds) (2001). *The Purchasing of Health Care by Primary Care Organizations: An evaluation and guide to future policy.* Buckingham: Open University Press.

Miller R, Peckham S, Checkland K, Coleman A, McDermott I, Harrison S, Segar J (2012). *Clinical Engagement in Primary Care-Led Commissioning: A review of the evidence.* London: Policy Research Unit in Commissioning and the Healthcare System. Available at: www.prucomm.ac.uk (accessed on 14 June 2013).

Naylor C (2013). 'Clinical commissioning groups: a north–south divide?' The King's Fund website. Available at: www.kingsfund.org.uk/blog/2013/03/clinical-commissioning-groups-north-south-divide (accessed on 14 June 2013).

Naylor C, Goodwin N (2010). *Building High-Quality Commissioning: What role can external organisations play?* London: The King's Fund. Available at: www.kingsfund.org. uk/publications/building-high-quality-commissioning (accessed on 14 June 2013).

Naylor C, Imison C, Addicott R, Buck D, Goodwin D, Harrison T, Ross S, Sonola L, Tiam Y, Curry N (2013). *Transforming our Health Care System: Ten priorities for commissioners.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/articles/ transforming-our-health-care-system-ten-priorities-commissioners (accessed on 25 June 2013).

NHS England (2013a). *CCG Assurance Framework 2013/14 (outline proposal and interim arrangements)* [online]. Available at: www.england.nhs.uk/wp-content/uploads/2013/05/ ccg-af.pdf (accessed on 14 June 2013).

NHS England (2013b). *Primary Medical Care Functions Delegated to Clinical Commissioning Groups: Guidance* [online]. Available at: www.england.nhs.uk/wp-content/ uploads/2013/04/pri-med-care-ccg.pdf (accessed on 14 June 2013).

NHS England (2013c). *Quality Premium: 2013/14 Guidance for CCGs* [online]. Available at: www.england.nhs.uk/wp-content/uploads/2013/05/qual-premium.pdf (accessed on 14 June 2013).

NHS England (2013d). *Towards Commissioning Excellence. A strategy for commissioning support services* [online]. Available at: www.england.nhs.uk/wp-content/uploads/2013/06/towa-commis-exc.pdf (accessed on 24 June 2013).

Raleigh V, Tian Y, Goodwin N, Dixon A, Thompson J, Millett C, Soljak M (2012). *General Practice in London: Supporting improvements in quality.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/articles/general-practice-london-supporting-improvements-quality (accessed on 14 June 2013).

Regen E (2002). *Driving Seat or Back Seat? GPs' views on and involvement in primary care groups and trusts.* Birmingham: University of Birmingham, Health Services Management Centre.

Roland M, McDonald R, Sibbald B (2006). *Outpatient Services and Primary Care: A scoping review of research into strategies for improving outpatient effectiveness and efficiency. A report to the NHS Service Delivery and Organisation R&D Programme from the National Primary Care Research and Development Centre and Centre for Public Policy and Management of the University of Manchester.* London: National Coordinating Centre for the Service Delivery and Organisation research programme. Available at: www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1518-082_V01.pdf (accessed on 14 June 2013).

Schoen C, Osborn R, Squires D, Doty M, Pierson R, Applebaum S (2011). 'New 2011 survey of patients with complex care needs in eleven countries finds that care is often poorly coordinated'. *Health Affairs*, vol 30, no 12, pp 2437–48.

Sheaff R, Sibbald B, Campbell S, Roland M, Marshall M, Pickard S, Gask L, Rogers A, Halliwell S (2004). 'Soft governance and attitudes to clinical quality in English general practice'. *Journal of Health Services Research and Policy*, vol 9, no 3, pp 132–8.

Smith J, Curry N (2011). 'Commissioning' in Mays N, Dixon A, Jones L (eds). *Understanding New Labour's Market Reforms of the English NHS.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/understanding-new-labours-market-reforms-english-nhs (accessed on 14 June 2013).

Smith J, Curry N, Mays N, Dixon J (2010). *Where Next for Commissioning in the English NHS?* London: Nuffield Trust. Available at: www.nuffieldtrust.org.uk/sites/files/nuffield/publication/where_next_for_commissioning_in_the_english_nhs_230310.pdf (accessed on 14 June 2013).

Smith J, Goodwin N (2006). *Towards Managed Primary Care: The role and experience of primary care organisations.* Aldershot: Ashgate Publishing Ltd.

Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R, Walsh N (2013). *Securing the Future of General Practice: New models of primary care.* London: Nuffield Trust.

Smith J, Mays N, Dixon J, Goodwin N, Lewis R, McClelland S, McLeod H, Wyke S (2004). *A Review of the Effectiveness of Primary Care-Led Commissioning and its Place in the NHS.* London: The Health Foundation. Available at: www.gloslmc.com/guidance/previous/PC%20led%20commissioning%2005.pdf (accessed on 14 June 2013).

Smith J, Walshe K (2004). 'Big business: the corporatization of primary care in the UK and the USA'. *Public Money and Management*, vol 24, no 2, pp 87–96.

Starfield B (1998). *Primary Care: Balancing health needs, services, and technology.* New York: Oxford University Press.

Thorlby R (2013). *Reclaiming a Population Health Perspective. Future challenges for primary care.* London: Nuffield Trust. Available at: www.nuffieldtrust.org.uk/publications/reclaiming-population-health-perspective (accessed on 14 June 2013).

Thorlby R, Rosen R, Smith J (2011). *GP Commissioning: Insights from medical groups in the United States.* Available at: www.nuffieldtrust.org.uk/publications/gp-commissioning-insights-medical-groups-united-states (accessed on 14 June 2013).

Thorlby R, Smith J, Barnett P, Mays N (2012). *Primary Care for the 21st Century: Learning from New Zealand's independent practitioner associations.* London: Nuffield Trust. Available at: www.nuffieldtrust.org.uk/publications/primary-care-21st-century-learning-new-zealands-independent-practitioner-associations (accessed on 14 June 2013).

Wilkin D, Coleman A (2001). 'From primary care groups to primary care trusts in the new NHS in England'. *Primary Health Care Research and Development*, vol 2, no 4, pp 215–22.