General practitioners as leaders of health service redesign; Case studies of clinical leadership in the English National Health Service

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(2597 words excluding quotations, box and references)

Abstract

Background

Clinical Commissioning Groups were established in England in 2013 to encourage General Practitioners to exert greater influence over the processes of service improvement and redesign in the NHS. Little is known about the extent and the ways in which GPs have assumed these leadership roles.

Aim

To explore the nature of clinical leadership by GPs within and around CCGs, and to examine the enablers and the constraints to implementing a policy of clinical leadership in the NHS.

Design and setting

A qualitative multi-case study approach was carried out in 6 diverse localities across the English NHS.

Method

Data were collected from the case study CCGs and their stakeholder networks using a review of relevant documents, semi-structured individual or group interviews, and observations of key meetings. The data were analysed thematically within and between the cases, informed by relevant theories.

Results

GPs prefer a collaborative style of leadership which may be unlikely to produce rapid or radical change. Leadership activities are required at all levels in the system from strategy to front line delivery and the leadership behaviours of GPs who are not titular leaders is as important as formal leadership roles. A new alliance is emerging between clinicians and managers which both draws on

their different skill-sets and creates new common interests. The uncertain policy environment in the English NHS is impacting on the willingness and the focus of GP leaders.

Conclusion

General practitioners are making an important contribution as leaders of health service improvement and redesign but there are significant professional and political barriers to them optimising a leadership role.

251 words

Keywords

Clinical Commissioning Groups; Clinical Leadership; General Practitioners

How this fits in

Clinical Commissioning Groups were created in the English NHS to encourage GPs to lead efforts to improve and redesign services. This study suggests that they can bring an important body of expertise and approaches to leadership activities but that there are significant constraints to them optimising their potential contribution.

Background

Clinical Commissioning Groups (CCGs) were created in the English National Health Service (NHS) in 2013 in large part to give general practitioners (GPs) a more influential leadership role in improving and redesigning clinical services.[1] As new professionally-led organisations, CCGs were expected to deliver on the challenge thrown down by policy makers 'to step up …… and change the system where this would benefit patients'.[2]

The proposition was that clinicians, especially GPs, had an understanding of patient priorities and would carry a higher level of credibility amongst their peers and patients than that achieved by managers acting alone.[3,4] Clinical leadership was assumed to be an essential component of both service improvement and service redesign. Both required leaders to engage people around them and to have a deep understanding of both the context and the content of clinical work.

The extent to which GPs working within CCGs were to be 'put in charge' of commissioning NHS services came as a surprise to many and was not part of the then government's election manifesto. Evidence from evaluations of similar budget-holding initiatives suggests modest impact at best.[5-9] Early evaluations of CCGs were positive about their potential as agents for change but apart from a few notable pioneers most were judged to be struggling to fully engage their clinical communities or to impact on their acute sector providers.[10-14]

The paper utilises a series of in-depth case studies to explore the nature of clinical leadership by GPs within and around CCGs, and to examine the enablers and the constraints to implementing a policy of clinical leadership in the NHS.

Methods

Study design

A qualitative multi-case study design [15] was chosen in order to develop a deep understanding of CCGs, clinicians' roles with those CCGs, and the nature and process of health service improvement and redesign. Ethics approval was granted by the Research Ethics Committee of the lead university.

Theoretical perspective

Since the focus of the study was on CCGs as new organisations within the NHS, Institutional Theory [16,17] was utilised as a guide to explore the extent to which new structures and governance arrangements can impact on the ways that people think and act, how these arrangements help to create their own norms and practices and how established ways of working are maintained and defended by vested interests. In addition, we drew on a range of leadership theories [18-20] to provide a conceptual structure to the data analysis and interpretation.

Subjects and setting

Preliminary scoping interviews were carried out in 2013 and early 2014 with senior clinical and non-clinical leaders from 15 CCGs across England in order to identify key areas for in-depth exploration. These CCGs were chosen by the research team because of their expressed interest in the study and because they represented a range of levels of organisational maturity, geographical locations and different socio-demographic populations. This scoping work identified three clinical and service areas - integrated care for frail older people, urgent care and mental health - where a significant amount of service redesign was taking place and where the learning from these areas had the potential to be transferable to other areas.

Six of these scoping case studies were then chosen for in-depth case analysis between 2014 and 2016. Those selected were explicitly focusing on service redesign in one or more of the target clinical areas and were geographically spread across England. Two were located in socio-economically deprived inner city areas, one in a large urban conurbation and three in mixed urban and rural areas. The case studies were mostly focused on single CCGs, though in two areas on groups of

neighbouring CCGs because they were working in partnership on service redesign projects. Data were also gathered from local authorities, Health and Wellbeing Boards, hospitals and community service providers and ambulance services. Individual participants in these organisations included CCG Chairs and Accountable Officers, clinical leads, CCG Board members, clinical and nonclinical project managers of provider organisations and representatives of the voluntary sector and patient groups.

Data collection

Data were collected from the case studies using documentary review, individual and group interviews and observation of meetings. The authors worked in pairs on one or more of the case studies. Relevant documentation was provided by the lead CCG and included strategy papers, minutes of formal meetings and progress reports of specific redesign initiatives. 202 semi-structured individual or group interviews lasting about one hour were carried out by the authors using a common semi-structured interview schedule. Subjects were selected iteratively within each case using a snow-ball sampling approach. The content of the schedule was influenced by the scoping interviews and explored the local context, the nature and outcome of the target redesign programmes, the types of leadership behaviours and the enablers and constraints to leading change. Most of the interviews were audio-recorded and fully transcribed. Board and operational meetings were observed and detailed field notes and verbatim quotes were collected for all interviews and observations.

Data analysis and interpretation

A thematic analysis [21] of the data was carried out, starting with a process of coding and categorising the data, and then identifying and developing themes based on emergent issues relating to the project aims. The analytical and interpretative process was conducted iteratively with data collection, informed and shaped by institutional and leadership theories, and the results

discussed and revised with other members of the research team, and sense-checked with a sample of the study participants themselves.

Results

The case studies illustrate a range of ways in which GPs are involved in leadership activities across the six localities. The different approaches are summarised in Box 1. Four main themes were identified from the case studies:

Leadership is enacted at different levels in the health system

The case studies illustrated how leadership needed to be exercised at all levels within the CCG and how different skills were required to operate effectively at these levels. The macro level required strategic leadership expertise. Individuals with these skills were more likely to be effective CCG Board members who were able to see the whole commissioning process from needs assessment through to monitoring delivery and improving outcomes. Relatively few clinical leaders seemed to be contributing effectively at this high level and in most of the case studies the strategic role was fulfilled by non-clinical managers.

At the meso level, clinical leaders were active members of programme boards, shaping the strategy for particular designated service areas and facilitating its delivery on the ground. At the micro level the role of clinical leadership was to flesh out the complexity of front line delivery and to support staff to do the work. Such leaders needed to have practical knowledge and credibility amongst their peers in order to be effective. In contrast with macro level leadership, many examples of meso and micro level leadership behaviours were observed in the case studies. Leadership activities need to take place synergistically at all three levels for substantive change to be enacted.

A collaborative style of clinical leadership appears to be most prominent in clinical commissioning

GPs seem to be more likely to utilise collaborative approaches to leadership than to adopt the 'heroic' leadership styles stereotypically associated with the NHS. This softer approach is manifest in the ways that GPs interact with non-clinical mangers within CCGs, in how they work with partners in other local organisations and in their relationships with GP peers across the CCG.

A collaborative approach is particularly apparent in the relationship with the clinicians and managers working in provider roles in local hospitals and community services. Much effort goes into building and maintaining local professional networks and maintaining social capital, as described by one clinician:

> *'I just pulled loads of people in, people that I've known for ages, like third sector organisations, people from children's mental health services, from the police, from anyone who was interested and wanted to be involved' (GP, case study C)*

The case studies suggest little evidence of a desire to destabilise existing provider relationships, even in situations where the commissioned service was unsatisfactory. Commissioning powers, such as radically changing or terminating contracts, were used sparingly. To a large extent this seems to be based on the view that providers were doing their best in difficult circumstances and that 'punishing' providers by destabilising existing arrangements was not appropriate. Loyalty and empathy seemed to trump market forces. As a consequence, the changes seen as a result of clinical leadership appeared to be relatively modest.

The collaborative leadership style was even more apparent amongst the large number of clinicians who did not occupy formal leadership roles associated with Board membership or clinical condition leads, but who did nevertheless exercise considerable influence amongst their colleagues:

> *'We've had a core of really strong clinical leaders who don't have positional power but [are seen as leaders because of] stuff they've done or their reputations' (senior manager, case study B)*

These non-positional or 'informal' leaders seemed to play a particularly important role in making things happen, often operating in a way that countered the prevailing culture of the CCG. They were less focused on what one interviewee described as *'corporate guff' (GP, case study E)*, and were more likely to challenge, ignore or express impatience with rules and guidance. Operating closer to front-line clinicians, they understood ambiguity and recognised the compromises that clinicians needed to make to keep the system running.

A symbiotic relationship is emerging between clinicians and managers

Several of the case studies highlighted ways in which the relationship between clinical and non-clinical leaders was developing and how the contributions of the two groups were different and complementary. One non-clinical manager was clear about what she thought clinical leaders brought to the conversation:

> *'I think they're (the clinicians on the Board) quite good at going back to the fundamental principles and, again, a lot of our GPs on our Board often remind us about, so what's the evidence base? What are the outcomes that we're expecting to get? How do we demonstrate value for money? And actually, bring an added level of vigour and rigour in relation to that process.' (senior manager, case study E)*

A number of GP clinical leaders identified issues that they were championing which had not previously been priorities for their CCGs, such as End-of-Life care and a stronger focus on the social determinants of health. Some managers spoke about the ways in which clinical leaders had additional traction with their colleagues, how they were effective at turning what might be perceived to be a managerial issue (such as a budget overspend) into a clinical one. One senior

manager described how sharing the communication of a message between clinical and non-clinical leaders could be highly effective:

> *'I find that if a general manager gets up to articulate a strategy or an initiative, they often get people lobbing in bombs to them, around why it won't work or what the obstacles are or why, clinically, it doesn't make any sense. It's much harder, I think, for people to be doing that to their peers, so if there's a very strong clinician locally, who's prepared to stand up alongside me and say, absolutely, they think that this is absolutely the right thing to do for patient care, that we should be doing as GPs and that we should be doing clinically, in relation to that element of it, that's a very powerful message for people to get into.' (senior manager, case study E)*

A clinical leader described what she thought she was able to bring as a leader:

> *'It's having a very good insight on, first of all, where my colleagues are in terms of culture, in terms of attitude to change and how ready they are to change and get involved in any new projects or new kind of system change, what is the best approach in terms of bringing them on board and involving them, engaging them' (GP, case study B)*

Another clinical leader described how he felt more able than his non-clinical colleagues to push back on directives from higher in the NHS and how he encouraged managers to do so as well.

A group of managers in one case study described what they called *'alliance leadership*', a model that required GP leaders to do more than just mediate between differing managerial and clinical perspectives. Their effectiveness was perceived to be based on their ability to surface and work through shared interests, such as patient safety, the effective use of resources and redesigning the roles of health professionals. Alliance leadership provided a forum where complex dilemmas could be tackled through dialogue and it was clear that building effective relationships between clinical and non-clinical leaders required much effort and considerable time.

The political context has a big impact on the nature of the clinical leadership

Whilst clear opportunities have been created for greater GP leadership by the development of CCGs, there was also much evidence from across the case studies that the political environment within and around CCGs was far from conducive to supporting clinical leadership behaviours.

Most of the GPs interviewed said that they had observed major changes in the structure and governance of general practice in recent years and they were sceptical that the current structures would last for long enough to see through substantive change. They suggested that this was why some of the case study CCGs were struggling to find any clinicians, never mind effective leaders, to serve on their governing bodies. As one clinician described:

> *'A lot of people are disillusioned and don't want to get involved. I mean, they've advertised so many times for governing body members because we need more clinicians but no success' (GP, case study D).*

As vehicles for change, it appeared that CCGs were increasingly constrained by the lack of clarity about their role in the emerging health system, their autonomy and their power, and by uncertainty about their future especially with respect to CCG organisational mergers.

With the rapid development of new policies and the emergence of new NHS organisations, there was a strong perception that only three years after being formed, CCGs were being side-lined and that other initiatives requiring clinical leadership, including GP provider federations, Primary Care Homes and Accountable Care Systems, looked like more attractive options for those individuals interested in leadership roles. In particular, the gradual disappearance of the internal NHS market and public concerns about conflicts of interest made the leadership of commissioning activities look less attractive to GPs than that of provider activities.

Discussion

This study describes the ways in which the introduction of Clinical Commissioning Groups in the English NHS has shed new light on health system leadership by GPs. It is clear that the reality is more complicated than the political rhetoric of 'GPs in charge'. The case study design has generated a deeper understanding of the nature of clinical leadership, and the enablers and constraints to exercising leadership behaviours. It highlights the preference of GPs for a collaborative style of leadership which may be unlikely to produce rapid or radical change, and the importance of leadership behaviours from GPs who are not titular leaders. It describes the need for effective leadership at all levels within the health system, though the strategic level is currently least well served. It outlines the emergence of a new alliance between clinicians and managers which both draws on their different skill-sets and creates new common interests. The study also illustrates the ways in which the fast moving and messy policy environment in the English NHS is impacting on the willingness and the focus of GP leaders.

The concept of health system leadership by general practitioners is a relatively new field to date [22,23] and this study surfaces a number of potentially useful results to guide future work. Several of the findings are compatible with the wider literatures of clinical leadership and organisational change. The suggestion that a more collaborative and distributed style of leadership may be more effective has been advocated by a number of experts in the field.[24,25] Spurgeon for example described an environment in which 'everyone is engaged in acts of leadership, where communication and making sense of conflict ensure that the process is democratic, honest and ethical [and] based on evidence and professional judgement'.[26] This aspiration contrasts with the reality of the more top down model of leadership often found in empirical studies of leadership in the NHS.[27-29]

The concept of 'informal' leadership has previously been described in the literature [30,31] but not within general practice where the ethos of autonomous and often anti-establishment practitioners

makes it particularly relevant. In terms of leading change, the literature differentiates between 'conformist' and 'deviant' innovation [32,33] and these case studies illustrate that both appear to be taking place within the context of CCGs. There is some evidence that the multiple and often contradictory policy initiatives taking place in the English NHS help to create space for deviant innovation from a small number of clinicians but it may also inhibit the leadership ambitions of the majority who require greater clarity and certainty in order to be effective leaders.[34]

The case study design presents a partial picture of clinical leadership and does not enable a judgement to be made about the extent to which CCGs as new institutions in the NHS were responsible for the observed leadership activities. Nor does it allow the reader to judge whether such a radical reorganisation of the health service in England represents the most cost-effective way of promoting clinical leadership. These are important policy questions which need to be addressed.

Whilst it is unlikely that CCGs in their current form will still be in place in the medium term, the focus of this work on the higher level principles and intent of CCGs as new institutions within the NHS has helped to elicit findings which are both transferable and enduring. The decisions required by NHS leaders will not get easier as the demands on the service continue to increase while resources remain constrained. There has never been a greater need for evidence-informed leadership.

This study was funded by the National Institute of Health Research, Health Services and Delivery Research Programme, Project Number 12/136/104. The full report, 'Mobilising Clinical Leadership in and around Clinical Commissioning Groups: A mixed method study', which also includes national survey data is scheduled for publication by NIHR in December 2017.

Ethical approval was granted by the Ethics Committee of the Open University.

Competing interests: None declared.

Acknowledgements: We would like to thank all of those who participated in the case studies and members of the Project Steering Group, Mrs Margaret Goose, Professor Steve Field, Dr Louise Restrick and Dr Mark Ashworth.

Box 1: GP involvement as clinical leaders in the six case studies

Case A	GPs on the CCG Board challenge provider clinicians to develop more coordinated approaches to adult mental health and better integration between urgent care and primary care, with out-of-hours GPs involved in implementing the latter
Case B	GPs on the CCG Board lead the formulation of new standards for primary care, and successfully influence others to follow, with locality GPs leading on implementation
Case C	GPs develop better working relationships between practices and with voluntary sector providers, and use their role on the CCG Board to fund a Wellbeing Hub for preventative mental health
Case D	GP Federation supports a local pilot for collaborating in providing GP services across a locality and integrating with community services, seeking support from the CCG
Case E	GPs on the CCG Board work with neighbouring CCGs to shape a programme of integrated care for the frail and elderly, and communicate this to the GP community
Case F	GPs operate at a strategic level of CCG and work with the local authority to conceptualise an Accountable Care Organisation, though only a small amount of wider involvement of GPs in a relatively narrow scope improvements to existing services

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