Clinical leadership in service redesign using Clinical Commissioning Groups: a mixed-methods study

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Scientific summary

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Background

This report presents the findings from a research project that was designed to reveal how effectively clinicians [particularly general practitioners (GPs)] have made use of the platform of Clinical Commissioning Groups (CCGs) to bring about the kind of redesign of service provision that was expected of them. The policy documents made clear that GPs, in particular, were invited to and expected to exercise clinical leadership. Our aim was not only to uncover whether or not they had risen to this challenge but, more importantly, where this had been achieved, what had been involved and what barriers had been surmounted.

When the CCGs were set up in 2012/13 they were designed to devolve considerable responsibility and accountability to clinicians – especially GPs. Such an innovation raised a number of important questions: would GPs and other clinicians 'step up' to meet the leadership challenge as was plainly expected in the policy statements? If so, how would they do so? What kinds of clinical leadership would emerge? What would they do with the new opportunity? In addition, crucially, the question arises as to what difference clinical leaders in and around CCGs have actually made. As far as we are aware, despite a number of research reports about CCGs (e.g. about their governance and their engagement of GPs), until now there has been no systematic reporting and analysis of the actualities of clinical leadership in and around CCGs in specific service redesign attempts.

Objectives

The overall aim was to assess and clarify the extent, nature and effectiveness of clinical engagement and leadership in the work of the CCGs. This was broken down into five main research questions.

1. What is the range of clinical engagement and clinical leadership modes being used in CCGs?
2. What is the extent, and nature, of the scope for clinical leadership and engagement in service redesign that is possible and facilitated by commissioning bodies, particularly the CCGs and the health and well-being boards (HWBs)?
3. What is the range of benefits being targeted through different kinds of clinical engagement and leadership?
4. What are the forces and factors that serve either to enable or to block the achievement of benefits in different contexts, and how appropriate are the different kinds of clinical engagement and leadership for achieving effective service design?
5. What can be learned from international practices of clinical leadership in service redesign in complex systems that will be of theoretical and practical value to CCGs and HWBs?

Theoretical perspective

The theoretical perspective we used to investigate this activity was based on institutional theory. Health care takes place within, and through, institutions. These institutions include GP surgeries, outpatient appointments, mental health institutions, and primary, secondary and tertiary care institutions. Emergent health and well-being perspectives extend the institutional field to include local authorities, voluntary agencies, housing associations and so on. These institutions are built over time and become taken for granted. These institutions become 'sedimented'. Sedimentation is a key concept in institutional theory. Changing configurations of service provision requires 'institutional work', but making such changes can be

problematical. Institutions are maintained by established interests using devices (such as professional boundaries), bureaucratic mechanisms (such as job evaluations and job grades) and cultural mechanisms (such as beliefs and norms). Change sometimes means potential threat; hence much institutional theory focuses on the stabilising and 'maintenance work' undertaken by institutional actors. For example, professionals and their professional bodies construct and seek to defend their 'jurisdictions'. Yet, as we show in this report, institutional work can involve modification of existing institutions and the creation of new ones. This interplay between defence routines, disruption and innovation is in many ways the story of the CCGs.

The building of institutions is underpinned by logics. Thus, a market logic requires plural agents able to compete on price and other bases, such as quality. A bureaucratic logic uses plans, rules and division of labour. A network logic relies on collaboration and negotiation. From time to time a particular logic may become 'dominant' and accepted. At other times logics are in competition. The very creation of CCGs was itself an outcome of institutional work – in this case work done at the parliamentary level led by a particular Secretary of State. The institutions created had a bias towards a logic of efficiency driven through competition, but the details of how the new institutions should operate in practice were left somewhat open. Hence, much more institutional work was required at a local level. This was the work we set out to investigate.

The CCGs, with 'GPs in charge' and a relatively open agenda for change, represented one such moment for a potential shift in the design of the institutional architecture. However, they were faced not with a blank sheet but with a set of existing institutions whose agents often sought to protect current arrangements. Another complication is that the nominated agents (in this case GPs) may not necessarily step forward to accept the 'opportunity'. In addition, crucial to the account given in this report, other institutional work designed to drive other changes to the health-care system can be seen to overlay and compete with the focal initiatives.

Research methods

The project proceeded in five phases. The first of these was an extensive scoping study across 15 CCGs from different parts of England covering major urban areas and rural locations. The second phase and component was the design and administration of a first national survey of all members of CCG governing bodies. This was undertaken in 2014 and had a response from 79% of all CCGs (12.4% of the total population of CCG board members nationally). The third phase was a major piece of work involving six main in-depth case studies. These cases were selected using purposive sampling. The national survey was used as a sampling frame, and this allowed investigation of a range of cases that illuminated selective aspects of clinical leadership in action in a variety of contexts. The fourth phase was a second national survey of governing body members, which was conducted in 2016. This survey allowed longitudinal comparisons and had a response rate of 77.5% of all CCGs and 12.2% of the total population of CCG board members nationally. The fifth phase was devoted to a set of international comparisons of findings and their interpretation in dialogue with different sets of international experts.

We sought to involve public and patients as far as was relevant and practicable at all stages. In the first instance, a nationally renowned patient and public involvement (PPI) representative, with very extensive experience of PPI, was appointed as co-chairperson of the Project Steering Committee. This representative was involved in all aspects of the research from the initial design to the discussions about dissemination of findings. During the course of the project, PPI was used mainly in relation to the specific service redesign initiatives that were the focal component of this study. These initiatives often had PPI arrangements in place and we tapped into these, rather than seeking to set up new arrangements. One extension of this approach was that a member of the project team sought permission to become an active participant member of a PPI group that was associated with one of the service redesign initiatives in the core case studies. Full ethics approval from the Research Ethics Committee overseeing the project was sought and full disclosure was made to members of the PPI group.

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Results

We summarise the findings in two subsections: results regarding CCGs and results regarding clinical leadership.

Findings relating to Clinical Commissioning Groups

- A number of CCGs were relatively passive. In these instances neither GPs nor managers had evidenced any scale of ambition for service change. However, other CCGs had been more active and had made an impact on secondary care, primary care or both.
- CCGs, overall, were constrained by other influential institutions and constrained by competing institutional logics and ambiguities.
- CCGs faced uncertainties about their autonomy, their power and their futures.
- Service redesign worked best when clinical leaders and managers worked in tandem.
- Some CCGs had sought to utilise their commissioning powers and they entered into extensive design of new and substantial outcome-based contracts with third-party providers (mainly in the fields of musculoskeletal and frail elderly care). Others had concentrated on collaborative working with existing providers in pursuit of new patterns of care.
- Policy initiatives at supra-CCG levels, most notably the *Five Year Forward View* (NHS England. *Five Year Forward View*. London: NHS England; 2014) and its associated new models of care and the sustainability and transformation plans (STPs), were increasingly relocating much of the inventiveness from CCGs into other hands.
- CCGs were increasingly sharing management teams and resources with their neighbouring CCGs.

Findings relating to clinical leadership

- Clinical leadership in and around CCGs is different in nature from that found in hospital settings where professional bureaucracies are entrenched. In the CCG context, cross-boundary intercession and negotiation across professional groups and across organisational boundaries is required.
- This requires different sets of capabilities; these were found to hinge around cross-boundary relationship building.
- We found clinical leadership practised in three arenas:

  i. the strategic apex of CCGs
  ii. programme board level
  iii. the delivery/clinical practice level.

- The imagining and articulation of a new service concept can arise in any of these arenas. However, effective and sustained service redesign required matching, mutually reinforcing and commensurate action across all three arenas. Clinical leadership is required in at least one of these.
- The programme board level of clinical leadership had a key role in resolving a variety of tensions between different clinical perspectives. Clinical and managerial leaders in this kind of board played a vital role in mediating between different managerial and clinical perspectives characteristic of arenas within the NHS.
- There are likely to be successive rounds of defining the nature of the new services and the skills involved. This defining work often involves rethinking the interfaces between previously overdefined and separate services that have become established under a contract-driven and somewhat adversarial model of commissioning.
- Achieving effective clinical input requires commissioners to find ways of providing reassurance that they understand how change can be managed collaboratively across the system, rather than competitively, with providers cast as winners or losers. Issues of continued viability of particular provider organisations may need to be faced, but this is more likely to be done effectively if commissioners join providers in thinking through what a viable future might look like for them.

The research found that, despite the limitations to the expected institutional work of service redesign using local commissioning, some clinicians in and around CCGs did rise to the challenge and seized the opportunity to find ways to create new and/or amended institutions. The report draws out the lessons from these more creative attempts. The processes of leadership, which we reveal in three different arenas (strategic, operational planning and service delivery), are illustrated in the context of CCGs; however, they also have relevance and carry lessons far beyond these particular institutions. CCGs happen to provide the natural experimental conditions, but how the dynamics of the interplay between policy-makers, managers and clinicians actually play out is of central relevance. Lessons can therefore be learned that go beyond these particular circumstances.

Novel examples of active clinical leadership in new forms of service design were uncovered. These occurred at different levels and in different arenas, and the patterns are described and illustrated in this report. At the other extreme, many CCGs struggled even to find GPs willing to serve on CCG governing bodies. In a significant number of cases, non-clinical managers rather than clinicians exercised the most influence; in yet other cases, hybrid manager/clinicians exercised influence. The problem perceived by many GPs was that too many non-clinical managers took their lead from the hierarchical structures of NHS England (NHSE) and thus the centre-led influence persisted. Moreover, within 3 years of their existence, other major nationally led initiatives and policy priorities took centre stage. Notably, STPs, launched in 2016, handed strategic service redesign to larger institutional footprints than the CCGs. Likewise, the influential NHSE initiative, the *Five Year Forward View*, placed emphasis on integration and collaboration rather than competition and commissioning. Many clinical leaders gravitated towards new provider organisations, such as the federations of general practices and other forms of large-scale general practice, rather than to the commissioning bodies.

Despite these challenges and limitations, we report on cases where GPs were encouraged by the climate of devolved leadership to seize the opportunity to redesign primary care by extending the reach and the quality of general practice. New workforce teams were constructed around GP surgeries and multiple professions brought in to provide more holistic care for patients – especially those with long-term conditions. Other examples of effective clinical leadership included changes to urgent care. The report examines initiatives in which GPs worked in tandem with paramedics and attended to emergency calls which would otherwise have resulted in ambulances inappropriately conveying patients to accident and emergency. Other examples include instances in which CCG leaders took greater responsibility to improve services offered by the hospital trusts. One of the more far-reaching attempts to leverage clinical leadership to redesign the health-care system concerned those instances in which integrated care programmes were launched. These brought together diverse health specialists alongside social workers and other support services to redesign the approach to care at population level so that it was more proactive rather than merely reactive, as had more traditionally been the case.

Conclusions

The report reveals details and illustrations of the processes of leadership by clinicians, by managers and by both in tandem. It demonstrates how these processes are played out in three different arenas. The analysis shows how institutional work in each of these arenas needs to take place interactively if a difference is to be made and sustained. Many instances were found where plans were constructed at the strategic level which failed to make a difference because the additional implementation work was not adequately done. Our analysis revealed the importance of the middle-level operational work, much of which took place in the arena of programme boards and related mid-level bodies. These had a focus on constructing the mechanisms, procedures and the protocols which helped translate grand conceptual plans into workable solutions. In addition, it was found that clinical leadership was required in the actualisation of service redesign through implementation leadership. This refers to the practice arena where clinicians adapt their practices to take advantage of the new schemas.

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Although the main context in which these processes are explored is that of the CCGs, they also have relevance and carry lessons far beyond these particular institutions. CCGs happen to provide the natural experimental conditions, but the dynamics of the interplay between policy-makers, managers and clinicians play out under many different circumstances. Much was changing during the course of the research project; this report reflects on the nature of the reactions to the changing context by the principal agents.

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