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# WHAT MAKES A TOP CLINICAL COMMISSIONING LEADER?

## / 2016

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# / Introduction

**Clinical Commissioning Groups (CCGs) have now been in place for three years and the positive impact they have made in transforming healthcare for patients and populations is evident. Integral to this success is the role of their leadership.**

CCGs differ from their predecessors in a number of ways, but central to the difference is that, for the first time, clinical leadership forms part of the fabric of a commissioning organisation and its decision making. Clinicians are now playing a leading role in local healthcare commissioning, working with senior managers in a new and dynamic partnership that has resulted in clear benefits for patients. This has been reflected in a number of NHS Clinical Commissioners reports, most recently *Delivering a Healthier Future*.<sup>1</sup>

We wanted to gain a better understanding of what makes a top clinical commissioning leader. To do this, we chose two viewpoints – through the clinical lens and the managerial lens. Clinical leaders and managers each bring important skills and expertise to CCGs and make essential contributions to their success.

This report details the results of our findings and also establishes some key asks. While the focus of the report is on what we are seeing in CCGs, the lessons are as relevant to the wider healthcare system as they are to the leadership of individual CCGs. Clinical leadership has had immense benefits for patients and we must nurture this or the NHS will be much poorer. The recommendations in this report aim to ensure that we have a vibrant and sustainable cohort of clinical commissioning leaders that can build on current success and continue to shape a health system fit for the future.

**Julie Wood, chief executive, NHS Clinical Commissioners  
Dr Andy Harris, chief clinical officer, NHS Leeds South  
and East CCG, and chair of NHSCC Chief Clinical Officers  
Network**



# / Executive summary



**CCGs play a crucial role in the way local health and social care services are delivered and how well the needs of diverse communities are met, and for the first time clinicians are working alongside managers in an equal partnership to create and implement a strategic vision for local health services.**

Giving clinicians a greater say in how the NHS is run is a frequently visited theme and has been central to government papers including *Equity and Excellence: Liberating the NHS*<sup>2</sup> and more recently the *Five-Year Forward View*,<sup>3</sup> which promises more influence for CCGs over the total NHS budget. Research evidence shows a link between the engagement of doctors in leadership and quality improvement<sup>4</sup> and the benefits have been explored in detail in a 2015 report by the Policy Research Unit in Commissioning (PRUComm), funded by the Department of Health.<sup>5</sup>

However, clinical leadership is only half the story. For a CCG to discharge its responsibilities effectively and make lasting improvements to patient outcomes, senior managers also have a critical role to play. In short, senior clinicians and managers must work together. They have to ensure different agendas are aligned, be astute political operators, understand the local healthcare system and contracts management, and master the NHS payments system.<sup>6</sup>

As well as highlighting the added value that clinicians bring to clinical commissioning leadership, we also looked at what managers contribute. We focused on two types of leaders: clinicians who occupy CCG leadership roles, either as clinical chairs or chief clinical officers (the accountable officer), and CCG leaders with a professional managerial background who occupy the accountable officer role.

Our overall aim was to establish what makes a top clinical commissioning leader. We wanted to know whether there were specific ingredients in the mix, so we interviewed 35 leaders (17 male and 18 female). Our research did uncover a number of specific behaviours and qualities; these include resilience, honesty, openness, integrity, patience and emotional intelligence. Top clinical commissioning leaders are also good communicators, which includes having excellent listening skills and the ability to instil clarity of purpose.

As well as the general leadership qualities needed by both clinical and managerial leaders, we looked at how CCG management is strengthened by both types working closely together and supplementing each other.

When we spoke to clinical commissioning leaders, whether managers or clinicians, they highlighted the difficult financial environment in which they operate and the need to commission for value and quality improvement while operating across organisational and professional divides with different cultures, knowledge and skills. We found they adapted their behaviours to the unique set of circumstances in which they find themselves. It was clear that no two CCGs are the same, each having different structures and distribution of responsibilities between the various committees and subcommittees.



Top clinical leaders use their ability to communicate the CCG's vision to their peers and have the resilience to ensure its objectives are met; the skills they have learned in the clinical environment need to be built on and often added to. Of the managers we interviewed, some trained as clinicians early on in their career (for example, as radiographers or nurses) but most have no clinical training. Therefore they bring a different set of qualities and skills to bear that complement those of their clinical counterparts. These will include competence when it comes the financial and statutory aspects of running a CCG and ensuring services are delivered effectively and efficiently.

We found evidence that successful managerial leaders understand the shift in dynamic from the more traditional and hierarchical management model. They take a more collaborative approach to support the clinicians in commissioning and system leadership. Even though they usually have statutory accountability as accountable officers, good managers recognise they can't set strategic vision and make decisions alone.

Many managers have embraced the opportunity to see the NHS through a clinical lens. However, there can be stumbling blocks to this partnership and personality traits inevitably have a bearing on the success of the relationship. Top commissioning leaders recognise a need for balance and work in such a way that they get the best from each other.

To support the next generation of clinical commissioning leaders, our interviews highlighted the need for a system that identifies clinical leaders much earlier in their career as well as the need for a more supportive environment that allows GPs to continue to contribute without becoming overburdened. We also found that it was preferable to support clinical and managerial leaders jointly rather than separately.

Succession planning is an important area for all CCGs and support will be needed not only to identify leaders earlier, but to ensure they are prepared for the role, develop the necessary skills and can use their personal qualities to ensure CCGs continue to commission for value improvement and better outcomes.



# / The added value of clinicians in clinical commissioning leadership

## **CCG leadership is set up to include clinicians with a professional background as GPs who act either as clinical chairs or as chief clinical officers, taking the role of clinical leader for the CCG**

Our interviews confirmed the added value that GPs bring to leadership, and this is also supported by research such as the PRUComm report.<sup>5</sup> This report found that GPs bring with them a frontline knowledge of patient experiences and service, and experience in dealing with other clinicians. It concludes that GPs and managerial leaders working together creates a symbiotic relationship that is greater than the sum of its parts.

### **Understanding the healthcare system**

Dr Andy Harris has spent the majority of his NHS career as a GP partner in a large training practice in Leeds, managing a population with diverse health and social care needs. Dr Harris is the chair of the NHSCC Chief Clinical Officers Network and believes CCGs benefit from the frontline experience of GP clinical leaders because of their direct contact with patients and knowledge of the service that patients receive, as well as their working relationship with staff and care workers.

“GPs can listen to patients and the public to establish priority demands for health services. They can use their clinical knowledge to identify what works and what doesn’t, and they have good insight into the services available. They also often understand the local population and its needs over generations and age groups, due to their long-term connection to a local area through a GP practice,” says Dr Harris.

The GPs we interviewed echoed this view, saying this understanding of the local area and patients is a prerequisite to making a case for change, both by being able to articulate a vision from a perspective of “living and breathing it”, and by explaining what they want to achieve for the local population.

Dr Barbara King is clinical chief officer at NHS Birmingham CrossCity CCG. She says: “It comes down to GPs having the ability to put the patient experience across and involve this in effective decision making.”

Dr Ian Orpen, clinical chair at NHS Bath and North East Somerset CCG says: “Really good clinical leaders bring strategic understanding and clinical insight. Having credibility with GP peers is extremely important when having to engage and persuade effectively.”

The PRUComm report confirms that GPs’ frontline knowledge of patient experience and services adds value to the commissioning process, but it asserts this needs to be backed up by data and a systematic overview to support and contextualise local and clinical knowledge. Having the right information can help CCG leaders make the case for change. The report says: “We found some issues with the way that data were obtained and used, and highlighted the importance of GPs working closely with information specialists to ensure that data were provided in a digestible and useful form.”

One example of this working successfully comes from Dr Andy Whitfield, chair of NHS North East Hampshire and Farnham CCG, who describes an instance where a mental health trust seemed to be an outlier in terms of performance. Rather than simply point the finger, a study was commissioned to explore the issue, based on an analysis of the data. This found the mental health trust wasn’t an outlier, but rather was much better at reporting issues than the NHS norm.

### **Making a credible case for change**

GPs can help their managerial colleagues make a credible case for change by drawing on their clinical expertise and local knowledge, both in relation to their peer group of clinicians and to local populations. Clinicians not only see the need to create a vision but can articulate it from a standpoint of personal, day-to-day experience. This means developing an easily understood narrative, a way of explaining what they want to achieve for the local population. Direct experience of helping to transform the system can be hugely rewarding, but understanding the local area and patients is a prerequisite to enabling this change and here clinicians can use their credibility to good effect.

Dr Anthony Kelly, chair of NHS South Worcestershire CCG, has been practising in the same area for almost 40 years and believes knowledge of the different stakeholders, coupled with his understanding of local issues, gives him credibility. “I feel that my experience and continued clinical involvement make my engagement with my local health and social care economy more credible, especially when long-held beliefs need to be challenged.” he says.



This frontline experience can also mean that clinicians find it less of a challenge to convince public and patients. Some managers we spoke to felt that clinical chairs are likely to command greater respect at public meetings. One manager recalled an event where challenges were coming thick and fast until the clinical chair, a GP, stepped in and the dissenting voices were calmed.

GPs' clinical experience allows them to communicate with and challenge fellow clinicians in a way that managers cannot. Dr Mary Backhouse, clinical chief officer for NHS North Somerset CCG, says: "Being a GP helps when it comes to establishing credibility with our members. With the challenges and different priorities facing the CCG, it will sometimes mean we take decisions that aren't always popular, but being practice based helps me to communicate with them and it also ensures that any issues raised are understood by my fellow CCG leaders."

GPs can see pathway development from a clinical perspective. Dr Harris makes the point that GPs are well positioned to make judgments about where to invest, based on their assessment of clinical risk. Having a clinical background is helpful in this respect and several managers we spoke to had a background in nursing. Deborah Fielding, chief accountable officer for Wiltshire CCG, says her clinical background in nursing and health psychologies is helpful in this respect. She says: "My own understanding of the clinical perspective means that when clinical leaders say they want to make a change, I can see what they mean. Many of my managerial contemporaries have a clinical background and this does make a difference."

However, fellow clinicians can feel as though the clinical insight becomes lost when a GP takes up a managerial role. There can be a perception that when they take up such a role within a CCG, they have "crossed to the dark side" and therefore lose credibility. Tracy Dowling, chief operating officer for NHS Cambridge and Peterborough CCG, says: "When a clinician moves into a clinical leadership role there is sometimes a perception of lost credibility because they have put on a grey suit, so the best clinical leaders make sure they translate the CCG vision in a way their peers can understand and engage with."

The PRUComm report confirms that GPs' clinical experience does allow them to add value to commissioning decisions, but this depends on a supportive environment that enables good quality information, careful chairing at meetings and a concerted effort to keep frontline practitioners informed and engaged.

## Adding value through collaborative working

Clinical leaders bring different skills and a different attitude to the role than their managerial colleagues precisely because they are working in different professional cultures. Maggie MacIsaac is chief officer at NHS North East Hampshire and Farnham CCG. She believes partnership working is the best way to build a good CCG.

She says: "The more I see people in action, whether you are a really strong clinical accountable officer, or an accountable officer who can build good clinical networks, it's about partnership working and everyone being clear about their own skillsets. In a leadership sense it's more about the organisation working together. If you are a clinical chief officer you need to be aware of the gaps and fill them from the executive team. If you are a non-clinical chief officer, then you have to bring in clinical leadership. Where you have a clinical accountable officer you need to have strong managers around you. If you are a non-clinician then you need good clinicians around you."

Clinical CCG leaders will inevitably be juggling different priorities. They may have practice responsibilities as well as wider roles within the local health economy. Clinical chair of NHS Bexley CCG Dr Nikita Kanani believes this can be beneficial and says that taking on different roles allows her to see where something has been done well elsewhere and apply it locally at CCG level.

The best managerial leaders understand these constraints, but at the same time help their clinical colleagues engage with concepts that may initially be alien to them. This means supporting them to understand the finer details of running a CCG and contracts management, but also being able to interpret this so that it means something to their primary care colleagues. Clinical leaders are effectively a bridge from one world to another. This is particularly true of chief clinical officers, who have a clinical background but also have insight into financial and operational management as their CCG's accountable officer.

In summary, good clinical leadership has the potential to support quality improvement, innovative approaches to commissioning at the local level and commissioning for value. However, this depends on joint working with managers and the right kind of organisational and developmental support.



# / The added value of managers in clinical commissioning leadership

**Just as managers recognise the attributes and qualities of their clinical counterparts, GPs appreciate the benefits of having the operational insight of managers**

## **Operational knowledge**

The most obvious benefit of managerial CCG leadership is insight into operational and financial detail. Managerial leaders are often accountable for the running of the CCG, understand how the organisation works and have a sound grasp of statutory responsibilities and contracts management. They are also likely to be well-versed in vision setting, strategic planning and transformation.

Julia Ross, chief executive of NHS North West Surrey CCG, says: “My sense is that GPs are good on business acumen, but they don’t always understand NHS contracts. They can certainly need help when it comes to political skills and their ability to network and give leadership across a wider clinical group.”

One manager with more than 20 years’ experience across industry, local authority and the NHS is John Wardell, accountable officer of NHS Nene CCG. He notes the support he provides in terms of the CCG’s statutory responsibilities. He says: “In some ways it is a little like being a conductor. Much of my role is reminding people about the need for clear plans and processes.”

## **Skills in delivery and process**

Developing the vision and setting strategic objectives is just the first step and delivery is the area where managers need to add value. Wardell says: “I think a lot of organisations struggle to go from planning to delivery – so really good managerial leaders make sure we have the right people to focus on planning and delivery.”

Helping GPs understand governance processes and change management is another area of strength for managerial CCG leaders. NHS Kernow CCG put together a development programme for GPs to help them get to grips with skills such as working with people and change management, bringing in people

who had faced challenging situations to share their experiences. Managers also have an understanding of the healthcare system and know what is possible locally within a national context. This brings an added dimension to the CCG leadership team. Deborah Fielding says: “It’s not enough to be passionate about healthcare. The challenge for practising GP CCG members is that they have been working with the same patient population for many years, which is effectively a micro version of the health system. Managers understand the macro version, which takes in health and social care and is very different.”

## **Providing context and background knowledge**

Managerial leaders also know how to put local knowledge into context and where to find the information needed to make informed decisions. Amanda Bloor took up the role of chief officer for NHS Harrogate and Rural District CCG in 2012 and has held a range of senior management roles within the acute sector, strategic health authority and primary care trusts. She says: “The experience of undertaking significant work on system redesign has prepared me for making difficult decisions and given me the insight to know what information I need to make them.”

Toby Sanders, managing director of NHS West Leicestershire CCG, highlights the example of an initiative to review mortality rates, which required an understanding of the different mortality measures and how to use them. The clinical leadership backed the initiative as it wanted to promote a culture of improvement and wanted to look at any lessons learned. There were some difficult media conversations, but the review helped to provoke the system to re-examine the way care was being delivered, in particular in terms of joint working across primary and secondary care. The result has been improved outcomes for patients by focusing on improving the continuity of care and care planning.



# / General behaviours and qualities of top CCG leaders

**The role of CCG leadership is critical to the success of commissioning, so the behaviours and qualities exhibited by top CCG leaders, whether managers or clinicians, are important. We found there was some overlap between the two, but there are aspects of their roles for which specific traits are valuable**

Top CCG leaders must have personal resilience. This means having the strength of character not to buckle under pressure. For example, most CCG leaders will be familiar with a situation where the local media have raised an example of failing care or poor performance or where the mood at a public meeting has turned sour. Resilience is of particular importance for clinical CCG leaders because they may be doing the job just two or three days a week. This means being able to compartmentalise and know which hat they are wearing at any one time.

Writing in the *Health Service Journal*,<sup>8</sup> Alex Davda and Dr Guy Lubitsh argue that the ongoing restructure of the NHS is a prime example of a professional sector being put through a test of its resilience. “The personal and organisational stresses have impacted upon careers, livelihoods and relationships, and the operational working of many departments,” they say. Many clinical leaders we spoke to have first-hand experience of this impact and point out that the consequences of taking on too much need to be considered.

Tracy Dowling agrees that resilience is an important quality for any CCG leader, but the challenge for clinical leaders is knowing they may end up back in practice and may therefore not want to take a stand on an issue that is not popular with clinicians.

“Many good clinical leaders we see have become involved in clinical commissioning leadership later on in their careers, which gives them more freedom”

Amanda Philpott is chief officer of NHS Hastings and Rother CCG and NHS Eastbourne, Hailsham and Seaford CCG. She believes it’s important to maintain a sense of perspective, particularly when facing criticism. She says: “What my clinical colleagues have noticed is the lack of respect and the number of times we are judged as being good or bad rather than from a more nuanced perspective. Clinicians who normally come through a route of being respected are surprised initially by how many people want to criticise them in their leadership role. You need a sense of perspective and to be discerning in terms of what you listen to.”

Clinicians and managers must also be open, displaying honesty and transparency. This is seen as vital in terms of building effective relationships within the CCG and with provider and community organisations. Amanda Bloor puts it simply: “It all comes down to relationships and at the end of the day we are all human so it takes time to develop a trusted relationship.” Being transparent about performance is a good way to build lasting relationships; clinical commissioning leaders must ensure up-to-date information about services is shared openly, particularly from provider trusts.

Dr Debbie Frost is chair of NHS Barnet CCG and also a GP partner. She endorses the importance of the ability to build lasting relationships.

“One of the qualities of a top CCG leader has to be relationship building. This means you have to understand the system from the perspective of partners and know how best to collaborate with them. At the same time, CCG leaders have to lead from the front by setting an example and setting the tone”

The need for openness is highlighted in the *Draft Framework of Excellence in Clinical Commissioning*.<sup>9</sup> This says a CCG must have “respectful and open relationships with its Health and Wellbeing Board partners, where constructive challenge and shared accountability are seen as the means to achieving improved outcomes for local communities.”

Having a respectful relationship with partners is a familiar scenario for Dr Stewart Findlay, Chief Officer at NHS Durham Dales, Easington and Sedgfield CCG. The CCG works very closely to its partners within the system, in particular public health at Durham County Council. Performance data are produced and shared across all parts of the system, including the acute provider, and a performance framework has been created to monitor performance and improvements.

A clear commitment to the service, and the qualities of openness and personal integrity, are stepping stones towards building trusting relationships. Many top CCG leaders become role models for public involvement and the dialogue that all staff, including the those on the front line, need to have with colleagues and patients.



The CCG leaders we interviewed all spoke of the need for patience. They understand that a lasting working relationship is not built overnight. Amit Bhargava, chief clinical officer of NHS Crawley CCG, says you can't hope to build relationships without having patience and admits it has taken time for him to build trust with all medical and clinical leaders across different organisations. NHS Sheffield CCG chair Tim Moorhead agrees, adding that dedication is needed to put in the "hard yards" to build relationships. He cautions against simply sitting back when something is not right. "It's about being proactive and spotting a relationship problem early and dealing with it by giving people a chance to talk," he says.

Emotional intelligence is also a recognised quality among top CCG leaders. The ability to appreciate and have insight into others' viewpoints is especially valuable when it comes to communicating the CCG's strategic vision. Top CCG leaders don't jump to conclusions, they take soundings from a wide range of trusted colleagues and invest time in understanding what they are being told.

Dr Caroline Dollery, chair of NHS Mid Essex CCG, says: "Good leaders listen well and build consensus, which starts from understanding another person's point of view." Taking the time to talk to people, listen and understand, helps clinical commissioning leaders build a common vision. One manager describes her clinical chair as being excellent in this respect. "She is never afraid to pick up the phone and ask someone what they think," she says.



# / The value of close collaboration for clinical and managerial leaders

## Clinical and managerial leaders may share general leadership qualities, but each type has a specific skillset that complements the other - so joint working is vital

Our interviews confirm that since CCGs were established in 2013, clinical and managerial CCG leaders have built productive working relationships. The PRUComm report<sup>5</sup> supports the view that an effective working relationship is facilitated by a history of working together. It suggests that GPs and managers in CCGs have the potential to develop a symbiotic relationship that enables them to work more effectively together than they would otherwise be able to do. This is dependent on mutual trust and clearly delineated responsibilities.

The interviews highlight the significance of collaborative working between clinical leaders and their managerial counterparts. One CCG managing director we interviewed says he took up a CCG leadership role primarily because it would allow him to promote collaborative system leadership and bring clinicians and managers together to work in partnership to improve the quality of services and outcomes for their population.

### Creating a vision for local health and care services based on a system overview

The importance of a strategic vision for local healthcare services has been highlighted by various studies, such as *Recent Trends in Leadership*.<sup>10</sup> "Organisations in the public, private and voluntary sectors need to picture themselves not only in terms of machines and pyramids, but also in terms of organic living systems, continuously evolving and adapting as they interact with a changing external environment," the report says.

Collaborative working is crucial to strategic planning and vision setting; the managers we spoke to recognised the value of clinical input. Tracy Dowling says: "Collaboration comes from mutual development and discussion, with clinicians providing objective clinical vision and managers working alongside to deliver managerial objectives." Deborah Fielding agrees and says: "Clinicians are important in vision setting, and in our CCG we work in a democratic way with the whole executive team setting the strategic vision. We then work together to make sure it is widely understood and on making it a reality."

NHS Surrey Downs CCG chair Dr Claire Fuller believes strongly in holding onto a clinical vision for service delivery. "You have to keep reminding people why it matters," she says.

Top clinical CCG leaders are able to hold on to this vision while juggling day-to-day clinical and management priorities. The devolved healthcare budget in Greater Manchester illustrates this well. GP and chair of NHS North Manchester CCG Dr Martin Whiting says even though the so-called Devo Manc is in full swing, primary care in the region is at different stages of the process. He has had to be adaptable to maintain a balance between everyday improvements and the overall vision. "Large scale reform has to be carried out across the whole system. Successful clinical leaders get all parties involved and are transparent in delivery to ensure engagement at all times."

Dr Andy Whitfield says: "You absolutely need to understand and recognise the bigger picture across the system and outside of your CCG. If you can understand the issues and challenges faced by partner organisations it's easier to find a way to work together to improve services for patients." A strategic vision for local and health and care services is in itself not enough; the narrative to communicate that vision has to be understood by a wide range of individuals, from providers to patients and the public.

The 2015 NHS leadership review<sup>11</sup> places great emphasis on the CCG chair's role in communicating the vision for local health services, but the chair's is not the only voice that needs to be heard in this respect. Dr Andy Harris says: "Relationships with providers are constantly evolving and communication is vital. The system is also becoming more complex and as much as this makes my role more interesting as a leader, it challenges me in my ability to communicate effectively across the board."

Toby Sanders echoes this in his description of what a good managerial leader can deliver. He says his biggest personal challenge as managing director has been striking a balance between nurturing and sustaining relationships with member practices and GPs at a local level and shaping and influencing the system leadership to effect change across a wider geographical footprint. His CCG works closely with two other CCGs, NHS



England and the local authority as a commissioner, at the same time collaborating with the NHS providers to improve services. “It is a very complex and fragmented landscape that has required significant interpersonal skills to enable successful collaboration,” he says.

Top CCG leaders are accustomed to negotiating their way through system-wide change. This entails finding a balance between over-arching strategy and operational delivery. This requires an understanding of the whole system. Dr Stewart Findlay says: “I strongly believe in empowering members and we have introduced an ‘Innovation per head’ budget to encourage them to try new ideas and initiatives. This also helps with levels of engagement across the localities.”

## Engaging with multiple stakeholders and making the case for change

Top CCG leaders are able to build a consensus view even when different CCGs are working in collaboration, with varying financial and performance challenges. Communicating with a wide range of stakeholders and making sure each is engaged is a time-consuming task, but a strategic vision is unlikely to be realised unless partners, other providers, patients and the public engage with it.

The PRUComm<sup>5</sup> report found that three out of its four featured case study CCGs were engaged with their provider, local authority and third sector colleagues in forums in which the wider needs of their populations could be discussed. The report concludes: “These groups are in part a function of the increasing pressure to integrate care across organisational and professional boundaries.”

Dr Mark Hayes, chief clinical officer of NHS Vale of York CCG, says: “As a clinical leader, it’s vital to be transparent and honest because there needs to be trust between a CCG, its members and other providers.” Dr Hayes encourages members and providers to stop “papering over the cracks” and be open about areas where developments are needed.

John Wardell, accountable officer of NHS Nene CCG, worked with clinical chair Dr Sam Everington in his previous post at Tower Hamlets CCG in east London, and emphasises that a joint approach to communication has worked well to pair clinical colleagues with their managerial counterparts. “There were times when Sam would step up and front a meeting and other times when I would,” he says.

The practicalities of good communication are important for Dr Stewart Findlay, especially for keeping CCG members up to date. He holds regular meetings with members, with an

incentive scheme to promote attendance. He also emphasises the importance of two-way communication and encourages full participation on with an open door policy.

Amanda Philpott says her clinical chairs are crucial for communicating to the public the vision and strategy set by the CCG governing body. She says: “I have a role to play in that too, of course, but mainly I complement my clinical chairs’ work by using my expertise to organise the resource we need to deliver the vision.”

Operational and financial challenges can affect the ability to work across organisations and deliver change. NHS Vale of York CCG has achieved national recognition in the area of integration of health and social care services. However, Dr Hayes knows that a financially demanding environment can hinder collaborative working within the system. He works hard to ensure collaborative working with the rest of the system, but it can be challenging. “Organisations work at different paces with different agendas and until these are all aligned, this makes my role as a leader tricky,” he says.

At the operational level, Dr Andy Harris believes sharing a culture of transparency on data and information is fundamental. NHS Leeds South and East CCG works very closely with NHS Leeds North CCG and NHS Leeds West CCG, and data sharing helps the CCG leaders understand the bigger picture and make the case for change. The CCGs recognise that different parts of the system need to work together, as part of a culture of open and honest cooperation, to identify and act on potential or actual serious quality failures in the interests of patients.

Dr Amanda Doyle, a GP for 20 years, is co-chair of NHS Clinical Commissioners and chief clinical officer at NHS Blackpool CCG. When engaging with stakeholders she says it’s important to be flexible and understanding. “You have to have an outwards focus. Few health economies have complete harmony between providers and commissioners, so focus on the challenges and tackle them as you go along – don’t wait for issues to escalate,” she says.

“Flexibility is key. Providers have different challenges so as a leader you need to show you understand each issue and address it differently.”

Our examples show that clinical and managerial leaders are able to make the case for change in different operational and strategic ways, and by communicating with different stakeholders. In addition, our interviewees all agreed that CCG leaders must draw on similar personal qualities to effect change. Honesty and integrity, echoed in the ‘Nolan Principles’ of public life,<sup>12</sup> are important qualities when it comes to engaging and making the case for change.



## Commissioning for value, improvement and better outcomes

Top CCG leaders commission for value, service improvement and better outcomes for patients. They bring clinicians together from across the system to make the case for change, with the support of managers to help break down the system and organisational barriers.

Sir Muir Gray, director at Better Value Healthcare at the Nuffield Department of Primary Care Health Sciences and former NHS chief knowledge officer, has outlined the shift in thinking that is required.<sup>13</sup> “Traditionally, we have looked at institutions and assessed their quality, and this is essential but we now need to look at populations and reflect on value,” he says. A good example of this is at NHS West Leicestershire CCG, which has established a large alliance contract across acute, community and primary care for elective procedures. The contract is focused on what is best for project outcomes rather than for the individual organisations involved. The creation of a collaboration leadership board has helped to remove the organisational barriers that existed previously to ensure the focus remains on patient care.

Dr Ian Orpen, clinical chair at NHS Bath and North East Somerset CCG, says his CCG looks at the needs of the patients it serves and reflects those appropriately. “We will use all the benchmarking and performance information available via the commissioning support unit to support our commissioning intentions. The financial challenge does make this difficult but we’re looking at new ways of working to support this such as pooled budgets for community services,” he says.

New ideas from the front line can often lead to more effective use of resources and improve outcomes for patients. Dr Darin Seiger, GP chair of NHS Nene CCG, cites the example of harnessing clinical passion and ideas into deliverable action. He said “We started off with full engagement and ended up with 300 schemes that our clinicians wanted to deliver. Clearly though this number was simply unmanageable. We therefore tested these schemes with our member practices, went through a process involving our locality groups and agreed we needed to focus a handful of schemes that would deliver real impact at scale, such as improving the care of our frail and elderly population.”

Involving GP practices in quality improvement is key to driving change and chief clinical officer Dr Barbara King highlights the progress made through NHS Birmingham CrossCity CCG’s in-house quality team. The team’s focus is on improving quality with regular communication on how each practice is performing. “We’ve also been able to improve performance by identifying carers in the community and properly assessing them. Currently over 4,000 carers have been identified and supported,” she says.

Dr Caroline Dollery outlines a similar initiative at NHS Mid Essex CCG, where critical care workers were at the heart of a project to reduce avoidable admissions.

Dr Paul Bowen, clinical chair of NHS Eastern Cheshire CCG, believes such initiatives inevitably involve an element of risk. However, he argues that CCG leaders should not be afraid to take calculated risks as doing so can offer valuable lessons for the future.

Top CCG leaders are therefore able to recognise the importance of innovation and allow innovative environments to flourish, but also that budgetary constraints mean the choice of initiatives to improve outcomes must be based on value and evidence. In short, top clinical leaders use their local knowledge and ability to make a judgment, encouraging frontline colleagues to come forward with ideas for discussion. Top managerial leaders use their operational and organisational knowledge to support this process.





Clinical leadership and managerial leadership are both needed to deliver quality improvement - that is why joint working between them is important. The ultimate goal is to have “managerially intelligent clinicians” and “clinically intelligent managers” who have built an effective working relationship.

# / Conclusion

## **Effective clinical commissioning leadership supports innovative approaches to commissioning at the local level, commissioning for value, and focus on quality improvement for local populations**

Clinical leadership and managerial leadership are both needed to deliver quality improvement – that is why joint working between them is important. The ultimate goal is to have “managerially intelligent clinicians” and “clinically intelligent managers” who have built an effective working relationship.

Top CCG leaders recognise the need for greater partnership working between clinicians and managers. They make it their priority to work collaboratively with their peers and use their communications skills and emotional intelligence to understand different viewpoints. Top CCG leaders know they don't always have the right answers. They are aware that as either a clinician or manager they have to work to bring out the best in each other. This mutual understanding and recognition has become the cornerstone of success when it comes to clinical commissioning leaders meeting their objectives and commissioning for value and improved outcomes.



By working together and recognising each other's strengths, clinicians and managers have been able to succeed. They encourage frontline innovation at the same time as using benchmarking and performance information to ensure transparency between commissioners and providers. This symbiotic relationship relies on having clearly delineated responsibilities between managers and clinicians. Clinicians add value because they can promote buy-in to the strategic vision among their clinical colleagues.

We know that many CCG leaders struggle and feel unsupported, but given that we know what success looks like we should now be better able to offer them the right support in their role. Whether it is by giving clinicians earlier exposure to projects and programme management courses, or by providing managerial clinical commissioning leaders with the support of a mentor earlier in their career, we now have a clearer idea of what can be done.



# / Development needed

## Support for clinical commissioning leaders already in post

Our interviews make it clear that more support is needed to encourage joint working between GP leaders and their managerial counterparts. Current development programmes tend to focus on either the GP or manager perspective. Given the importance of a collaborative, symbiotic relationship, it makes sense to provide joint support to both groups, as well as bespoke development opportunities for each.

CCG leaders also call for more systematic support for GPs entering managerial roles. The majority of clinical commissioning leaders we spoke to said they fell into clinical leadership; it wasn't a planned career path, and they were singled out because of their credibility, confidence and knowledge of local health services. When they started out in clinical leadership the support systems were not there and effectively the only way to learn was by doing the job.

Current peer learning and development support for existing clinical leaders (either as chairs or clinical commissioning officers) is not good enough. We need to improve this support to help clinicians interface with their peers about common issues and problem solving.

## Support for future generations of clinical commissioning leaders

We need to start leadership development earlier in the careers of clinicians, and develop a narrative that encourages GPs in member practices to want to consider portfolio careers involving GP leadership in commissioning organisations and in leading new models of care. Improvement in succession planning across the system would help get potential leaders into structured training programmes sooner. Future clinical commissioning leaders shouldn't have to wait until an opportunity presents itself to start developing – this development should be taking place regularly.

A recurrent theme throughout the interviews was a need to inspire the next generation of leaders, so they feel they want to become clinical commissioning leaders, either in CCGs or emerging new models of care. Future CCG leaders should be offered joint development programmes to ensure they understand the benefits of joint working and bringing out the best in each other. We must develop bespoke programming that will help this, and that is accessible to GP leaders, as traditionally delivered 'managerial type' programmes are not easy for 'jobbing' GPs to attend.

Clearer career development for both men and women leaders was called for, especially by chairs. They suggested better use of peer networks, allowing more time for reflection as well as access to high-quality coaching. NHSCC's 2015 report *Women in clinical leadership*<sup>14</sup> established that only 42 per cent of senior GPs are female, while salaried GPs – who make up almost a quarter of the GP workforce – are 71 per cent female. CCGs should be identifying and supporting those women who have the potential to be the clinical leaders of the future, and the NHSCC report suggests a number of ways in which they can do this, including working with organisations such as the Faculty of Medical Leadership and Management to develop a talent management plan. CCGs should ensure they have identified as wide a pool of talent as possible, and that the flow through the system is maintained and resourced.



# / Key asks

## 1. Clarity about the future of the system

CCGs are relatively new statutory bodies and the inclusion of clinicians working alongside managers is certainly welcome. The evidence shows there are clear benefits in terms of better commissioning decisions and improved outcomes. However, in order for succession planning and support networks to develop, we need a clear narrative about the importance of commissioning and clinical commissioning leadership, and assurances that this will not be at the mercy of political whim. It is also critical that clinical leadership is actively encouraged and there is recognition that the wider system benefits from having clinicians involved at the leadership level. The importance of having effective clinical leadership supporting the new sustainability and transformation plan processes should therefore be recognised and be expected by the arms length bodies overseeing their delivery.

## 2. Commitment to developing and supporting GP leadership

The call for a more supportive environment was reflected in many of our interviews, with many clinical commissioning leaders talking of an urgent need for a more “forgiving environment” in which to nurture existing talent. This includes being part of a flexible system that allows clinicians to develop their leadership skills while continuing to practise. Encouraging portfolio careers was seen as a good thing as it helps clinicians to avoid burnout.

## 3. More and effective leadership programmes and development for clinicians and managerial leaders

A more joined-up development programme for managers and clinicians leading commissioning organisations is needed, rather than trying to develop each group in isolation. The development of one type of leader shouldn't be seen as any less significant than the development of the other. While this was evident from our interviews, being able to discuss issues away from the coal-face in a safe environment with a formal leadership development programme for each type of leader was also seen as important. NHSCC is currently therefore seeking support from NHS England to build the chief clinical officers' network it supported during 2015 into a clinical leaders' development network, providing some safe space and time to support what CCOs and clinical chairs say is critical to their learning and growing so they can lead transformation locally across their CCG and local health and care system.



# / Interviewees for the report

NHS Clinical Commissioners and Hunter Healthcare would like to thank the following people who were interviewed for this report

## Gender of interviewees

Male – 17

Female – 18

## Names and positions of interviewees

Name	Title	Organisation
Dr Adrian Hayter	clinical chair	NHS Windsor, Ascot & Maidenhead CCG
Amanda Bloor	chief officer	NHS Harrogate and Rural District Commissioning Group
Dr Amanda Doyle	chief clinical officer	NHS Blackpool CCG
Amanda Philpott	chief officer	NHS Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG
Dr Amit Bhargava	chief clinical officer	NHS Crawley CCG
Dr Andy Harris	chief clinical officer	NHS Leeds S&E CCG
Dr Andy Whitfield	clinical chair	NHS North East Hampshire & Farnham CCG
Dr Anthony Kelly	clinical chair	NHS Worcestershire CCG
Dr Barbara King	chief clinical officer	NHS Birmingham CrossCity CCG
Dr Caroline Dollery	clinical chair	NHS Mid Essex CCG
Dr Claire Fuller	clinical chair	NHS Surrey Downs CCG
Dr Darin Seiger	clinical chair	NHS Nene CCG
Dr Debbie Frost	clinical chair	NHS Barnet CCG
Deborah Fielding	chief officer	NHS Wiltshire CCG
Dr Gora Bangi	clinical chair	NHS Chorley and South Ribble CCG
Dr Ian Orpen	clinical chair	NHS Bath & North East Somerset CCG
Dr Jane Povey	deputy medical director	Faculty of Medical Leadership and Management
John Wardell	accountable officer	NHS Nene CCG
Joy Youart	accountable officer	NHS Kernow CCG
Julia Ross	chief executive	NHS North West Surrey CCG
Katherine Sheerin	chief officer	NHS Liverpool CCG
Maggie Maclsaac	chief officer	NHS North East Hampshire and Farnham CCG
Marcus Warnes	accountable officer	NHS NHS Staffordshire CCG
Dr Mark Hayes	chief clinical officer	NHS Vale of York CCG
Dr Martin Whiting	chief clinical officer	NHS North Manchester CCG
Dr Mary Backhouse	chief clinical officer	NHS North Somerset CCG
Mary Hutton	accountable officer	NHS Gloucestershire CCG
Dr Nikki Kanani	clinical chair/ FMLM quality lead	NHS Bexley CCG
Dr Paul Bowen	clinical chair	NHS Eastern Cheshire CCG
Dr Phil Moore	deputy clinical chair	NHS Kingston CCG
Dr Stewart Findlay	chief clinical officer	NHS Durham Dales CCG
Dr Tim Moorhead	clinical chair	NHS Sheffield CCG
Toby Sanders	managing director	NHS West Leicestershire CCG
Tracy Dowling	chief operating officer	NHS Cambridge CCG
Dr Vicky Pleydell	chief clinical officer (stepped down)	NHS Hambleton, Richmond & Whitby CCG

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# WHAT MAKES A TOP CLINICAL COMMISSIONING LEADER?

## / 2016

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