

ABSTRACT

Clinical commissioning groups (CCGs) were set up under the Health & Social Care Act (2012) in England to commission healthcare services for local communities. Governing body nurses (GBNs) provide nursing leadership to commissioning services on CCGs. Little is known about how nurses function on clinical commissioning groups. We conducted observations of seven formal meetings, three informal observation sessions, and seven interviews from January 2015 to July 2015 in two CCGs in the South of England. Implicit in the GBN role is the enduring and contested assumption that nurses embody the values of caring, perception and compassion. This assumption undermines the authority of nurses in multidisciplinary teams where authority is traditionally clinically based. Emerging roles within CCGs are not based on clinical expertise but on well-established new public management concepts which promote governance over clinically based authority. While GBNS claim an authority located in clinical and managerial expertise, this is contested by members of the CCG and external stakeholders irrespective of whether it is aligned with clinical knowledge and practice or with new forms of management, as both disregard the type of expertise nurses in commissioning embody.

Key words: case study; clinical commissioning groups; governing body nurses; leadership; authority; observation.

INTRODUCTION

The pressure to contain and reduce costs affect health systems globally and as a consequence, different health systems have made efforts to restructure to assure efficiency

savings (Author et al., 2016). Restructuring has led to increasingly managerialist systems (Rudge, 2015) building upon on existing forms of new public management (Berg et al 2008). These managerialist systems have used change management models to realign NHS practices (Iles & Sutherland 2001) following successive NHS reforms (Health & Social [HSCA] 2012; Author et al 2014; Author et al 2016b). Iles & Sutherland (2001) argue that the frequency of successive change in the NHS has produced emergent forms of change rather than planned, effective change. Clinical Commissioning Groups (CCGs) are further examples of new public management (Author et al., 2016). CCGs commission 60% of health services in England (Secretary of State for England, 2012); and comprise an elected Governing Body of General Practitioners (GPs), and a nurse, a secondary care¹ consultant, and lay members, as well as employees from local authorities and local health services. The nurse member of the CCG governing body is referred to as a governing body nurse (GBN) (Royal College of Nursing [RCN], 2012b). CCGs commission a range of services for local communities and are responsible for approximately two thirds of the total NHS England budget or £71.9 billion in 2016/17. CCGs are independent, and accountable to the Secretary of State for Health through National Health Service (NHS) England. Compared to Primary Care Trusts² (PCTs) which led on commissioning services before the HSCA (2012), CCGs have greater freedom to decide which health services to offer. CCGs operate under increasingly pressured budgets (NHSE, 2013) and commissioning is complicated by impending devolvement of public health to local authorities, and moves to integrate health and social care. Therefore, while the power and responsibility of these commissioning bodies is greater than previous

¹ Secondary care refers to services provided by medical specialists who generally do not have first contact with patients (e.g. cardiologists, urologists).

² Primary Care Trusts were precursors to CCGs, responsible for commissioning primary, community and secondary health services for providers

commissioning bodies i.e. PCTs, commissioning choices may be increasingly constrained. Our paper discusses findings from an observational study of governing body nurses in two CCGs in England, and forms part of a small programme of research by Author et al (2016a, 2016b; in press). Our findings contribute to a developing understanding of the history of nurses' involvement with strategic roles in governance (Davies, 2003) and leadership (Butterworth, 2014; Latimer 2014) in health systems.

Background

Following pressure from the RCN, (2012b), each CCG was obliged to appoint a nurse to its governing body to shape patient-centred service delivery. It was expected that these nurses would have experience of commissioning, service redesign, safeguarding and monitoring of standards. They would bring a strategic view³ informed by expertise from direct patient care delivery to population level commissioning (NHS Commissioning Board, 2012; RCN, 2012b; NHSCC. 2016). The RCN (2012) asserts that GBNs draw on enduring nursing values; namely, holism and a concern with care, compassion, dignity and safety. The RCN's view was that nursing leadership was essential to advance the aims of the CCG; however what was meant by nurse leadership and hence what CCGs expected from GBNs was unclear. The recent NHSCC (2016) briefing on the role of the nurse on the CCG governing body has to some extent clarified what is expected from GBNs. It emphasises GBNs' translate their expertise in direct patient care to informing and influencing commissioning services at the population level. However it says little about what informs or shapes this translation. NHSCC identify two types of nursing role: the registered independent nurse member of the CCG governing body and the executive nurse employed by CCGs with responsibilities for CCG activities. This

³ A strategic view defines the goals, actions and resources, often identified by particular organisations, needed to achieve desired outcomes; in this case, those associated with nursing.

lack of clarity and the divergence of roles had been highlighted by early reports on CCG activity (Trevithick, 2013; McCann et al, 2014; Author et al, 2016a).

In work on professional knowledge and authority, Richardson (1999) argues that the growth and development of the medical profession has been dependent on individuals maintaining their clinical knowledge base and scope of practice. However a new form of public management is increasingly apparent within public services. Here the increased use of contracted providers introduces competition and with it a greater emphasis upon performance, output and accountability (Larbi, 1999). Lawler (2005) asserts that in these new forms of public management⁴, the term 'leadership' is virtually indistinguishable from 'management', and that generalised management and leadership knowledge are valued equally, if not more so, than traditional forms of clinical authority.

Recent pilot work by Author et al. (2016b) concluded that the intended role of GBNs in "bringing a unique patient-focused whole team perspective to decision making in commissioning" (NHSCC, 2016) is difficult to realise within CCGs, given the influence of the new public management discourse on commissioning. This prioritises rationality, the creation of autonomous agencies and the devolution of budgets (Berg et al., 2008), as well as an increased emphasis upon performance, output and accountability (Larbi, 1999). Newly emerging public management roles are not based on clinical knowledge and scope of practice, even when being carried out primarily by clinicians (Latimer, 2014). It should be noted that new public management has been influential in the NHS in the UK for several decades although NHS managers may not be aware that this discourse shapes their management practices.

⁴ New public management emphasises the intensification of work, the measurement of performance in service delivery and cost efficiencies. It predominantly identifies with private sector managerial techniques and ideologies where focus is on performance management, increased surveillance of work, oversight and regulation through inspection and audit (Berg et al. 2008).

The type of leadership promoted by new public management prizes governance over clinically based authority (Richardson, 1999). Traditional nursing values of caring, holism and compassion (RCN, 2012; Shahrian et al., 2013) may be difficult to assert in a commissioning context which is dominated by a belief that subjective experience and job related knowledge are less important than skills in general management (O'Shea et al., 2016). Traditional forms of nursing authority are not dissimilar to clinical medical authority as the NHSCC and RCN argue, i.e. their authority is based on expertise in direct patient care delivery. However, nursing is a gendered profession and consequently, has struggled to assert an objective evidence base practice to its authority rather than authority being based on subjective caring actions (Davis, 1995; Latimer, 2014) or a virtue script (Leary, 2014). It has struggled with being viewed as clinically authoritative in Richardson's sense.

METHODOLOGY

The aim of the project was to explore how GBNs work within CCGs. Given that there is very little work in the area, an observational case study methodology was chosen which used non-participant observation of CCG meetings, informal and formal interviews with CCG members at those meetings and with other CCG members (Burawoy, 1998).

Design

Two CCGs (we use pseudonyms Weatherspoon and Rutherford in this paper) were selected for maximum variability after inviting all CCGs in London to participate in the study.

Selection of observations, and both informal and formal interviewees was purposeful and driven by the research aim (Burawoy, 1998). CCG meetings were selected if they were public meetings and/or the nurse chaired the meeting or was attending to give evidence. The informal interviewees were selected if individuals contributed to a CCG meeting as well as

the nurses we observed at the meeting. Formal interviewees were approached if they were a GBN, worked in a CSU or in another role for the CCG.

Data collection

Data collection occurred over a six month period from January 2015 to July 2015. Prior to the observations taking place, verbal informed consent was obtained from members of the meetings. Observations of two Board meetings and five internal (i.e. not open to the public) CCG meetings were undertaken by two researchers (HA, CT); data were digitally recorded field notes. Informal interviews with five members of the CCGs and members of the Commissioning Support Unit⁵ (CSU) were conducted in cafés, travelling between meetings and in waiting rooms by both researchers. Potential formal interviewees were contacted personally after an observation and invited to take part, then given a participant information sheet and consent form to sign, which were returned to the research team. Two of the research team (CT, HA) conducted semi-structured interviews with seven members from Weatherspoon and Rutherford CCGs.

Ethical issues

Ethical approval was given by university ethics committee. Ethical concerns relating to observation and interview data were raised by both CCGs and reassurances sought regarding confidentiality and anonymity before access was permitted.

Data analysis

The formal interviews with the CCG members and the observations at the CCG meetings were audio recorded, transcribed verbatim and manually analysed by the two researchers.

⁵ Commissioning Support Units are a non-clinical advisory group funded by the NHS to support acute Trusts, NHS England, local government, and also, the work of CCGs. Their remit includes overseeing the reconfiguration of local services and transactional support (IT, HR and business intelligence).

Notes of informal interviews were written up and analysed thematically. Validity and rigour were achieved through data being repeatedly parsed by the researchers in an inductive thematic analysis and notes made to identify and categorise preliminary themes according to the steps outlined by Clarke and Braun (2013). Analysis generated subordinate descriptive themes, ultimately refined into interpretative superordinate themes, representative of tentative theoretical explanations.

FINDINGS

Our sample included one part time primary care nurse, Anna, elected to support the part time GBN at Weatherspoon but not a GBN herself; Berenice the part time GBN at Weatherspoon CCG (a secondary care nurse lacking experience of primary care which is the focus of CCG commissioning); Hilary the GBN at Rutherford CCG who also had an executive role on Rutherford CCG Board. We also interviewed the finance officer, a member of the commissioning support unit and the head of commissioning at Rutherford CCG, and the lead for quality at Weatherspoon. Our findings suggest that these GBNs faced challenges:

- In retaining a patient centred focus
- To nursing leadership and bringing a nursing perspective to commissioning from members of CCGs
- In negotiating professional relationships externally to the CCG
- In negotiating leadership within CCGs irrespective of part time and full time status as executive GBN roles.

Tensions in retaining a patient centred focus in CCG work.

The consensus amongst members of both CCGs taking part in the study was that the ambition of their work was strongly rooted in patient-centred aspirations. These aspirations

marked the CCG as different to past commissioning arrangements, as articulated by a CSU member at Rutherford, the CCG “[...] is more clinically led [...] in a way that [...] the professional executive committee in a PCT, [...] never really achieved”.

Informal strategies to maintain a patient centred focus included bringing clinical material into meetings; for example, by relating how the families and children GPs treated or knew had been affected by the work of the CCG. More formal strategies included the Chair of a CCG meeting promulgating the CCG’s aim,

“To provide the best health possible to the residents of XXX, encourage self-care, develop effective care pathways and to focus on quality of service. [...] this message has been condensed and will appear as a screen saver on everyone’s computer. [...] every CCG member will be issued with cards, also showing the vision statement, so that wherever they go, when asked, they will be united in their quest”. (Observation CCG)

This statement seemed like a proclamation, with the inference perhaps, that unless reminded by their screen savers, CCG members may disregard the patient incentive as a key motivator. The statement suggested that the patient-centred aim produced an uncomfortable tension in the CCG at odds with the expressed patient-centred, visionary ambitions. In another example, at a CCG public Board meeting there was a long debate over an agenda item. The researcher observed that a lay member felt such detailed discussion of minutiae seemed removed from patient experience, telling the researcher: “This is nit picking [the debate over the agenda]. I don’t know what they’re on about. It’s the patient agenda that should be nit-picked. This is all about organisational bureaucracy [...]” (Observation Weatherspoon CCG Board meeting). Following this Board meeting, this tension

was repeated by Hilary in relation to CCG employees for whom “the NHS icon on their (CCG employees’) computers” [could] be the only reminder of their purpose” (Informal interview GBN Rutherford CCG). It appears that developing stronger patient and public involvement (PPI) in the delivery of healthcare, while central to health reform in the NHS, may be hard to achieve (Ocloo and Matthews, 2016). The tension described by Hilary and the patient above reflect Freeman’s findings that managers find conflict between professional and corporate agendas (2013). This is further illustrated below.

Moreover, whilst CCG staff were reminded of, and may indeed have held, patient-centred values, the financial reality of commissioning healthcare and the constraints of ‘new public management’ were clearly at odds with these values.

“In terms of where quality and finance, [...] you’re wanting assurance that those cost reductions are not going to impact adversely on the quality, that’s going to be a conflict, with the number one priority about actually reducing costs”. (Interview CSU member Rutherford CCG).

For Hilary the dilemma was how to “make a discussion of contracts [at CCG meetings] about patients?” (Observation Rutherford CCG) suggesting that the ethos of new public management in CCG meetings presented a challenge. A challenge also experienced by lay representatives on the CCG. During another observation, following a lengthy report of statistics by a trust member regarding ‘did not attend’ (DNA) patients, the Lay Chair observed sharply that the patient focus was getting lost:

“The action actually says that we’re looking for ways to reduce the DNAs not just look at the differences and understand them, so actually this is more than just a bit

of an analysis, isn't it? It's about planning some actions to put that right once you understand the information" (Observation Weatherspoon CCG).

Another manifestation of this tension and conflict between patient-centred and corporate values was observed in contract review meetings. Here Trust activities are reviewed against contracts to provide services by the commissioning CCG. The tension between financial target data and patient experience was particularly evident. Our observations showed that NHS Trusts were doggedly challenged against agreed standards and questioned about the relevance of the data to patients despite being requested for such data from CCGs. Data scrutiny at CCG review meetings represented an important measure of clarity and authenticity. However equally, such detailed data scrutiny disguised CCGs' key aspiration to achieve patient centred care.

The nursing leadership role - bringing a nursing perspective to commissioning

Our findings suggested that GBNs had to continuously negotiate relationships within the CCGs with other professionals *and* lay members, and with their external partner NHS trusts. These negotiations revealed a lack of clarity around the nursing leadership role and whether nurses brought a nursing perspective to commissioning.

Anna and Berenice described their leadership style as "democratic, loose, facilitative" and at the same time, "strong and action orientated" (Observation Weatherspoon CCG), depending upon content and context. For them, the facilitative element of leadership was realised through the expression of shared knowledge and "a historical friendship ...[and] bond [with trusts]" (Observation Weatherspoon CCG). Berenice and Anna believed that a facilitative leadership style with the trusts enabled a beneficial association, moving relationships with them from "combative" to cooperative (Interview GBN Weatherspoon CCG). At Rutherford,

Hilary was perceived by one CCG member as “the leader and [the] expert, [who] would use the part time nurse person for that softer side of things”; by another, as a participative leader, “the keeper of values that are shared by their team” (Interview Rutherford CCG). Hilary asserted that a facilitative, non-hierarchical leadership style was compatible with the GBN executive role, and tried to resolve the conflict between the dual professional and managerial role by referring to “integrated nursing leadership”:

“[...] we’re not an army with one person at the top and a Christmas tree of an organisation underneath it [...] I also lead from a nursing point of view about professionally improving service”, (Interview GBN Rutherford CCG)

However findings also suggested that in fact Hilary’s approach was markedly executive and formal with external stakeholders and Hilary acknowledged that CCGs may be governed rather than directed by values: “creat[ing] an industry of process as opposed to doing what is the right thing by the patient” (Observation GBN Rutherford CCG). The findings in fact implied an uncomfortable relationship between nursing values and the GBN role irrespective of the part time or full time executive nature of the role.

Relationships with external partner trusts

Relationships with external partner trusts were key to the smooth functioning of the CCG yet the three GBNs in this study had completely contrasting attitudes to their external colleagues. For example, Hilary stated that “the Director of Nursing [from a local acute Trust] had little conception of the health problems addressed by the CCG, yet was dismissive of their work”. However, despite scepticism about this comment, Hilary believed that GBNs were perceived as “clipboard toting nuisances” by their acute care colleagues (Observation Rutherford)”. This was felt to be an injustice as Hilary felt that “[my] peers ha[ve] a narrow

focus and “limited [...] impact on local patients’ health” (Observation Rutherford CCG). Yet at the same time, Hilary was equally ambivalent about local practice nurses, describing them as “a red herring that diverted attention from the work of the CCG” (Observation Rutherford CCG).

A more relaxed approach was observed at Weatherspoon which generated a less strained atmosphere with external partners. Anna displayed a relaxed attitude in her relationship towards external providers by trusting they had pre-read reports and allowing the CCG to go “straight to questions” (Observation Weatherspoon CCG), in stark comparison to CCG Rutherford, where the trusts’ reports were meticulously dissected. Berenice and Anna felt that their leadership style facilitated “honest” relationships whereby the Trust could telephone the CCG “and say, we’ve had a serious incident, we just want you to know”. (Interview Berenice Weatherspoon CCG). Berenice suggested that an authentic relationship did not detract from scrutiny.

In her part-time capacity, Anna supported Berenice with authority on the CCG although she was less assertive and executive than Hilary. However HA noted how Anna’s authority was potentially undermined by a colleague at one meeting advising Anna and seeming to direct the agenda (Observations Weatherspoon CCG), possibly reinforcing Anna’s ensuing hesitancy when asking questions of her team, “Shall we...could you....I suppose we could” “Is it ok if I ask you a question?” (Observation Weatherspoon CCG).

Yet the data hinted at Anna’s capacity for a more authoritative style, where, in the face of challenging questions, she communicated her power and stayed calm,

“One GP [...] voices concerns [...] quickly moving to dissect some of the statistics she [Anna] has presented [...] [Anna] appears unflustered and presents a more expansive break down [...] and competently explains that she has asked the Trust to do a lot of

work around these issues, calling for better assurance [...]”(Observation Weatherspoon CCG).

The findings suggested that Anna’s power was both enacted and perceived differently according to the context in which she worked; authoritative at the public CCG meetings and more hesitant at internal CCG review meetings when she was undermined.

In contrast to Anna’s chairing of CCG review meetings, our observations at Rutherford CCG where Hilary chaired meetings, suggested an unequal power relationship between trust representatives and CCG and CSU members, particularly associated with trust performance versus the achievement of targets set by the CCG. For example, in response to a trusts’ report about staff shortages one GBN

“Emphasise[d] that the lack of staff in the xxx report must be followed up as it [was] a safety issue – implications for [the] CCG were that safety would be compromised and [the] contract to ensure safe practice, not fulfilled”. (Observation Weatherspoon CCG).

Since the CCGs hold the power in awarding the contracts, the GBN’s use of the phrase ‘safety issues’ in conjunction with the implied threat of an unfulfilled contract was of significance. This focus on performance and accountability in relation to awarding contracts challenged comfortable relations between CCG and trust staff.

The Rutherford CCG was observed framing two challenges, in which the GBN played a pivotal role. The GBN began with positive affirmation, before the CSU “challenged” the trusts to account for certain parameters using direct if not blunt questions about performance:

Hilary: “You’ve [Trust representative] covered lots, haven't you? Yeah, that’s brilliant”.

CSU member: “One of your slides was about patients cancelling their surgery at short notice [...] why are your patients cancelling their surgery at short notice?” (Observation Rutherford CCG).

On another occasion, Hilary combined humour with challenge. In this extract, Hilary opens the meeting by admitting to being “in an impish mood today”. However, later, when responding to a lack of clarity from a trust representative, this stance shifts to one of direct, firm and authoritative challenge, raising (again) the possibility of a contract query notice as to whether the commissioning of services from a particular provider will be maintained:

“So it would be really useful to have that information before the next meeting, because I think at some point we will have to consider whether we contractually do something about it through contract query notice and things. We’ve chosen not to go down that route often with the Trust because we’ve got such a good relationship, but I think we need to sort this out”. (Observation Rutherford CCG).

One CSU member considered humour a “conflict management tool [...] in order to diffuse a situation or make a point [...] but not[...]in a confrontational way”, an essential tactic according to him, since CCGs have “very limited levers” faced with discord from providers, implying little external support for CCGs (interview CSU member Rutherford CCG). These various ‘tools’ showed how difficult relationships between trusts, CCG Board members and CSU members could become as each side enacted their roles and responsibilities under the HSC Act.

Despite observing the consistent, calm and persistent justification of trust representatives in the face of challenging questions, their explanations did not consistently satisfy the GBNs, whose exactitude was evident in the call for more substantive and transparent data to authenticate claims. Such requests for evidence at review meetings were interpreted in the

analysis as indications of tension between the patient-centred aspirations of the CCG and new public management and personified by Hilary's anxious comment about accountability during an informal interview, "I [GBN] am not brushing things under the carpet. Everything is in my report. [...] No, no, no, the matter will be clarified" (Observation Rutherford CCG).

Part time or full time executive GBNs – negotiating leadership within CCGs

In addition to the tensions for nursing leadership on CCGs and with external stakeholders, there was little understanding of the role of part time nurses on CCGs amongst the non-nurse executive and importantly, the full time executive GBN. According to Hilary, nurses (generally) do not have "a strategic head on them". This view was repeated in the interview with the finance officer at Rutherford CCG who considered that part-time nurses were "at that lower level". These views appear to reinforce (perhaps falsely) a gendered (and rather negative) view of nursing and nurses. But interestingly this was echoed in Anna's interview who said "strategic matters went over her head" (Observation Weatherspoon CCG). However, both Anna and Berenice appeared skilled in commissioning, in negotiating with stakeholders. There was at the very least uncertainty about how part time GBN roles, even when undertaken by Anna, an experienced primary care nurse, could contribute to nursing leadership in commissioning. Hilary considered their influence as "limited, with "a narrow scope of experience" (Interview GBN Rutherford CCG). This view contrasted with Anna and Berenice's views of their role as active contributors: "Neither of us [part time] are frightened about saying things in meetings or putting forward that view" (Interview Berenice Weatherspoon CCG).

DISCUSSION

In the context of CCGs, a nursing professionalism based on clinical and gendered forms of authority becomes problematic because such authority is contested by members of the CCG and external stakeholders irrespective of whether it is aligned with clinical knowledge and practice or with new forms of management. Both disregard the type of expertise that nurses in commissioning embody. We conclude that there is an emerging but highly individualised practice of nursing in commissioning on CCGs.

Our findings suggest that these GBNs worked hard to construct a coherent role as clinical leaders on CCGs but that their attempts at nursing leadership in CCGs is challenged both within and externally to the CCG. Richardson (1999) considers that the claim to professional status gained through a medical model of practice may be tenuous in the bureaucratic environment of “competitive client-focused health care service which is based on accountability and collaboration with others in clinical governance” (462). Our findings suggest that clinical authority (or a lack of it) remains influential in how GBNs are viewed in commissioning; and that new public management, which is well entrenched in the NHS, may further constrain traditional claims to (professional) nursing leadership externally to the profession. We suggest that both the part-time non-executive (Berenice/Anna) and full-time executive GBN (Hilary) worked hard to bring a nursing perspective to commissioning. Hilary (rightly or wrongly) believed senior nursing peers external to the CCG did not value the GBN role although CSU and CCG colleagues did. Berenice and Anna who shared the non-executive GBN role as part time appointments, considered themselves as leaders both within the CCG and with senior nurses in provider trusts. Yet, during observations, we detected a subservience which diminished Anna’s authority in interactions with the Lead for Quality; and the views about part time GBNs held by Hilary and other CCG members at

Rutherford, arising perhaps from limited understanding of their purpose, may also have been unhelpful more generally. It is interesting then that recently the NHSCC (2016) has suggested that CCGs adopt a full time executive who is embedded in CCGs as the model for the GBN role.

Our findings suggest a much more embattled and gendered positioning of GBNs, than is presented by national advisory and policy bodies the RCN (2012) and NHSCC (2016). Work by Millar et al. (2010) and Freeman (2013) help illuminate this positioning of GBNs in face of powerful interests and obstacles to nursing leadership on CCGs. Place, type of contract and role of the GBN on the CCG emerges as important as GBN struggle to assert their authority within the CCG and outside. Mabey et al. (2010) argue that understanding leadership as 'place-making' – GBNs' place in CCGs – may help explain the different perspectives we observed and how these perspectives might be in conflict. Our findings suggest that as GBNs sought to justify their positions on CCGs they implicitly revealed an anxiety over their 'place' on CCGs (Millar et al 2010; Freeman 2013) and their role in decision making.

The distinction between leadership and direct clinical expertise is not easily disentwined. In previous research (Frankel, 2008), nurses described a clinical leader as a role model who encouraged, inspired and assisted others to reach clinical competence. Heal (2008) defines clinical leadership as "providing expert clinical practice, facilitating change, disseminating evidence-based practice and improving communication in and beyond the health team". This suggests moving beyond the historical 'doing nurse' as profiled by Walker (1997), towards leading others to improve nursing practice and patient care but both definitions are based on clinical expertise. Interestingly, it is these precise qualities which form the job profile for a GBN position on a CCG as outlined by the RCN (2012c). Anna and Berenice were

more obvious nursing leaders in this respect, remaining as clinical nurses as opposed to Hilary who had moved into management some years before. However Hilary's profile is more reflective of the majority of other GBNs as O'Driscoll et al (in press) suggest from their analysis of the 2015 annual survey of commissioning nurse leaders.

Our findings suggest that, irrespective of whether the GBN is full time or part time, they respond to the demands of the role similarly. Both Berenice and Hilary appeared to feel that their authority as a GBN may lack credibility: for Hilary, because of a lack clinical authority in the locality and for Berenice, because she lacked credibility within the CCG as a secondary care nurse. This is important as traditional clinical credibility has formed the basis of claims to professionalism (Richardson, 1999; Latimer, 2014). Hilary, the full time GBN in this study, argued forcefully and to the detriment of part time colleagues in other CCGs, that contrary to the traditional view of professional clinical authority, based upon maintaining a knowledge base and scope of practice (Richardson, 1999), a strategic view of health is an equal claim to authority and professionalism. Hilary recognised that an authority grounded in strategic thinking and planning may not be as valued as clinical authority. This situation may be worsened because GBNs are working in an unstable period following the Francis and Keogh reports⁶ (Francis, 2013; Keogh, 2013) and moreover in the context of a concern with clinical performance and governance in the NHS. Berenice defended against potential criticism of her lack of credibility within the CCG by emphasising relationships with local trusts which were enhanced by her ability to facilitate rather than confront while achieving the same ends of governance and accountability. It is notable that in both cases, irrespective of full time or part time employment, these senior nurses are supported by a part time

⁶ The Francis and Keogh reports were commissioned by the British Government following numerous episodes of poor care and elevated mortality rates at key Foundation Trusts in the UK.

primary care nurse although their relationship with that primary care nurse is very different. This means that their leadership position is *not* founded in clinical knowledge or expertise. Given the assertion that the term 'leadership' is increasingly virtually indistinguishable from 'management' (Lawler, 2005), the struggle that these GBNs describe in defending their roles suggests that a new nursing role in new public management organisations is being constructed in CCGs. Their nursing identity appears to be swallowed up in the public management and business ethos demanded by the Health & Social Care Act (2012). Evaluation of these new roles may not be in terms of whether the post holder is clinically credible but what difference their management of the service makes to the quality and efficiency of public services (Weisbrod et al., 1978).

These findings raise interesting questions about professionalism in a multi-professional context and the management of professional relationships both internally and externally to the organisation. This was evident in awkward tensions between Hilary's self-perceived professional identity as a nurse and as a member of a CCG. Our data suggest that the aspirations for the work of CCGs were strongly patient-centred. At the same time there was such an extensive scrutiny of performance and accountability of trusts by CCG members which detracted from talk at meetings being directly about patient-centred matters. Thus, the researchers observed everyday practices in the CCGs at odds with their expressed visionary ambitions.

This does not mean however, that nursing values cannot be enacted meaningfully, but there appears no clear measure as to what effective leadership for nursing in CCGs entails. It is clear from our findings that these nurses used a range of directive leadership strategies and

more participative strategies when scrutinising local trust activity. Both strategies entailed nurturing cooperative relationships and careful negotiation and may not be so different. Moreover, it can be difficult for GBNs to develop facilitative relationships with the trusts, since the legacy of the Francis and Keogh reports have given rise to unintentional fear in relation to accountability which could undermine the review meetings and, for GBNs, a desire to enact nursing values. Equally, there are aspirational inconsistencies resulting from the bureaucratic demands of CCG business and person-centred philosophies of care, where the latter values are constrained by new public management.

In all of this, the lay and public members perform an important role, grounding more executive goals by importing the patient perspective. And yet, the findings testified to the disempowerment of these groups, which was capable of quelling their voice. This aligns with contemporary evidence (Coulter and Ellins, 2006; Vincent and Coulter, 2002) that whilst patients can contribute to healthcare in ways that enhance their personal care, changes at a higher end organisational level are seldom affected. Moreover, despite the supportive policy context of patient involvement, progress to achieve greater involvement is patchy and slow, so that actually enhancing democratic principles and accountability is often tokenistic (Martin, 2008; Trivedi, 2009; Beresford, 2013).

Limitations

Our sample was restricted to two CCGs and a small number of interviews and observations. Our findings are intended to promote discussion about an unexplored area of nursing practice rather than provide generalisable findings. We suggest that more qualitative work

needs to be undertaken in different CCGs to fully understand how GBNs perform in other commissioning teams. More data on how nurses came to be incorporated into the CCG structure might also be useful in furthering knowledge about their roles.

CONCLUSION

This article contributes to our understanding of the development of commissioning in England and of nurses' roles (GBNs) in commissioning **and the influence of new public management on new forms of governance in the NHS since the changes to the NHS since 2012**. We discuss the social, political and historical trends of the development of nursing in commissioning in the context of work on traditional authority versus new emerging forms of public management and suggest that the authority of nursing may be undermined by its historical location in clinical expertise. Our findings suggest that GBNs function within the framework of new public management and that their leadership style is framed and at times constrained by tensions between patient-centred commissioning and a target-driven commissioning model. The somewhat conflicting data about the roles (part time, full time, supporting or seconded) and identities of GBNs in this paper may also reflect the process by which GBNs came to join CCGs at the 11th hour to increase nursing influence such that the term 'clinical' was not clearly defined or described. It was a last minute, pragmatic addition to an already-completed structure – in which nurses are still having to find their way. While our data are located in a specifically English setting, understanding of the current challenges that GBNs face, findings will help commissioning nurses in international settings to prepare for shifts in healthcare systems to new public management. And help prepare nurses in the UK for the forthcoming shift to strategic commissioning, in which commissioning for the NHS and local government will be integrated and based on much larger footprints than

those typically covered by CCGs today

<https://www.kingsfund.org.uk/blog/2016/06/strategic-commissioning-nhs>.

Our findings suggest that neither current professional preparation programmes or clinical managerial experience may prepare nurses for these types of strategic roles. Skills grounded in clinical credibility may not be predictors of service management skills which are required to develop quality and efficiency of services in the future (Iles & Sutherland 2001). Finally our findings suggest that there is a predominant attitude that nurses are not qualified for leadership or strategic managerial roles and that gender politics continues to present a significant barrier to success in nursing leadership roles.

Key Points

The role of the governing body nurse is intended to bring expertise in direct patient care to commissioning services at population level. There is little empirical work exploring the nursing contribution to commissioning decision making.

Our findings suggest an emerging yet contested nursing role in commissioning patient-focused services. These practices vary across CCGs, are shaped by the dynamics of each CCG and are articulated through a GBN's ability to negotiate relationships both within the CCG and externally with key stakeholders in local health economies. Traditional forms of clinical authority which draw on expertise in direct patient care delivery and management are challenged by new public management on CCGs.

Our findings contribute to a developing understanding of the history of nurses' involvement with strategic roles in governance (Davies, 2003) and leadership (Butterworth, 2014;

Latimer, 2014) in health systems including commissioning (NHSCC, 2016) – and of the political frameworks that have shaped this history. By providing understanding of the current challenges that GBNs face, findings will help commissioning nurses in international settings to prepare for shifts in healthcare systems to new public management.

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