Methods of Mobilizing Clinical Engagement and Clinical Leadership in and around Clinical Commissioning Groups:

First Year Findings February 2014 to February 2015

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Introduction

This three-year project is designed to examine the variety of ways and the extent to which CCGs address the challenge of engaging clinicians and deploying clinical leadership in the redesign of services. We are in search of effective practice. In particular, we are assessing the extent to which these efforts lead to successful inroads into the achievement of integrated care. A prime focus therefore is upon cross-boundary working which transforms care.

Crucially, even within their short life span new policies and new developments mean that the significance of CCGs remains contingent. The policy landscape continues to change: some of the developments could potentially enhance the role of CCGs (for example, securing greater leverage through co-commissioning) other developments could potentially eclipse the influence of CCGs (for example, the growth of GP federations and the power exercised by central bodies). Much depends on how the clinical leaders act – and how other participants in the wider system also act. There is little that is automatic. An important policy initiative is the Better Care Fund which offers a pooled budget to support health and social care services to work more closely together. CCGs and HWBs have statutory duties to promote and encourage delivery of integration within their local areas (Monitor 2014). But this does not necessarily mean that GPs will control this space, Monitor states that in the future: ‘we expect that the range of NHS foundation trusts will include integrated care organisations (ICOs), as well as other innovative forms’ (Monitor 2014) (sec.4.1). Provider clinicians rather than commissioners may drive the development of integrated care
(Robertson et al 2014). As a consequence, the context is fluid and dynamic; the CCGs are not fixed institutions from which one could read-off certain outcomes. Rather, interpretation requires a *process perspective* (Parry 1998). As he notes: ‘Change is an essential aspect of the process of leadership. Hence, change incidents can be the basis of investigation of the leadership process’ (1998: 86). Clinical leadership and CCG enactment we approach as social processes with dynamic features rather than as fixed entities. Such processes need also to be understood in wider social context (Selznick 1957).

In sum, our analysis of policy documents and of studies of shadow CCGs and their predecessor bodies tended to find that while there is much ‘in principle’ support for the general idea of clinical leadership through commissioning, the extent of implementation of the idea (apart from a few notable pioneering exceptions) remained uncertain and contested. Other policies and institutions put checks on the exercise of power by these bodies. However, although practice to date falls some way short of stated policy intent, we conclude that there have been some significant advances in the exercise of clinical leadership by GPs which exceed patterns seen previously. The priority now is to ensure sustainability of these advances and their wider emulation.

Drawing on our first year of field research we seek to assess three themes:

1) The influence (power and resources) of CCGs in the wider context of health system institutions
2) The influence (power and resources) of clinicians, their engagement and leadership;
3) Impacts to date.

**Research methods**

The project is proceeding in a series of phases which include detailed case studies and national surveys. Through a number of international partnerships the work is also open to new ways of thinking by learning from international practice. The eight case studies undertaken so far included interviews with chief officers, clinical chairs, GP governing board members, lay members, nurses and secondary care doctors. In addition, a wider network of 15 CCGs has been used as a reference group to assess emerging trends and developments. The early findings were used to design a national survey instrument which was administered to the governing board members of all CCGs. This report also includes findings from early analysis of data from 500 completed questionnaires. The survey was conducted using a postal questionnaire and an online version. Returns were made all role occupants on CCG Governing Bodies including, for example, chief officers, accountable officers, chairs and clinical leads, GP representatives, lay members, finance officers, secondary care doctors, nurses and practice managers.
**Findings**

The CCGs, as new institutions, offer clinicians (and managers) a different platform from which they can potentially reshape and redesign services so that the patient experience and patient outcomes improve and the health system is sustainable.

The rationale for the focus on the influence of CCGs in the context of the wider healthcare system is that unless CCGs have sufficient power and influence, then other aspects such as training and development of clinicians for CCG work are of secondary concern. Of course power and influence is both a system function and also shaped by action. It is necessary to look at both.

For each of these three focal areas there are grounds for optimism and pessimism. Below we seek to cut through the complexity of the initial findings by assessing the balance sheet of the positives and negative signals to date. We begin with the negative side of the balance sheet before assessing the more positive case.

**Reasons to be cautious**

Under this heading we consider the extent of CCG power and influence; clinical leadership capabilities and resources; the degree of transformational change achieved or not achieved; and the extent of clinical influence.

It is important to begin with an assessment of power and influence because if these bodies are judged to have little influence then other debates about behaviours and development become less relevant.

**The extent of CCG power and influence**

In our national survey, 53% of CCG Governing Body members judged NHSE to have ‘little or some influence locally’ and 47% judged it to have between ‘quite a lot to very extensive. Thus the assessments of these governing players were broadly balanced. One could view this as a significant advance for localism or as a sign of a significant legacy of central power and influence.

**Clinical leadership resources and capabilities?**

The King’s Fund and the Nuffield Trust found that ‘enthusiasm appeared to be waning among many of the clinical leaders who first established CCGs and only a limited pool of interested GPs was emerging to replace them’ ((2015: 41). We too found concerns about the supply of next generation of clinical leaders; the pipeline appeared underpopulated. Yet we also found that efforts have been made to engage GPs who are interested but nervous by encouraging them to lead task and finish groups, specific clinical programmes, and sub-CCG localities. These forms create leadership ‘in little chunks’ and a form of distributed leadership. The emergence of the General Practice Federations (on the provider side) is promoting some new
clinical leadership but this presents some risk to staffing the commissioning side given that the provider stance is perceived as more ‘natural’ for GPs.

**Evolutionary rather than transformative change**

The nature and scale of the challenges facing the NHS – and hence the commissioner bodies - have been spelled out many times. NHS England (NHSE), the national-level body which oversees the CCGs, has stated the agenda as the need for ‘major service changes’ and reconfigurations. These changes, they say, must be clinically-led and underpinned by an evidence base. These commissioners should be playing a leading role in the design and development of proposals while working with local authorities and the public (NHS England 2013).

There is little evidence thus far, that the CCGs as a whole have risen to this challenge. The Five Year Forward View (NHSE 2014) has sketched out ‘new models’ which indicate the anticipated scope and scale of change. Few CCGs have so far sketched out such holistic models.

When asked about the extent of progress made in four specified service areas including the known major areas of work such as frail elderly, emergency care, and mental health only around 20 per cent of respondents claimed that ‘significant progress’ had been made. Again it is worth remembering that these respondents are the chief architects.

The majority of respondents when asked about the objectives and points of distinctiveness of their CCG began by talking about institution building, about new ways of behaving and of new procedures. The narrative hinged on ‘not being like a PCT’. For example, a GP chair of one of the case study sites stated the core, distinctive objectives as follows:

> We wanted to create something that was different from a PCT in that it was clinically-led, that reached out and embraced and involved patients and the things that were important to them. So, for us, the aim was to focus on health outcomes but the kinds of health outcomes that were important to patients. (GP Chair of CCG)

Another informant described a shift in style and approach that could characterise the CCG as being different from the former PCT:

> There used to be quite an adversarial commissioner/provider split, we wanted to use clinical leadership to create a different kind of environment so that we could have discussions between commissioners and providers around what we could do together to improve health outcomes. (GP Chair of CCG)

This institution building – the setting up of the CCGs, their operational procedures and recruitment for roles etc. – has understandably taken up much of the attention and time of CCGs thus far. But they are now in a position to undertake transformative change in part impelled by the Five Year Forward View and by co-commissioning
initiatives. We are able to track such transformations ‘live’ in our case study sites as they are happening.

The extent of clinical influence?

If a key measure is clinician influence then a possible negative might be the uncertainty about the relative power and influence of managers and of clinicians in steering the CCG. Our case study evidence suggested that a significant number of GP governing board members felt that their management teams were still primary drivers as under PCTs – albeit to a lesser extent. Our survey evidence underscored this pattern. When asked to apportion average degrees of influence the result was as shown in Figure 1:

![Figure 1: Relative Degrees of Influence on CCG Governing Bodies](image)

There is insufficient evidence so far to say whether GPs or professional managers are the more ambitious in terms of radical service redesign.

GPs set up to offer extended services in primary care beyond the main GP contract. They allow GPs to offer services at scale and to share expertise. These federations have their own membership; they have voting procedures and a leadership team. Some GPs who were formerly involved as CCG commissioning leaders have moved across to be provider leaders. In some regards these bodies help foster ambition but on the other hand they can confuse in that they present a parallel and in a way an alternative clinical leadership structure.

Intriguingly, some senior leaders and managers even within the CCGs see the Federations – and indeed other providers – as the potential main source of innovation and service redesign. As commissioners they argue that they are less well placed to shape service redesign than providers and they welcome ideas from providers – especially if the providers are working collaboratively.
The scale of ambition

There have been a few instances where the scale of ambition has been extensive and planned change far-reaching. Examples include the outcome-based contracts using a prime contractor launched by Bedfordshire CCG and Staffordshire CCGs. The collaboration between four Staffordshire CCGs to commission a Prime Provider for cancer and end of life care is one of the most ambitious initiatives to date. The contract, valid for 10 years and worth a total of £1.2bn, was awarded to Circle an independent contractor. Circle also won the musculoskeletal services prime provider contract awarded by Bedfordshire CCG. This is worth £120m over 5 years.

Push backs to such ambitions have already been in evidence. Bedford Hospital refused to sign the sub-contract offered by Circle for its part in the musculoskeletal service as it says the impact of loss of services is threatening its wider sustainability. And there was even more robust resistance by powerful provider trusts to an Oxfordshire CCG plan for a prime provider contact. The Oxford teaching hospitals fought back and the clinical lead was forced to resign. These instances suggest some grounds for caution.

Reasons to be optimistic

On the plus side of the balance sheet there are: strong indicative signs of more proactive and cross-boundary clinical leadership; clinical leadership resources and capabilities; progress in secondary care and in acute care interventions; and moves towards integration of services.

More proactive clinical leaders

Clinical leaders seemed to be more willing to challenge or ignore diktats and messages from above, and to encourage their managerial colleagues to do the same. The clinician/manager relationship is changing to one of greater mutual understanding, inter-dependency and an acknowledgement of complementary skills. Clinical leaders also tend to dislike bureaucratic processes and are more likely to focus on outcomes. As an extension of this they are interested in driving a different set of priorities - for example, a multi-morbidity rather than single disease focus, and end of life care with an emphasis on 'a good death'.

Perhaps most crucially, there are signs that clinical leaders are starting discussions with their colleagues about a new conceptualisation of what it means to be a doctor, emphasising a professional responsibility for making the system work and for population health, as well as an obligation to individual patients.

Added to this, 80% respondents judged CCG influence in shaping local health economy as between ‘quite a lot’ to being ‘the main shaper’. That said, 20% viewed CCGs as ‘not influential’ and given that the respondent were all members of the governing body this is a notable and important minority view.
Clinicians are testing-out new leadership styles and encouraging a more distributed style of leadership - bottom up, enabling more than performance managing. Further, leadership tasks and contributions such as setting out a compelling vision, communicating with the public, building collaborations with other stakeholders – all these key tasks we found to be mainly done jointly by both managers and clinical leaders. As might be expected, the only activity where clinicians where ‘mainly responsible’ was in communicating with other clinicians in primary care – most especially with other GPs.

Clinical leadership resources and capabilities?

Despite the difficulties, virtually all clinical leaders – GPs, nurses and Secondary Care doctors on CCGs – maintained that the clinical engagement and the opportunity for clinical leadership was better than was the case under PCTs.

Interventions in the acute sector were said by some to be more effective as they were handled on a clinician to clinician basis. It was argued that there was a stronger clinical voice from CCGs compared with PCTs and that this voice had enabled a much more constructive relationship with doctors in the hospitals. Stories were told of some early wins. Some clinical chairs indicated how they had brought a clear clinical voice and perspective to bear on lax hospital practices in a manner not achieved by PCT managers. Others pointed to redesign examples: ‘We managed to get a GP-led emergency care centre in A&E in 3 months when the PCT had tried to achieve this for 5 years and failed’ (clinical chair).

Informants said that they needed to move from fragmented and inadequate contracting arrangements to a more developed arrangement with sounder relationships, underpinned with contracts that set out expectations, with payment mechanisms fit for purpose and in an integrated manner so that multiple providers met the needs of a given population group. Current circumstances fell short of this ideal.

The ‘offer’ to the provider hospital trusts was often of the following kind:

As a commissioner I say to medical directors and FT chief executives: “Look, this is the vision. We're running out of money and we're going to have to deliver a better quality for less money. We think the approach is to focus on patients and we'd like you to be sitting around the table helping us with that, to co-produce new models of care”.

Progress in Primary Care

One of the interesting divides was between those CCGs which placed emphasis on addressing needs in primary care and those which assumed their role was to be mainly restricted to commissioning secondary care. Part of the explanation stemmed from experience and the legacy effect: those CCGs with experience in tackling primary care concerns tended to continue to do so. Path dependency was in play. Leading CCGs in the former group established networks which peer-managed the GP cohort. They worked towards building from a ‘stable platform’ of primary care. ‘As a CCG even though we were not directly responsible for the GP contract and pay and rations
we felt it important to work at developing a sound primary care service and to help GP practices find new ways of working’ (Chief Officer).

Clinicians are more able and more willing to challenge unacceptable performance by their colleagues and they are doing so with the expert help of managers (for example using more sophisticated incentive schemes rewarding collective behaviours).

**Integration**

Two policy initiatives from the centre have pushed the integration agenda. The 14 Pioneers CCGs serve as demonstration sites and the Better Care Fund requires councils and CCGs to work together to move a proportion of the health budget into the social care budget. The aim is to support patients with long-term conditions to be supported while living at home. Savings are expected as there should be less demand upon the acute sector. The risk is that hospitals may continue to experience a similar level of demand and will thus need to be paid. Both initiatives were centre-led though the operational details are left to the CCGs.

A common narrative at CCG level reflected this idea of a shift towards ‘integration’ and ‘integrated care’. Often this extended to moves to join-up health and social care. This was sometimes achieved through pooled budgets.

The scope of ambition when expressed in abstract terms was at times far-reaching. The widely accepted narrative was the intent to shift care from acute hospitals to care ‘closer to people’s homes’ (often meaning actually in people’s homes with support services). Related themes include ‘reducing unplanned admissions’ and reducing length of stay in hospitals. A core mechanism was to use multidisciplinary team case management for identified patients with extremely complex needs. But the scale of such innovations was normally limited.

Activities directed at integration have been much discussed in and around CCGs but mainly these remain only as plans. Health and Wellbeing Boards have been even more tentative in their work. Some of the more notable interventions have occurred in those areas with Pioneer status who have worked with local authorities to provide new services for people with long term conditions or people with complex needs. These often include social needs including housing, alcohol or drug dependency and other needs which require more than a GP or medical input.

A key aim is to pull together a range of community-based services around long-term conditions in place of episodic and fragmentary care.

Most of those patients are case-managed but they're managed through getting our community district nurses/OTs to work with the practices and they then meet with the practices to discuss these patients. The most complex of them are referred in to a MDT [multi-disciplinary team] meeting where there are representatives from all parts of the system - community matrons, OTs etc. The MDT is run by a GP and a geriatrician together, there's the geriatricians from both our big providers, there's social care and mental health workers. They work together reviewing shared clinical records to work out who should be case-managing and supporting these patients. (CCG Clinical Lead)
Such examples were impressive. But even these instances tended to be fairly small-scale when compared with the rest of the ongoing activity.

**Discussion**

Overall, there are mixed signs and indicators concerning the effective mobilisation of clinical leadership. Some CCG participants have adopted a cautious stance as if they could hardly come to believe that significant local clinical leadership could be really exercised. Others have acted as though it were true and have taken the policy makers at their word.

Some CCGs when asked about their work made very little reference to interventions in GP services; instead they talked about their progress in relation to secondary care, integrated care and reduced admissions. Yet, conversely, a few CCGs identified their main contribution as bringing about much needed improvement in GP services. This usually related to improved access and to improved services brought about through transparency, peer review and robust challenge. This distinction between a relative hands-off, and relative hands-on approach with regard to GP services was one of the main contrasts found between CCGs.

Another issue is the way GPs play their role. Some general managers argued that GPs had a tendency to ‘jump in and fix’ and to get involved in detail from a provider perspective rather than fully grasp the commissioning brief. Instead of working to a commissioning cycle starting with population needs they allegedly tended to leap in with solutions.

In assessing the role of CCGs through the lens of their actual activity and behaviours, it is necessary to attend to their span of influence, their degree of autonomy and their scope for manoeuvre vis-à-vis NHSE and other bodies. CCGs are certainly perceived by the players within as less beholden to any higher authority than their PCT predecessors were in relation to the SHAs. So some degree of independence and autonomy was perceived – underpinned by the ‘membership’ status and nature of the CCGs. That said, a few chief officers did remain cautious and there was a degree of compliance with the requirements and expectations of NHSE. Some regions were perceived as seeking to continue in a command and control style. CCGs in general saw themselves as being better able to resist these attempts.

CCGs are only one part of a larger system. Despite some of the rhetoric such as ‘GPs in charge’ there is a complex web of other forces and players. The Secretary of State for Health still sets ‘challenges’ (expected standards and priorities) and NHSE seeks to make sure these are addressed. There are cost issues and capacity is continually being taken out of the system – for example, there are fewer hospital beds. There are still nationally-set standards for example relating to emergency care. CCGs are thus not entirely free agents. But working within this institutional field a significant number of GP leaders have shown how the obstacles and the limitations can be overcome.
Activities and interventions take place in three broad spheres: commissioning, shaping and monitoring services from acute providers; influencing primary care provision; and community and social care. Work with Health & Wellbeing Boards might be considered a fourth sphere. The new relative autonomy is, however, circumscribed by the fragmentation in commissioning - with specialist, primary, and public health nominally resting outside their direct commissioning purview. Attempts at aligning these parts may be in their infancy but the potential is evident.

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**Further information**

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**References**


