Commissioning and GPs: to commit[tee] or not?

Julie E. Drake

Abstract

Clinical commissioning groups (CCGs), part of the National Health Service since April 2013, are complex organisations requiring buy-in by GPs for strategic success. CCG budgetary deficits and lack of sustained engagement by GPs have been reported. This article utilises evidence of GP experience in commissioning models to determine the factors that may influence engagement in the governance of CCGs by GPs, which is crucial if clinically led commissioning is to be part of a financially sustainable NHS.

Key Words: Clinical Commissioning Groups; NHS; Governance

Introduction

Clinical commissioning groups (CCGs) are groups of practices responsible for commissioning healthcare for a population. GP commissioning has taken different forms in the UK (see Greener and Mannion (2008) for a review). These commissioning models began under the broad description of New Public Management (NPM), and are 'experiments' (Broadbent and Laughlin, 1997) with resource management implications. Osborne (2010) summarized NPM: taking lessons from private-sector management; the growth of hands on management; focus on entrepreneurial leadership; emphasis on input/output control, evaluation, performance management and audit; disaggregation of public services to the most basic unit (in the case of GP commissioning with the GP as first point of patient contact); and markets, competition and contracts for resource allocation. NPM and a reform agenda that emphasises governance structures have combined in CCGs such that the initiative impacts the organisation but also individuals living and contributing to policy as models are brought to life by the 'actors' who take on different roles. What would good governance look like, is GP involvement important and how might it be encouraged?

The individual role of GPs has not recently been considered in CCGs - yet so much is expected from GPs *in* commissioning and clinical leadership needs leaders. Pollitt (1993) recognized, "reforms did not merely alter lines on organisation charts: huge changes of role and skill were involved for those groups of staff concerned" (p.181). Ham (2014) has highlighted the importance of leaders in secondary care in acute trusts. Now consideration needs to be given to lead roles in primary care. Many GPs have acquired commissioning roles and skills, including leadership, since fundholding in 1991, and those experiences can provide valuable lessons that can inform policy and the future of CCGs.

What do CCGs look like?

CCGs have a statutorily required governing body - the board, remuneration committee and audit committee. The main board should include GPs from the practice area, a registered nurse and a specialist doctor in secondary care led by a clinical lead and an accountable officer. Therefore under prescribed structures some GPs have to be involved in the governance of CCGs. CCGs have binary accountability; statutory to the NHS Commissioning Board (NHSCB) and, as a membership organisation, to the practices. There is variety in the configuration of the board and a mix of clinical and non-clinical participants in 221 CCGs. For example the Accountable Officer (NHSCB, 2012) can be a clinician providing they are supported by an expert manager, or vice versa, and the clinical lead might be a doctor or nurse. With multiple GPs within practices there are limited places for GPs from individual practices to be involved at board level or for all practices to be represented. Individuals have choices about the role they volunteer for and how they shape it. Furthermore, all GPs have choices about the level of personal engagement with CCG responsibilities and outcomes.

Despite an onus on clinical leads, GP representation on boards has decreased since shadow CCGs were formed. Less than a third of CCG boards have GPs in the majority (Kaffash and Money, 2014). Earlier commissioning models and NPM 'experiments' were associated with bureaucracy and, if GPs do not get involved in CCGs through committees, then imposed management through non-clinical leadership may ensue. This lack of engagement is not a new phenomenon. Doctors are reluctant and resistant to engage in management roles, as first reported in secondary care (for example, Dopson, 1994; 1996). Although GPs have had less opportunity, compared to hospital doctors, to get involved with management and governance of the NHS, reluctance has occurred in primary care (Cowton and Drake, 1999). Now GPs appear to be showing reluctance to commit to a governance role in CCGs.

GP engagement

Some GPs have already been involved in committees as part of NHS governance and within commissioning models. GPs were board and/or committee members in Primary Care Groups (PCGs) and later, as examined by Abbott *et al*. (2008), as part of Professional Executive Committees (PECs) within Primary Care Trusts (PCTs). Abbott *et al*. (2008) noted that GP engagement with committees decreased when committees "moved further away from the clinical workforce" (p. 304). CCGs bring governance through committees much closer to the clinical workforce in general practice than PCGs or PCTs did as they represent grouped practices bound together by a budget. However, engagement in lead, or governance roles, is less than hoped for. Engaged GPs have experienced no increase or decrease in their engagement in CCGs one year on indeed some GPs report being less 'highly engaged', and, if they were without a formal role, remained less engaged and involved (Robertson *et al*., 2014).

It is important that GPs are given, or choose, roles and become engaged in management, managerial decisions and committees that support the strategic direction and mission of the NHS. GPs are the conduit in the policy that requires general practices in CCGs to engage with stakeholder groups (NHS Institute for Innovation and Improvement, 2011), channelling the patient voice, demonstrating local governance to meet the needs of the community it serves. There is an inherent assumption that some GPs will get involved in governance to put the patient at the heart of the NHS and push the clinical perspective up through the hierarchy. Yet, Goldberg (2014) identified a risk that GPs will become 'disenfranchized from commissioning'. It is an apriori condition that commissioning models need to engage *some* GPs to contribute to organisational models to help address the key issues facing the sustainability of the NHS. Further, engaged GPs can champion commissioning so that fellow GPs understand more about the organisational structure they have to function within. Thus, engagement does matter and insight into conditions GPs favoured in past models provide lessons that will encourage involvement on boards and committees to facilitate 'buy in'. This is increasingly important in respect of commissioning and financial management within the NHS at a crucial time where only one in three CCGs are confident of not being in deficit in 2015-16 (Appleby *et al*., 2014). It is too early for evidence on the current model to determine the conditions favoured, so this paper draws on evidence from cases of GP engagement in earlier commissioning models. It identifies factors that will influence engagement in the

committees to support the strategy of clinically led commissioning. These factors are even more important now as GPs may be less likely to be committed this time because of the sense of *déjà vu* noted by Lapsley (2008), having been subject to successive NHS reforms.

Cases of career in early commissioning models

Six case studies of GPs, in a single county in England, over a 10 year period, are drawn upon. All had been lead partners for their respective practices during fundholding. The participants were first interviewed under fundholding in 1998-1999 and later interviewed in 2009 about their experiences of PCGs, PCTs and Practice Based Commissioning (PBC) with a series of open interview questions. These past experiences revealed the factors that influenced GPs to adopt (or reject) non-clinical responsibility and roles. The perspective provides insight on how to engage some GPs in governance of CCGs. It reveals conditions that might make GPs satisfied with governance arrangements of the bodies to which their practice is affiliated, even if they choose not to be in the 'lead' role. It is vital to consider an engaged body of GPs and not a single GP or a few champions who sit on committees. There is a shortfall in the number of GPs (RCGP, 2013) as more GPs are retiring with the loss of resource and expertise. Hence, understanding those who have experienced policies before, late career GPs, may mean fewer of them become disenfranchized and choose not to leave the NHS while still considering how GPs as a larger group will react to roles taken in commissioning models.

Three sections follow. The first describes a typology of GPs in lead partner roles based on the evidence from a longitudinal panel study of six GPs. The second section examines how the types of GP engaged in the commissioning models subsequent to fundholding. The third section discusses issues from the cases that suggest the factors that may influence engagement in the committees of CCGs and makes recommendations for successful engagement.

Commissioning pioneers: case studies and typology

The longitudinal study began with twelve practices and concluded with six case studies of GPs. Practices *volunteered* for early commissioning for both positive and negative reasons (Cowton and Drake; 1999: Ennew *et al*.,1998) and the enthusiasm of those taking on a lead role did not necessarily have a positive correlation with the practice motivation for

fundholding. A typology was created based on twelve GPs characterising the different types of lead partner from a two-dimensional analysis of reasons for the *practice* going fundholding and the individual enthusiasm of the GP. There were three types of GP: guardian; opportunist; and, reluctant innovator. Table 1 shows the career status of the 6 GPs alongside the 'type' assigned during the early commissioning model of fundholding.

GP	**Type**	**Career Status as a GP**
1	Guardian	Semi-retired
2	Opportunist	Retired
3	Opportunist	Full-time
4	Opportunist	Full-time
5	Reluctant innovator	Full-time with time buy out as PCT clinical lead in a specialist area
6	Reluctant Innovator	Resigned on date of interview

Table 1 GP by type and career point

Guardians were enthusiastic participants in commissioning focussed on the contracting, data and computerisation as part of the commissioning role. They sought to protect their own practice and its patients by improving the practice infrastructure through computerisation and increasing service capacity. The *guardians* protected the practice facing opposition from fellow partners on commissioning as a policy and an overall negative set of factors for the practice going fundholding. The guardians used the contracting tool to manage the patient experience of those on their list and develop in-house services.

On the other hand *opportunists* (enthusiastic GPs leading practices going fundholding for positive reasons) were found to be adept in using government policy, working on a macro scale beyond the practice. Opportunist organized schemes to develop the organization, not always emphasising protection of their own patients. They were often keen to influence primary health care beyond the practice boundary, looking at the geographical region. Moreover, they were found to avoid an ennui suffered on a personal level by general practice, being more 'political' in their motivation than parochial.

A third type emerged, the *reluctant innovator*, who was part of a practice going fundholding

for negative reasons, similar to guardians, but less intent on developing/guarding the practice, being more outward looking. Reluctant innovators aimed, for example, to keep the local, tiny hospital open and often headed up the scheme because no other person stood forward to do so.

The typology is used to give insight into a range of potential GP views on participation and activity in governance roles, and particularly committees in CCGs. The experience of those GPs participating in the chronology of commissioning reveals some of the factors that both encouraged and discouraged engagement in the governance of commissioning units.

Individual reflection on commissioning

This section examines issues emerging from the case studies when the different types of GP engaged in successive commissioning models. What was their role? What did the GPs like and dislike? What engaged them, or discouraged them, in representing their practices or motivated them to choose a committee role? The implications for CCGs are further considered in the third section.

The guardian: GP_1

GP_1 was involved in early PCGs, as joint chairman. He handed over full responsibility to the joint Chair who had "bundles and bundles and bundles of time… it wasn't working as two people largely because I couldn't give the commitment and I wasn't sure of the direction". The direction was described as 'political' with multiple agencies involved in commissioning, with less emphasis on individual practice aims – and patients. GP_1 described the local Council and Social Services being involved as "pretty uninteresting". He did not put himself forward for other PCG committees seeing them as making little difference, nothing really happening, nor little identifiable benefit in being personally active in external relations between the practice and the PCG, "…couldn't see any purpose in it":

> *... bits applied to medicine I quite liked but I'm not heavily into joined up management type stuff…bringing this service and that service...not what I'm good at.* (GP_1*)*

GP_1 did not have a role in the PCT and nor were other partners from his practice. There was more dissatisfaction with politics at play:

There was a lot of reading involved in all these things ... don't get a buzz out of that, I get a buzz out of doing things I can directly see a benefit for my patients…some or all of them were political appointments. (GP_1)

The creation of larger boards through levels of commissioning was less successful in committing GP_1:

...it was such a big board (PCT) with fifteen to twenty people... very difficult to get a small feel to it where you got shared agreement ... an awareness that if you had somebody from the council, a councillor on the board, and you were saying something important it would get back...it wasn't like you were having a conversation and saying that's a good idea we'll do that tomorrow [in the practice]...I just wasn't enamoured with the political process I think I was waiting for some change...I didn't give up for good. (GP_1)

It seems board members were courting favour with agencies aligned to primary care but little discussion and decision making that impacted at GP service level. GP_1 was unable to exercise a guardian role to protect the practice and see benefit for patients. However, later, PBC did engage the GP as being part of the decision making process which was important to him:

...suddenly to be involved in group with energy that's making a big difference and, with a few more decisions in our favour, I think we'll make crucial difference to how care can be delivered and the sort of access of the area...it's developing the organisation...I help make the decisions more rounded... ($GP_{1)}$

$GP_{1,}$ was able to bring the clinical and practice perspective to PBC and by being able to do that became engaged in commissioning for a second time with personal satisfaction. As commissioning decisions and outputs impacted more on the practice and its workforce the engagement of the guardian was sealed.

Opportunists: $GP_{2,}$ GP_3 and GP_4

Like GP_1, GP_2 wished to be involved in PCGs but realized that members were "people who were more interested in politics, to my way of thinking, and not those who actually understood hands on general practice". He described being "generally ignored" and frustrated with administration and management created by non-medical staff and there was less opportunity for the opportunist:

diktats that came down… the financial side of it was done by diktat not by agreement so that they would change the rules... rules that were arcane, were a little confused…It wasn't a major problem because you know that any GP who

was running his own practice and had any business sense would use the system. **(**GP_2)

There was no committee participation with PCGs for opportunist GP_2 and GP_3. However GP_3, after describing the period 'as the doldrums' did secure a place on the PEC (Professional Executive Committee), the role of which was to add "clinical perspectives to decisions that were taken elsewhere in the PCT" (p.299, Abbot *et al*. 2008). Like GP_2, GP_3 hankered after the proximity of commissioning to the practice benefit, particularly the data and information it generated :

... frustration because you used to remember what you had achieved, what leverage you used to have, what you might have achieved, all the statistics you had… There have been changes for the better but also changes for the worse... eventually I thought – OK I'll give it a go, trying again. That was the route by which a GP might attempt to influence the acute trust…the purchase of secondary care. **(**GP_3)

GP_3 found a way to engage and influence. GP wanted more involvement at committee level consistent with his opportunist type "purely for selfish reasons because I knew by being here, though I wouldn't get any favours, I could drive forward policy on 'x'". GP_2 clearly loathed the perceived bureaucracy. GP_2 volunteered for a working party in an area of national policy of his own personal interest rather than directly benefiting practice and patients. Opportunists disliked the inability to execute original ideas and inability to get on committees:

... somebody at the PCT whose job it was to go round and check the notice boards in GP's surgery's to make sure that they had good information on them… notice board monitor integrated with a another job… to make us think that we had representation that was meaningful but in fact I cannot remember a single decision that they made that was actually beneficial to us and detrimental to the PCT. If I wanted something I would go for it myself, and argue with the PCT. **(**GP_2)

GP_3 liked to be involved with the data generated at practice level, using it use it to make a difference, which bodes well when GPs in CCGs can engage stakeholders to provide data for evidence based commissioning. GP_3 became disenfranchised when "the dissenting view [his] wasn't always acknowledged in the minutes and I got cheesed off" culminating in GP_3's pique and subsequent resignation. Notably, the fraught relationship and tensions arising from PECs was not unusual, for example evidenced by Abbot *et al*, (2008) in a study of two PCTs, with PECs moving away from inclusiveness of the clinical workforce, this was borne out:

> *… I became disillusioned because I thought I was just being used as a rubber stamp…I'm not a representative of the GPs. I was appointed by you [the PCT] via an interview so don't quote me as agreeing to all these changes.* **(**GP_3)

GP_3 was unhappy and perceived his view to be taken as collective representation rather than being there for clinical perspective, nor did he approve of his view being taken as collective. There was little interest in a committee role within PBC and he had resigned from lead roles within the practice. Where once he was engaged, he became disengaged.

Unlike GP_2 and GP_3, GP_4, had multiple committee roles before and after his activity in fundholding. Some roles restricted him in taking further roles due to conflict of interest (for example, Non Executive Director at the Health Authority). He lamented the PCG period "not that it was a spent force, we just didn't see any changes from the PCG" and he did favour GPs working together:

> *...what we did manage to do was to actually get the GPs sufficiently united to form our own on call cooperative which was interesting and exciting... worked extremely well indeed.* **(**GP_4)

And, the not so favoured:

> *...active fundholding GPs put themselves up for election to primary care groups and got elected. They changed once they got the part... they got told that they had corporate responsibility for the decisions made by the PCG.* **(**GP_4)

Asked to summarise what he got from PCTs, the answer again was 'not a lot' with him "more cynical". He commented on conversion of some GPs into PCT managers referring to one GP; "he's a director not a medical GP any more". PBC became a significant low for GP_4, largely due to indicative rather than real budgets, although he had been enthused about it:

> *We saw it probably as fundholding, more complete but without the benefits... we didn't have a much freedom to move the money around. I'm the wrong person to speak to, my colleague was the Chairman of a large PCG he took over from me… I just got so peed off…the mind-set of the people [at the] PCT stonewalling.* **(**GP_4)

Like GP_1 and GP_2, GP_4 attentively observed the activity of his peers who are chosen to 'represent' them in the guise of taking committee roles. GP_3 was conscious of being held as the consensus view holder and was troubled by it. Thus there were those who

had been observed as content in adopting and holding a corporate view but those taking a corporate view are a disappointment to some of those they represent. However the six GPs in this study have been experienced in the rapid succession of changes in the NHS and may well be more likely to be disgruntled or disenfranchized.

Reluctant innovators: GP_5 and GP_6

GP_5 began as a reluctant innovator, unenthusiastic about fundholding. As PCGs began she was part of the "sort of steering committee" but the practice shared premises with another practice that had a GP who decided to stand against GP_5. After a split vote she found herself "not having much to do with it [role in PCG] after that". She had wanted to be involved and seemed sad that she had not achieved personal involvement at committee level. She attributed a link between practice sizes and GPs getting on committees, primarily because it was one vote per GP, thus the larger the practice ("some very powerful practices at that time") had more votes:

> *They were motivated ... political animals …some practices just aren't bothered and only moan when things go wrong. I wanted here to be represented because we serve a very deprived population…make sure our patients get a fair crack of the whip… if you're not in there fighting for them sometimes it is easy to forget people because they are not middle class and articulate.* **(**GP_5)

This reluctant innovator was moving towards a guardian type. GP_5 demonstrates the dilemma faced as a GP as patient advocate when there are limitations to the degree of involvement imposed by different models of commissioning. Getting on committees was hard and when the practice was out of favour, faces 'did not fit' resulting in no committee involvement for this motivated GP_5. Later GP_5 was involved in steering committees and the development of a clinical lead role in PCTs but *"Guess what – same old!"* referring to the same GPs from larger practices being involved at committee level.

GP_5 and GP_6 contrast as GP_6 presented a difficult and short interview where it emerged, after some resolute and stunted responses, that GP_6 had resigned on the day of the interview. GP_6 also differed from GP_5 in her shift to guardianship type as his lack of enthusiasm deepened in the era of PCGs, "... less hands on and lost controls". He participated in a fundholding group alliance of similar practices that could work together during the move to PCGs but "took more of a back seat. I went to the meetings and sat there".

Evidently another partner came along at the time and gradually took over what GP_6 described as "that sort of role" defined as:

> *Sort of external management as opposed to internal management within the practice. So he's taken over that role, he's become a member of the LMC…goes to meetings with the practice manager.*

It seems this reluctant innovator was usurped by an opportunist type, though the role had not been clearly defined, as a partner who had become more externally engaged began "to take over more and more". GP_6 considered that the practice had "lost out" in being part of a PCG and that personally he got "nothing much at all, I don't think - I got stressed". On the respective roles and contribution of GPs during this time he stated that "I don't think I can put anything into words really" and the tone was wry humour.

When asked directly what sort of people got onto committees the response was a "definite clique of people that got on…I think I was being a bit cynical about what went on in the committees". He did not assign himself to being part of that group, or clique and finally:

> *When it was fundholding everything was, or everything was to do with our practice, was out in the open, we knew exactly where we were, we knew exactly what the money situation was even though it is not real money, it was sort of virtual money, and then it was PCTs. It sort of got vague, and now it's even vaguer.* (GP_6)

Discussion

This section identifies issues from the cases considering how the evidence might influence engagement in the governance of CCGs by GPs, broadly: not every GP can be involved; GPs representing GPs is a delicate matter; and, GPs become involved in, or disengaged from, roles in management and committees for different reasons. Therefore, individual GP motivation, type and perception of GPs in other roles may impact on how harmonious binary accountability can be.

Initial observations and implications

At the simplest level, the evidence suggest that GP commitment to CCGs, through committees, will be stronger when roles and committee activity is closer to the clinical workforce, clinical activity and therefore aligned closer to GPs' individual practice and patients. Some GPs do not mind working in grouped practices when they perceive clinical

impact but they do not like large committees (boards) that lose clinical impact which has implications for the size of both CCGs and constituent committees.

Essentially, there are three kinds of GP to engage in CCGs: the representative on the board; those that want to represent and do not achieve the place on the board; and, those that do not want to represent. It emerges that GPs like roles to be defined and responsibilities to be clear, including to patients, in order to sustain engagement. The roles defined by the NHSCB are a good starting point for GPs to be aware of how they might engage but there is scope for choice and variability in CCG roles and the mixture of clinical and non-clinical members. There are challenges and questions for binary accountability. For example: what roles are most engaging for GPs; what factors sustain engagement; and, what influences satisfaction of GPs without a structural role? Not only are there different roles, there are GPs at different stages of career and with different experience of different commissioning models. Experience of commissioning may contribute to success of the CCG by helping to ensure a "governing body that must take account of the longer term consequences in setting business model and strategy" (p.5 Imison *et al*., 2011). However, there are multiple risks for CCGs that need further exploration to avoid: a politicized board that may disengage a significant proportion of GPs within a CCG (GP_1, GP_2), to the extreme of retirement (GP_6); larger boards convened to get everybody involved but which may not be effective (GP_1); too much multi-agency related discussion and not enough impact at primary care service level (likely to further disenfranchise GPs); and, risk of larger practices dominating the board (GP_6). There are matters from the case studies that will help engagement of GPs to give more 'clinical voice' on committees but first the complexities need consideration, primarily representation and politicisation.

Getting GPs on committees

Not all GPs can sit on the main governing body within a commissioning structure and represent their practice and patients. Some GPs may be happy to engage at sub-committee level, some may have no CCG role and 'be engaged' *if* the main board is not perceived as overly political. The politicized board presents a risk of being a deterrent to some GPs engaging in a committee role for two reasons; decisions are not congruent with the 'in practice' peer group attitude to commissioning hence the role of representing a practice is not attractive; and a risk of being perceived as the non-medical GP by other members of the profession. The need is for a stakeholder board with the GP in situ as the patients' advocate

and an advocate for fellow GPs (without alienating them) and the individual practice – a 'guardian'. Moreover, careful selection from candidates putting themselves forward for appointment to the board is significant, given the geographical nature of practices within CCGs and the history of general practice, and GPs, in a locality. On the one hand experienced GPs may be ideal but at a risk they may be classed as the 'same old'(GP_5).

The impact of over politicisation of the board should not be underestimated as it may be compounded by the issue of GPs on boards representing other GPs, that is non-board GPs. Politicisation impacts on non- board GPs' perception of the board representatives' behaviour, for two reasons: firstly, when decisions are remote, for example multi-agency inter-play (GP_1, GP_5) and do not have immediacy for the services at practice level the non-board GPs become disillusioned with committee activity; *and* non-board members become disillusioned with committee members who take a political career in commissioning. This suggests that there are the 'wrong sort' of GPs, likely the opportunist type, focussed on extraneous relationships that will undermine CCG success when it is measured by engaging the broader GP population. The 'wrong sort' attached to CCGs may exacerbate feelings of déjà vu, bureaucracy and politics associated with PCGs and PCTs. A disengaged non-board peer group, for example disgruntled like GP_2 and GP_3, with worst case scenario the exit point of GP_6, means large numbers of GPs may be disenfranchised.

It seems that GPs representing GPs is a delicate matter perhaps arising from the level of professional autonomy and worsened by worries about being perceived as the renegade GP who might actually want a lead role in management or governance. GPs in this study did not like to be ascribed as spokesperson with 'one GP world view', nor do they like to see peers becoming a 'non-medical GP' as described by GP_4. It seems that the collective view is a difficult one for GPs to take. This may be remedied with role descriptions and communication up and down the governance structure that is transparent and practice focussed. Recognising diversity of views from each practice and a growing appreciation over time of the clinical led roles as CCGs mature as organisations may ease issues of GPs as representatives. GPs in the study were troubled by being (e.g. GP_3) in a representative position, nor did they like to be there as a rubber stamp without having their voice heard. Thus there are challenges in the way CCGs and committee GPs manage and communicate their role and activities to avoid peers perceiving them as 'going over to the dark side of the corporate board'. The aim should be to avoid disenfranchising non-board GPs.

Despite the availability of multiple candidates, participation in boards is falling, thus what type of GP should be encouraged? Guardian types are those who will contribute to make CCGs a success for the membership body. They are enthusiastic about policy but keep the patient as the focus of the reasoning behind taking a lead or committee role. Opportunists' tendencies would mean more likely to engage with policy and become political, possibly more corporate, with the consequence of losing the support of membership practices and GPs. On the other hand, reluctant innovators would not have the enthusiasm to be a strong board member and may simply be the rubber stamp. However, the more disenchanted GPs become with the board, the more likely the reluctant innovator will end up there. Lack of enthusiasm caused shared roles to evolve ($GP_{6)}$, as did competition (GP_1). Joint roles do not seem to work in the long term (GP_1 and GP_6) as inevitably, one GP stands down which increased the number of disenfranchised GPs.

What way forward?

GP commitment to CCGs is a complex area with committee engagement being just one consideration in the success of CCGs. There are four recommendations: firstly, careful attention to how GPs get 'into office' so that the membership engage with commissioning; secondly, a strong degree of impact on the board by the GP elect to be the 'clinical voice'; thirdly, governance and decision making that reaches individual practice level transparently – to emulate the guardian; and a GP who is seen not to be too political, nor opportunistic, who can represent all the practices within the CCG and not minding taking a collective view. These conditions will be supported by good communication of governance and will be key for more GPs to feel enamoured with their CCG or as one GP in the study foresaw:

> *...I don't think commissioning is going to work... I mean if you get a committee to design a horse you end up with a camel...everything will come down to the lowest denominator...if I were part of a commissioning group why the hell would I care if I overspend...*

This paper does not purport to include all potential views on participation and activity in commissioning, nor to prescribe how to get GPs to commit and engage in commissioning towards its success. The analysis does provides insight into GPs participating in the chronology of commissioning, revealing some of the factors that both encouraged and discouraged engagement in the governance of commissioning units. CCGs are complex entities that are highly accountable to the public and government with published guidance on good governance derived from corporate and non-corporate governance models, but they are

truly unique. With statutory accountability and membership accountability they must have the clinical voice and that means engagement of doctors, which brings a different context to governance. The area is fertile ground for research in appreciating governance in non-corporate settings to help policymakers, professional bodies and associations contextualise governance for success in CCGs. Further, the typology of GPs within the paper will be helpful in future research which should examine the views of commissioning GPs and examine membership structures that will provide insightful analysis of how governance in CCGs might be analysed, designed and be effective.

Conclusion

The article has reflected on the experiences of GPs in successive commissioning models, bringing implications for the success of CCGs and giving indications of how commitment of GPs can be facilitated. The CCG model has potentially good signs of achieving clinical engagement: real budgets with commissioning proximity to patient; data for engagement with stakeholder groups in the locality for evidence based commissioning; and, clinical leadership. Prima facie the indicators of CCG success are twofold: the level of GP engagement on boards; and, CCGs not in deficit. For contribution to the financial sustainability of the NHS the focus should not be about GPs taking an individual lead role but how that GP link with governance can engage a body of GPs. Achieving GP involvement and clear communication will contribute to good governance. However, how GPs get to a board position may need some attention in terms of the rules of CCG to facilitate the right sort of GP with characteristics that engage other GPs within the CCG structure. With GP engagement decreasing and deficits increasing, how CCGs are being governed and how they are structured will require monitoring and evaluation of CCGs as a sustainable model with emphasis on identifying good practices that provide value for money.

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