Briefing June 2015

Collaboration in clinical leadership

The role of secondary care doctors on CCG governing bodies

At the heart of clinical commissioning is the commitment to empower clinicians throughout the NHS. There is no better place to see the potential of clinicians working together than through the clinically-led conversations that are occurring across the country between clinical commissioning groups (CCGs) and their secondary care providers to drive service improvement and better outcomes for patients and populations. The secondary care doctor role on CCG governing bodies is one element of that empowerment process and can greatly support the wider objectives of CCGs.

NHS Clinical Commissioners (NHSCC) and the Royal College of Physicians (RCP) have developed this briefing to support members to understand the diverse ways that CCGs have harnessed the secondary care doctor role at a local level and make it work – recognising the limitations and making the most of the opportunity. By using a set of member case studies, we illustrate some of the challenges, opportunities and tips for making the role work.

Royal College of Physicians

NHS Clinical Commissioners
The independent collective voice of clinical commissioning groups

Introduction

The inclusion of the secondary care doctor role on CCG governing bodies was an important development in the evolution of clinical commissioning. It was seen as a key mechanism for strengthening the healthcare expertise that is held within a locality – bringing a collective clinical view on health and care and an understanding of patient care in the secondary care setting.[1]

Since 2012, the path to establishing the role has been varied among CCGs. From a CCG perspective, it took some time for these new roles to become established and some are still not fully embedded, particularly as the legislation that made the role a statutory part of the CCG governing body provided little specific guidance to CCGs on how the role should operate, leaving local areas to define the role for themselves. It also stipulated that secondary care doctors could not join a CCG governing body in the same local area as their main clinical practice – they had to come from outside the CCG's geographical constituency.

Similarly many secondary care doctors also described the challenge of balancing competing commitments: most continued to practise clinically, and many were involved in other senior leadership roles in their own provider trusts that placed further demands on their time away from the CCG.

Despite the practical challenges in the past two years, there are also some positive stories. From working to 'break down the barriers' between primary and secondary care, to leading audit and data analysis, there are examples of secondary care doctors and CCGs working together in a remarkably diverse range of ways.

NHS Clinical Commissioners (NHSCC) and the Royal College of Physicians (RCP) believe that the secondary care doctor role is one of many clinical roles that are critical in driving the shared ambitions of CCGs. For many CCGs, there are some points to consider to make the role work. We believe the benefits of effective joint working far outweigh some of the practical challenges of setting the role up. We have developed this joint briefing to support our members to understand the mutual benefit of harnessing the secondary care doctor role to meeting its full potential by supporting the wider ambitions of the CCG to deliver good care to our populations.

This briefing begins with a recap on the key elements of what the role can offer and our tips for making it work. We also include five case studies in this briefing to illustrate how a number of CCGs and their secondary care governing body members are working as partners.

Understanding the role

The NHS reforms introduced under the Health and Social Care Act (2012) established CCGs at the centre of local healthcare commissioning. These reforms also required CCGs to appoint clinical leaders to its governing body, including at least one secondary care doctor. This requirement meant that CCGs could draw on a wider pool of clinical expertise in shaping local services, helping to break down barriers between different parts of the local health economy. However, there were some limits set as the role could only be taken up by a secondary care doctor who usually worked outside of the CCG's local area. The inclusion of this role was, however, not meant to limit the CCGs access to local clinical expertise as this was also considered essential to success in transforming care pathways for local people.

Along with this new role came some flexibility, as CCGs were given the ability to shape how the secondary care role was delivered in their area. As a result, we've seen real diversity in the ways that CCGs and the secondary care doctors on their governing bodies are working together.

The case studies in this publication show a number of key themes.

A fresh perspective

Secondary care doctors are relative newcomers to the local commissioning landscape. This offers consultants the unique opportunity to bring a fresh perspective to CCGs, where they can help to challenge preconceived ideas about good practice and pose different questions that challenge conventional wisdom. Many of the case studies in this briefing show that CCGs have used their secondary care doctor role as a board non-executive role. Providing both critical challenge and insights into the realities of secondary care service delivery, this constructively critical approach has been a key way in which secondary care doctors have been able to make a real difference to the work of CCGs.

"The inclusion of the secondary care doctor role on CCG governing bodies was a key mechanism for strengthening the healthcare expertise that is held within a locality"

NHS Castlepoint and Rochford CCG: Having a respected view

"We therefore decided, as an organisation, that we needed to focus on the new role providing us with a strong strategic clinical perspective"

CCG view
Dr Michael Saad (Chair)

When we were first established as a CCG, this was a new role that was statutorily required to be part of the newly-established CCG board. The exact nature of their job description was very much open to interpretation. The resources that were made available, for this and other appointments, were extremely limited. We therefore decided, as an organisation, that we needed to focus on the new role providing us with a strong strategic clinical perspective. I'm aware that some CCGs see this role to be that of a medical director, but we do not.

Our secondary care doctor has been a very strong member of our board, highly respected by clinicians, lay members, and managers. Their views are always respected. We use them in our remuneration and procurement committee, interviewing for senior management, board-to-board meetings, social engagements and virtual meetings. I have personally sought their views on some major decisions I have had to make, and each time I haven't been disappointed with the honest and frank opinions.

Unfortunately, like all NHS work, the demands on the time of our secondary care doctor role far exceeds that they had originally committed to on contract. We will be needing more time this year, and we will be reviewing the contract. As one of the few CCGs taking on co-commissioning this year, we face new challenges around GP conflict of interests and good governance. We will again be requiring them to play a key role in helping to shape the CCG and guide us with our decision-making over a much greater range of services. This role is really vital to our board.

Writing this, I have thought back to when I applied for the position of secondary care doctor on Castle Point and Rochford CCG's governing body. I was asked at interview how I could enhance the CCG's work. Perhaps surprisingly my view has not changed; I have an interest in commissioning, ongoing experience in the acute sector and I think it is a privilege to be involved in commissioning for the people of Castle Point and Rochford CCG.

My role involves sharing responsibility for all aspects of the CCG's business and, as a secondary care specialist doctor, to bring a broader clinical view. I have a day a month for this activity, one session for reading the board papers and one to attend the board meeting. In reality I also am a member of the remuneration and procurement committee and have helped score 'any qualified provider' enhanced service applications.

This role demands frontline insight into secondary care services, and I was pleased to bring my experience regarding service redesign, clinical pathways and system reform to the strategic work of the CCG. For me, the most rewarding aspect of the role is the opportunity to bring an independent and strategic clinical perspective, like when I was asked to co-chair the joint clinical executive with a neighbouring CCG and when I was able to provide input to the appointment of a new accountable officer for Castle Point and Rochford CCG.

If I think I can add value to commissioning discussions and decisions then I have the confidence to make my views heard and make a difference to people in Castle Point and Rochford. It is reassuring to have my contributions valued by both my main employer and the CCG, and to have my role enhanced with requests by the CCG to take on wider strategic roles including sharing the responsibility of choosing the new accountable officer.

"My role involves sharing responsibility for all aspects of the CCG's business and, as a secondary care specialist doctor, to bring a broader clinical view"

Secondary care doctor view
Dr Rachael Liebmann

Shaping the role locally

The reforms that established CCGs as the lead commissioner in local health economies also established the secondary care doctor role as a statutory requirement on CCGs' governing bodies. Legislation and official guidance offered CCGs some flexibility in how they shaped this role locally, meaning that local areas have had the opportunity to make the secondary care doctor role work for their unique needs. This flexibility has resulted in significant diversity in the way secondary care doctors are delivering their roles in CCGs across England. While some are chairing their CCGs' commissioning sub-committee and delivering much of the commissioning leadership in their area, others are bringing a fresh perspective to audit or quality assurance, and others are in roles that focused wholly on their contribution to the governing body itself. Working hours reflected this variety, with some secondary care doctors contracting to deliver 48 hours of work for their CCG each month, while others CCGs contracted only four hours of secondary care doctors' time per month.

Working across geographical boundaries

CCGs are required to appoint secondary care doctors who usually work outside the local area. For CCGs and many secondary care doctors, this initially seemed like a barrier that prevented them from drawing on well-established networks of influence that they'd developed through their own provider trusts. After a few months in the role, however, most secondary care doctors started to describe the benefits of working outside their own locality. Many described being freed up from what could otherwise be some challenging conflicts of interest – an issue highlighted in one of our case studies. Working across geographical boundaries enables secondary care doctors to bring a truly fresh perspective, without a vested interest in the local providers where they practise clinically. Nonetheless, practical difficulties with this arrangement exist: CCGs struggle to recruit secondary care doctors from 'out of area', while secondary care doctors have described long travel times as a barrier to CCG work. The system will need to think creatively about how to overcome these challenges without undermining the fresh and objective thinking that secondary care doctors can bring.

"We have heard how CCGs have gained from consultants' first-hand experience of how secondary care services operate in practice. "

Breaking down barriers

We have heard how CCGs have gained from consultants' first-hand experience of how secondary care services operate in practice. Secondary care doctors have been able to advise CCGs on how to reach out to those who lead service delivery at the front line, how to make sense of data about hospitals and clinics, and how to break down barriers between commissioners and providers. Many have described the constructive challenge they've provided, helping to make sure that the aspirations of local commissioners make sense to those delivering services in provider trusts. The secondary care doctor role has not offered universal expertise on all fields of medical practice; it has been and continues to be much more – a practical insight into the realities of service delivery and a strategic insight into the opportunities for different parts of the system to work together.

Conflicts of interest

Secondary care doctors have highlighted how they've worked within their CCGs to manage conflicts of interest without compromising clinical involvement in the commissioning process. As secondary care doctors are prohibited from joining a CCG governing body if they also work in a provider trust in the same local area, they are usually the only doctor on the governing body not to work in clinical practice in the same area. Many have described how this unique position has enabled them to provide clinical leadership of CCG work when other clinical commissioners have been excluded from the process due to conflicts of interest that arise from their connections to local primary care. However, one of our case studies highlights how secondary care doctors can sometimes face their own challenges in managing personal conflicts of interest, particularly where circumstances mean their CCG responsibilities start to impact on their own employing provider trust.

Diversity

A key challenge for the system is the need to encourage a more representative spread of secondary care doctors to take on the opportunity to join CCG governing bodies. In particular, there is a relatively untapped pool of expertise among secondary care doctors at different stages of their consultant careers, as well as women doctors and black and minority ethnic doctors. While 32.5 per cent of doctors on the specialist register are female and 48 per cent are black, Asian and minority ethnic (BAME), these groups are significantly underrepresented in the current cohort of secondary care doctors on CCG governing bodies.[2]

NHS Leeds West CCG: Senior expertise and support

"The role brings both a wealth of individual experience and wisdom as well as a critical eye for detail"

CCG view
Dr Gordon Sinclair (Chair)

Our secondary care doctor has been a member of our governing body for two years and has been instrumental in supporting and developing Leeds West CCG as it has matured.

The secondary care role has three dimensions from my point of view:

- firstly as a "director" with joint responsibility to ensure the success of the organisation on behalf of the population we serve
- secondly as an "expert" in his field to support and advise the CCG
- thirdly as an independent advocate for our patients along with our other three lay members.

The role brings both a wealth of individual experience and wisdom as well as a critical eye for detail when understanding the nuances of decision-making around secondary care commissioning in particular. Assuring the quality of patient care is a key part of the role as with all our governing body members, and this role certainly brings the necessary challenge to our work.

As a recently retired senior clinician and medical director, this insight of understanding how clinicians behave and interact is really useful and can help balance the natural primary care bias that can emerge in GP-based clinical commission groups. He manages this contrast in a very considered and thought-out manner and makes a natural choice to chair our clinical commissioning committee, which is composed from all of our clinical leaders and acts as the "idea generator" for the CCG.

I took on this rewarding role after retirement from full-time work and am certain that my many years of knowledge of the services in Leeds, including time as medical director at Leeds Teaching Hospital, help me with understanding and networking between primary and secondary care – this is a real asset that secondary care doctors can offer to CCGs.

This role requires me to operate at a strategic level, which means that I chair a number of meetings and the most successful is our clinical commissioning committee, which meets monthly and brings together clinical leaders and the top management team. I believe our biggest achievement has been the development of GP locality working and an extended hours scheme for seven-day working – paid for by the CGG. This already looks like it has reduced pressure on emergency care this winter.

The secondary care doctor has a key role in quality assurance and governance of the CCG, as well as being an active member of the governing body. My previous board experience and background of leadership roles help make me have a bigger impact.

My role is not exclusively that of a non-executive; increasingly I am using my specialist skills and experience to support particular pieces of work. For me this is about helping excellent local GPs develop into first-class clinical leaders through mentorship, developmental workshops, and encouraging links with the FMLM.

The CCG feels much further on in its development compared with two years ago and we are now facing up to the difficult challenges of the NHS, around delivering high-quality, affordable care. We have a clear strategy based on health needs analysis and are beginning to tackle inequalities, as well as a focus on service change. We also have excellent public and patient engagement, which keeps us focused on what really matters.

Lastly, my involvement in meetings of my CCG's governing body and other committees means I have the opportunity to ensure the concerns of secondary care are represented in discussions and in emerging views about service delivery. I believe this is a very worthwhile job and would strongly encourage other physicians and doctors to get involved with these CCG roles.

"My role is not exclusively that of a non-executive; increasingly I am using my specialist skills and experience to support particular pieces of work"

Secondary care doctor view
Dr Peter Belfield

Making the role work: tips for CCGs and secondary care doctors

Set the scene for your new secondary care doctor

Among the current cohort, less than 50 per cent of secondary care doctors reported having had an induction and those who didn't described this as a real barrier to progress.[3] A clear induction process helps to make sure your secondary care doctor has the information they need to operate effectively. Knowing who's who at your CCG, how things are structured and what are the aspirations and vision of the CCG will empower this key governing body member to start making a difference from day one.

Be creative when recruiting

The secondary care doctor role on CCG governing bodies is a relatively new one that is still growing in profile, meaning that many skilled secondary care leaders are not aware of this opportunity to shape local commissioning. In addition, because CCGs can only appoint those secondary care doctors who usually work outside the CCG's local area, it makes recruitment to these roles even harder. A key challenge for CCGs will be to use creative approaches to recruit, drawing on examples of good practice in other areas, and making use of national clinical leadership networks, such as those hosted by the Faculty of Medical Leadership and Management (FMLM) or NHS England. In addition they will need to identify the unique features of the role – what specific skills they require and what those skills need to add to the CCG's wider objectives. Meanwhile, professional and membership bodies including NHSCC and the RCP are working to raise the profile of the secondary care doctor role as an important opportunity for clinical leadership in the commissioning system.

Agree your shared expectations

The flexibility of the secondary care doctor role means each CCG has the opportunity to determine how best this role can deliver for the unique needs of each local area. From leading major transformation programmes to bringing a fresh perspective to the governing body, there is significant diversity in the ways that secondary care doctors are adding value to CCGs' work. This variety and breadth makes it even more important that secondary care doctors and CCG leaders agree shared expectations, making clear how the secondary care clinical perspective can lever the greatest impact in each CCG, and establishing realistic boundaries around working arrangements (including contracted time).

Be realistic

As most secondary care doctors in this role are also committed to clinical work and other leadership roles in the NHS, it is important to be realistic about how much time can be committed to CCG governing body work. Secondary care doctors are encouraged to think carefully about how many CCGs they can support effectively at one time, particularly as some secondary care doctors are on the governing bodies of two, three, or even four different CCGs.

Reach out to a broader pool of expertise

The consultant workforce represents a wide pool of people with diverse experience but the breadth and depth of this expertise isn't being fully exploited. CCGs are encouraged to consider how they could reach out to a wider, more representative cross-section of consultants, particularly women, BME doctors, and doctors at an earlier stage in their consultant career. Secondary care doctors who are coming towards the end of their term of office should support their CCGs in reaching out to a diverse pool of candidates for their replacement. Recruitment practices, role expectations and organisational culture may need to be reviewed.

Forge and support networks

CCGs are encouraged to capitalise on the important networks that many secondary care doctors will bring from their experience as clinical leaders on the front line of delivering care. CCGs and their secondary care doctors are encouraged to work together to agree how best to make use of these networks. Likewise, secondary care doctors should reach out to their counterparts in CCGs across the country to draw on peer support, share learning, and identify good practice that they can bring to their CCG.

Think and act creatively

The inherent flexibility of the secondary care doctor role is an opportunity for commissioners to think creatively about how to get the best value from the consultant on their governing body. Secondary care doctors can make a difference to local commissioning in any number of ways – from a fresh pair of eyes that can bring challenging questions to governing body meetings, to an expert in the realities of service delivery, to a new perspective on quality assurance or data. CCGs are encouraged to think creatively about how to make the most of the unique skills and expertise that secondary care doctors can bring.

Take part

The secondary care doctor role can be hugely rewarding. It offers clinical leaders new opportunities to help shape local healthcare for the better. It also offers new challenges for secondary care doctors to grow their leadership and influence across the system – from negotiating governing body meetings to getting to grips with the terminology of commissioning. Secondary care doctors of all specialties can not only have a real impact as a CCG governing body member, they can gain much from their experiences too, so why not take part?

NHS West Hampshire CCG: Bringing internal challenge and steer

"The perspective the role can bring to a board meeting is useful – it can challenge preconceived ideas about acute hospitals and enables effective debate"

CCG view
Dr Sarah Schofield (Chair)

The role of the secondary care doctor on CCG boards was not clearly defined at the outset of the reforms, but with two years since its inception it has become increasingly apparent the important role our secondary care colleagues can make to the commissioning agenda.

The perspective the role can bring to a board meeting is useful – it can challenge preconceived ideas about acute hospitals and enables effective debate. Understanding how important it is for all those involved in caring for patients to continually seek ways of working together, the secondary care consultant can help to build local relationships and aid the development of the clinical community; they can work with GP leads and commissioning teams in their negotiations with trusts to help unlock the 'sticky' problems. The consultant is an asset to the wider CCG team in bringing experience into the heart of the organisation.

I have greatly valued my experience as secondary care consultant on a CCG. It now seems so obvious that CCGs should have secondary care input at a strategic level and I hope secondary care organisations soon recognise how much they would benefit from the reciprocal involvement of primary care professionals in their decision-making and governance.

I sought the role to be part of an exciting new opportunity to take clinical leadership seriously and to fulfil a career-long dream of seeing closer working between primary and secondary care. While I endorse putting GPs in the driving seat, commissioning is not a transactional process – it requires mature dialogue between experts in all aspects of care and patients.

Having retired from clinical practice I am allowed to work in my old patch with people I have long respected. That gives the advantage of a knowledge of the geography, history and people (I had been a medical director more than once) but I also had some initial uncertainties about whether I could shake off my inevitable affiliation to the organisation I worked in for 25 years and about how I could remain relevant after having not practised clinically for five years. Two years later, I see that the latter has helped to stop me from considering myself an expert in any one specialist clinical field and instead empowered me to bring the broad secondary care perspective. I recognise that neither I nor any other secondary care doctor could be an expert in 60-plus clinical specialties – and that isn't what we're needed for. I appreciate that I am not exposed day-to-day to the considerable contemporary pressures in secondary care, but I can bring first-hand insight into the culture, practices and idiosyncrasies of secondary care – it is this insight that is central to the secondary care doctor role.

Governance and leadership are also key demands of the role. I hope that my experience as a clinical leader within and outwith secondary care means I have contributed to the CCG's clinical governance, having been a member of a number of boards and further hope I have helped with assurance and the interpretation of quality metrics. Applying the appropriate, useful challenge to competent executives is a tricky balance; assurance is not binary despite the beliefs of some external forces!

Overall it has been a very positive experience for me but, more importantly, has it been so for the CCG? My most powerful observation is the glaringly obvious value of bringing knowledge of all relevant sectors to strategic decision-making in the NHS, and why only in commissioning? Has it really taken 60 years to acknowledge that, and how are we to ensure that we build on this in the inevitable changes the future will bring?

"Commissioning is not a transactional process – it requires mature dialogue between experts in all aspects of care and patients"

Secondary care doctor view
Mr Peter Lees

NHS North Somerset CCG: Clinical leadership and local insight from secondary care

"It has been helpful to have the external challenge from another clinician with a different perspective"

CCG view
Dr Mary Backhouse (Chief clinical officer)

The secondary care clinician position on the CCG governing body was an opportunity to bring a different clinical perspective and understanding. Our secondary care doctor brought his experience as a senior hospital clinician as well as a consultant orthopaedic surgeon. A number of members of the governing body were new to board work and so people have developed together. It has been helpful to have the external challenge from another clinician with a different perspective. As a CCG we commission from three acute hospitals and it has been very helpful to have challenge on areas of poor performance by someone who understands the internal functioning of a hospital and how things can be delivered well.

Over the two years it was great to see our colleague develop their understanding of the needs of our population and the function of commissioning. We wish them well on the next stage of their clinical leadership journey.

I applied for this position in early 2013 for two reasons. Firstly, I wished to provide a hospital-based perspective to help the CCG address local challenges. In particular, some local trusts found their small size made it financially and clinically difficult to provide cost-effective care for its resident population. Secondly, I had recently finished a six-year period of clinical leadership in Taunton and I was looking for the next leadership challenge for me to pursue alongside my full-time clinical workload as a consultant orthopaedic surgeon.

I am very pleased to have taken on this role and inevitably there have been highlights and challenges during my two years in post. It has been very refreshing to be taken out of my usual environment and enjoy the new challenge of governing body meetings with a variety of clinical and managerial staff. These meetings are held in open session and in the initial stages it was a steep learning curve to see members of the public sharing forceful opinions and feeling aggrieved about some of the decision-making made by the previous primary care trust that pre-dated the CCG.

This role requires the ability to bring a fresh perspective and a willingness to challenge. I've been able to offer a unique perspective as a hospital clinician, meaning I could provide scrutiny and challenge to the metrics provided by the various hospital providers; this is a key element for many secondary care doctors on CCG governing bodies.

There have been unexpected challenges too. Managing conflicts of interest is a central part of this role, but it became a much larger issue for me in my position than I initially thought – and in unexpected ways. Weston Hospital's future was a main agenda item for the CCG and, as I worked for a nearby hospital trust that competes with some of the small hospitals in North Somerset, I had to accept that a principal aim of mine – to help with the sustainability of local providers – would be impossible. Unfortunately this conflict ultimately brought my role to a premature end and while I would wholeheartedly recommend this type of role to other hospital consultants, I feel I could have achieved even more if I hadn't been serving a CCG in the immediate vicinity of my own hospital trust. This is perhaps why it is so valuable that CCGs must appoint secondary care doctors from outside the local area.

"This role requires the ability to bring a fresh perspective and a willingness to challenge"

Secondary care doctor view
Mr Andrew Clarke

NHS Rotherham CCG: Enhanced decision-making

"The secondary care doctor also ensures that the governing body is well informed when making judgements around acute provider quality issues"

CCG view
Chris Edwards (Chief officer)

At NHS Rotherham CCG all key decisions are led by clinicians. Our 150 GPs have great insight into the needs of the population and how patient pathways operate from a patient perspective. Our secondary care doctor further enhances the quality of decision-making by ensuring that all key decisions take into account the perspective of a hospital clinician. Our secondary care doctor helps our governing body understand the culture and complexities of acute hospital services and their input ensures a clinical perspective across the whole patient pathway underpins all key decisions.

The secondary care doctor also ensures that the governing body is well informed when making judgements around acute provider quality issues. The CCG is also better placed to support and challenge acute providers to provide the best possible acute services for Rotherham patients.

Two and a half years into my role, I would like to feel I have made some difference to what my CCG has achieved. I constructively challenged my colleagues on whether our decisions and actions are in the best interests of the people we serve. I asked for assurance that the information we receive is valid, accurate and applicable, especially that regarding the secondary care setting. And I actively looked for the missing information and assurance (which can be tricky!). Overall, I feel I brought an outside perspective to the governing body, being those fresh set of eyes and helping to bring in new ideas and perspectives.

It took a little while to understand that, as well as taking on all the roles of a board member, I was there to offer a secondary care perspective to the board and not be the sole voice of the entire local secondary care landscape. This is key to the secondary care doctor role in general.

I am now stepping down from my CCG role after 28 months in post, so what have I learnt? The role has exposed me to the way that different parts of the health service operate, so I've learnt a lot about how the NHS works. I have greater respect, sympathy and understanding of the impossible task the GPs have to deliver. I've seen how a good management system works, how a well-run meeting should look and how to contribute constructively to a change process. As my role requires me to bring a different perspective, I've learnt how to challenge where appropriate, how to positively encourage major developments and how to contribute in a small way towards the success of this top-performing CCG. And I've even had an opportunity to work on developing a national network for doctors in the secondary care doctor role on CCG governing bodies.

Why then am I stepping down? I believe the greatest value comes when the secondary care doctor can be that fresh set of eyes. For me, after two years or so in post that becomes more difficult. Practically, as this role is a part-time one, managing my time was extremely difficult, particularly as my role within my own trust has developed and expanded.

Is this an important role? Absolutely. Done well, this role gives the CCG the invaluable asset: an external clinical supportive challenge. The secondary care doctor gets a unique opportunity in their development, giving them a real working insight into the commissioning process and primary care. This is a real opportunity to make a real difference.

The CCGs can and do work really well for the NHS, so why not be part of it?

"The CCGs can and do work really well for the NHS, so why not be part of it?"

Secondary care doctor view
Dr Harry Ashurst

A note on the development of this briefing

This briefing is developed from case study research by NHSCC and the RCP (conducted in early 2015) and builds on joint work led by the RCP and FMLM in 2014 to delve deeper into the secondary care doctor role on CCG governing bodies. Through surveys, workshops and one-to-one engagement with the first cohort of clinical leaders in the secondary care doctor role on CCG governing bodies, this work explored what this new role meant in practice. We heard countless stories about the hugely varied ways in which secondary care doctors are making their mark nationwide and how local commissioners can support them to achieve an even greater impact for patients and health services in their patch.

References

1. NHS Commissioning Board (now NHS England) CCG governing body members: Role outlines, attributes and skills **www.england.nhs.uk/wp-content/uploads/2012/09/ccg-members-roles.pdf**
2. GMC specialist register April 2015, **www.gmc-uk.org/doctors/register/search_stats.asp (Accessed 29 April 2015)**
3. Unpublished survey of secondary care doctors on CCG governing bodies conducted by the RCP and FMLM, October 2013.

Further information

- NHS England guidance on CCG governing body membership and roles: **www.england.nhs.uk/wp-content/uploads/2012/09/ccg-members-roles.pdf**
- BMA guidance on how consultant doctors can get involved in commissioning: **www.bma.org.uk/practical-support-at-work/commissioning/consultants-how-to-get-involved**
- Faculty of Medical Leadership and Management: **www.fmlm.ac.uk**
- NHS England Learning Environment: **www.learnenv.england.nhs.uk**
- NHS Clinical Commissioners: **www.nhscc.org**
- Royal College of Physicians: **www.rcplondon.ac.uk**

Share your views with us

NHSCC and the RCP would be keen to hear any member views on the examples and points raised in this briefing. Please contact us at **office@nhscc.org**

Acknowledgements

NHSCC would like to thank the following individuals for their case studies for this briefing:

Castle Point and Rochford CCG

- Dr Michael Saad, chair
- Dr Rachael Liebmann, secondary care doctor

Leeds West CCG

- Dr Gordon Sinclair, chair
- Dr Peter Belfield, secondary care doctor

North Somerset CCG

- Dr Mary Backhouse, chief clinical officer
- Mr Andrew Clarke

Rotherham CCG

- Chris Edwards, chief officer
- Dr Harry Ashurst, secondary care doctor

West Hampshire CCG

- Dr Sarah Schofield, chair
- Mr Peter Lees, secondary care doctor

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Notes

NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice from the front line to the wider NHS, national bodies, Government, Parliament and the media. We're building new networks where they can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.

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