General Practitioners Committee

NHS WHITE PAPER

Shadow consortia: Developing and electing a transitional leadership

GPC guide to the NHS White Paper

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STANDING UP FOR DOCTORS

BMA

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1. Introduction

The Government's plans for the future of commissioning will require the formation of GP-led Commissioning Consortia and, in the interim, the formation of shadow consortia.

This guidance outlines a number of options that will need to be considered when developing the transitional leadership structures that will take shadow consortia forward. It also gives guidance on how to appoint the transitional leadership, giving information about elections, and selection / election processes.

The exact approach used will depend largely on local circumstances, and is for local determination. Whatever options are ultimately chosen, it is vital that they have the confidence of all parties, and that any selection/election procedures are scrupulously fair.

> *Note: It is vital that a distinction is drawn between the transitional leadership of a shadow consortium, and those who will lead the GP-led Commissioning Consortium that follows. Although many of the issues raised in this paper will be relevant to the organisation of GP-led Commissioning Consortia as well, this paper is directly relevant only to the formation of shadow consortia. GPC will produce further guidance on the formation of GP-led Commissioning Consortia at the appropriate time.*

2. Developing transitional leadership structures

Once the basic structure of the shadow consortium has been defined and agreed, it will be important to consider the leadership structure that will be put in place. This leadership will provide the shadow consortium's strategic leadership, and steer its development to full GP-led Commissioning Consortium status.

There are many different leadership structures that may be suitable, and the exact approach chosen will vary, depending on local circumstance. Some shadow consortia may prefer a formal board structure, others may prefer a looser transitional leadership group. For the purposes of simplicity, we have referred to "transitional leadership" throughout this guidance.

The decision about what structure would be most appropriate locally should be made in consultation with a variety of groups. As well as the GPs and practices involved in the shadow consortium, we would suggest that, as a bare minimum, the PCT and LMC should be involved in this work. Any decisions should be taken with care, and an eye to future developments – while it is almost always technically possible to make changes to organisational structures later, it can sometimes be challenging to reach agreement on a change.

Some of the key issues that should be considered when developing a transitional leadership structure are addressed in this section.

2.1 Size of transitional leadership

Although a larger transitional leadership is likely to be more diverse, and will be able to directly represent more groups, care should be taken to ensure that the transitional leadership is not so large that it becomes a talking shop and is unable to function effectively. The optimum size of the transitional leadership will depend on a number of factors, including:

- Size of the shadow consortium
- Level of anticipated workload
- Level of funding available
- Number of qualified candidates available
- Working arrangements with other shadow consortia (eg, will the shadow consortium form part of a federation, will a single shadow consortium be divided into a number of localities?)

It is likely that a transitional leadership team of between 6 and 10 members will be sufficient for most eventualities.

2.2 Who should be represented on the transitional leadership?

It will also be important to consider who should be represented on the transitional leadership. The majority of the transitional leadership should be GPs, but consideration should be given to whether other groups should be involved, and in what capacity.

Allowing all GPs to stand for election to the transitional leadership, regardless of whether they are partners, salaried or freelance/locum GPs, will give the shadow consortium access to the widest range of talent, including the many salaried and locum GPs with significant managerial and commissioning experience, and will hopefully increase the transitional leadership's overall effectiveness. Sessional GPs may face fewer conflicts of interest than GP contractors.

Shadow consortia will need to work closely with a wide range of other groups and external organisations. Allowing other groups to join the transitional leadership, either as voting members or non-voting members of the core transitional leadership team, or to offer their expertise and advice on an ad hoc basis – for example, by participation in task or reference groups – may help the transitional leadership to function effectively. However, as noted above, care should be taken to ensure that the transitional leadership does not increase in size to unmanageable levels. Examples of groups that shadow consortia may need to work closely with include:

- Patient groups
- Practice staff (for example, practice managers and practice nurses)
- Doctors from outside of primary care
- The Local Authority
- The LMC
- The PCT (to support transition)

2.3 Chair and Deputy Chair

Every shadow consortium's transitional leadership will need to have a Chair. It may also be helpful to have a Deputy Chair. Some of the larger shadow consortia may also find it helpful to elect a small executive committee to address detailed day to day matters.

There are a number of ways in which a Chair could be elected. One option is for the Chair to be elected at the same time as the transitional leadership, by the same electorate. This could be achieved either by running a separate election for Chair, or by appointing the candidate for the transitional leadership who receives the most votes as Chair. Another option is for the transitional leadership members, at their first meeting, to elect a Chair from among their ranks. The same approaches could be used to elect a Deputy Chair, or even a small executive committee, if required.

2.4 Accountable Officers and senior management staff

PCTs will remain legally responsible for commissioning until their authority is transferred to consortia by statute, but this does not necessarily prevent shadow consortia from developing a shadow Accountable Officer, or Chief Executive role. It is likely that most shadow consortia will want to separate the roles of Chair and shadow Accountable Officer, however, it is possible for the shadow Accountable Officer to also be the Chair.

If the Chair is not also the shadow Accountable Officer, then the post could be open to either a GP from within the shadow consortium, a GP from outside of the shadow consortium, or could be a lay person. However, it is likely that the majority of shadow consortia will want to appoint a shadow Accountable Officer from a completely open field, in order to ensure access to the widest possible pool of quality candidates.

Once a shadow Accountable Officer is appointed it would be good practice for the shadow Accountable Officer, and not the transitional leadership, to normally be responsible for appointing the shadow consortium's staff, although the transitional leadership will probably need to have additional involvement in the appointment of very senior management staff, such as the Chief Financial Officer. In cases such as this the whole transitional leadership need not necessarily be involved in the decision – the interview process could be delegated to the Chair or a small sub-group, working together with the shadow Accountable Officer. The PCT or SHA should be able to provide HR assistance to support this appointment process, particularly in the very early stages of shadow consortia formation.

2.5 Length of existence

The transitional leadership of a shadow consortium should not automatically become the Board of the successor GP-led Commissioning Consortium when it is formally created. An entirely new process will be required to select the final GP-led Commissioning Consortium Board.

It will, therefore, be necessary to make clear that the transitional leadership's existence will be time limited, and that it will have to step down when the shadow consortium is wound up. Any rules for this will also need to take into account the possibility that a shadow consortium may be wound up early to allow a new shadow consortium to be established – for example, if two shadow consortia agree to merge, or if a single shadow consortium splits into multiple, smaller shadow consortia.

2.6 Recall

It is possible that the transitional leadership may become out of touch with the views and needs of the members of the shadow consortium, particularly in a time of significant change within the NHS. It would, therefore, be prudent to ensure that a mechanism exists to hold the transitional leadership to account and, *in extremis*, to allow their recall.

There are a number of ways that a recall could be triggered. The most common is to require that a certain percentage of the shadow consortium's members confirm in writing (for example, via a petition) that they wish to recall the transitional leadership. When setting the percentage required to allow this a careful balance needs to be struck between keeping the number high enough that a small minority cannot disrupt the running of the transitional leadership, and keeping the number low enough to ensure that it remains practical for a recall to be instituted.

It may be appropriate to require that the transitional leadership can only be recalled after an Extraordinary General Meeting of some kind, which itself could be called by a set percentage of the shadow consortium's members, or at the shadow consortium's regularly scheduled Annual General Meeting.

2.7 Conflicts of interest

Every member of the transitional leadership will have outside interests of one kind or another, and some of these may conflict with the interests of the shadow consortium. For example, they might own or be employed by a business from which the consortium is likely to commission services, or they may be a senior member of an organisation such as a local council, or the LMC, which the shadow consortium may come into conflict with. In the interests of transparency and retaining the confidence of the profession, it is vital that clear guidelines are drawn up to address any potential conflicts of interest.

Often this can be addressed simply by requiring members of the transitional leadership to declare all of their interests and to allow either the transitional leadership member or others to highlight any times when they believe there may be a conflict of interest. However, when drawing up governance rules it would be useful to consider whether some conflicts of interest would be so severe as to prohibit someone from taking part in some decisions, or even to be disqualified from holding some positions in the transitional leadership.

3. Appointing/electing the transitional leadership

Once the structure of the transitional leadership has been agreed, the next step will be to develop an appointment process to ensure that all of the leadership posts are filled.

From initial publication to announcing the results, the appointment process is likely to take up to a few months to complete. It is therefore important to plan as far in advance as possible. Developing and publishing a clear timetable can help with this.

It will be important to ensure that whoever is appointed to leadership roles has not just the competencies required to fill the roles, but has the support of local GPs. It may therefore be appropriate to develop a combined selection/election process, rather than to just appoint or just elect the transitional leadership.

Whatever approach is taken to the appointment process, it is vital that it is conducted fairly and impartially. Equally important, it must be seen to be conducted fairly and impartially. Because of this, great care should be taken over the planning and running of the appointment process, and this section outlines a number of issues that should be considered.

3.1 Who should organise the appointment process?

Careful thought should be given to which organisation should be given responsibility for running the appointment process, and to ensuring that there are no conflicts of interest.

LMCs may be best placed to lead on many aspects of this process, as an impartial body. As noted below, they could liaise with other organisations, such as the local PCT, to develop competencies. Many LMCs also have particular experience in running democratic elections, and they would be well placed to run shadow consortia elections in many areas. However, care should taken to address conflicts of interest, both real and perceived. In areas where there may be a conflict of interest, for example if an officer of the LMC organising the appointment process also wishes to stand for a position on the transitional leadership, it may be prudent to ask a neighbouring LMC, or an external organisation, to organise the process.

There are a number of organisations that specialise in organising elections and have substantial experience of organising elections for the healthcare sector. As well as offering support in designing elections, they can run ballots directly and act as returning officers to ensure that the ballot is not only conducted fairly, but is seen to have been conducted fairly.

3.2 Selection against competencies

If a transitional leadership is elected solely on the basis of a popular vote, this could result in a leadership which is initially popular, but whose members may not actually possess the skills required to do the job.

Therefore, consideration should be given to whether it would be appropriate to require all candidates for leadership posts to meet certain competency requirements before being entered into an election. This would limit the pool of candidates standing in the election by automatically rejecting any candidates who do not meet pre-specified competencies.

The required competencies should be agreed before the appointment process begins, and the PCT and LMC should be involved their development, subject to appropriate safeguards being put in place to avoid any potential conflict of interest among those developing the competencies. The Department of Health and GPC both plan to provide guidance on the development of competencies for shadow consortia leadership roles.

Once nominations have been received, each candidate will need to be formally assessed against these competencies. To avoid accusations of bias, it may be appropriate for an external organisation (perhaps the HR department of a local PCT, or a local hospital trust) to undertake these assessments, and possibly even to support the earlier process of developing competencies. It may also be appropriate for a short period to be built into the timetable during which candidates who are initially rejected as not meeting the competencies have an opportunity to appeal the decision.

If, once a shortlist of candidates who meet the specified competencies has been formulated, there are more candidates than places available on the transitional leadership, then an election could take place.

Alternatively, if it is decided at the beginning of the appointment process that an election would not be appropriate, it may instead be possible for a board of appointment to appoint candidates against the set competencies via interview. If this approach is chosen, a great deal of care will need to be taken to ensure that the board of appointment has the full support of local GPs, and that there are no potential conflicts of interest.

3.3 Publicity and seeking nominations

The appointment process should be publicised as widely as possible, to ensure that all who might be interested in standing are aware that it is taking place and have the opportunity to submit a nomination/application form. To ensure transparency, the rules governing the appointment process should be published.

Wide publicity at the nominations stage (and possibly even in advance of the nominations stage) will have the benefit of increasing awareness. This will hopefully result in an increased number and quality of candidates and, if an election is held, an increased turnout which will increase the election's overall legitimacy. Greater publicity also reduces the risk that anyone can claim that they were excluded from the process because they were not made aware it was taking place.

Examples of ways in which the appointment process could be publicised include:

- LMCs and PCTs can send information directly to GPs for whom they have contact details
- Local LMC newsletters
- It may be appropriate to place advertisements or formal notices in the local press
- Local professional groups (for example, sessional GPs groups and practice managers groups) could be approached and asked to circulate information

Any nomination period will need to be long enough to ensure that there is time for anyone who might be interested in standing to find out about the process, and then to submit a nomination form. In practice, this usually means a period of between two and four weeks, which allows potential candidates who might be on holiday to also get involved. If undertaking the role is likely to be time consuming, it also allows time for potential candidates to discuss the matter further with partners or employers.

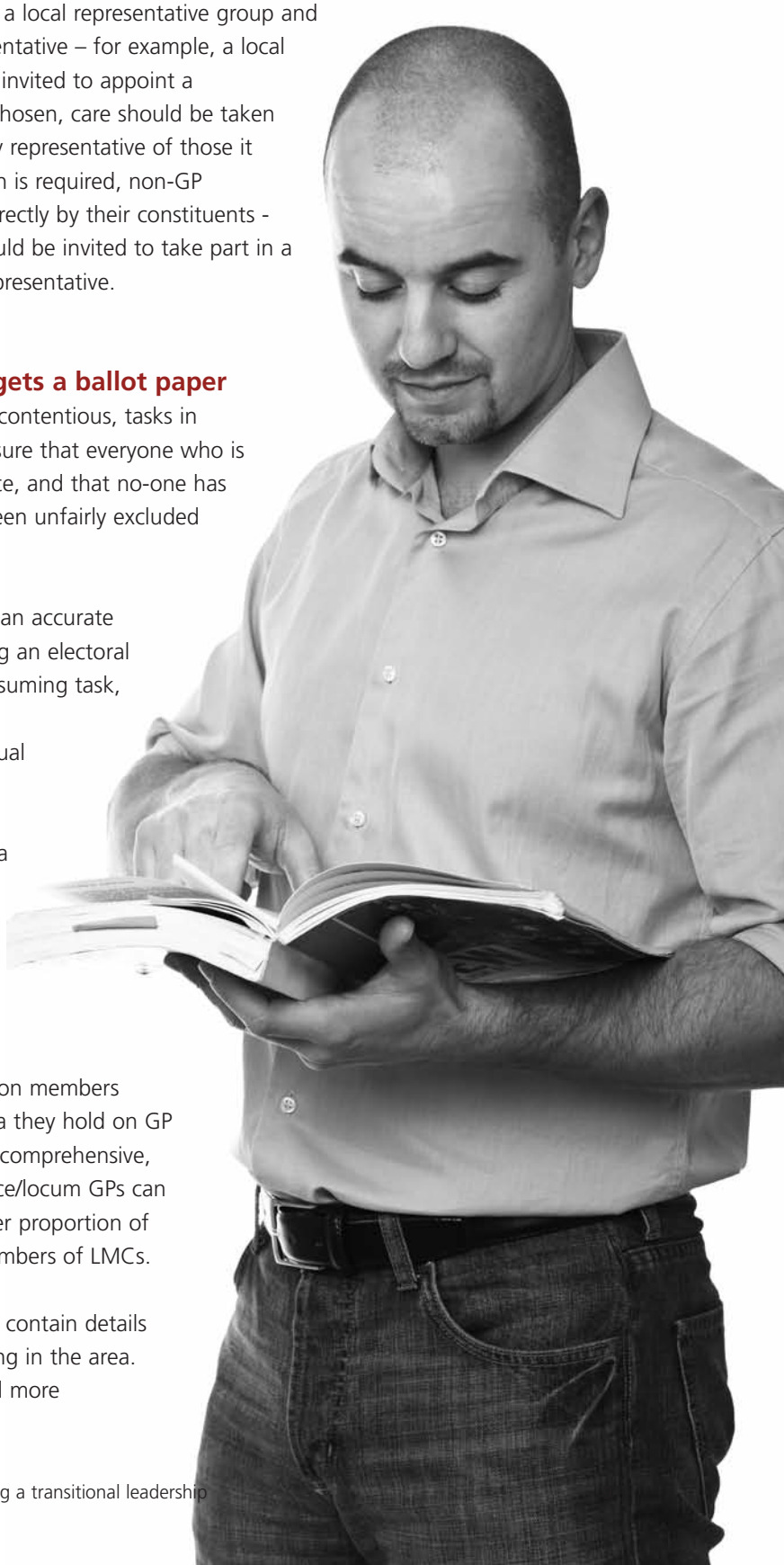
3.4 Defining the electorate

If an election is required, the exact composition of the electorate will depend, in part, on the composition of the shadow consortium and will, ultimately, be subject to local determination.

There are various ways in which an election could be organised, and it is up to each consortium to decide on the exact voting structure to be used. Whatever voting structure is chosen, it is vital that it is both inclusive, and seen to be inclusive, of all GPs within the consortium's boundaries.

If each GP working within the shadow consortium's boundaries (whether partner, salaried or freelance/locum (including those doctors who work solely in the out of hours setting)) is entitled to vote, this will ensure that the transitional leadership has a broad base of support from all GPs. The more that GPs feel that they are stakeholders in the shadow consortium, the more likely they are to closely align themselves with its commissioning objectives.

If a decision is taken to include non-GPs in the transitional leadership, they could be co-opted by approaching a local representative group and asking them to nominate a representative – for example, a local Practice Managers group could be invited to appoint a representative. If this approach is chosen, care should be taken to ensure that the group is actually representative of those it purports to represent. If an election is required, non-GP representatives could be elected directly by their constituents - for example, all Practice Nurses could be invited to take part in a ballot to select a Practice Nurse representative.



3.5 Making sure everyone gets a ballot paper

One of the most challenging, and contentious, tasks in organising any election is making sure that everyone who is entitled to vote actually gets to vote, and that no-one has grounds to claim that they have been unfairly excluded from taking part.

It is, therefore, vital to ensure that an accurate electoral roll is compiled. Compiling an electoral roll can be a difficult and time consuming task, and therefore work on this should commence as far ahead of the actual election as possible.

Identifying all GPs working within a particular area can be difficult at times, as there are not always comprehensive data sources available. The three main data sources available are:

- **LMCs** generally hold good data on members working within an area. The data they hold on GP partners tends to be particularly comprehensive, but data on salaried and freelance/locum GPs can be less comprehensive, as a lower proportion of these groups are levy-paying members of LMCs.

- **PCTs** hold performers lists which contain details of the majority of doctors working in the area. As with LMCs, PCTs tend to hold more

comprehensive data on GP partners than salaried and freelance/locum GPs, who are more likely than partners to be registered on the performers list of one PCT and work in another PCT area.

- **Individual GP practices** will be able to provide information on GPs who are working, or (particularly in the case of freelance/locum GPs) have recently worked, at the practice. Care should be taken to ensure that data provided by practices is accurate and that practices do not intentionally or accidentally exclude anyone who would be entitled to vote.

None of these sources of data should be regarded as entirely comprehensive and, in order to ensure the greatest possible level of accuracy, it would be best practice to use all three together to compile a register of the electorate.

To avoid disputes over eligibility, it may be appropriate to compile an electoral roll which lists all eligible voters on a certain date (usually the date the election begins). For example, if the election begins on 1st February, the electoral roll should aim to capture all eligible voters on that day. Any who would have been eligible before or after that date (for example, GPs who move to the area after 1st February) would be excluded from this particular election, although they should be eligible to vote in future elections.

Given the increasingly mobile nature of the GP workforce, consideration should also be given to how those GPs who work, or hold contracts, in more than one shadow consortium should be treated. For example, it may be decided that it would be appropriate for them to be eligible to vote in the area in which they are on the performers list, or the region in which they spend the majority of their working time. It will be important to ensure that GPs who work in more than one consortium area are not able to vote in multiple consortia. GPs who know that they are on another PCT's performers list and locum and salaried GPs who are not based at a single practice should be encouraged to contact the election organisers as soon as possible to establish their eligibility to vote.

Regardless of how much effort is put into compiling data on the electorate, it is likely that a few people who are eligible to vote will be missed off the register. To combat this, elections should also be publicised as widely as possible (see Section 3.3), and clear instructions should be given to allow anyone who does not receive a ballot paper to claim one.

3.6 Types of ballot and counting the results

There are a number of different voting systems. Examples include First Past the Post, Alternative Vote, and Single Transferrable Vote (STV). The Electoral Reform Society has developed detailed guidance that explains the difference between each different voting system, and their strengths and weaknesses. This guidance can be accessed on the ERS website:
http://www.electoral-reform.org.uk/article.php?id=5

For elections where a relatively large electorate is electing multiple candidates to multiple vacancies (for example, where 10 candidates are standing for election to 6 seats), STV is often the most practical choice. Although STV ballots can be counted using freely available software (for example, openSTV), they can also be counted by a professional balloting organisation. Asking an external organisation to act as the election's returning officer may add to perceptions of the election's legitimacy.

In order to ensure that the transitional leadership is as broadly representative as possible, and to avoid the risk that seats could be concentrated in the hands of one or two practices, it may be appropriate to apply counting rules in any election to ensure that not more than one or two members of the transitional leadership can be members of the same GP practice.