# Discussion paper on the post of Primary Care Network Clinical Director

## March 2019

**Draft 2**

**Introduction**

The paper "Investment and Evolution", produced jointly by NHS England and the BMA, gives an introduction to the role of Primary care Network (PCN) Clinical Director (CD) and focuses mainly on the timescales for appointment and resources available. The BMA's PCN Handbook has more information on the Clinical Director role and this document is intended to support practices locally to make practical decisions on how practices can appoint their CDs.

This is an attempt to assist PCNs in acquiring a Clinical Director and to give guidance on good practice rather than a strict set of rules that can be imposed. It is for practices to name their CD and whilst assistance from CCGs and LMC may be regarded as positive, it is practices who will form each PCN and practices need to support and trust their Clinical Director.

**Constraints on Implementation and possible short term solutions**

The biggest problem for developing PCNs is that member practices need to agree their membership, ensure this "fits" with the wider CCG geographic boundaries, and then name a CD by May 15th. The need to fit with the overall CCG picture is because all practice populations must be included within a PCN and therefore a group of practices whose formation into a PCN would isolate or exclude a neighbouring practice or practices is unlikely to be able to register with the CCG.

**The process of naming a Clinical Director must be led by member practices. Whilst the BMA recommendation is that the CD should be a GP from within the PCN, it is up to the PCN to make that decision and the Director could be another clinician or someone from outside the area of the Network.**

**Some scenarios:**

Where practices are already working as a locality and wish to register as a PCN they may wish to retain their current clinical lead as an Interim CD and delay any formal process for 6 to 12 months. See below under "Acclamation".

Neighbouring PCNs could share a single CD although care should be taken not to lose the advantages of close relationships between the CD as spokesperson for the network and member practices and their community. The typical size of 30-50,000 citizens is effective partly because it allows relationships to develop over an effective area.

There is no reason why the CD position could not be a job share. There does have to be an "accountable" CD therefore it will not be acceptable, for example, for every practice to undertake part of the role.

Helpful CCGs may wish to encourage the appointment of current "CCG" GP leaders, such as current or former CCG Board members. In many cases this may seem a positive initiative but great care should be exercised in avoiding the hurried appointment of the same or usual faces. PCNs are an entirely new form of GP alignment and encouraging a new kind of leader, possibly one with no baggage or conflicts of interests, might be a signal to all GPs and practices that this is a real change.

**Possible Appointment processes**

**Election**

This method often appeals to GPs' democratic instincts and there is something to be said for a CD to have the confirmed backing of the practices. The issues this raises however are:

This tends to favour current or established GPs and acts against the development of new leaders. A new type of leadership might be what a PCN needs since it is a new type of organisation.

Establishing the basis of any election is complex. Is it one vote per practice, per GP, per population block etc.? Does it include partners, salaried GPs or all GPs? Is it just to include GPs? Do part time GPs have less influence?

Who will run the election? The LMC is the likely organisation, but will it insist on one common methodology covering the points above?

**The simplest election format would be one vote per member practice. This could be managed internally by the PCN, although outside scrutiny would be preferable.**

**Selection**

The CD is an operational role which requires particular skills and attributes. A selection process, led by practices is therefore one logical means towards appointing the most suitable person. This also has its issues:

How to ensure the best candidates apply. This applies to both election and selection but selection may discourage some clinicians unused to such a process.

Who selects or short lists and by what criteria?

Who is on the interview panel? Practice representatives, but form which practices, external members such as CCG or LMC?

**Acclamation**

In some areas there may already be a GP clinical lead covering the proposed PCN area. Practices might agree informally to appoint this GP as their CD. Such a decision might be useful in the short term but it could introduce future problems as it omits the establishment of a reliable governance and appointment process.

In these circumstances it would be advisable to make such an appointment interim and subject to a more formal process within 12 months.

Whichever method that the Network decides to utilise, it is highly recommended that appropriately robust governance procedures are put into place. This will ensure that the individual appointed to the role has the support of the Network membership and that the process would pass scrutiny in terms of due diligence. This is essential because decisions will be made on the use of public funds by CDs on behalf of PCNs. The role profile for the Clinical Director is included in the contract document and outlines the responsibilities. The Clinical Director must know and understand the practices of the Network, in order to provide the appropriate leadership required to establish and develop a successful Network.

Consideration will need to be given as to how the funding provided for the Clinical Director role is used. This could be provided to the Clinical Director directly as a form of remuneration, or if the Clinical Director is a partner or employee of a member practice, it may be provided to that practice in order to fund the necessary backfill to cover the absence of the individual from their practice role whilst undertaking their PCN duties.

In selecting an individual for the Clinical Director role, the following responsibilities of the role should be considered:

1. Developing relationships and work closely with other PCN Clinical Directors, Local Medical Committees (LMCs), local commissioners and clinical leaders of other health and social care providers
2. Working collaboratively with other PCN Clinical Directors, playing a critical role in helping to ensure full engagement of primary care in developing and implementing local system plans.
3. Providing strategic and clinical leadership to the PCN, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices
4. Providing strategic leadership for workforce development through assessment of clinical skill-mix and development of a PCN workforce strategy
5. Supporting PCN implementation of agreed service changes and pathways and work closely with member practices and the commissioner and other networks to develop, support and deliver local improvement programmes aligned to national priorities
6. Developing local initiatives that enable delivery of the PCN's agenda by working with commissioners and other networks to meet local needs and ensure comprehensive coordination

It should also be noted that whilst there is no requirement for a Clinical Director to be appointed from within the Network, we would recommend that the first option should be to consider an appointment from within. Some practices may wish to recruit externally for someone to specifically take on this role in the long term. Due to the need to be able to get various aspects of the Network up and running within a relatively short space of time however, it is strongly recommended that, at least initially, it remains an internal appointment.