

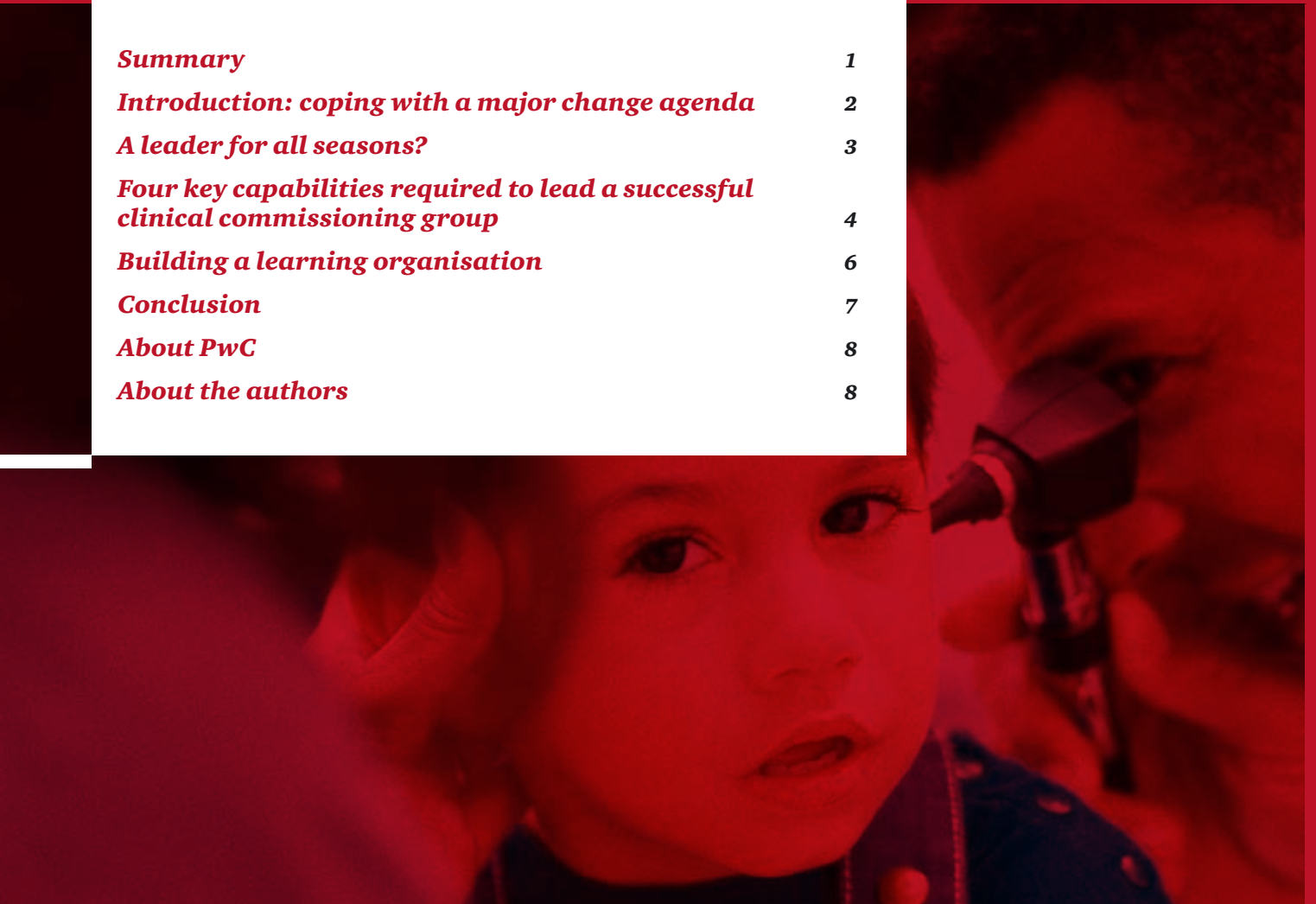
A leader for all seasons?

Talking Points

Why clinical commissioning
groups need different leadership
for different times

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Summary

Clinical commissioning groups should expect to have different leaders taking prominence through the various stages of development, as the range of skills required are beyond the capabilities of one person. Each member of the leadership team may step forward to play a greater or lesser role according to the evolving needs of the consortium and the seasonal demands of the commissioning cycle. Leadership needs also to occur at different levels within the groups which means building support and commitment from constituent practices.

By ensuring that sufficient time is spent reviewing their performance and way of working, leadership teams can ensure they function effectively and stay focused upon the strategic goals. Psychometric testing, feedback, reflection and coaching will aid the process and help make the most of the different skills and personalities of each individual.

The price of failure for clinical commissioning is high, both financially and clinically. However, by adopting a flexible approach to leadership, groups can avoid the wastage of having the wrong leader at the wrong time, the instability of dismissing leaders and instead build organisations that adapt to a changing environment, delivering clinical excellence and greater value.

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Leadership and learning are indispensable to each other.

John F. Kennedy

Introduction: coping with a major change agenda

As the transition to clinical commissioning gathers pace, possibly the single biggest concern for new clinical commissioning groups is choosing the right leader.

This is understandable given the huge upheavals in the NHS, which are putting the top teams under intense pressure to bring greater efficiency, improve clinical outcomes and reduce health inequalities.

Taking charge of a clinical commissioning group is a major step change for GPs and other clinicians. At best they will be used to roles leading practice based commissioning, whilst many are accustomed to working largely as individual practitioners within a practice. Each group is likely to be accountable for a substantial budget, typically with 20-30 practices and a patient population of 200,000 or more.

Interdependencies with multiple stakeholders and providers add a further web of complexity, while the dynamic political conditions have created uncertainty over the final structure and lines of reporting.

The leaders will be responsible for putting in place appropriate governance, including accountability, decision-making responsibility and financial management. Change management is critical, as groups will have to gain sustained support from local GPs if they are to encourage all clinicians to embrace the commissioning agenda. A good leader will generate supporters and build commitment.

This challenging environment demands a more 'corporate' approach to leadership, with greater accountability, a wide range of skills across the team and the willingness and flexibility to cope with uncertainty.

The price of failure

Many fear that, with the wrong leader at its helm, the group risks sliding quickly into a spiral of poor operational and financial management, leading to declining clinical outcomes.

This would necessitate a change at the top, creating additional organisational strife as well as upsetting the individual concerned, especially if he or she expected to be in the position on a permanent basis (as is typically the case in general practice).

A leader for all seasons?

The size and complexity of a typical clinical commissioning group requires a different approach to leadership that goes beyond traditional, rigid, hierarchical models. It's highly unlikely that any single person possesses the breadth of skills and personal attributes to be a leader over several years.

Rather than viewing leadership as a permanent state, those on the top team should see their roles as flexible and (to some extent) interchangeable, with each prepared to take on varying levels of involvement and authority at different times. This may mean changing leaders as the organisation evolves, depending upon the particular challenges being faced.

There are parallels here with organisations in the private and charitable sectors; a dynamic, entrepreneurial approach may be the best way to get the business going, yet once the organisation has grown into a going concern, with a large number of employees/members, a more operational approach is necessary.

Instead of a classic hierarchy, the group should build a strong overall leadership team with shared accountability and complementary skills and experience, to support the leader and provide successors at various phases.

Even within the annual commissioning cycle, different individuals could take a lead role through the various stages of origination, relationship building, consolidation, and negotiation with providers through to final delivery of services. Commissioning is a particularly complex process that many PCTs have struggled to master, and those responsible will have to possess or buy in skills in public health management, procurement, contract management and negotiation. A more fluid organisational structure also enables groups to adapt more quickly to any change in political direction.

Four capabilities required to lead a successful clinical commissioning group

To ensure that leaders possess the right skills for the job, it may help to draw up a list of attributes that the leadership team should possess before being considered for election leadership role.

The main skills required of the leadership team are:

Transformational: the NHS is expected to improve the quality of healthcare while keeping costs down. Building a strong clinical commissioning group is a major change programme that will require radically different ways of working amongst GPs, other clinicians and other stakeholders. It's widely acknowledged that many change programmes don't deliver on their promises due to an inability to bring those affected "on board", so leaders will have to demonstrate strong change management skills, with a real ability to influence and encourage all clinicians to transform their approach to providing care.

Relational: clinical commissioning group leaders will need to manage relationships with a wide range of stakeholders including: patient groups; practice staff (for example, practice managers and practice nurses); managers of provider organisations; clinicians from outside of

primary care; the local authority; the local medical community (including hospitals and other providers); the PCT (during transition); the Health and Well-Being Board; and local MPs. This requires strong interpersonal skills and an ability to understand the varied and changing needs of diverse groups of people and organisations.

Accountable: with clinical commissioning group activities under very close scrutiny, leaders will be accountable for keeping budgets under control and spending wisely, while achieving challenging improvements in clinical outcomes. This calls for sound financial literacy, an understanding of financial governance and an understanding of how to invest the budget wisely in order to interpret the numbers and understand the overall position of the group.

Organisational: the size and budget of a clinical commissioning group is of a totally different magnitude to Practice Based Commissioning, or a GP practice, and will require strong managerial and operational skills. Although technical expertise can be brought in, leaders should have a good understanding of how to run an organisation and an ability to manage external and/or outsourced providers.

Distributed leadership, changing over time

It is unlikely that these skills will reside in any one person, indeed it is probably undesirable for an organisation that needs to operate in such a complex environment to have a single person with these leadership responsibilities. Instead a form of distributed leadership that covers a team and constituent practices is far more likely to be effective. This does not necessarily mean adopting a consensual style at all times; once the principle purpose (vision) and working styles (behaviours and values) of the group are agreed, leadership tasks can be assigned and individuals held accountable for delivering them.

In addition, leaders will be expected to understand and address the strategic changes facing the NHS, the local health economy and frontline clinical care. The team as a whole should have the ability to build and manage an organisation that delivers the commissioning agenda, while setting realistic goals. Above all, they need to have demonstrated leadership skills, with the commitment to learn and develop, and a strong ability to listen to others.

As the chart below shows, each of these four capabilities will come to the fore at different stages in the consortium's development.

1. Start-up phase: transformational

Driving the creation of a new organisation – or transitioning from a PCT – demands a high-energy leader focused on building the group. He or she will have to set up the new structure and galvanise everyone involved to get behind the change.

2. Development phase: relational

Given the many and complex interdependencies with stakeholders and providers, this stage requires an emphasis on leadership that can build relationships and negotiate effectively, to ensure that every party is aware of its role and that

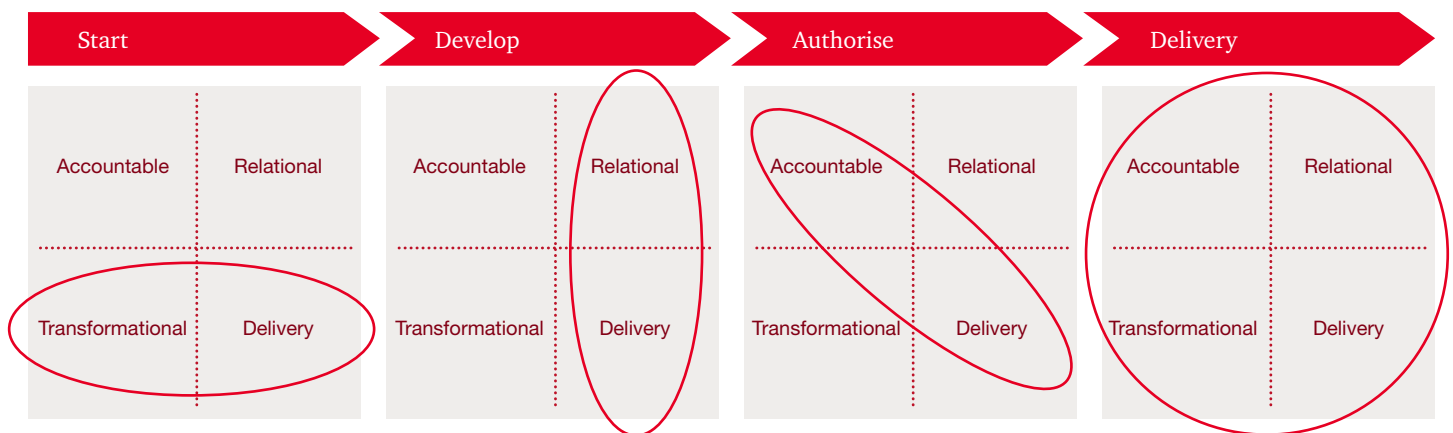
providers are committed to delivering high-quality services.

3. Authorisation phase: accountable

As the group starts to commission services, there is a need for strong controlling, performance management and financial skills, to track service quality and costs versus budget, and confirm that clinical standards meet expectations. Part of the challenge here is to install controls that monitor expenditure and quality of service, to keep track of progress and spot any weaknesses or variances. Given the rising demand for NHS services, and pressure on budgets, such improvements are vital to the success of the group.

4. Delivery phase: transformational/relational/accountable/organisational

As the organisation starts to mature, the leadership team has to demonstrate a wide range of skills to manage day-to-day operations, continue to deal with stakeholders, chair meetings and handle ongoing budget and performance issues. As mentioned, this will almost certainly be beyond the capabilities of one individual, so it's critical that the team is open to taking responsibility for different tasks, and can interchange roles easily. The commissioning process may call for a specific role within itself, and it's possible that a chief executive could be hired from a PCT or even from the private sector.



Building a learning organisation

From its formation, the leadership team should acknowledge that roles may well change over time, so that each member learns to accept and embrace his or her evolving contributions. In this way a change in leader will be viewed not as a crisis but as a natural event.

To create a cohesive team with shared goals and values, the leaders should devote a significant amount of their time (possibly as much as 20%) to review progress, working style and effectiveness. These sessions are not merely a 'nice to have' and should be seen as an essential part of everyone's job. Although a big commitment, such a reflective approach should encourage continuous improvement as well as collective responsibility and accountability.

By taking regular time out from the high pressure of daily work, leaders can maintain focus on the group's strategic vision and evolving objectives, and avoid getting over-involved at a micro, day-to-day level.

Psychometric testing techniques such as Myers-Briggs (which assesses different personality types and how they tend to work) and Belbin® (which looks at how people operate within a team) can assess the profile and working style of each member. This knowledge can be used to help the team function more effectively, and ensure that the composition of people is complementary. The team would also benefit from coaching, and be encouraged to share information readily.

Not everyone is likely to have experience of working in such a large and complex organisational structure, so it may also be useful to choose one member to take responsibility for overall team governance. This role could be similar to that of a senior non-executive director, setting the expectations for each role and applying independent judgement to the way leaders operate.

Such a constant review process is designed to enhance leadership skills and team effectiveness rather than specific technical skills. When applied in a consistent and professional manner, it should make a real difference to performance and ease any fears about choosing the wrong leader.



Conclusion

With the stakes high, clinical commissioning groups have to quickly develop into a smoothly efficient operation that continues to improve the public's health within very tight budgetary constraints. Such demands put immense pressure on leaders, who will be directly accountable for results.

Clinical commissioning groups not only have to establish new organisations – they also have to enhance their management skills to succeed. Most of the clinicians chosen to lead these groups will not have experienced managerial roles of such scale and complexity. Consequently, team-building takes on a high priority,

in order to create a mutually supportive, learning organisation that can meet its challenging targets.

Through careful governance, it's possible to set clear expectations for leaders in terms of accountability and behaviour, while leaving sufficient flexibility to meet the inevitable politically-driven changes. To manage each stage of development, the leadership team has to make the most of its full range of talents and recognise that different individuals may take a more prominent role at different times. Changing a leader should be considered a natural stage in evolution rather than a crisis.

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