

Clinically Led Commissioning

Sept 2011

Clinical Commissioning

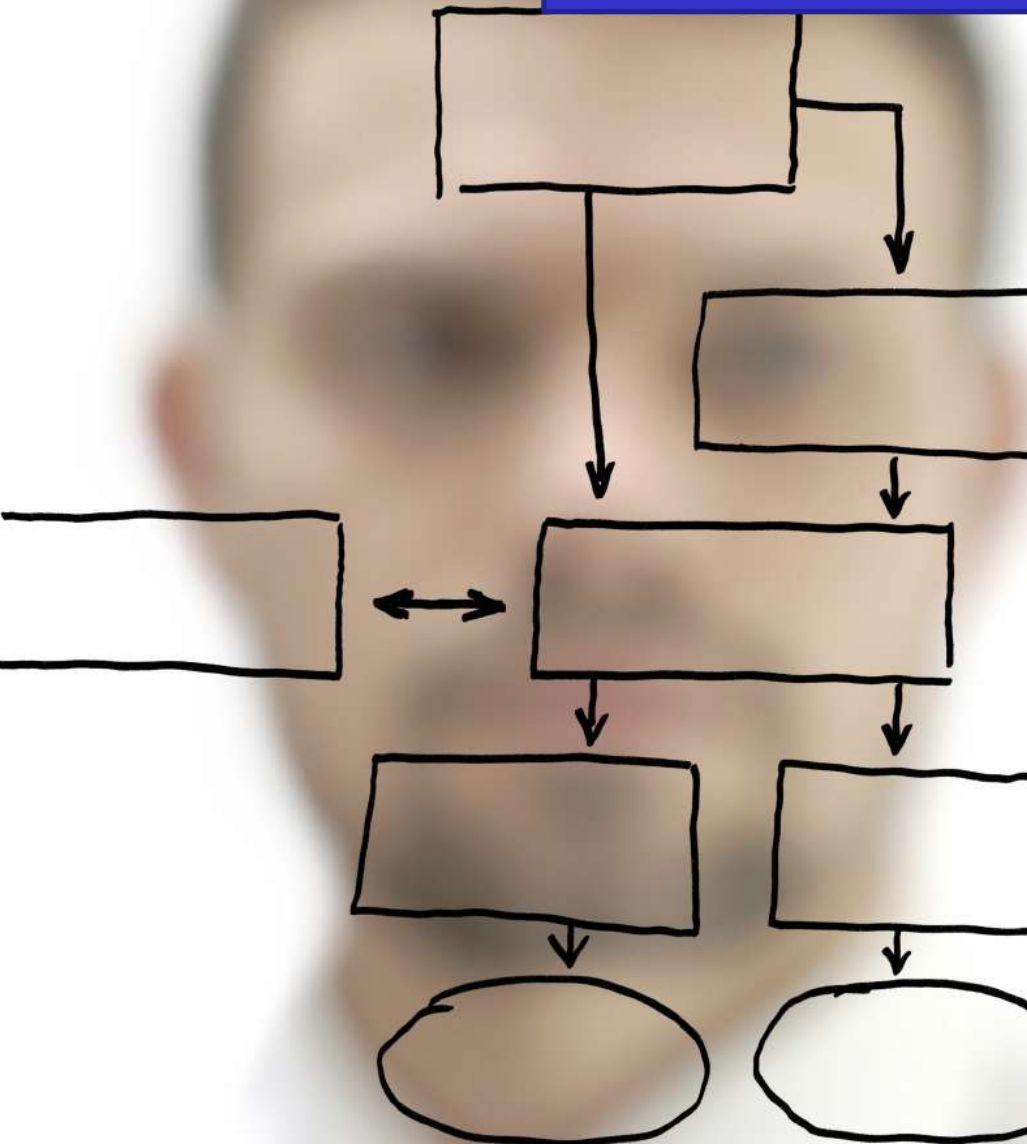
Agenda

- Where are we?
- Architecture changes
- Authorisation and risk assessment
- Current Issues
- QIPP Commissioning Actions
- Leadership

Reasons for Change

- Clinicians at the heart of decision making
- Involvement and Empowering Patients
- Best outcomes in the world
 - Driving up quality

New Architecture



SHA Clusters

PCT Clusters

Single operating
system

Primary Care

Dental

Armed Forces

Prison

Specialist Services

Health and Well Being
Boards



Clinically led Commissioning Group Governance

Issues: **End State**
NCB Relationship
Authorisation
Commissioning Support

The greater danger for most of us lies not in setting our aim too high and falling short; but in setting our aim too low, and achieving our mark.”



Pre Authorisation Risk Assessment

- Clinical ownership
- Commissioning boundaries
- LA boundaries
- Size

To be authorised consortia will need to demonstrate...

Clinical focus and added value

Engagement with patients and communities

A clear and credible plan to deliver quality improvement within the allotted financial resource

Capacity and capability to deliver all their responsibilities, including delivery of financial control

Collaborative arrangements for commissioning with other consortia, Local Authorities and the NHS CB

Leadership capacity and capability

Clinical Focus and Added Value

Standards

Plans to assess local need, reduce inequalities, and ensure continual quality improvement, to improve patient experience and outcomes

Demonstrate engagement of constituent GPs, also the involvement of other clinical professionals.

Tests

- Are key programmes of work led by clinicians from a range of appropriate disciplines?
- Arrangements for effective participation of all the consortium's practices
- Is the consortium engaging with stakeholders
- Does the consortium have plans to use peer to peer challenge

Evidence

- Joint Health and Wellbeing strategy
- Commissioning plan
- Constitution
- Membership agreement
- 360 degree input
- Face-to-face meeting

Collaborative arrangements for commissioning

Standards

- How does the consortium plan to work with other consortia and local authorities?
- What commissioning support arrangements do they have in place to help them commission across wider geographies?

Tests

- Partnership arrangements e.g. pooled budgets, lead commissioning etc in place with other consortia and local authorities
- Effective ways of working with NHS CB in place
- Suitable arrangements in place to access the right public health advice.
- The consortium is a member of all relevant shadow health and wellbeing boards
- Robust commissioning support arrangements in place to support collaboration

Evidence

- JSNA/Health and Wellbeing strategy
- Commissioning Plan
- Constitution
- Commissioning support arrangements
- 360 degree input
- Face-to-face meeting

Draft Authorisation Issues Raised

- Why?
- Accountability and authorised with conditions
- NCB Relationship
- Support services
 - Running costs
- Sustainability



Consortia Support

**Consortia will succeed or fail
by quality of support**

Need to identify functions

Need to consider scale

Alternative models

Voluntary sector

Independent sector

QIPP



The King's Fund 10 High Impact Changes

1. Self-management
2. Primary prevention
3. Secondary prevention
4. Managing ambulatory conditions
5. Integrating mental & physical health care

The King's Fund 10 High Impact Changes

6. Care coordination & integration
7. End-of-life care
8. Medicines management
9. Managing elective activity
10. Managing emergency activity

Enablers

- Post Industrial Primary Care
- Integrated Care
- Systematic and proactive management of Long term Conditions
- Empowerment of patients
- Population management

Leadership



The Essence of Leadership

Management is the equivalent of *déjà vu* (seen this before), whereas leadership is the equivalent of *vu jàdé* (never seen this before)

What's your style?

- Visionary
- Participative
- Pacesetting
- Coaching
- Directive
- Affiliative

ZRs First Law



$$SP = (C * I) CR$$

SP = Sustained Performance

C = Capabilities

I = Incentives

CR = Constructive Relationships

Ownership

Building Collaboration

- Define and build a shared purpose
- Cultivate an ethic of contribution
- Develop scalable processes for coordinating people's efforts
- Create an infrastructure in which collaboration is valued and rewarded

Paul Adler Charles Heckscher HBR July 2011

Issues for Clinically Led Commissioning

- Size
- 1000 Leaders
 - Charisma not same as Leadership
- Sustainability
- Balance quality, cost effectiveness and experience

Issues for Clinically Led Commissioning 2

- Consequences for poor performance
- Manage insurance risk
- Specialist co-operation is crucial
 - Different incentives needed
- Time needed to develop to maturity

Patients the greatest untapped resource

- Improving the care process
- Building health literacy
- Selecting treatments
- Strengthening self-care
- Ensure safe care
- Training professionals
- Shaping services

Engaging Patients in Health Care Angela Coulter

