Devolving healthcare services redesign to local clinical leaders: Does it work in practice?

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Abstract

Purpose

The purpose of this article is to present the findings arising from a three year research project which investigated a major system-wide change in the design of the NHS in England. This radical policy change was enshrined in statute in 2012 and it dismantled existing health authorities in favour of new local commissioning groups built around GP Practices. The idea was that local clinical leaders would 'step-up' to the challenge and opportunity to transform health services through exercising local leadership. This was the most radical change in the NHS since its inception in 1948.

Research design/Methods

The research methods included two national postal surveys to all members of the boards of the local groups supplemented with 15 scoping case studies followed by six in-depth case studies. These case studies focused on close examination of instances where significant changes to service design had been attempted.

Findings

We found that many local groups struggled to bring about any significant changes in the design of care systems. But, we also found interesting examples of situations where pioneering clinical leaders were able to collaborate in order to design and deliver new models of care bridging both primary and secondary settings. The potential to use competition and market forces by fully utilising the new commissioning powers was more rarely pursued.

Practical implications

The findings carry practical implications stemming from positive lessons about securing change even under difficult circumstances.

Originality/contribution

The article offers novel insights into the processes required to introduce new systems of care in contexts where existing institutions tend to revert to the status quo. The national survey allows accurate assessment of the generalisability of the findings about the nature and scale of change.

KEYWORDS

Devolution, Clinical Leaders, Commissioning Groups, Service Redesign.

Introduction

Throughout the world, healthcare systems face fundamental well-known challenges: increasing demand, higher expectations and rising costs (Walshe and Smith 2016; Barlow 2017). In an attempt to meet these challenges, many jurisdictions have sought to 'redesign' services, most notably by trying to shift elements of care away from expensive hospital settings into less expensive, out-of-hospital, community settings (Ham 2018). These latter have the potential to offer local and more integrated care, staffed by multi-disciplinary teams. Many initiatives across different national settings have been designed to achieve these goals by devolving the redesign and reform of healthcare services to local groups of clinicians and managers to own the challenge and to design innovative solutions (Exworthy 2001). Decentralization of health services has been a pervasive idea across many health systems based on the proposition that smaller, locally-governed structures will be more agile and accountable (Saltman et al. 2007; Currie et al. 2009; Regmi 2014). Few, if any, of the international attempts to allocate accountability to local clinical groups have been as far-reaching as that found in the English NHS. But it has not been alone in moving in that direction. The Quebec health system has experimented with new institutions in the form of Health and Social Services Centres designed to integrate acute, community and home care (Cloutier et al. 2016). It has tried to shift from a service-based to a population-based approach. However, in that experiment, there was rather less of an expectation that it would be done by clinicians and more of the weight was handed to managers in order to translate grand policy into meaningful action. 'Practice Networks' in Germany and 'Care Groups' in the Netherlands are organisations with between 50 to 150 GPs which represent and put forward the GP voice in negotiations with health insurers and the provincial governments which, in a sense, 'commission' health provision (Busse and Blumel 2014). In the Dutch system, there are some regional collaborations between hospitals and GP practices and some facilities have a shared entrance. They are funded by the local insurer (Kroneman et al. 2016). In Sweden, GPs groups have jointly developed new models of care in conjunction with hospitals. However, on the primary care side, these initiatives have been limited to individual practices rather than the wide population coverage and scale of the initiatives in the NHS (Anell et al. 2012). In the USA, despite the high-profile cases such as Kaiser Permanente, the dominant model is of professionally managed organisations and systems without any expectation that Family Physicians would be in a position to lead significant changes (Mossailos et al. 2017). In summary, while many countries have aspects of the locally-driven approach to health care reform none have anywhere near the scale and ambition of the recent changes to the NHS in England.

The high-level policy shift which created Clinical Commissioning Groups (CCGs) in England represents the most far-reaching example, so far, of an attempt to tackle the well-known catalogue of problems by handing a large part of the healthcare budget to local

consortia of GPs (Department of Health 2010; 2011). The initiative as a whole, which allocated to these bodies two-thirds of the total NHS England expenditure (in 2018 thus nominally handing them a budget of £75.6 billion) inevitably introduces debate about the relative merits of market versus cooperative and collaborative approaches. The massive natural experiment also raises questions about what can be learned from it about this kind of approach to tackling the problems facing health systems more generally.

Clinical Commissioning Groups in outline

All GP Practices (that is, GPs located together in clinics of around five or so General Practitioners) have to be a 'member' of these local clinical commissioning groups (CCGs). These groupings of practices typically have between twenty five to one hundred GP Practices in membership. At the time of the research, 2014 to 2016, there were 210 CCGs across England as a whole. A fairly typical CCG represented around 250 to 900 GPs. The number of patients covered by a CCG could range from around 250,000 up to around 900,000. Following a number of CCG mergers in 2016-2018, the total number of CCGs has been reduced to 195 and further mergers are now being encouraged. The largest CCG now has 177 GP Practices in membership and covers a population of 1.34 million people (NHS England 2018). The groups are given the power and responsibility to commission local services from hospitals and other providers whether in the public and private sectors or a mixture of both. Commissioning refers to a process starting with a systematic assessment of population needs, followed by the planning of appropriate, cost-effective provision using the purchasing power allocated to the CCGs. Initially, CCGs were only authorised to commission for secondary (i.e. mainly hospital) care, but from 2016 onwards, NHS England began to allow CCGs to also commission primary care. By April 2018, 178 CCGs had been given delegated commissioning responsibilities which included primary care (NHS England 2018b). This had previously been handled by the centre because of concerns about potential conflicts of interest as local GPs would be potentially purchasing services from themselves and each other. This expansion of the CCG remit could be seen as evidence of a further strengthening of devolution and localisation. But as we will see, that is only part of the picture.

Each CCG is led by an elected governing body made up of GPs, other clinicians including a nurse, a secondary care consultant, and lay members. As their title suggests, the policy intent is to see these groups as 'clinically led'. In the original formulation, only General Practitioners were represented (assisted by professional managers). But, following protests from many quarters, the concession was made to require each CCG to include a nurse and a secondary care doctor on their governing body (often also known as the CCG Board). Thus GP Consortia became CGGs. In practice, CCGs remain essentially GP membership organizations. But, to reflect the general spirit of the wider clinical representation, we use the term 'clinical leadership' to reflect the wider clinical influence whilst recognising that, in practice, this mainly reflects GP influence. Each CCG Governing Body (also commonly known in some cases as 'Boards') has a Chair and an Accountable Officer (some CCGs used the terms Chief Executive for this but for consistency we will use Accountable Officer in all cases). In most cases, the Chair position was taken by a GP and the Accountable Officer

position by a non-clinical manager. There are some variations on this pattern as some Accountable Officers are also GPs.

Those CCGs managers who are not clinicians tend to be tied-in to the wider hierarchical structure of the NHS for career purposes. The national bodies (mainly NHS England) but also the Care Quality Commission (an independent regulator) and NHS Improvement (another regulator which attends to financial sustainability and management as well as care safety), tend to exercise their very considerable influence through the CCG Accountable Officers. Given that CCGs are meant to be local membership bodies it is a moot point as to how much power and influence these managers wield. Indeed, the exercise of influence and power within CCG (between GPs and other clinicians and non-clinical managers) is one of the issues open to empirical inquiry as is also the question of the external influence of the CCGs across the wider health system. The findings reported below shed light on these questions.

This article presents the findings from a research project which was designed to reveal how GPs actually made use of the platform of Clinical Commissioning Groups to bring about the kind of redesign of service provision that was expected of them. Where this had been achieved, what had been involved and what barriers had been surmounted?
When the Clinical Commissioning Groups were established they were intended to devolve considerable responsibility and accountability to clinicians so that they had the capability and authority to design and implement more effective services (Department of Health 2010; Department of Health 2012). Such an innovation raised a number of important questions: Would GPs and other clinicians 'step-up' to meet the leadership challenge as plainly expected in the policy statements? If not why not? If so, how would they actually go about (re)shaping services? Despite a number of research reports about CCGs - for example, about their governance and GP engagement (Checkland et al 2012; Miller et al 2012; Robertson et al 2014; Robertson et al 2016; McDermott et al 2017) until now there have been few systematic attempts to analyse the actualities of CCGs in specific service redesign attempts, and the role of GPs in achieving new models of care. Insights into such practices and processes carry lessons about the leadership and institutional work beyond the specifics of these particular groups (Storey and Holti 2013).

Theoretical Perspective

The theoretical perspective we used in order to investigate this activity was based on institutional theory (Thornton et al 2012). Healthcare takes place within and through institutions. These include GP surgeries, outpatient appointments, mental health institutions, primary, secondary and tertiary care institutions. Emergent health and wellbeing perspectives extend the institutional field to include local authorities, voluntary agencies, housing associations and so on. These institutions are built over time, they become taken for granted and 'sedimented': that is, new routines are laid on top of others (Cooper et al. 1996; Scott 2014). Making changes to the configuration of service provision requires 'institutional work' – that is, 'purposive action aimed at creating, maintaining, and disrupting institutions' (Lawrence and Suddaby 2006: 217). Working within institutions, actors draw upon

'institutional logics'. These are socially constructed sets of 'assumptions, values, beliefs and rules' (Thornton and Ocasio, 1999: 804). Working within these social rules helps secure legitimacy. 'Legitimacy is a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions' (Suchman, 1995: 574).

This perspective places emphasis on how individual and collective agency shapes institutions while also being constrained by them. Such shaping can be problematical. Institutions are maintained and defended by established interests. For example, professionals and their professional bodies construct and seek to defend their 'jurisdictions'; likewise bureaucracies tend to resist disruption. Change often means potential threat to at least some interest groups, hence, much institutional theory focuses on the stabilising and 'maintenance work' undertaken by institutional actors (Cloutier et al 2016). This interplay between innovation, disruption and defensive routines, is, in many ways, the story of the CCGs. It helps explain why the powers devolved to clinicians via the CCGs have resulted in such limited impact.

Where devolved local change agency does take place, it is important to understand the kinds of institutional work that actually occurs. This can vary from 'strategic' work in conceptualising the nature and contours of a new service; through to instigating work in getting the idea underway and with some traction; and on through to trialling and then embedding practices at an operational level (Lawrence and Suddaby 2006; Cloutier et al. 2016). The extent to which these processes occur sequentially or iteratively is an empirical question in each case.

The building of institutions is underpinned by 'logics' (Dunn and Jones 2010; Greenwood 2010; Besharov and Smith 2014). Thus, a market logic leans towards the value of competition; a bureaucratic logic cleaves to the use of plans, rules and division of labour; and a network logic inclines towards collaboration across distributed units. From time to time, a particular logic may become 'dominant' and accepted; at other times, logics are in competition (Reay and Hinings 2009). The very creation of CCGs was itself an outcome of institutional work – in this case work done at Parliamentary level led by a particular Secretary of State. The institutions created had a bias towards a logic of efficiency driven through competition (by encouraging market-making behaviour) but the details of how the new institutions should operate in practice were left somewhat open. Hence, much more institutional work was required at local level. It was an open question whether the local actors would in practice pursue market or collaborative logics, or indeed, how they might combine either, or both, of these with a bureaucratic logic, for example, using rules and regulations in the procurement or administration of contracts for service provision.

The CCGs, with 'GPs in charge', and a relatively open agenda for change, represented a moment in time with potential for significant shifts in the design of the institutional architecture (Department of Health 2010; Department of Health 2012). But, they were faced not with a blank sheet but with a set of existing and sometimes powerful institutions and agents who could, and did, seek to defend their existing arrangements. Another complication

is that the nominated agents for the proposed devolution of influence and responsibility (in this case GPs) may not necessarily step forward to accept the 'opportunity'. And crucial to the account given in this article, other institutional work designed to drive different kinds of change can be seen to overlay and compete with the focal initiative. In the light of these considerations, the question of how these local agents would respond to the apparent opportunity to exercise transformative influence can be seen as contingent upon a complicated array of institutional arrangements. It was unclear how they would fare as agents of institutional change given the presence of several other competing agents, and also what mixture of institutional logics would result. Our research sought to clarify how these local agents – especially the clinical leaders – would navigate these waters.

Research Methods

The project proceeded in four phases. The first was an extensive scoping study across 15 CCGs from different parts of England. This work was designed to allow exposure to a variety of conditions such as urban and rural locations and to diverse socio-economic circumstances and to map the range and variety of practice by CCGs under these diverse conditions. The second phase was the design and administration of a national survey of all members of CCG governing bodies. This was undertaken in 2014 and had a response from 79% of all the 210 CCGs and 12.4% of the total population of all 3,800 CCG board members nationally.

The third phase was a major piece of work involving six in-depth case studies over a period of 18 months. These cases were selected using purposive sampling. To help with this, the results from the first national survey were used as a sampling frame and this allowed investigation of a range of cases which illuminated selective aspects of clinical leadership in action under a variety of contexts. This in-depth case study work was the heart of the project in that the research team were seeking out the details of the roles played by the CCGs and the processes underpinning the inner-workings of the CCGs. We drew on Eisenhardt's qualitative research guidance on building theory from cases (Eisenhardt 1989; Eisenhardt and Graebner 2007). In total, during this phase, there were 65 interviews with GP Chairs and other GP members of the Governing Bodies; 36 interviews with Accountable Officers and other senior managers sitting on Governing Bodies; plus interviews with nurses, secondary care doctors and lay representatives sitting on these bodies. The novel feature of this phase of research was the approach we adopted to understanding the work and the contribution of the CCGs by focusing on the specific initiatives they had taken to engineer innovations in health service design and delivery. These were found to centre on the areas of more integrated care for the frail elderly, mental health and the redesign of services for urgent care.

The fourth phase was a further national survey of governing body members which was conducted in 2016. This allowed longitudinal comparisons and it had a response rate of 77.5% of all 210 CCGs and 12.2% of the total population of 3,800 CCG board members nationally. The profile of respondents reflected the composition of CCG boards, thus, the largest number of respondents to the surveys were GP members of these boards (25% of the total) but all other categories such as accountable officers (10%), chairs (15%), nurses (6%),

finance directors (6%) and lay members (18%) were also represented along with nurses and others (20%).

The research thus used a mixed-methods approach. In this paper we draw on all four phases of the investigation but with special focus on the qualitative data from the core case studies and the quantitative evidence from the national surveys.

Results

Drawing upon both the case studies and the national survey data, it became evident that the local actors in a large number of CCGs were relatively passive. In these instances, neither GPs nor managers had evidenced any scale of ambitious practice in bringing about service change (despite ambitious plans in some cases). But, in a minority of CCGs, clinical leaders were found who had been more active and had made an impact on secondary care, primary care, or both. Examples are provided below and interpretations made of how these innovations were achieved. CCGs, overall, were constrained by the power and influence of other institutions and they were constrained by competing institutional logics and ambiguities. Operating within the wider landscape of competing institutions, CCGs faced uncertainties about their autonomy, their power and even their future existence. Part of this uncertainty was fuelled by additional new centre-led initiatives which sought to change the institutional landscape. Most notable among these centre-led interventions were two initiatives. The first was a policy document, *The Five Year Forward View* (NHS England 2014). This promulgated centre-led new models of care. However, to accord with the institutional logic of devolved accountability, it set out alternative types and left local jurisdictions with the apparent freedom to choose which they preferred. The new models were variants of more 'integrated care' approaches which in themselves set a corrective to the erstwhile emphasis on competition and the use of purchasing power by CCGs as a fundamental logic. A year later (December 2015) the centre went a step further and mandated the use of Sustainability and Transformation Plans (STPs). These required NHS institutions and local authorities to work collaboratively to produce joint plans which would make efficiency savings by linking health and social care across large geographical areas. Forty four areas were designated as the place-based footprints for these plans. The plans, produced usually with considerable input from management consultancies, had to be submitted for approval by late 2016. The STPs were loose collaborations of multiple CCGs and health providers such as hospital trusts alongside their local authorities. They are now termed Sustainability and Transformation Partnerships. Thus, CCGs remain the statutory bodies for commissioning but they are required to work within STPs so as to enable more regional planning. STPs became the approved repositories for transformation funding.

So far, we have outlined briefly the key developments at what institutional theorists would term the 'field level' (Greenwood et al 2010; Reay and Hinings 2005, Reay and Hinings 2009). It can be seen that competing institutional logics were *built-in* to the reformed system. The main question we now go on to try to answer is how the main actors at the key

organizational level (in this case mainly the GPs and managers in the CCGs) responded to these opportunities, constraints and competing (to an extent even contradictory) logics.

We begin the reporting of results with an overview of findings from the national surveys as these allow an understanding of the general pattern across the country, and in particular the extent to which GPs using the CCGs perceived themselves as agents of service redesign and improvement. Key sub-questions here included how much power and influence they perceived these bodies to have and how much power and influence they perceived that clinicians really had in practice within these bodies. We then present findings from the detailed case studies: these allow access to a different kind of understanding about the processes used by the pioneering clinical leaders who had succeeded in bringing about at least some degree of meaningful change in service configurations.

Results from the national surveys

The survey evidence pointed to uncertainty in the minds of board members of CCGs about the power of these bodies relative to other NHS institutions. Thus, as Figure 1 shows, while around 50% of respondents judged that 'My CCG' carried the most influence in terms of local service design, the other half judged that other bodies were more influential. Of these, NHS England was seen as the next most influential institution in shaping service redesign and the growing importance of collaboration between CCGs is indicated. But the fact that nearly half of CCG board members themselves judged that their CCG did *not* exercise the most influence might be expected to be a potential curb on expectations about the exercise of leadership by CCG clinicians or other CCG players. The results are shown in Figure 1.

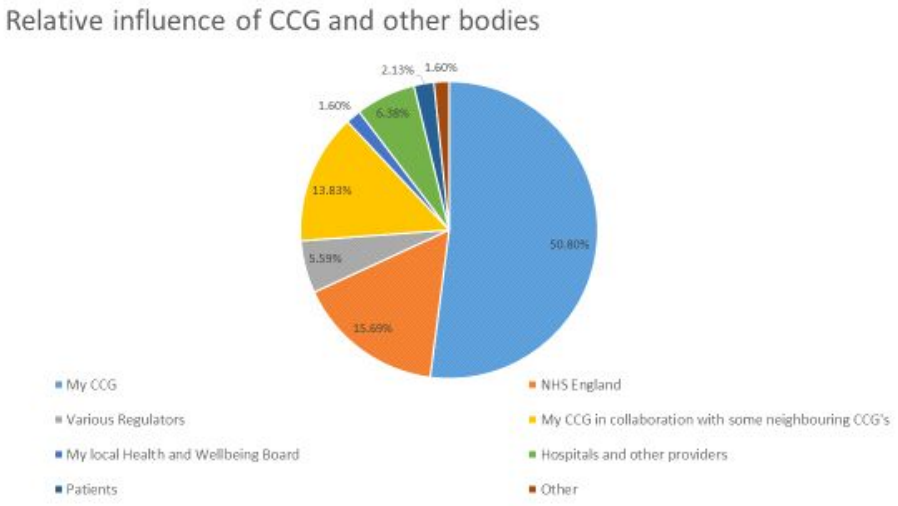

Figure 1: Relative Influence of CCGs and Other Bodies

Deeper digging revealed that it was the Chairs who were most likely to claim CCG influence but other role-holders, most notably Finance Directors, took a less optimistic view. Likewise,

less than half of the Accountable Officers perceived their CCG to be the most influential body in shaping services locally. Further, many GPs on CCG boards reported that they were disillusioned with their CCG experience. For example:

> *The CCG is becoming increasingly bureaucratic … We are increasingly subject to government directives and with short deadlines. There is no space for creative solutions from the CCG. I am angry and sad at the current state of CCGs.* (GP member of Governing Body)

Another survey question asked about the relative influence on the redesign of services across the local health economy. 38% of respondents said their own CCG was the major player. This is hardly a ringing endorsement of the official policy line that CCGs carried the main responsibility. Other bodies cited as influential by respondents included NHS England (14%) and local collaborations of CCGs (18%). There were significant differences in this assessment depending on the role of the respondent with regard to their views about NHSE and NHS Improvement. GP members of the governing bodies were most likely to perceive NHSE and NHS Improvement as influential. These findings suggest that the reality of CCG influence is rather less than was implied by the policy intent.

Respondents from CCGs rated as 'inadequate' by NHSE (annual assessments of CCGs are made by this central body) were far less likely to judge their CCG as having influence. In contrast, respondents from CCGs judged as 'outstanding' were much more likely to perceive their CCG as influential. It may be that the pattern of institutional influence is reflected in performance. Or, it may be that this pattern suggests the possibility of a self-fulfilling prophesy: those expecting low impact achieved just such; conversely those assuming they had influence were able to exercise it. There is also yet another possible interpretation: the low and high performers sensed the state of play and disowned or owned responsibility accordingly.

During the period of the field research, the idea of collaboration between CCGs grew in importance. CCGs were increasingly sharing management teams and resources with their neighbouring CCGs and participating in joint service redesign programmes. It was hardly mentioned at the time of inception but, over the following years, CCG leaders began to collaborate of their own volition and gradually NHSE started to encourage this practice. This seemed a tacit admission that the footprints of the 2010 CCGs were too small and that planning required larger areas and a larger populations (by 2018, as a result of mergers, there were 195 CCGs). We found an association between the degree of collaboration between CCGs and the rating scores of CCG performance as judged by the regulatory body. The CCGs rated as 'good' were disproportionately collaborating more with their neighbouring groups; those rated 'inadequate' tended to be acting alone; but on the other hand, those rated as 'outstanding' were seemingly able to be self-reliant. And perhaps they didn't want to collaborate with others in case this impacted on their performance ratings. When asked to rate the influence exerted by hospitals and other providers, it tended to be respondents from CCGs rated as 'inadequate' who were more likely to accord highest influence of these bodies. This may reflect the reality of

powerful local hospital trusts or it might reflect a lack of will or capability in tackling these providers. 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 muscular skeletal and frail elderly care). Others had concentrated on collaborative working with existing providers in pursuit of new patterns of care. These collaborations presaged later policy initiatives at supra-CCG levels - most notably, the *Five Year Forward View* and its associated new models of care (NHSE 2014) and the STPs (Edwards 2016). These initiatives increasingly relocated much of the inventiveness away from CCGs and into other hands.

We turn next to the question of the exercise of influence *within* CCGs. Given that the policy intent was to create commissioning organisations *led by clinicians* (Darzi 2008; Department of Health 2012), and most especially by GPs (Department of Health 2010), we wanted to know whether these institutions had lived up to that aspiration. The survey results revealed that managers and GPs were both considered influential and there was no clear lead role exercised by the GPs. Indeed, between the 2014 and 2016 surveys, there was a slight shift towards a greater influence among managers. Other members of the governing bodies including the lay members, secondary care doctors and nurses were rated as far less influential. When responses were separated out by role it was evident that GP members were the least convinced that they had the most influence. Finance Officers were clear that managers and not GPs exercised most influence. We asked 'who sets the compelling vision?' There might be an expectation, using principal-agency theory, that GPs would be the visionaries and set the course direction and managers would be the delivery agents. But this seemed not to be the case. Responses indicated that the predominant view from these insiders was that it came from managers and GP members equally. There was a similar pattern of response in answer to the question who mainly communicated with patients and the public. Building coalitions with other CCGs and with provider organizations would seem to be another key role for CCGs. Once again it was managers who were reported as more active on this front.

This leads to the question: what, if any, distinctive contribution is made by GPs and other clinicians in CCGs? Responses fell into categories such as 'knowledge and understanding': constituted both by professional knowledge and knowledge from front-line experience. There were also claims of analytical and evidence-based thinking from GPs along with 'common sense and pragmatism'. A further dimension was the claim to an 'independent perspective' of a kind not open to most managers. As one informant expressed it: 'GPs bring a healthy dose of challenge and remind staff of how it is in reality'. This attribute was linked to a sense of credibility and trust from patients. Although the form of the question asked for identification of the kinds of *positive contributions* that clinical leaders make, some respondents none the less used the space to express more critical views, such as: "I'm not sure they do". As these reservations stem from governing board members with a close-up view of proceedings in CCGs, it is especially interesting to note the scepticism about the impact of clinical leadership.

We also asked about the obstacles to achieving clinical leadership. The most common response was that GPs didn't have the time to fulfil the CCG role adequately. More than 92% of respondents gave this response. Respondents also took the opportunity to use this question to identify what they saw as the source of the failings and difficulties faced by CCGs. Hence, many GP respondents pointed to wider problems of the health service at large (such as 'fragmentation', 'complexity', 'political interference', and 'bias in favour of the acute sector'). Some managerial respondents used the question to highlight shortcomings in the GP contribution ('poor attendance', and 'lack of system-wide understanding'). A categorization of the various types of obstacles reported is shown in Figure 2.

Figure 2: Types of Obstacles to GP Leadership in CCGs

All types of respondents were ready to say that 'lack of time' was a major issue but, beyond that, divisions opened up with some managers suggesting that GPs lacked the will and commitment to even want to devote time to CCG work and that there were shortcomings in capability. Some GP respondents argued that the sources of the problem were deeper – that they extended to intractable system problems such as fundamental diversity of objectives; lack of autonomy for the CCGs to influence the system because of the power and influence of other bodies such as NHS England, and the power of the acute hospitals. In other words, there was evidence of a perceived vicious circle. Yes, many GPs were reluctant to step forward to commit significant time and energy to the work of the CCGs, but they contended this was because there was little incentive to do so and indeed little point in so doing because bigger forces were stacked against this being a rational action. A vicious circle of lack of clinical engagement and institutional responses was set in motion and this is depicted in Figure 3.

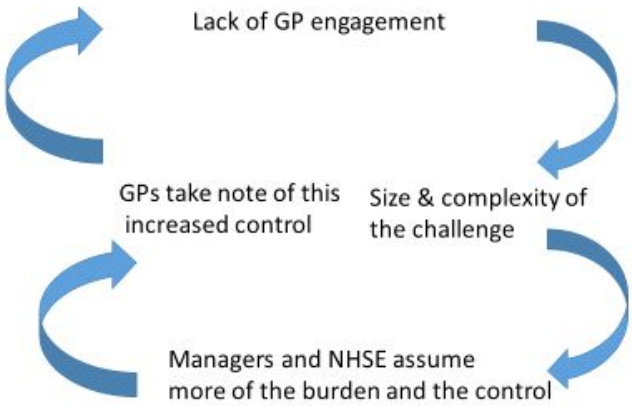

Figure 3: Vicious Circle of Lack of Clinical Engagement

This circle was mutually reinforcing. Talented, energetic, potential leaders were reluctant to step into active roles as leaders of service redesign on CCGs. Other system players, including managers and influential bodies such as NHSE and NHS Improvement, judged that the problems facing the service were so large and urgent that they themselves needed to step-in. This, in turn, further confirmed the suspicions of GPs and gave justification for limiting the amount of engagement.

Overall, the survey data allows understanding of the broad picture across the country. That picture was broadly one of limited influence of CCGs and of the clinicians within them, in terms of how far they were able to take significant initiatives in redesigning the delivering of healthcare. Our findings did, however, include evidence of *some* such initiatives, representing a degree of success in delivering on clinical ambitions to reshape services.

Also of note was that, as predicted by institutional theory (DiMaggio and Powell 1991; Battilana and D'Aunno 2009), there was considerable evidence of imitation across CCGs. CCGs form a loose community of practice, they have learned a common language and their ambitions are, in part at least, formed by the wider institutional field. Hence, at a general level, there were very frequent mentions in the free-text sections of the survey of common phrases summarising strategic intent, for example: ‘a shift of resources from acute to primary and secondary’; ‘bringing care closer to home’; ‘reducing hospital admissions’. Other comments were responses to national initiatives: use of the Better Care Fund and co-commissioning. Conversely, some referred to initiatives being stopped by NHSE. Another common theme was delegated commissioning for primary care since 2014 but the impact of this seemed to have been limited – a finding replicated by other research (McDermott 2018).

A straightforward frequency count of most mentioned impacts resulted in a list which placed the reform of musculoskeletal services by moving many of them from acute to community

settings, as the most common. The second most popular initiative was the set of changes made to mental health by increasing self-referral to talking therapies. The third in line were the improvements to frail elderly care with an aim to reduce emergency admissions. This included changes which integrated services and changed access routes into A&E.

Case study evidence

In order to gain a deeper understanding of the processes and relationship dynamics underpinning the initiatives described, it is necessary to draw upon insights from the detailed case studies. These help to reveal what actions GP leaders have taken, what obstacles they encountered, and how they overcame these. The four cases described below also illuminate precisely how the GPs undertook institutional work by using local commissioning groups as means to bring about change.

Case A: Reform of General Practice in a Large Conurbation

In this case, the senior leaders of the CCG (the Chair and the Accountable Officer, both GPs) used the platform of the new institution to mobilize all GP practices to attain an agreed standard of service. This new baseline of primary care had not been achieved under previous arrangements and the CCG governance structure was utilized to harness peer pressure to ensure and enforce the standard across the city for the first time. Building on that achievement, these same clinical leaders pressed on to promulgate a higher set of service standards based on an extended GP service offer. This second standard was based on an opt-in, unlike the first which was mandatory. Nonetheless, once again peer pressure helped to ensure that over half the GP practices conformed to this higher level of service. Hence, overall, in this case, local clinical leaders had successfully used the devolved powers to bring about significant improvement in the general standards of primary care.

Case B: Mental Health Alliance

In this case the reform initiative originated at the Programme Board level of the CCG – that is, a tier below the main board. A GP lead for mental health commissioning worked with a senior CCG manager to bring together existing NHS mental health providers of psychological therapies and with voluntary sector organisations that also provided therapy and/or support services. The CCG took the initiative to support and resource three mental health alliances: one for children and adolescents, one for adults of working age, and one for adults suffering from dementia. These alliances did not replace the existing separate contracts for services between the CCG and individual providers, rather they were resourced to improve coordination between, and learning across, the different providers so that service users encountered a more integrated set of services. GPs and managers from the CCG collaborated with clinical and managerial leaders in the provider organisations to overlay the established institutional logic of market-based contracts with a network logic of collaboration. This linked to a logic of improving public health through making services easier to access and navigate, and a logic of efficiency because waiting lists were reduced by preventing

inappropriate referrals. In summary, the local leaders used their commissioning powers to persuade multiple providers of mental health services to collaborate much more effectively.

Case C: Redesign of Urgent Care

In this case, the initiative arose from collaborative discussions between the CCG GP lead for urgent care and the urgent care providers who were represented on an urgent care programme board. There was shared concern about the excessive load on the main local hospital emergency department (ED). Senior paramedics from the ambulance service collaborated with the out-of-hours GP provider and the hospital to propose a new urgent care service, where a GP from the out-of-hours service would team up with a paramedic to staff an ambulance during the night shift. This would be sent to selected calls where the controller judged that there was a strong possibility that an attendance at the hospital could be avoided through the combined efforts of a GP and paramedic. This would typically be the case for an older frail person, living at home with a care package, but who had experienced some additional difficulties during the night. The service proved that it could avoid a significant number of ED attendances and indeed subsequent unnecessary admissions. This was achieved through the institutional work between GPs and paramedics working on the service and on the programme board, crafting protocols for this new service, blending their existing ways of working to address more effectively the needs of those who call ambulances during the night. Following a trial period, whilst GPs and the CCG itself continued to advocate the new service, it was however, significantly undermined by the wider pressures on the ambulance service itself, which was challenged by a national shortage of paramedics. The ambulance service decided it needed to prioritise its deployment of paramedics within regular ambulance crews. The GP-paramedic ambulance was replaced by a 'GP in a car', working with a less qualified emergency technician.

Case D: Extended and Integrated Primary Care

In this case, the conceptualising work and organizing work was done by a GP outside the formal CCG structure. But the institutional work was prompted and enabled by the ideology surrounding local service redesign. The basic idea was to bring together a cluster of hitherto independent and separate GP Practices to work more closely together so that they could offer extended and integrated care services especially for complex cases among the frail elderly. The initiative involved creating new services in the community staffed by new healthcare roles and supported by a central shared services team and common-access electronic data. The new roles included enhanced care practitioners, nurse practitioners, health coaches and mental health support teams. The aim was two-fold: to transfer care out of acute settings into community settings and at the same time offer a more integrated, holistic, service built around the patient's wider needs. There was, in tandem, a new community-based dementia service which relocated assessment and care of these patients away from the mental health hospital. This saved a great deal of money for the commissioners. The institutional work required to set up these alternative integrated services was extensive. It required securing special funding, it required persuading clinical colleagues to join the initiative, it required IT

support and it required persuading the CCG to provide the funding. What was revealed by this case was the enormous amount of work required to create this new service offer. It also revealed the highly contingent nature of the support offered by partners – for example, the commissioners eventually withdrew funding for the community-based dementia service and relocated that back to the specialist trust despite the extra cost involved. The reason apparently was to sustain the viability of that trust. Another lesson related to the wider extended primary care service itself. Stakeholder support was once again found to be highly contingent. The commissioners – the CCG – were reluctant to commit dedicated funding, but without that funding guarantee, the service innovator found it extremely difficult to invest in the start-up costs of the new services.

Cross-case lessons

The case studies illustrate 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. Lessons can be learned from these more creative attempts and they have relevance 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.

Overall, our cases revealed that institutional work at local level tended to focus on strengthening a logic of collaboration between commissioners and providers, and required successive rounds of defining the nature of the new services and the skills involved. This defining work involves rethinking the interfaces between previously over-defined and separate services that have become established under a contract-driven and somewhat adversarial model of commissioning. In the CCG context, cross-boundary intercession and negotiation across professional groups and across organisational boundaries was required. This necessitated capabilities of cross boundary relationship building.

As Clinical Commissioning Groups are not conventional hierarchical organisations, exercising 'leadership' in and around them is of a different nature to that found in an organisation such as an acute hospital or a corporation. As 'membership organizations', CCGs were oriented towards an approach to leadership which paid regard to consultation and persuasion rather than overt direct instruction or direction. This played out at three levels so that clinical leadership was located in three main spheres. One of these was at the strategic, policy-making level, typically located at the CCG Governing Body, but sometimes also involving other strategic bodies above this level. A second was found in the setting of programme boards and similar bodies responsible within a CCG for the operational commissioning of particular groups of services. A third was in the delivery setting, where some of the clinicians involved in providing innovative services worked on the operational and practice aspects in a manner which exemplified implementation leadership.

Our analysis showed how institutional work in each of these arenas needs to take place interactively if a difference is to be made and sustained. Many other 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. The imagining and articulation of a new service concept can arise in any of these arenas, but effective and sustained service redesign required matching, mutually-reinforcing, and commensurate action, involving clinicians, across all three arenas. Our analysis revealed the importance of the middle level operational planning 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. The programme board level of clinical leadership also had a key role in resolving a variety of tensions between different perspectives. Clinical and managerial leaders in this kind of board played a vital role in mediating between different managerial and clinical perspectives.

In all three spheres, most progress was made with regard to primary care. Less observable were any significant impacts on secondary care or much deployment of the power of commissioning and de-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. A common problem encountered was concern about threats to the continued viability of a particular provider organisation if certain contracts were withdrawn from them or scaled-back. In other words, the CCGs were caught up in a wider 'system maintenance' problem.

Discussion and conclusions

So, has the radical experiment of devolving healthcare leadership to local level with GPs in charge worked? From the evidence we accumulated, the overall answer is to some extent yes but to some extent no. The dramatic policy initiative which disbanded the existing regional and local health authorities in England while putting in their place new local commissioning groups led by GPs did not, overall, bring about the kinds of significant service redesigns that were anticipated. The purchasing power allocated to GPs was handled cautiously by these actors. This, we found, was because many GPs serving on CCGs boards were not convinced that they had the power and influence which the policy documents tended to suggest. This reflects the findings from other sustained studies of CCGs (Holder 2016 et al; McDermott et al 2017). Our explanation for this is that the new institution of the CCGs had to operate within a field occupied by other players drawing upon other logics. In some cases the experience of ambiguity and lack of impact resulted in disillusionment and a lack of active engagement in the CCGs by GPs. Managers thus came to wield greater influence. The problem, as perceived by many GPs, was that too many non-clinical managers took their lead from NHS England's hierarchical structures and thus the centre-led influence persisted. Moreover, within just a few years of their existence, other major nationally-led initiatives and policy priorities took centre stage. Notably, the Sustainability and Transformation Plans

(STPs) handed strategic service redesign to larger institutional footprints than the CCGs. The logic and legitimacy of local action was challenged by an alternative which posited the idea of more strategic action at a less local level. The more dominant recent institutional logic has been the call for Integrated Care Systems (ICS) with much larger population footprints than those occupied by CCGs.

Clinicians serving on CCGs found that they had to juggle with competing logics. The policy at the time of their launch was based on using GPs as holders and wielders of purchasing power. They were expected to use market competition to drive efficiency. But, very soon, the centre-led new models of care proffered a pathway based on integration and collaboration. GP leaders on the CCG bodies became confused and to a considerable degree thwarted by these competing logics. Neither logic (competition versus collaboration) became dominant. Many of the initiatives, as illustrated by the four case examples reported above, were relatively discrete, piecemeal, attempts to rationalise services by persuading multiple providers to work more collaboratively and to integrate the services offered to patients. This kind of effort was largely required as a response to earlier policies which had fragmented services on the basis of a logic based on the idea of competition.

Those GPs 'stepping up' to the leadership opportunity thus found that they faced many challenges. Budgets and funding structures tend to ossify institutional arrangements and thus, even when wider total system gains can be demonstrated, powerful forces within existing sub-systems were found to restrict change. Consequently, many of the more interesting institutional changes were often piecemeal initiatives, often dependent on special temporary funding and vulnerable to shifting changes in priorities. Extant institutions tended to be defended vigorously by incumbent actors (as predicted by Currie et al 2012).

Yet, despite the overall modest impact of devolved powers to local clinical groups, some interesting novel examples of active clinical leadership in designing and bringing about new forms of service design were uncovered as illustrated by the four case studies reported here. The actors were not fully bound by the 'iron cage' of institutions (DiMaggio and Powell 1991). In these instances, there was an emphasis on improving collaboration between providers and between providers and commissioners. The successful instances of service redesign seemed to depend on unusual levels of passion and commitment from clinical champions (GPs and nurses working together in a sustained and resilient manner). Noteworthy also was that these engaged actors worked in a dual capacity – as both commissioners and providers.

Even if system redesign using local commissioning groups did not work out as planned, the innovation triggered a whole array of initiatives. It raised expectations, gave legitimacy and permission for experimentation and triggered unexpected developments. The pattern was thus varied. The sources of these different experiences and outcomes included the inherited legacy of relationships under previous institutional arrangements, and the kinds of leader(s) who stepped forward to enact the role of change agents under the new devolved system. The findings reflected the summary observation made by Lawrence et al who noted that

institutional work is characterised by 'myriad day-to-day equivocal instances of agency that, although aimed at affecting the institutional order, represent a complex mélange of forms of agency - successful and not, simultaneously radical and conservative, strategic and emotional, full of compromises, and rife with unintended consequences' (Lawrence et al. 2011: 52-53). This neatly captures and reflects much of the experience of agents of CCGs as they hesitantly sought to influence their local institutional health systems.

While the main context in which these processes were explored in this project was that of clinical commissioning groups, the dynamics revealed are likely to have relevance and carry lessons far beyond these particular institutions. CCGs provided the large-scale natural experimental conditions in this instance, but a similar interplay between policy-makers, managers and clinicians play-out also under many other institutional arrangements where health service leadership is devolved to local levels. Compared to other international examples of clinical engagement in devolved systems, the CCGs in England can seem like a bold experiment. As noted above, they go further in scale and scope in bringing local clinical leadership into key healthcare design decisions. But, our evidence also suggests that their potential has been limited by the exercise of other forces and other logics, including, for example, a desire for more integrated planning which extends beyond the local, and the exercise of influence by players other than GPs.

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