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Clinical leadership through commissioning: Does it work in practice?

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Abstract

In tune with much international practice, the English National Health Service has been striving to transform health care provision to make it more affordable in the face of rising demand. At the heart of a set of recent radical reforms has been the launch of 'clinical commissioning' using the vehicle of local groups of General Practitioners (GPs). This devolves a large portion of the total healthcare budget to these groups. National government policy statements make clear that the expectation is that the groups will 'transform' the organisation and provision of health services. In this article we draw upon interviews, observations and analysis of internal documents to make an assessment of the extent to which clinical leaders have seized the opportunity presented by the creation of these groups to attempt transformative service redesign.

Keywords

Transformation; Clinical commissioning; Medical Leadership; Integration; Health-service redesign

Introduction

Faced with rising costs and rising demand, many countries have sought to redesign the configuration of their healthcare provision [1]. Notable international comparative initiatives have included medical groups looking after defined patient populations in the USA [2] including integrated health systems such as Kaiser and Geisinger [3], the use of commissioning and independent practitioner associations in New Zealand [4, 5], attempts at whole system planning, and managing long-term conditions by moving care into community settings in a number of countries [6]. These initiatives, which find reflection across many international settings, albeit often in fragmented

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and partial ways, have been uniquely bundled in the English national health system on a very large scale using the institutional vehicle of Clinical Commissioning Groups (CCGs). More than half of the total health budget has been devolved to these local bodies. Crucially, they are membership organizations which are, in the main, led by General Practitioners (GPs). This means that in formal terms, primary physicians have been allocated the task of steering their local health systems. The policy narrative suggested that this reform, placed on a statutory footing in 2012, allowed the removal of significant numbers of managerial posts and elevated the 'clinical voice'. It is a narrative of devolved decision making to local clinicians with an expectation that this informed and credible voice would be able to reshape health service provision in a way that was not achieved by previous commissioning organisations. It has been a bold experiment and one worthy of close scrutiny.

The nature and scale of the challenges facing the NHS – and hence by implication these key bodies - have been spelled out many times [7]. NHS England (NHSE), the national-level body which oversees the CCGs, has stated the agenda as the need for 'major service changes' and reconfigurations in order to meet changing healthcare needs and rising expectations. These changes, they say, must be clinically-led. The clinicians chosen to lead were the GPs. They were given power by devolving to them what in England are known as 'commissioning' responsibilities. This means they are allocated a budget and they are expected to use needs assessment techniques to help inform their choices when it comes to planning and allocating healthcare provision and its associated expenditure. Thus, GPs as nominated lead clinicians should be playing a significant role in service redesign using the vehicle of CCGs [8]. In sum, the move to use primary care physicians to meet budgetary and care challenges through far-reaching service redesign can be considered as an experiment on a massive scale. Lessons can be learned not only for participants in England but for observers in many other countries where aspects of the change package are also underway or being contemplated.

There is little evidence in the literature thus far as to whether the CCGs as a whole have risen to this challenge. This leaves a considerable and important empirical research gap. There is little doubt that the policy context raises high expectations about transformational change in the service mix [9]; it places clinicians at the forefront of leading those changes; and it envisages CCGs as one of the main institutional mechanisms to enable clinical leaders to bring about the desired changes.

Out of this landscape three crucial question arise: first, whether the clinicians who occupy these leadership roles share the radical ambitions; second, what steps they have taken to realise them; and third, whether the *realpolitik* of surrounding extant bodies (including for example, the regulators, NHSE both nationally and in regional form, local authorities and other bodies) and serious financial pressures constrain the delivery of whatever ambitions they may have.

Existing research on CCGs is based on a mix of case studies plus inference by drawing on lessons from the predecessor bodies, that is, earlier forms of GP fundholding and local GP-led commissioning [10-14]. These reports noted that the precursor bodies were characterised by pockets of enthusiastic take-up, but also by problems such as gaining GP buy-in, and the absence of impact at scale. Other research reflects practice when CCGs operated in shadow form (up until April 2013). These studies found decision-making and power essentially 'captured' by the boards of CCGs and that arrangements for representation of member GPs were underdeveloped and weak [15]. Less than half of GPs have judged that their CCG really reflected their views [16]. Concern has been expressed about how CCGs would be able to exert influence over GP Practices as these are members of the CCG [17, 18].

Wherever the internal power may reside there is the broader question as to whether these local commissioning bodies are being ambitious enough. Sir Neil McKay, former chief operating officer at the Department of Health has argued 'Small scale changes can help, but on their own they will be insufficient. What we are crying out for is more radical, clinically-led solutions across health and social care systems' [19].

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 (between CCGs and NHS England) which extends their role to reshaping primary care as well as secondary). But other developments could *potentially eclipse* the influence of CCGs, for example, the power exercised by central bodies is an obvious threat. Additionally, developments on the provider side could marginalise the CCGs. These include consolidation of diverse providers of both primary and secondary care which in effect may be taking-over the planning of care, and the emergence of 'GP federations' which are GP provider which may siphoning-off a good deal of the seemingly very scarce clinical leadership talent.

Much will depend on how the clinical leaders behave in practice. There is little that is automatic. New nationally-led policy initiatives continue to emerge. These include an imperative for some pooling of local budgets to encourage health and social care services to work more closely together [20] but this does not necessarily mean that GPs will control this space. Provider clinicians rather than commissioners may drive the development of integrated care [21]. The context is very fluid; the CCGs are not fixed institutions from which one could read-off certain outcomes. Rather, interpretation requires a *process perspective* [22]. 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 the social context [23].

In sum, an analysis of policy documents and of studies of the nascent CCGs and their predecessor bodies tended to find that while there was much 'in principle' support for

the general idea of clinical leadership through commissioning, and the use of these authorisations and powers for transformative change, 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. The extent to which current CCGs have scope to bring about significant change remains unclear. Drawing on recent research we seek to illuminate the three aspects noted above: first, the degree and nature of the scale of ambition harboured by clinical leaders in CCGs; second, the nature and extent of achieved change; third, the scope for manoeuvre against a wider institutional context.

Research methods

This paper is based on data gathering in six CCG during the twelve month period January to December 2014. The research during this period was an early-stage scoping study and designed as part of a longer-term project. Field research was supplemented with an extensive literature review covering clinical leadership and clinical commissioning groups. The case studies involved face to face interviews with chairs of CCGs, chief officers, GPs elected to the governing bodies, nurse representatives, secondary care doctors with a seat on the governing bodies, lay members and others constituting board membership. A total of 60 interviews were conducted. Most interviews were of one hour duration and about half of the interviews were recorded and transcribed.

Research methods also included systematic observation of 14 CCG meetings including governing boards, locality groups and member's councils (GPs). Another source of insight into a CCGs aims and objectives was to interpret behaviour as revealed through activity patterns and the ways in which budgets were spent and this data was supplemented with interviews with informants about their priorities and activities and those of their CCGs. The focus was upon the scale of ambition alongside activity and achievements.

The 'discovery' of the aims and objectives being pursued by the various CCGs and their leaders is by no means as straightforward as it may at first appear. There are some key documents such as the CCG Constitutions and the Strategic Plans which present formal and official statements about missions and objectives. These often tend to have a generic character. For example, many CCGs seem to share similar espoused objectives: such as reducing health inequalities and a focus on population health. Accordingly, in our research, we wanted to dig deeper into actual behaviour rather than just espoused intentions. Accordingly, we focused on triangulating accounts from multiple informants and then tracked the patterns alongside action plans, investments and impacts.

Findings

Reflecting themes raised by interviewees we can assess ambition and impact under four headings: institution building; hospital improvement; primary care improvement; and the implementation of integrated models of care. We attend to each of these in turn.

Institution building

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 around 'not being like a PCT'. (Primary Care Trusts were the predecessor bodies which were larger, and more like mini health authorities; GPs exercised a marginal role in these bodies). The 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.
> (GP Chair 1)

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 2)

This illustrates the idea of a better clinician-to-clinician set of relationships. This is based on mutual respect and professional regard but the impact seemed limited in practice. CCG leaders and managers had invested much time, thought and effort in institution building:

> There is work to be done in making the governing body more effective in terms of both strategic and the governance responsibility. This is something that is a long way from the experience of most GPs. Few of the GPs who sit on our governing body have had Board experience before. So, it has been an incredibly steep learning curve about what is it you're actually sitting on a Board to do. (GP Chair 3)

There was uncertainty about the relative power and influence between clinicians and managers in steering the CCGs. Most persons in Chair positions were GPs; but most chief officer roles were occupied by career managers. We found the proportions varied across the country; in some areas it was more common to have a GP as the chief officer; in other parts of the country (for example, London) it was most unusual.

There is insufficient evidence so far to say whether GPs or professional managers are the more ambitious in terms of radical service redesign. Evidence gathered suggested a variegated picture. A very notable finding however, was that, in a number of cases, even GPs who held board-level positions complained that their ideas were ruled-out by managers and that the managers had the backing of powerful figures in NHSE and the Clinical Support Units. (These latter are business services bodies hosted at launch by NHSE). Thus, ambitions were sometimes curtailed or reshaped by surrounding bodies.

To achieve their ambitions, a number of CCGs have decided to work collaboratively with their neighbouring CCGs. Often the arrangements were made easier and even prefigured by legacy arrangements. Experience to date might suggest that significant large-scale transformation requires such cross-CCG collaboration. The most celebrated case to date is Greater Manchester where health and social care budgets are to be merged for a population of 2.6 million thus raising questions about the future role of the constituent local CCGs. This plan is not to be operational until 2017. Ambition and scope for action also exists at a lower level within CCGs. Some of the CCGs contain a number of 'localities' and in some instances these are the active units where GP engagement takes place. In such instances, the role of the governing body level may be to help facilitate such local action and to bring it all together in a coordinated way. Localities may also be used as the level at which GP referral data is assessed and compared. However, localities do not have sufficient influence or resources to bring about transformational change, so, where decision making is devolved to this level the scope of ambition has to remain constrained.

A notable development in institution building which may place a strain on the leadership pipeline is the emergence of GP 'federations'. As noted, these are provider bodies of 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. There is some evidence that the provider role is more attractive than the commissioner role for most GPs. In some regards, these bodies help foster ambition but on the other hand they can confuse in that they present a parallel, 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.

Hospital improvement

Interventions in the acute sector revealed a mixed picture. In our research, one argument that was heard was that the stronger clinical voice from CCGs, when compared with PCTs, had enabled a much more constructive relationship with doctors in the hospitals. Stories were retold 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). Another observed:

> I spend quite a lot of my time going into big acute trusts and one of the things that's always amazed me is just how disempowered these people [hospital doctors] feel. There is a sense that they've been done to, they're told what to do. I can offer them the opportunity to be enabled, so it's not about GP commissioning, it's about clinical commissioning (GP Chair 4).

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. They also aspired to working in an integrated manner so that multiple providers met the needs of a given population group. Current circumstances fell short of these ambitions.

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". (GP Chair 5).

That at least is the proposition. The actual response is, in comparison, usually more measured and conditional. However, some things are beginning to change. Through the process of 'co-commissioning' NHSE is beginning to share responsibility for 'specialist' acute commissioning (that is, the rare conditions end) with CCGs. This is a controversial area. Many respondents thought that NHSE had not been effective and that they were now seeking to 'pass the buck'.

A key concern when discussing how to commission services from hospitals was the tension between contracting versus relationship-building. As one CCG chief officer noted: 'You can use the threat of a tender process and a lead provider to make everybody think, "Gosh, I must come on board and demonstrate I'm working in partnership", but the reality is if you try and then put a contract around that, you risk

blowing apart that relationship and those who don't get the lead provider role may walk away".

Another problem was fear of new lines of fragmentation: "whoever is providing the diabetes service will look for every reason why they won't accept people with mental health problems or frail and elderly or some other category".

Perhaps the biggest problem of all regarding any ambitions surrounding the commissioning of hospital services was that not only did they account for the largest proportion of the budget but in practice they were found to be (beyond the rhetoric of a shift of services to the community) virtually a fixed cost. Setting up some community based service was the easy part; diverting money from a hospital (de-commissioning) was an entirely different matter. Local hospitals were not to be 'de-stabilised'. As one CCG chair lamented, "contrary to the general thrust of our efforts, the latest diktat from NHSE instructs us to budget to protect the hospital budget". Such instances again raise the question of the degree of autonomy and influence of CCGs.

Primary care

In our research 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. The leading CCGs in the former group established networks which peer-managed the GP cohort. One informant emphasized the focus on primary care : 'As a CCG, even though we were not directly responsible for the GP contract, their 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).

Other initiatives found in the primary arena were the development of 'enhanced services' which incentivised primary care to offer preventative services and early stage interventions to avoid cases progressing into a secondary care phase. Additionally, we found interventions built around risk-stratifying the population and offering patients at high risk a proactive care plan and support from a multi-disciplinary team. There were also instances of 'social prescribing' whereby GPs could refer a patient with social rather than strictly health needs to a range of provider organisations – mainly in the voluntary sector. Examples included people with issues related to housing, transport, dependency and social isolation.

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. These services, such as in the musculoskeletal area, often straddle

the primary and secondary care divide. A prime or lead contractor may offer to effect radical change in the total service offer. But push-backs to such ambitions were encountered. Some hospitals refused to sign the sub-contract offered by the lead contractor on the grounds that the loss of parts of their former services threaten wider sustainability.

Such cases indicate how CCG ambitions can be resisted. But in any case these ambitious plans are not typical. Most CCGs in practice have so far been more measured and piecemeal in their initiatives. One of the case studies awarded a lead provider contract for diabetes care to one of its acute providers and they took overall responsibility for the population group with diabetes. This lead provider manages the whole value chain including primary, community care and social care. In this instance the initiative was worked-through with current providers rather than by going out to competitive tender. Children's services have also been subject to a lead provider model. In one version, the CCG asked the current group of providers to work out for themselves who would be the lead provider and service integrator. An extension of this kind of initiative is where a cluster of CCGs work in partnership with each other to develop such services. These examples of initiatives actually taken illustrate the extent and scale of much of the activity so far undertaken by moderately ambitious CCGs.

Integration

Two national policy initiatives have pushed the integration agenda to forge a more effective link between health and social care. One of these initiatives awarded 'Pioneer' status to a very select number of CCGs so that they could act as demonstration sites – that is, be leading examples of good practice in integrating health and social care. A second initiative from government has been a so-called 'Better Care Fund' which 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 cared for 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. The scale and scope of ambition here, when expressed in abstract terms, often tended to be 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 teams for identified patients with extremely complex needs.

Activities directed at integration have been much discussed in and around CCGs but mainly these remain only as plans. 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. (Clinical Lead)

Such examples were impressive and could be fairly said to demonstrate scale of ambition and of delivery. That said, such initiatives were often still at the margins of activity and had yet to become mainstream.

Discussion

What can be learned from this large-scale, nationwide, attempt to devolve health care commissioning to local groups of GPs? In particular, what can be learned about the actual scale of ambition of those clinicians presented with this opportunity and how they have handled it in practice? What can system designers in other countries learn from this experience? Assessment, of course, depends on the frame of reference. When set against the expectations of 'transformation' described in the Health and Social Care Act (2012) which established CCGs and gave GPs the lead, the ambitions, as articulated by the CCG leaders actually in post, appear rather modest. Likewise, the extent of actual achievements to date seems limited. However, if measured against previous attempts to enact local commissioning, then both the articulated ambitions and the actions to date appear more positive, progressive and, in some exceptional cases, even impressive.

There is a range of practice. Multiple, mainly small-scale initiatives are underway; but coherent whole-system change seems very difficult for these institutions to engineer. Indeed, a major difference between the English CCGs and the physician-led medical groups and independent practitioner associations in the USA [2, 3], is that the CCGs

operate within a highly contingent institutional and political environment. Their room for manoeuvre we found to be quite tightly constrained. Unlike the USA, these local actors in the English context operate on a relatively tight leash.

Whether CCGs simply lack sufficient power to bring about radical service redesign, or whether they lack ambition, experience and capability to tackle the bigger agenda items we found to vary. Most of the visioning of the 'new models of care' has come from national bodies such as NHS England and the regulators. The essential role of leaders in CCGs might best be described as '*implementation leadership'*. That said, we also found a range of experience with regard to ambition and action across the CCGs. A few demonstrated far-reaching ambition and had already taken steps towards re-organising care so that health and social care had become more integrated. Multi-disciplinary teams (MDTS) had been established comprising a mix of GPs, nurses, other clinical professionals and social workers. At the other extreme, some CCGs had so far made little real difference. In between, there were cases where fragmented experimental initiatives were underway.

Some CCG leaders had taken the initial allocation of commissioning responsibilities between NHS England (NHSE) and the CCGs rather literally. Because of concerns about potential conflicts of interest, the responsibility for commissioning primary care services (most notably GP services) was allocated to NHSE, while CCGs were allocated other services most notably secondary care. In consequence, 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. On the specific theme of 'challenge' – i.e. the notion that GPs are better able to converse with and influence other clinicians – including doctors in secondary care – there is some conflicting evidence. A number of GP leaders claimed this had been one of the main contributions they had been able to make as a result of their position in a CCG. But in other cases the claim was made by some managers that clinicians were too inclined to adopt a collegial, even clannish, stance with their fellow professionals and thus fail to challenge robustly enough.

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 a vis NHSE and other bodies. CCGs are thought to be less beholden to any higher authority than were their predecessors. This degree of independence and autonomy was perceived as underpinned by the 'membership' status of the CCGs. But membership engagement was often weak and some chief officers remained inclined to comply above all with the requirements and expectations of NHSE.

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. There are still nationally-set standards, for example, those relating to emergency care. CCGs are thus not entirely free agents.

These findings reflect knowledge in organizational theory [24]. New institutional theory places emphasis upon the shaping power of existing institutional forms upon human agency. In the CCG context, there are competing existing institutions – for example, the commissioning institutional arrangements and the professional identities of the primary care clinicians.

To conclude, findings in relation to our three fundamental questions are as follows. First, do the clinicians who occupy CCG leadership roles share the radical ambitions? We found this only up to a point. When assessed against steps actually taken – and indeed articulated plans – the rhetoric stemming from national players is found to be the more ambitious (and of course the more politicised). Second, what steps had been taken to realise expressed ambitions? The findings here reflect those made in the point above. Third, whether the *realpolitik* of surrounding extant bodies alongside the serious financial pressures constrain the delivery of whatever ambitions they may have? The finding here is that the contextual constraints were many. Without, in any degree, detracting from the undoubted impressive endeavours of some local clinical leaders, the overriding judgement has to be that when local plans bump-up against powerful vested interests or against national priorities the local ambitions tend to be curtailed.

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