Martin Marshall, Richard Holti, Jean Hartley, Tatum Matharu and John Storey

GP leadership in clinical commissioning groups:

a qualitative multi-case study approach across England

Abstract

Background
Clinical commissioning groups (CCGs) were established in England in 2013 to encourage GPs 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 of GPs in CCGs, and to examine the enablers and barriers to implementing a policy of clinical leadership in the NHS.

Design and setting
A qualitative multi-case study approach in six localities across England. The case studies were purposefully sampled to represent different geographical localities and population demographics, and for their commitment to redesigning specified clinical or service areas.

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

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

Keywords
clinical commissioning groups; clinical leadership; general practice; health service redesign; leadership; qualitative research.

INTRODUCTION

Clinical commissioning groups (CCGs) were created in 2013 in the English NHS following the Health and Social Care Act in 2012, as statutory bodies responsible for the planning and commissioning of healthcare services for their local area. They were introduced in a large part to give 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 given by policymakers:

'... 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 local needs, and would carry a higher level of credibility among their peers and patients than would managers acting alone.[3,4] Clinical leadership was assumed to be an essential component of service improvement and service redesign. Both required leaders to engage people around them and to have a deep understanding of the context and the content of clinical work.

The extent to which GPs working in 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 pioneer CCGs, most were judged to be struggling to fully engage their clinical communities or to impact on acute sector providers.[10-14] This article examines a series of in-depth case studies to explore the nature of clinical leadership of GPs in and around CCGs, and to examine the enablers and barriers to implementing a policy of clinical leadership in the NHS.

METHOD

Study design

A qualitative multi-case study design was chosen in order to develop a deep understanding of CCGs, clinicians' roles within those CCGs, and the nature and process of health service improvement and redesign.[15]

Theoretical perspective

Because the focus of this study was on CCGs as new organisations in the NHS, institutional theory was used as a conceptual and analytical 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.[16,17] In addition, relevant leadership theories were

M Marshall, MSc, MD, professor of healthcare improvement, University College London, London. **R Holti**, MSc, PhD, professor of professional learning; **J Hartley**, MSc, PhD, professor of public leadership; **T Matharu**, MSc, PhD, research fellow; **J Storey**, MSc, PhD, professor of management, The Open University, Milton Keynes.

Address for correspondence
Martin Marshall, Department of Primary Care and Population Health, UCL Medical School, Upper 3rd Floor, Royal Free Campus, Rowland Hill Street, London NW3 2PF, UK.

Email: martin.marshall@ucl.ac.uk

Submitted: 16 October 2017; **Editor's response:** 30 October 2017; **final acceptance:** 1 December 2017.

This is the full-length article (published online 9 May 2018) of an abridged version published in print. Cite this version as: **Br J Gen Pract 2018; DOI: https://doi.org/10.3399/bjgp18X696197**

How this fits in

Clinical commissioning groups were created in the English NHS to encourage GPs to lead efforts to improve and redesign services. There is currently little empirical research describing the extent to which this has been achieved or the ways in which it has been enacted. This study suggests that they can bring an important body of expertise and approaches to leadership activities. It also suggests that there are significant barriers to them optimising their potential contribution, in particular, uncertainty in the policy environment about further organisational change in the NHS.

used to provide a conceptual framework to aid data analysis and interpretation.[18–20]

Subjects and setting

Preliminary open scoping interviews were carried out in 2013 and early 2014 with senior clinical and non-clinical leaders from a purposive sample of 15 CCGs across England to identify key areas for in-depth exploration. These CCGs were chosen by the research team because of their expressed interest in the study following an introductory letter to all CCG chairs, and because they represented a range of levels of organisational maturity, geographical locations, and different sociodemographic populations. This scoping work identified three clinical and service areas that involved a significant amount of service redesign and where the learning from these areas had the potential to be transferable to other areas: integrated care for frail older people, urgent care, and mental health.

Six of these scoping case studies were then chosen for in-depth case analysis between 2014 and 2016. These six were selected because they were explicitly focusing on service redesign in one or more of the three clinical and service areas mentioned above, and because they were geographically spread across England. Two were located in socioeconomically deprived inner-city areas, one in a large urban conurbation, and three in mixed urban and rural areas. The case studies mostly focused on single CCGs, although in two areas they focused 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 non-clinical 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. A total of 202 semi-structured interviews were carried out, of which approximately three-quarters were with individuals and one-quarter with groups of stakeholders. The interviews lasted for around 1 hour and were carried out by the authors using a common semi-structured interview schedule (available from the authors on request). Interview subjects were selected iteratively within each case using a snowball 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 barriers to leading change.

Most of the interviews were audio-recorded and fully transcribed, although a small proportion of the data were collected informally and recorded using field notes. Twenty-four board and operational meetings were observed and detailed written records, including verbatim quotes, were collected for all interviews and observations.

Data analysis and interpretation

A thematic analysis of the data was carried out by the researchers responsible for each case study, 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.[21]

The analytical and interpretative process was conducted iteratively with data collection, was informed and shaped by institutional and leadership theories, and the results were discussed and revised with other members of the research team, and sense-checked with a sample of the study participants.

RESULTS

The case studies demonstrated a range of ways in which GPs are involved in leadership activities across the six localities. The different approaches are summarised in

Box 1. Types of GP involvement as clinical leaders in the six case studies

Case	Types of clinical leadership used
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 preventive 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 frail and older people, 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, although there is only a small amount of wider involvement of GPs in a relatively narrow scope of improvements to existing services

CCG = clinical commissioning group.

Box 1. Four main themes were identified from the case studies and are described accordingly.

Different levels of leadership

The case studies illustrated how leadership needed to be exercised at all levels in 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 frontline delivery and to support staff to do the work. Such leaders needed to have practical knowledge and credibility among their peers to be effective. In contrast with macro-level leadership, many examples of meso-level 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.

Collaborative style of clinical leadership

GPs appear to be more likely to use 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 managers in 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 show 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 appeared to be more significant than 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 among 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 among 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 appeared 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 GP interviewee (case study E) described as *'corporate guff* and were more likely to challenge, ignore, or express impatience with rules and guidance. Operating closer to frontline clinicians, they understood

ambiguity and recognised the compromises that clinicians needed to make to keep the system running.

Symbiotic relationship 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)

One 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 up 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.

Impact of political context on leadership

While clear opportunities have been created for greater GP leadership by the development of CCGs, there was also evidence from across the case studies that the political environment in 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, let alone 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 agents 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 3 years after being formed, CCGs were being sidelined and that other initiatives requiring clinical leadership, including GP provider federations, primary care homes, sustainability and transformation partnerships, and accountable care systems, were 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 appear less attractive to GPs than that of provider activities.

DISCUSSION

Summary

This study describes the ways in which the introduction of CCGs in the English NHS has shed new light on health system leadership of GPs. It is clear that the reality is more complicated than the simple political rhetoric of 'GPs in charge'. This study has highlighted 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 of the health system, although the strategic level is currently least well served. It outlines the emergence of a new alliance between clinicians and managers that draws on their different skillsets and creates new common interests. This study also illustrates the ways in which the fast-moving and complicated policy environment in the English NHS is impacting on the willingness and the focus of GP leaders.

Strengths and limitations

The use of a theoretically informed case study design has generated a deeper understanding of the nature of clinical leadership, and the enablers and barriers to exercising leadership behaviours. The approach does, however, present 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.

Comparison with existing literature

The concept of health system leadership by GPs is a relatively new field to date,[22,23] and this study has uncovered a number of potentially useful insights to guide future work. Several of the findings are compatible with the wider literature relating to 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 *et al*,[26] 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'*. This aspiration contrasts with the reality of the more top-down model of leadership often found in empirical studies of leadership in the NHS.[27–28]

The concept of 'informal' leadership has previously been described in the literature,[29,30] but not in 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,[31,32] and the case studies described in this study 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 to be effective leaders.[33]

Implications for research and practice

It is unclear whether the radical reorganisation of the health service in England in 2013, of which the formation of CCGs was one part, represents the most cost-effective way of promoting clinical leadership. This is an important policy and research question that needs to be addressed. Although 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 in the NHS has helped to elicit findings that are transferable and enduring.

The decisions required by NHS leaders will not get easier as the demands on the health service continue to increase while resources remain constrained. The development and implementation of sustainability and transformation plans/partnerships in England, the most recent of the NHS reforms that promotes cross-sectoral service redesign, presents a new set of opportunities to further develop clinical leadership. There has never been a greater need for evidence-informed leadership.

Funding

This study was funded by the National Institute for Health Research (NIHR), Health Services and Delivery Research Programme, Project Number 12/136/104. The full report, which also includes national survey data, was published in January 2018: Storey J, Holti R, Hartley J, *et al*. Clinical leadership in service redesign using Clinical Commissioning Groups: a mixed-methods study. *Health Services and Delivery Research* 2018; **6(2)**. https://doi.org/10.3310/hsdr06020.

Ethical approval

Ethical approval was granted by the Ethics Committee of the Open University (HREC/2013/1570/Storey/1).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

Acknowledgements

Thanks to 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.

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