

Leadership in Clinically-led Commissioning Consortia

GPC guide to the Health
and Social Care Bill

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Introduction

Clinical leadership will underpin the success of clinically-led commissioning consortia (CCC). The defining feature of CCCs will be clinicians leading their peers from the front: engaging professionals in thinking and behaving differently in order to improve the health and healthcare of the consortium population in a sustainable manner. In short, clinical leaders will need to make the new system work.

While many GP leaders have emerged in the past, PCT-employed GPs have not always gained the local profession's confidence and support. In contrast, others have become involved with Local Medical Committees (LMCs), many of whom have enjoyed widespread support from GPs, but not all have been able to influence the direction of the NHS.

The nature of clinical leadership in CCCs will therefore need to be different from that which exists under the current arrangements. Consortia will require firm support from local GPs if they are to engage with all clinicians and encourage them to take ownership of the commissioning agenda to achieve its objectives, while managing challenging budgets within the QIPP agenda. The leadership of CCCs will require the necessary legitimacy, enthusiasm, influence and vision to fulfil these objectives in such an environment.

This guidance note should be read alongside the GPC document '*Shadow and Pathfinder consortia: Developing and electing a transitional leadership*'.

http://www.bma.org.uk/images/whitepaperGPCguidance6_apr2011version_tcm41-205257.pdf

The tiers of consortium leadership

Clinically-led commissioning consortia are likely to require four tiers of leadership that will be common to all consortia:

1. The chief officers of the consortium: consortium chairman/clinical lead, accountable officer (these may be the same person) and chief financial officer.
2. The consortium management committee
3. Lead clinicians with a defined role
4. Practice commissioning and prescribing leads

Consortia are initially to form in 'shadow' or 'pathfinder' mode, and it is not expected that this leadership structure will be in place from the beginning of this process. Rather, shadow consortia should explore their leadership needs locally, and build an appropriate structure that responds to those needs and circumstances, based on this model.

Some consortia will have a fifth layer, depending on their structure, that would provide management leadership across a group of consortia. This group is likely to be comprised of representatives from each consortium management committee, and it may become the point of contact for large external organisations such as acute trusts and local authorities.

Although much of the national rhetoric about clinically-led commissioning focuses on the role of GPs, not all leaders will be from general practice. For consortia to be successful they will require the right people with the right skills and competencies in the right roles. As such, other clinicians – consultants, public health doctors, staff grade doctors – and other health care professionals such as nurses or pharmacists may be appropriate leaders in certain roles.

The chief officers of the consortium

These people will be the overall leaders of the consortium with ultimate responsibility for it. The average large consortium of 500,000 patients will have a commissioning budget of over £600million, and a considerable consortium management budget. These individuals will therefore need to be of the highest calibre to lead and be responsible for such an organisation. They may be elected from within the consortium management committee, or directly elected by the consortium constituents. Either way, their competency as leaders of a large organisation will be essential.

Given this financial responsibility, it is expected that the accountable officer of a consortium will be statutorily responsible for ensuring that their consortium complies with its obligations under the forthcoming Health and Social Care Act. Consequently, the NHS Commissioning Board will ensure that all accountable officer appointments are appropriate, and may have the power to terminate the appointment of an accountable officer and appoint another one. It is also anticipated that accountable officers and chief financial officers may be able to perform their roles for more than one consortium. Note that the powers discussed in this paragraph are subject to the passage of the Health and Social Care Bill 2010-11 and any amendments to it. The BMA is seeking to remove the power to dismiss an accountable officer from the Bill, and replace it with a power for the NHS Commissioning Board to instruct a consortium to find a new accountable officer. This will also mean that GPs who are accountable officers will be free to speak as advocates for their patients, and not forced to become “yes” men or women of the NHS Commissioning Board.

Whatever form the legislation finally takes, all of the chief officers of the consortium will be assessed against the efficient and effective performance of their organisation.

Consortium management committee leaders

Clinicians on the consortium management committee will be responsible for discharging the statutory functions of the CCC. This will include responsibility for commissioning, budgetary and contract management, as well as other inherited PCT functions. Management committee leaders will necessarily require core competencies to fulfil these duties. Many doctors may already have these skills and competencies, but where they do not, they can be acquired via appropriate training such as that provided within the NHS by the National Leadership Council:

<http://www.nhsleadership.org.uk/>

The proposed Faculty of Medical Leadership and Management will also be able to help in this regard.

However, it is important that these GPs do not simply become NHS 'clones' and replicate the roles of previous PECs or PBC leads, since the success of clinical leadership will essentially result from being inspiring, innovative and most importantly having an understanding of the perspective, concerns and aspirations of ordinary GPs. Such an understanding will ensure that consortium leaders develop policy that is more likely to engage and change GP behaviour. One of the biggest challenges that these leaders are going to face will be ensuring they can properly lead and be recognised as leading all the GPs within a consortium when, on the one hand they have little or no direct role in the provision and management of the core work of practices (providing primary medical care and running the practice business) but, on the other hand they will be performance managing certain aspects of that work. It is therefore important that such leaders have proper legitimacy and are selected/elected appropriately, so that they can fulfil both their roles in terms of having the requisite statutory competences, but also the clinical leadership skills of commanding support from their constituent colleagues. The LMC can offer appropriate local support and guidance for this process, as well as being a valuable resource for future management committee GPs to develop policy cognisant of the perspective of constituent GPs.

Lead clinicians with a defined role

It would not be appropriate for leadership to be concentrated within the few management committee clinicians on the 'top table'. This would be insufficient to engage with the wider constituency of GPs. CCCs should make use of a sub-management committee tier of clinicians who could lead on specific clinical areas, or analytical activity to profile and stratify healthcare needs, service redesign and pathway development, medicines management, or take a lead in GP education and systems of peer review. This would exploit the full potential of talent and resource within local areas and widen leadership involvement to the full range of healthcare professionals, not only doctors but nurses and pharmacists too. This will be particularly attractive to clinicians who wish to be a portfolio lead rather than being involved in statutory management committee activity. It is important that shadow consortia identify such sub-management committee leadership positions as part of their development.

Practice commissioning and prescribing leads

The defining difference between clinically-led commissioning consortia and previous GP commissioning arrangements is the imperative for all GPs and practices to sign up to a corporate agenda, in which a practice's resource may partly be linked to the overall performance of the consortium. Practices themselves are not homogenous units, but made up of administrative staff, nursing staff and a variety of doctors including partners and sessional GPs. The practice unit as an organisation will require internal leadership to ensure that it plays a productive part in contributing and adhering to the corporate consortium agenda. This will inevitably require the changing of systems within practices and holding specific clinical and administrative meetings so that there is a consistency and a collective ethos amongst all clinicians and staff, in particular with regards to referral management and prescribing. It would further be helpful for each practice to have nominated commissioning and prescribing leads, who would be the first point of contact responsible for disseminating and implementing CCC policy. To further strengthen constituent practice engagement, practice leads would be expected to attend consortium wide meetings, where CCC policy could be shaped from the bottom up, in partnership with Commissioning Board leads.

Resourcing clinician leadership involvement

The clinical leaders of commissioning consortia will have considerable responsibilities and will need to be held to account for fulfilling these. To deliver the leadership agenda and discharge their responsibilities effectively, it is important that clinicians and practices are properly resourced, rather than trying to squeeze in work between surgeries or in a compromised manner. This resource will enable GPs to have protected time with backfill or alternatively offer loss of earnings compensation for sessional GPs who wish to take on a leadership role. Once consortia are fully operational, this resource will come from the consortium's management allowance. While consortia are in shadow form this resource should be provided by the PCT from the consortium development fund set out in the NHS Operating Framework 2011. GPs and practices will need to consider the superannuation implications of these payments if they are not received directly from the PCT.

This resource should be viewed as a necessary modest investment to reap far greater productivity gains, as required under the QIPP agenda, which can only be achieved by enabling widespread GP engagement and corporate behaviour within CCCs.

It is important that consortia do not focus only on resourcing the lead management committee GPs, but should ensure that there are resources available for all tiers of clinical leadership engagement. Leadership should be a living reality that permeates the entire consortium from the chief officers down to practices, which will also require internal leadership with protected time.

LMC leaders and shadow consortia

Many current LMC officers will have the requisite qualities to play a role within their consortium. This is potentially a difficult area, and all such GPs should consider whether any conflicts of interest would arise by their acceptance of such posts. However, in general terms, it is advantageous to both an emerging consortium and the local GP population if the LMC leaders are involved in the development of the consortium through the shadow or pathfinder stage. They will be well placed to assist with the forming of an organisation that carries with it its constituent GPs and practices – an element essential to the success of consortia.

Nonetheless, the GPC would expect all GPs to declare any conflicts of interest they may have in working with shadow consortia, and to remove themselves from any decisions where this may be considered a factor in the decision. The GPC would also like to see PCTs keep a register of interests of the members of shadow consortia during the transition period.

However, it would be completely improper for a GP to hold a substantial role within their LMC and be a clinical leader in the consortium once the transition stage was completed or following the formal transfer of commissioning responsibility to CCCs in April 2013. LMCs will have an important role in holding CCCs to account, especially in the management of practice commissioning performance, and any conflicts of interest at this point would be unacceptable.

Appendix 1 – The qualities and competencies of clinical leaders

It is essential that clinicians who are involved in commissioning consortia have the right skills and competencies to manage the commissioning of NHS services effectively and to lead the practices in their consortium through the changes ahead.

Below are a set of suggested managerial and leadership qualities and competencies:

- Demonstrated leadership ability and/or willingness to develop leadership skills. This will include and a keenness to learn and a strong ability to listen to others.
- Previous engagement in commissioning and/or clinical service development, or a keen interest in commissioning.
- Ability to engage well with GPs and other clinical and non clinical staff in practices, as well secondary care, community, and mental health clinical and non-clinical staff, and develop staff to deliver the clinical commissioning agenda
- Willingness and ability to understand strategic changes facing the NHS and the local health economy, as well as front line clinical care, and provide strategy leadership.
- Ability to build and manage a suitable organisation to deliver the commissioning agenda, whilst setting realistic goals within the organisation.
- Personal commitment, drive and capacity to lead through a challenging agenda and deliver against agreed outcomes. The ability to innovate and inspire others to achieve these outcomes.
- Good knowledge/understanding of NHS management and the NHS, with particular regard for the funding of primary care and general practice, and an understanding of GMS, PMS and APMS contracts. It will be necessary for consortium leaders to understand and be sensitive to variability in performance between GP practices.

Please note that although this is one view of leadership and management, there are many others. Clinicians may also wish to refer to the *Medical Leadership Competency Framework* provided by the NHS Institute for Innovation and improvement:

http://www.institute.nhs.uk/assessment_tool/general/medical_leadership_competency_framework_-_homepage.html

Many clinicians already have a number of these qualities, though not all of them will be clinical leaders at the present time. Similarly, the right clinical leaders may not currently be working in commissioning. An appropriate selection process, sensitive to local requirements, must be employed to ensure that the right clinicians become leaders of GP-led commissioning consortia.

Appendix 2 – Example job description for transitional clinical commissioning GP leader

Period of Contract:	Post required until 31 March 2013 with six-monthly review
Key Stakeholders:	GP's Practice staff PCT clinicians, managers and staff Secondary care clinicians and managers Local Authority and Public Health teams Patient and public involvement groups Neighbouring PCT and GP consortia
Overall Purpose:	To undertake a key clinical leadership role in transition and in establishing the shadow arrangements for clinical consortium

1. Clinical leadership/development of strong and effective GP commissioning consortia

- 1.1 Working through the PCT localities, provide strong visible clinical leadership in the development of clinical commissioning.
- 1.2 Work closely with GPs and the PCT to develop the vision and model for clinical commissioning across PCT, and lead, in partnership with GP and PCT colleagues; in the implementation of a model of effective commissioning consortia by 2013.
- 1.3 Strengthen engagement of all clinicians in both primary and secondary care in clinical commissioning – to ensure effective clinical decision-making and use of resources.
- 1.4 Identify and facilitate delivery of development programmes to develop clinical commissioning skills across practice clinicians and other personnel.
- 1.5 Support the development of an effective shadow consortium to deliver the secondary care commissioning agenda, and to develop the capacity and capability of practices.
- 1.6 Develop improved and effective engagement of other NHS, local Authority and voluntary sector organisations in clinical commissioning.
- 1.7 Develop the engagement of the public in the clinical commissioning agenda.

2. To develop an accountable clinical commissioning organisation

- 2.1 Identify the organisational support that will be required by the shadow consortium.
- 2.2 Identify methods to procure effective and efficient organisational support, initially to the interim commissioning group and subsequently to the consortium.
- 2.3 Over time, to identify and develop the managerial requirements and governance structure, including arrangements for an accountable officer for the established consortium, by 2013.
- 2.4 Identify the skills that will be required to lead a large accountable statutory NHS body, including understanding all governance and financial risks, such that new consortium arrangements minimise and manage those risks.
- 2.5 Support development of an effective and dynamic clinical commissioning committee.

3. Strategy and service redesign

With a team of clinical GP leaders:

- 3.1 Contribute to the development of the vision and strategy for clinical services including prioritising services for redesign and developing community alternatives to hospital care. Work effectively with the PCT to support the development and delivery of strategic commissioning activities based upon a public health model of health needs assessment
- 3.2 Develop a programme of service redesign and identify appropriate clinical leads in support of this.

4. Resource management

- 4.1 Recognising the developmental nature of the move to full GP commissioning by 2013, work with a team of clinical GP leaders to incrementally engage in local service provider contracts and clinical programmes and pathways.
- 4.2 Ensure clinical evidence based decision making within clinical commissioning arrangements.
- 4.3 Lead work on the development of effective referral management processes.

5. Partnership working

- 5.1 Develop effective relationships with a range of clinical partners including secondary care and public health providers and other key groups such as the Local Medical Committee.
- 5.2 Participate at relevant regional and clinical networks.

6. Governance

- 6.1 Implement robust governance arrangements for clinical commissioning including arrangements to manage potential conflicts of interest (such as ensuring a register of members' interests is maintained) and a clear separation of commissioning and provision.