

# The governance of consortia

GPC guidance

May 2011

**NHS** REFORM

There are many different ways that clinically-led commissioning consortia will commission services for their patient populations. Similarly, there are many different forms that the governance arrangements of consortia could take, reflecting the different shapes and structure of these organisations.

The GPC has advised from the outset that consortia should be large enough to manage financial risk effectively, negotiate with external organisations from a position of strength, procure commissioning support services without losing control of the commissioning process, and use their larger management allowance to employ the best consortium staff. However, many consortia plan to form much smaller organisations than this, at least initially. Some may be large but cover a small area in a densely populated city, while others may be dispersed across a large rural area. Some consortia may decide to form a federation in order to pool their resources and develop a commissioning support unit which they jointly manage to support their work. Others may have a number of locality commissioning groups underneath a single consortium.

This diversity will reflect the differing health needs of the patient populations within the UK and the variety of local and historic arrangements that already exist. Consequently, it is not possible to be prescriptive in describing the governance structure that any one consortium should put in place. Indeed, the government has made it clear that they will not specify consortia governance arrangements. Nonetheless, it is necessary to identify a framework, or set of principles, that describe the appropriate functionality of a consortium. This will ensure that a consortium is a viable, transparent and accountable organisation, has a sufficiently strong GP voice, involves other clinicians and other stakeholders at the right time, and above all has the confidence of the local population on whose behalf it is working.

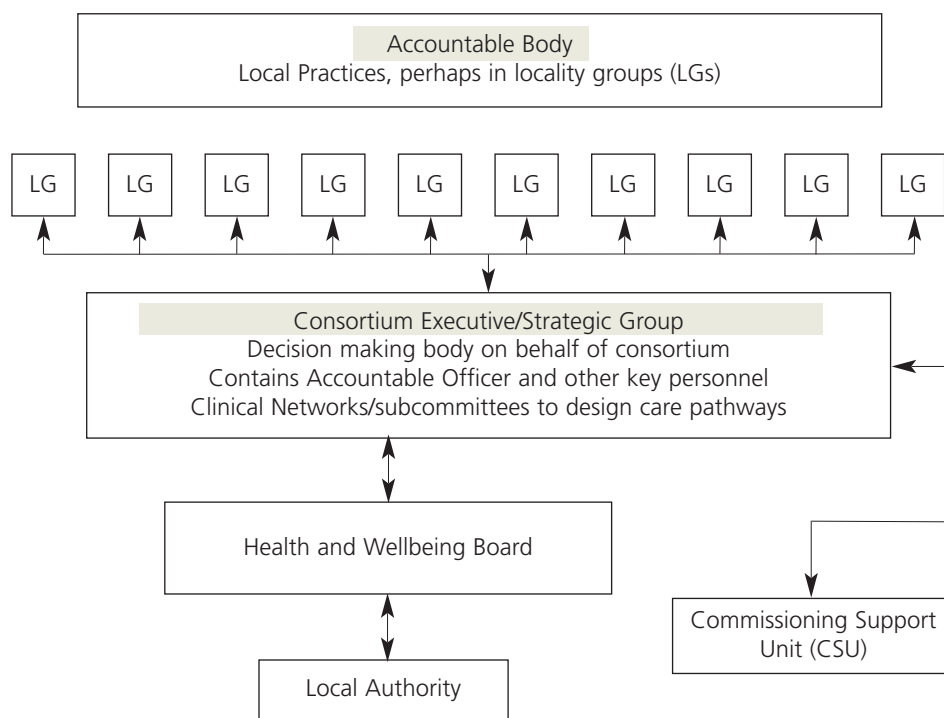
## A framework for consortia governance

At a basic level, every consortium will need to make high-level strategic decisions on the direction of commissioning and the fulfilment of their statutory responsibilities, but will also need to make day-to-day decisions on the management of the commissioning process and of the functions of the consortium generally. Many consortia may choose to split these roles between:

- an 'Accountable Body', which would include representatives of the constituent practices, and would be, as its name suggests, accountable to the public, patients and practices, in addition to the NHS Commissioning Board and Health & Wellbeing Board;
- an 'Executive/Strategic group' within the consortium, which would hold the decision making functions for the consortium and include the Accountable Officer and other key personnel. The constitution of the consortium should encompass sufficient flexibility for executive group to form subgroups, and clinical networks, which could include consultants, directors of public health, nurses and managers;

- an 'audit group' would hold in check the Accountable Body and Executive/Strategic Groups and ensure the probity of the decisions made.

We have resisted using the term 'board' as it is felt that to do so would imply the continuation of PCT boards and PCT governance arrangements, when a new approach to the governance of commissioning is required. In establishing governance arrangements flexibility will be required, dependent upon the size of the population, the number of constituent practices and the geography of the area. This flexibility should also extend to the considerations about the best place for other health care professionals to be involved within the structure; this would be better than any rigid suggestions that lead to tokenistic appointments.



Further to the groups discussed above, it is likely that each consortium will also have a number of task-orientated subcommittees/clinical networks with the specific intention of exploring certain clinical pathways or areas of care. Moreover, those consortia with additional responsibilities, such as research and development, will require governance arrangements that reflect this. However a consortium chooses to develop its governance arrangements they should meet the following principles:

- **Financial accountability** – the consortium must have a method for monitoring its financial performance and making changes to its commissioning decisions accordingly. This must be a transparent process as large amounts of public money will be discharged by consortia.

- **Legitimacy of the consortia leadership** – there must be an appropriate mechanism to enable the selection and election of the consortia leadership but also their replacement before the end of their tenure when necessary. All GPs, regardless of contract status, should be able to stand for selection and election. This will bring transparency and legitimacy to a consortium and may help prevent the concentration of power in a few hands. The GPC has produced clear guidance on electing a consortia leadership here:  
[http://www.bma.org.uk/images/whitepapergpcguidance6\\_apr2011version\\_tcm41-205257.pdf](http://www.bma.org.uk/images/whitepapergpcguidance6_apr2011version_tcm41-205257.pdf)

Particular emphasis is placed on selection against competencies (section 3.2 on page 7) , which is designed to ensure that the candidates standing have the requisite skills to be active and effective healthcare commissioners; the NHS Commissioning Board is likely to issue a set of standards for clinical leadership which would have to be met by candidates standing for election. This would not be designed to stifle democracy, but to ensure that the local health economy is to be managed by those best able to perform the role.

- **Clinician involvement** – successful commissioning is only possible with the active involvement of appropriate clinicians in the commissioning process at relevant points. This may mean a permanent seat for a public health representative on the Executive/Strategic group and certainly requires as a minimum the involvement of specialists in the design of pathways. This is likely to reflect local circumstances strongly, but it is important that these provisions are laid out in the governance arrangements from the outset. The commissioning of effective secondary care, community care and mental health services cannot take place without wider clinical input and real engagement of the clinicians who work and have expertise in these areas. For example, clinical networks could strengthen professional relationships across health sector boundaries, encourage clinical innovation between specialists and their primary care colleagues and enable different parts of the system to plan and work together. Through the promotion of collaboration, the system will minimise fragmentation and destabilisation and instead encourage planned change and service development. The development of clinical networks would require both the support of commissioners and NHS managers. They would further be strengthened by the input of a mix of patients and carers who are experts in conditions. The size of networks would vary according to the rarity of the condition and the size of population within specialties. Some would be regional, linked to academic health centres and feeding into the work of a number of commissioners. Others would be more localised.
- **Probity** – there must be a separate group or mechanism within the consortium, such as an audit group suggested above, that oversees the probity of the commissioning decisions and ensures that conflicts of interest are not allowed to prejudice the commissioning process. Some consortia may consider an independent chair would help overcome the perception of conflicts of interest within a consortium, although this would not offer the direct link to practices provided by an elected GP chair and could reduce the accountability of the consortium.
- **GP majority** – there should be a majority of GPs on the Accountable Body and the Executive body of the consortium. This majority could take the form of representatives from each practice, or representatives of each commissioning locality, or simply the elected GP

representatives/leaders. In consortia representing larger groups of practices, it may be necessary to establish smaller locality groups to ensure fair representation.

- **Practice engagement** – there must be a strong relationship between the consortium and individual practices, with both parties having set responsibilities with regard to the other. Consortia representing large geographical areas, or those with large groups of practices may find it beneficial to establish smaller locality groups or federations. Practices should receive financial recognition for the time and work they provide for the consortium.
- **Patient engagement** – there must be genuine and meaningful engagement with patients at some point in the commissioning decision-making process. Patient representatives could sit on one of the groupings described above, or they could be observers to those groups. Consortia should consider which of its decision-making groups should meet in public. It is important that patients can see that decisions are made fairly and transparently and that they are part of this process. The BMA's Patient Liaison Group will publish a toolkit on patient engagement shortly.
- **Accountability to the public** – the contribution of local councillors is important, but it is not essential for them to sit on a decision-making body as this would risk politicising the commissioning of local health services. Councillors would be welcome as observers, and will also have an important role to play in the proposed Health and Wellbeing Boards.
- **Lay management** – it is essential that consortia have the right expertise available to fulfil their functions and it is therefore likely that every consortium will employ lay managers (or external commissioning support) to assist with the commissioning process. Consortia should be designed to ensure that lay managers support the elected representatives of the organisation, and do not, as with previous primary care organisational structures, start to exclude clinicians from direct commissioning decisions.
- **AGM** – the consortium should hold an annual general meeting that will be open to all GPs working in the area and members of the public. Meeting papers should be made public in the same way as current PCT and SHA papers are.
- **Minimal bureaucracy** – consortia must develop a structure that is affordable but is also effective. Any executive/strategic groupings must be small enough to be able to make decisions but the overall structure must take into account good governance standards and be accountable to the public and its constituent practices.
- **Consortium name and branding** – whilst the name that a consortium chooses to give itself is a matter for its membership, how it chooses to brand itself does make an important statement and has a direct link with patient and public engagement. Despite the huge degree of publicity about the reforms it is quite possible that a large proportion of the public is unaware of the changes in prospect. For example, the use of the NHS name and logo with a consortium's name is clear and concise way of explaining this to the public as consortia formally take over from PCTs.

The GPC has already produced guidance on the leadership of clinically-led commissioning consortia. This explores the nature of leadership at different levels within the consortium, and suggests a set of competencies that clinical leaders will require. The guidance discusses four tiers of leadership that are likely to be common to most consortia:

- The chief officers of the consortium: consortium chairman/clinical lead, accountable officer (these may be the same person) and chief financial officer.
- Those on the 'executive/strategic group' or 'audit group' (collectively described in the document under the heading consortium management committee)
- Those clinicians leading on specific clinical areas, or analytical activity in a task-orientated subcommittee (collectively grouped in the document under the heading lead clinicians with a defined role)
- Practice commissioning and prescribing leads (these latter two tiers may also be part of a larger body)

It is strongly recommended that consortia should consider these tiers when designing their governance structures and refer to the guidance on the nature and responsibilities of these roles: [www.bma.org.uk/images/whitepapergpcguid9leadgpccommission\\_apr2011\\_tcm41-205332.pdf](http://www.bma.org.uk/images/whitepapergpcguid9leadgpccommission_apr2011_tcm41-205332.pdf)

## Examples of governance arrangements

Below are a number of examples setting out how a consortium may be organised. The GPC does not endorse any particular structure, but expects all consortia structures to conform to the framework outlined above.

### Example one

*The consortium has a Council and an Executive. The Council, which meets every 2 months, has representation from all member practices, as well as social services, local consultants (and other senior secondary care doctors as appropriate) and community nurses. A public health consultant linked to the consortium also attends as do prescribing, commissioning and information lead managers. The chair of the local patient and public group attends – they chair a PPI forum with links to every practice Patient Participation Group in the consortium, providing a broader range of public views than simply involving a local councillor. The Council sets the strategic direction of the consortium and holds the Executive to account.*

*The Executive is directly elected by all GPs and practice managers of the member practices and includes GPs (partner or sessional) and practice managers, with GPs being in the majority. All elected members have been through a prior process to ensure they have the necessary*

competency for the role, this being done by an independent panel. The lay PPI chair is also a member of the Executive. The public health consultant and PCT commissioning manager supporting the consortium attend the Executive group. The elected members make decisions, bearing in mind the strategic direction set by the Council. The elected members decide which of them will be the Chair, but there is no reason why this could not be a directly elected role (after a prior competency assessment by an independent panel). The consortium will employ a chief operating officer and financial officer who will also become part of the Executive. An independent audit committee will also be established. As the consortium develops the Executive could develop in to a more formal Board which would meet in public as required.

The consortium works closely with its neighbours and is developing a commissioning support unit that will work on behalf of them all. Through sharing resources this organisational structure will provide the necessary specialist commissioning support required.

### **Example two**

An Executive Management Board comprised solely of GPs makes decisions for the consortium. The board members are appointed following a competency assessment and election from all local GPs and are thus individually accountable to the consortium constituents. The chairman is also the accountable officer and therefore accountable to the NHS Commissioning Board for the consortium decisions. The Board has 5 GP members, while the chairman is directly elected by the GP body. The Executive Management Board is supported by a management team, lead by a chief operating officer.

The checks and balances in this system are provided by the Clinical Advisory Committee and Oversight Committee. The Clinical Advisory Committee provides wider clinical input, including other GP representatives, nursing, public health, consultant, SAS, social services, patient and public representation. This committee would also be responsible for the competency assessment process to appoint consortia board GPs. The board would have a duty to seek the advice of the Clinical Advisory Committee wherever relevant, to consult it on significant decisions, and to consider any challenges to its decisions made by the committee. However the Clinical Advisory Committee would have no power to make decisions itself or veto board decisions and the board would not be directly accountable to it. The committee could refer any serious concerns it had about board decisions to the Oversight Committee.

The Oversight Committee would assess any matters referred to it and scrutinize the work of the consortium board. It too would have no veto or decision-making responsibilities, but could formally pass any significant concerns to the NHS Commissioning Board. The Oversight Committee would be a streamlined, high calibre body, with an appointed membership. LMCs would have a statutory role on both the Clinical Advisory Committee and the Oversight Committee.

This example would require a large consortium, with a patient population above 500,000.

### **Example three**

*A shadow consortium Steering Group was formed to oversee the formation and election of a shadow consortium and Board. Representation on the Steering Group includes representatives from the area's localities, practice management, practice nursing, practice based commissioning executive, salaried GPs, sessional GPs, local PCT, GP Forum, Commissioning Executive Committee, and Local Medical Committee. The consortium agreed to work under the name "NHS [consortium's name] Consortium"*

*The consortium agreed that it should work with consortia colleagues in neighbouring areas to tackle shared issues, for example, where patients share pathways of care with the main secondary care providers.*

*Following establishment of the Steering Group, further consultation and education events were undertaken to ensure wide consultation of the entire GP community in the decisions made around formation of a consortium Board, governance and responsibilities.*

*Following consultation with all General Practices in the area and a ballot of all GP partners, salaried and sessional GPs, it was agreed that the consortium would be led by a democratically-elected Board. This Board would be made up of GPs and other health professionals representing a number of locality geographical areas in the area and other significant stakeholders. It would include one GP from each locality (agreed minimum of 5 partners and 2 salaried GPs on Board), one nurse representative, one practice manager, one allied health care professional, one representative from the Local Authority, one patient forum representative and the Chief Operating Officer. The Board will formally meet on a monthly basis.*

*The Board will be supported by the Managing Director, Borough Director, and Director of Finance of the Commissioning Support Unit (CSU).*

*Each Board member has delegated decision making authority and will be accountable to the electorate and the organisations where they are drawn from. Board members will be responsible for sharing developments with members of their respective Localities and, in turn, providing feedback from constituent General Practices to the Board. Board members will spend time supporting General Practice each week discussing commissioning issues (such as patient pathways, variations in referral patterns and utilisation of resources) as well a wider contract performance and service improvement. Board members will meet with constituent practices on a weekly basis.*