Deciding how to pay: remuneration for clinical commissioners

Key points

- From April 2013, clinical commissioning groups (CCGs) will be responsible and accountable for decisions about the remuneration of clinicians involved in CCG activity.
- CCG remuneration committees will have some complex decisions to take to ensure remuneration methods and rates are proportionate, fair and appropriate for recruiting and retaining high quality individuals.
- CCGs will need to be alert to reputational risks associated with the remuneration of clinicians for commissioning work, and must balance the needs for clinical leadership of commissioning activities and for continuity and stability in general practice.
- This Briefing suggests ten recommendations to help ensure transparency, fairness and sustainability.

As the new NHS commissioning system is established, many GPs and other healthcare professionals are taking on new roles and extended responsibilities as clinical commissioners. The remuneration arrangements that clinical commissioning groups (CCGs) agree will be one of a number of mechanisms for ensuring clinicians feel enabled, supported and motivated to get involved in CCG work. This Briefing is designed to support CCGs as they navigate the complexities of remuneration for clinical commissioners. It identifies key issues to be aware of and suggests ten recommendations to help ensure openness, fairness and sustainability.

Background

From April 2013, CCGs as independent statutory bodies will be locally accountable for agreeing the rates and methods of remuneration that will enable them to operate effectively.

Remuneration, as used in this Briefing, refers to the payment or compensation given to an individual for their work. For CCGs, such payments will have to be made to staff but also to members of the governing body, and a range of other ‘non-employed’ individuals involved in CCG activities. This will include lay people and specialist patient and professional representatives as well as clinicians, managers and other

Audience

- CCG members
- CCG chairs and accountable officers
- CCG chief operating officers and chief finance officers
- Other members of CCG governing bodies and remuneration committees
- LMC secretaries
- PCT cluster finance, HR and commissioning leads
healthcare workers from constituent member practices.

The CCG model of governance, leadership and delivery means that the remuneration arrangements may be more complex and varied than for other NHS organisations. Many of the clinicians who take on senior management roles within a CCG (for example, as chair or accountable officer) will do so on a part-time basis and combine their commissioning work with clinical practice within another organisation. Other individuals will make a regular contribution to a CCG as a member of the governing body or other committees. If a bottom-up, member-driven approach to the running of CCGs is to be realised, large numbers of people will also be undertaking ‘CCG work’ on an ad hoc or project basis.

The past experience of primary care trusts (PCTs), and recent media interest in this issue, have shown that the remuneration arrangements CCGs put in place will require careful consideration to ensure preparedness, openness, accountability and sustainability for the years ahead. This Briefing aims to support CCGs in establishing policies and procedures that are fit for purpose. Focusing on the remuneration of GPs and other primary care professionals based in CCG member practices, it includes four main sections that:

• clarify the nature of CCGs’ responsibilities and the need for openness in relation to remuneration decisions

• summarise lessons from the transitional arrangements as experienced by PCT clusters and emerging CCGs during 2012/13

• suggest ten recommendations to ensure transparent and sustainable arrangements

• compile a list of guidance and sources of useful information.

This Briefing does not cover the remuneration arrangements for PCT staff transferring to CCGs. For human resources guidance in this area, please see Clinical commissioning groups – HR guide.1

Changing responsibilities

The need to agree remuneration policies for individuals involved in NHS commissioning on a part-time, ad hoc or ‘non-employed’ basis is not new. PCTs have significant experience in managing this. To date, they have been responsible for the remuneration of clinical leads involved in practice-based commissioning, professional executive committees (PECs) and other local commissioning structures. Each PCT was required to have a remuneration committee which set local guidelines on the rates and types of payment awarded, with the strategic health authority (SHA) providing oversight on these payments to ensure regional consistency.

However, rates and payment arrangements have varied considerably across the country. Depending on individual and organisational circumstances and the nature of the contribution to commissioning activities, payments may have been made on hourly, sessional or prorata salaried rates, to the individuals themselves or to their employing or host organisation or partnership, and may or may not have included backfill and ‘on-costs’ (i.e. holiday pay, pension contributions and expenses, etc).

In particular, payment arrangements depend on the type of contract or other relationship the individual has with the paying authority, for example whether they are self-employed, are salaried on a PCT payroll, or treated as officers on payroll, i.e. without employment rights but hosted for tax and National Insurance purposes.

PCT clusters are now establishing transitional payment arrangements for clinical leads involved in emerging CCGs. These decisions are still being made through PCT remuneration committees, which will remain accountable for such decisions until 31 March 2013. However, while PCTs still hold this statutory responsibility they need to involve the leaders of the emerging CCGs to ensure the payment arrangements are acceptable and fit for purpose in the new system.

Local medical committees (LMCs), are also supporting local discussions and negotiations over remuneration arrangements. They can play an important brokerage role for practices, professionals, CCGs and PCTs, as well as providing practical advice on the affordability and acceptability of payments and the implications of different contractual arrangements.
New arrangements
The Health and Social Care Act 2012 legislates that remuneration decisions will be locally devolved in the new system. From April 2013, authorised CCGs will have the autonomy as statutory bodies to set their own rates of remuneration for senior leaders and executives, and each will have a remuneration committee as part of its governing body. NHS Commissioning Board Authority guidance states that remuneration committees will make recommendations on:

- decisions about pay and remuneration for employees of the CCG and people who provide services to the CCG
- allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

Decisions about remuneration should be informed by the Hutton fair pay principles, be locally accountable and have due regard for Her Majesty’s Revenue and Customs (HMRC) rules in regard to PAYE and taxation.

To support the principle of local determination, there is no detailed national guidance on the specific rates of payment that should be made for clinical or lay participation in CCG activity. However, the NHS Commissioning Board Authority has set out some high-level guidelines that CCGs may wish to consider for the remuneration of GP members of governing bodies (see box).

**Guidelines for the remuneration of GP members of governing bodies**

For GPs on a CCG governing body, the NHS Commissioning Board Authority suggests payments may either be made:

- to the practice and at a reasonable rate to that practice, in line with practice earnings; or
- at a rate which allows the practice to provide backfill, recognising that a locum cannot replace an experienced partner on a like for like basis, and that some additional locum time would be necessary; or
- to the individual in line with any sessional rate they already receive from local practices per session; or
- to the individual in line with local average sessional rates per session.

**The need for openness and balance**

Both now and in the future, the Government has promised greater transparency in terms of public sector spending. According to the current guidance for CCGs this will require them, as statutory bodies, to foster a culture of openness and publish financial statements, which should include the detail of remuneration payments and allowances. Any agreed remuneration will need to be presented in the context of a high-quality job specification and related performance management arrangements. Payments will need to be agreed transparently and fairly and be subject to public scrutiny.

In the NHS, remuneration policies should take account of the public sector principles for pay set out in the Hutton Fair Pay Review (2011), as outlined below.

- Remuneration should fairly reward each individual’s contribution to their organisation’s success and be sufficient to recruit and retain executives of sufficient calibre.
- Remuneration must be set through a process that is based on a consistent framework and independent decision making based on accurate assessment, weight and performance of roles.
- Remuneration is determined through a fair and transparent process through bodies that are independent of the executives whose pay is being set, and who are experienced in the field of remuneration.
- There is a coherent approach to senior pay across the organisation.

For emergent CCGs, remuneration will be a new and fairly complex area for decision making. They will need to ascertain rates that, in their particular local circumstances, will enable them to recruit and retain individuals of sufficiently high quality and with the right experience. However, CCGs may (individually or
collectively) risk some reputational damage if the public and/or media perceive payments they make to individuals to be too varied or disproportionately high in comparison to wider public sector pay. Such headlines can be perceived as additional costs to the NHS or suggest a lack of fairness in pay.

**Broad lessons from the transitional arrangements for CCG remuneration**

To gather insight into the payment arrangements being put in place across the country, the NHS Confederation asked a sample of its PCT cluster members and registered CCGs to volunteer details of their transitional and proposed ongoing remuneration policies for clinical commissioners. A number of LMC secretaries were also asked to give their views on the ways in which local decisions are being made. The examples set out in this Briefing are anonymised, but highlight some important observations and lessons to be aware of when managing locally determined payments.

**Local determination leads to variation.** Emerging CCGs and PCT clusters have a diverse spread in the types, rates and methods of payments they are currently making. In many cases, arrangements for shadow CCGs have been inherited or carried over from prior clinical commissioning arrangements such as practice-based commissioning groups.

In some cases, there are differences between the payment arrangements for different GP practices in the same CCG or cluster and it is not always clear what such payments cover, for example whether it is only direct payment for undertaking the responsibilities of the role, or also covers backfill costs, holiday pay, pension contribution, sick leave, etc.

Where there has been a process of standardisation, this has tended to involve agreeing to pay a consistent rate for all clinical leads of a particular profession (for example, all GPs) no matter what role they undertake within the CCG, rather than assessing the value of different types of roles and contributions. This raises questions about the rationale for differences between, and fairness in, payment between doctors and other health professionals such as nurses or practice managers holding similar CCG roles.

Individuals involved in this from both PCT clusters and CCGs recognise that commissioning groups will need to develop more sophisticated approaches and will rely on the scrutiny and review of their remuneration committees and the skills of their lay members to get this right. However, some of this will involve migrating a complex and diverse set of payment arrangements within their localities to something with more internal consistency.

While the governing bodies of CCGs will have responsibility for remuneration decisions, a practice-led approach to establishing appropriate and fair payments will be important to maintain a sense of local autonomy and build strong foundations for openness and trust among constituent practices.

Some CCG leads anticipate that the exposure of differences in rates and allowances may cause tension and difficulties, not just within a single CCG attempting to achieve internal standardisation, but also between neighbouring CCGs if different rates are agreed. CCGs in the same region or with similar profiles may benefit from working together to agree remuneration policies and will need to handle discussions and negotiations of these carefully.

**Different remuneration arrangements have different implications for tax status, superannuation and National Insurance.** PCT clusters have highlighted that certain payment arrangements may be problematic.

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**Case study: Variation within CCGs**

There are four CCGs in Area A, three of these are paying sessional rates and one is paying an hourly rate. Sessional payments are for four hours and include benefits (i.e. locum cover, holiday pay, expenses, pension contributions) but there are inconsistencies between practices in the number of hours that each considers a ‘session’ and specific benefits the payments cover. Each practice has a different payment agreement with their former PCT. The implications of this variance for CCGs and their constituents are that the payments can seem inconsistent or unfair. Going forward, CCGs will need to manage these variations and work with neighbouring CCGs and LMCs to support transparency.
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For the payee and/or payor in relation to HMRC rules. This tends to occur when a GP practice partner undertakes a CCG role and has their remuneration paid directly to their practice. From the perspective of HMRC, if a GP is considered to be providing a ‘regular service’ to the PCT/CCG they are entitled to be on the PCT payroll (either as an employee or as an “Officer”), which makes the PCT liable to pay employer National Insurance contributions, superannuation and apply PAYE deductions at the employed level.

CCGs will need to be aware that, if remuneration payments do not cover on-costs like National Insurance contributions and superannuation, they will be incurred by GP practices, putting them in a difficult financial position. Employment contracts and taxation are complex areas and CCG remuneration committees need to be aware of such issues in order to avoid potential penalties from the HMRC. Further guidance in relation to the above may be needed for CCGs in the future.

Case Study: Variation between CCGs

In Area B, there are three CCGs that have developed from three different practice-based commissioning groups. Each remunerates GPs at different sessional rates. These rates were agreed a while ago and are part of an inherited arrangement.

“Our CCG is on the lower sessional rate, and we don’t feel there is any need for the CCGs to pay differently considering the practice populations are very similar. We do not want to make this an issue and involve the LMC yet as it may cause some problems working with the other two CCGs going forward.”

CCG chief officer.

‘As GPs take on specific roles as chairs, accountable officers or executive members of CCGs, staffing levels and work plans within their practices are likely to change’

CCGs can consider ways of pre-empting this by identifying more sustainable local options. For example, one CCG has created a salaried GP scheme that provides a backfill service for practices whose GPs are involved in CCG work. This means practices can be more confident that their ‘locums’ are well informed, supported, and familiar with their procedures, and that costs will not increase unexpectedly, which creates flexibility and capacity in the workforce across the CCG.

Defining what should be remunerated as ‘CCG work’ may not be straightforward. A number of CCGs are looking for clarity on the remuneration of GPs without specific CCG roles who participate in activities outside of the CCG board or other core executive activities; for example, those attending events for or meetings of CCG member practices. One CCG highlighted that it was remunerating GP involvement in quarterly ‘member forum’ meetings and was concerned that there was no wider benchmark on the appropriateness of this. As a small CCG, the consequence
was that a significant proportion of their indicative operating costs were being used to support member engagement, causing concern about their ability to afford wider clinical input for specialist projects. This suggests CCGs will need to be clear about their priorities for constituent involvement and what they are prepared to remunerate.

**Guidance on salaries and remuneration rates for key ‘statutory’ roles would be welcomed.** Some CCGs felt they required specific support in developing the remuneration arrangements for secondary care specialists (nurses and doctors) involved in CCG work. There was some concern about general availability for CCG work and the affordability of the rates of payment for senior consultants. One suitable option could be to reimburse trusts for consultant time on a sessional or secondment basis rather than to pay a specific remunerative rate to the individual – this supports the payment of PAYE or other HMRC considerations as the time is contracted from the consultant’s employing organisation and also enables backfill, but could raise issues regarding perceived conflicts of interests.

CCGs and PCT clusters also suggested they were having difficulties deciding the overall pay structure for a number of salaried roles – including that of accountable officer and chief finance officer. Both CCGs and PCT clusters said they would welcome some national benchmarking on payment ranges as these roles need to be comparatively paid. They felt that such standardised rates could be for guidance only and be locally adapted to account for regional variation (i.e. London Weighting), the nature of the role and type of applicant.

The NHS Commissioning Board will be producing further information about remuneration in June 2012. This is likely to cover the payments for accountable officers, chief operating officers and chief finance officers only.

**Uncertainty during transition may be a barrier to engagement.** The new system is still being established, and some clinicians may be unwilling to put themselves forward for CCG work until there is greater certainty and stability. They may also want some security that if their CCG role does not work out they will have a practice position to return to. This makes succession planning difficult for both practices and CCGs at the moment. CCGs may need to build stronger assurances among general practice around the compensation and employment rights they provide to GPs who decide to step away from CCG roles or are voted out of office at some point in the future. For interim clinical leads who are currently being remunerated through PCT clusters for CCG work during transition, some clarity is also needed on how their redundancy from these roles should be managed if they are not appointed to lead roles in an established CCG.

**Case study: Adjusting employment contracts**

During transition, PCT cluster C has developed a special employment contract for GPs who are part of CCG governing bodies in its locality. The cluster established a statement of employment (a document which sets out employment terms) for GPs, ensuring they get the same level of remuneration as previously received for their involvement in commissioning work for the PCT. This allows the GPs to be paid via the PCT payroll and taxed at source.

After taking advice from the LMC, as well as consulting directly with GPs, this was identified as the best solution for transition. The willingness of GPs to take up these contracts depended on their personal circumstances – for some there were tax implications for their self-employed status around National Insurance and pension contributions – but early involvement of the LMC and accountants who supported the PCT cluster and GPs to understand the tax implications in some detail enabled agreement on a consistent approach for all the individuals involved.
currently have an opportunity to access and capture extensive advice and learning from PCT, and other, colleagues about transitional arrangements and assess how these can be developed and applied by fully established CCGs.

**Recommendations**

This *Briefing* suggests ten recommendations to support CCGs to navigate some of the complexities of remuneration arrangements for clinical commissioners. The headlines are below, with more detail on pages 8 and 9.

1. Take advice.
2. Get things set up now.
3. Secure the right skills.
4. Create a culture of openness and transparency.
5. Be clear about what you are paying for.
6. Be prepared to consult and negotiate.
7. Plan for sustainability.
8. Support clinical leads.
10. Be prepared to adapt.

**Outstanding questions**

In the process of developing this *Briefing* NHS Confederation members identified some outstanding questions that require further consideration.

- **Local determination versus fairness and consistency**
  According to the high-level principles for governing body payments, including local determination, remuneration can vary within, as well as between, CCGs. There is, however, some unease about how this sits alongside the principles for fairness outlined by the Hutton Fair Pay review. Is there enough clarity available for CCG remuneration committees to decide what constitutes fair and reasonable yet affordable pay, or would more guidance on this be helpful?

- **Remuneration for CCG constituents**
  With all general practices required to be members of CCGs, there are questions raised about what the most appropriate methods are for remunerating their involvement in commissioning activities. Over time, for example, would it be more appropriate to incorporate practice payments for engagement as part of a CCG within primary care contracts (i.e. general or primary medical service contracts) rather than providing remuneration from CCGs’ commissioning budgets?

- **The VAT liability for contracted GPs**
  While the provision of healthcare is generally exempt from VAT, many peripheral activities of GPs attract VAT at 20 per cent. Broadly speaking, VAT can apply to charges made for GP work carried out for the benefit of a third party as opposed to a patient, potentially making charges for population-based commissioning activities liable for VAT. LMCs have highlighted that they would welcome further guidance on this issue.

- **NHS Confederation viewpoint**
  The NHS is going through an intense period of change and CCGs will be under considerable public pressure to get their payment arrangements right.

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‘If CCGs are given early support on their remuneration arrangements they will be freed up to focus on commissioning improved outcomes and quality in patient care’

In producing this *Briefing*, the NHS Confederation advocates for practical support for CCGs with regard to remuneration both now and in the future. We believe that if CCGs are given early support on their remuneration arrangements they will be freed up to focus on commissioning improved outcomes and quality in patient care.

The NHS Confederation is always keen to receive feedback and to involve members and colleagues in our work. If you have any comments, ideas or reflections on the content of this *Briefing*, would like to discuss the issue in more detail, contribute to future work in this area or otherwise get involved, please contact Julie Das, Policy Manager (Commissioning) at julie.das@nhsconfed.org.
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Take advice
During the transitional year, work with your colleagues and partners (PCT cluster and SHA staff, local medical committees and other CCGs) to strengthen your plans for remuneration post April 2013. Take advice on the best processes, identify the risks, the tax implications (i.e. from the HMRC), the legislative requirements, and any lessons from existing remuneration committees. Within this, take advice on the best ways to respond to the public scrutiny of payments.

The changing responsibilities for CCG remuneration and the lessons from transitional arrangements suggest a need for good preparation and time for consultation and engagement with a range of constituents. To support this, the NHS Confederation has developed a list of ten recommendations for CCGs to increase the transparency, fairness and sustainability of remuneration arrangements.

**Ten recommendations for CCG remuneration**

1. **Take advice**
   During the transitional year, work with your colleagues and partners (PCT cluster and SHA staff, local medical committees and other CCGs) to strengthen your plans for remuneration post April 2013. Take advice on the best processes, identify the risks, the tax implications (i.e. from the HMRC), the legislative requirements, and any lessons from existing remuneration committees. Within this, take advice on the best ways to respond to the public scrutiny of payments.

2. **Get things set up now**
   Establish your remuneration sub-committee in shadow form early on during transition in order to set up its terms of reference – identifying its role, objectives, function and to be in a strong position to define and recruit the most appropriate and skilled members. (During transition, work with your PCT cluster remuneration committee, which remains accountable to 31 March 2013, as it will need to endorse your plans).

3. **Secure the right skills**
   Ensure that the lay members of your remuneration committee are truly independent, have the skills and background to provide a high level of scrutiny, review and judgement when agreeing payments.

4. **Create a culture of openness and transparency**
   Collaborate and communicate the remuneration rates you propose within your locality and amongst your CCG neighbours – specifically among GPs, lay members, GP practices, CCGs, salaried and locum GPs, secondary care providers and local medical committees to ensure fairness. Be open from the start to avoid reputational damage both inside and outside your locality.

5. **Be clear about what you are paying for**
   Remuneration is not just about covering backfill but also the payment for the duties within the role. Carefully detail what your payments are for, i.e. the specification of the role and its duties, who is entitled to it, what it covers, how it’s paid, and how it’s calculated. Be aware of the tax implications for individuals in the employment contracts you agree with clinical leads (i.e. especially for National Insurance and pension contributions).
Ten recommendations for CCG remuneration (continued)

6 **Be prepared to consult and negotiate**
Test and consult on the upper and lower limits for payments and work with your clinical leads, health professionals and local medical committees to understand what areas there are for flexibility. Encourage the development of alternative solutions if decisions cannot be reached.

7 **Plan for sustainability**
Think through the long-term implications of your remuneration arrangements for GPs, secondary care clinicians and their organisations. You may need to find the most suitable options for backfill in order to support substantial clinical involvement, i.e. salaried GP schemes with locum cover built in, recruiting specialist consultants and nurses through secondments.

8 **Support clinical leads**
Try to agree the reasonable participation of clinical leads in CCG activity early on to support the balance of time between CCG and practice commitments. Outline the anticipated time commitments, the needs of the role, and establish flexible working practices (i.e. virtual working for activity outside of the board, planning meeting dates up to one year in advance).

9 **Keep things simple**
To ensure your remuneration arrangements operate transparently, you may want to establish simple payment structures. Think about the applicability of flat, inclusive salaried rates across your governing body, or remuneration bands according to the skills of individuals you recruit.

10 **Be prepared to adapt**
As well as creating a culture of openness for payments you agree, it will also be beneficial to be open to the fact that you may not get your remuneration arrangements right in the first instance. Be prepared to let your arrangements settle and factor in time to make adjustments to get it right.
General guidance for CCGs on remuneration (as of May 2012)
NHS Commissioning Board Authority
All the documents below are available and updated on the NHS Commissioning Board website: www.commissioningboard.nhs.uk/resources/resources-for-ccgs

- Developing clinical commissioning groups: towards establishment (2012)
  Provides high-level guidance on the governance of CCGs and accountabilities for remuneration sub-committees.

- Clinical commissioning group governing body members: role outlines, attributes and skills (2012)
  On page 30 (draft dated April 2012) there are high-level principles relating to reimbursement and remuneration for governing body members.

- Best practice resource/practical toolkit – for the appointment of lay members to clinical commissioning groups.
  A tool to support the effective appointment of lay members.

- Clinical commissioning group governing body committees: terms of reference
  Includes a terms of reference template for CCG remuneration committees.

- Clinical commissioning groups – HR guide and frequently asked questions (2012)
  This guide provides practical advice about how CCGs can approach the main HR issues that they are likely to encounter as they become established, beginning with the senior appointments process, transfers of staff and remuneration.

Other guidance

- For tips on reputation management and the questions to ask more widely, see NHS Confederation (2009), Reputation management: a guide for boards. www.nhsconfed.org/Publications/reports/Pages/Reputation-management-guide.aspx

- To test your overall operating costs as a CCG when you have agreed your rates of remuneration, use the Department of Health’s Ready Reckoner tool. An upgraded version of the tool will be released in 2012. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129992

- For wider handbooks and guidance on arranging audit committees (points may be relevant for remuneration committees) see the Healthcare Finance Managers Association website. www.hfma.org.uk
Acknowledgements
The NHS Confederation would like to thank the following groups and individuals.

- All the PCT clusters, clinical commissioning groups and LMC secretaries that shared their insights and experiences for the content of this Briefing.

- Mike Walker, HR lead for clinical commissioning groups and commissioning support organisations, NHS Commissioning Board Authority.

- Anna Garrod, senior policy executive (NHS GP Division), the British Medical Association, for supporting access to LMC secretaries.

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