Moving Towards Accountable Care - *Developing an Effective Clinical Leadership Model*

This thought leadership article seeks to explore one of the most critical enablers of accountable care: **Clinical Leadership**. It highlights key factors that need to be considered to develop effective clinical leadership in an effort to aid health and care leaders build their 'blueprint' for accountable care.

The Move Towards Accountable Care

Accountable care is rapidly becoming the 'buzz' word in the NHS - an umbrella term that incorporates the national direction of travel set out in the Five Year Forward View towards New Models of Care. Although proposed models such as Multi-Speciality Community Providers and Primary and Acute Care Systems differ in scale and scope, they ultimately aim to achieve the same end goal - establishing a network of providers (or potentially a new provider organisation) who are jointly accountable for the care provision and health outcomes of a prospectively defined population over a period of time and for an agreed cost under a contractual arrangement. These can synonymously be referred to as models of 'accountable care'.

Accountable care is being proclaimed as the 'silver bullet' that has the potential to solve the financial challenges facing the NHS and to address the ongoing pressure on maintaining or improving the quality of care. Although evidence is gathering in England – both organically through the evolution of health and care systems and through the national Vanguard programme – the jury is still out on whether they will deliver what is needed quick enough to turn around the proverbial oil tanker that the NHS has become.

Although much can be learnt from the international experience of accountable care, with examples of best practice from the likes of Alzira, Kaiser Permanente, CareMore and Canterbury, some words of caution must be raised. The timescales to develop these high performing systems are long, with many having taken years if not decades to develop, often with significant setbacks along the way. In the early years, many organisations are able to realise quality improvements, however implementing cost savings can be more difficult to achieve. Although these transformative care models have the potential to deliver better outcomes at lower cost, their adoption in England needs to recognise the environmental differences of where these models have been successful. For example, differences around the political acceptability of public and private partnerships, the variation of national involvement in setting of local strategy, payment at point of care and flexibilities to develop innovative contractual payment mechanisms.

Enablers of Accountable Care

- A compelling vision and strategy that is owned at all levels within individual organisations and the wider system
- Effective managerial and clinical leadership
- Transparent and robust governance that drives improvements in quality of care for the individual and populations
- Innovative contracting and payment models that incentivise a population health model of care to address both health and wellbeing needs
- Tailored/targeted disease management programmes with integrated care provision that emphasise prevention and low level interventions
- Effective performance management systems linked to payment models at an organisation, team and individual level
- Empowered patients and communities who build community capacity and support each other and themselves in their health and wellbeing
- Advanced Information systems that support information sharing and greater collaboration for the benefit of the patient
- Cutting-edge technology to support care closer to home and the self-management agendas
- Business intelligence to support population stratification and advanced economic and financial modelling
- Investment in workforce development and a culture of shared leadership and continuous improvement

The key enablers of accountable care are well rehearsed and a rapid review of literature and the emerging feedback from the Vanguards highlights the most significant ones (see above). The enabler that we believe has the least traction in the NHS, is the most vital and complex to develop and underpins many of the others, is 'Clinical Leadership'. Only through committed and effective clinical leaders aligned to the organisations' strategy can clinical, operational and financial integration/alignment occur to achieve the goals of improving the quality of care, patient outcomes and financial results.

Defining Clinical Leadership

Clinical Leadership within the NHS has been defined as "to motivate, inspire, and promote NHS values, to empower and create a consistent focus on the needs of the patients being served. Leadership is not just to maintain high standards of care, but to transform services to achieve even higher levels of excellence".[1] Although the concept of clinical leadership is a relatively new one – its history rooted in nursing where staff took up managerial roles – it has now broadened to encompass anyone with a clinical background holding a leadership position. This is typically the case in provider organisations. However when translated into a commissioning environment, clinical leadership still predominantly rests in the hands of General Practitioners. Although this enables CCGs to fulfil their constitutional requirements as member organisations, this is not necessarily ideal as there is considerable value in employing more diverse clinical leadership in the commissioning cycle and decision making processes.

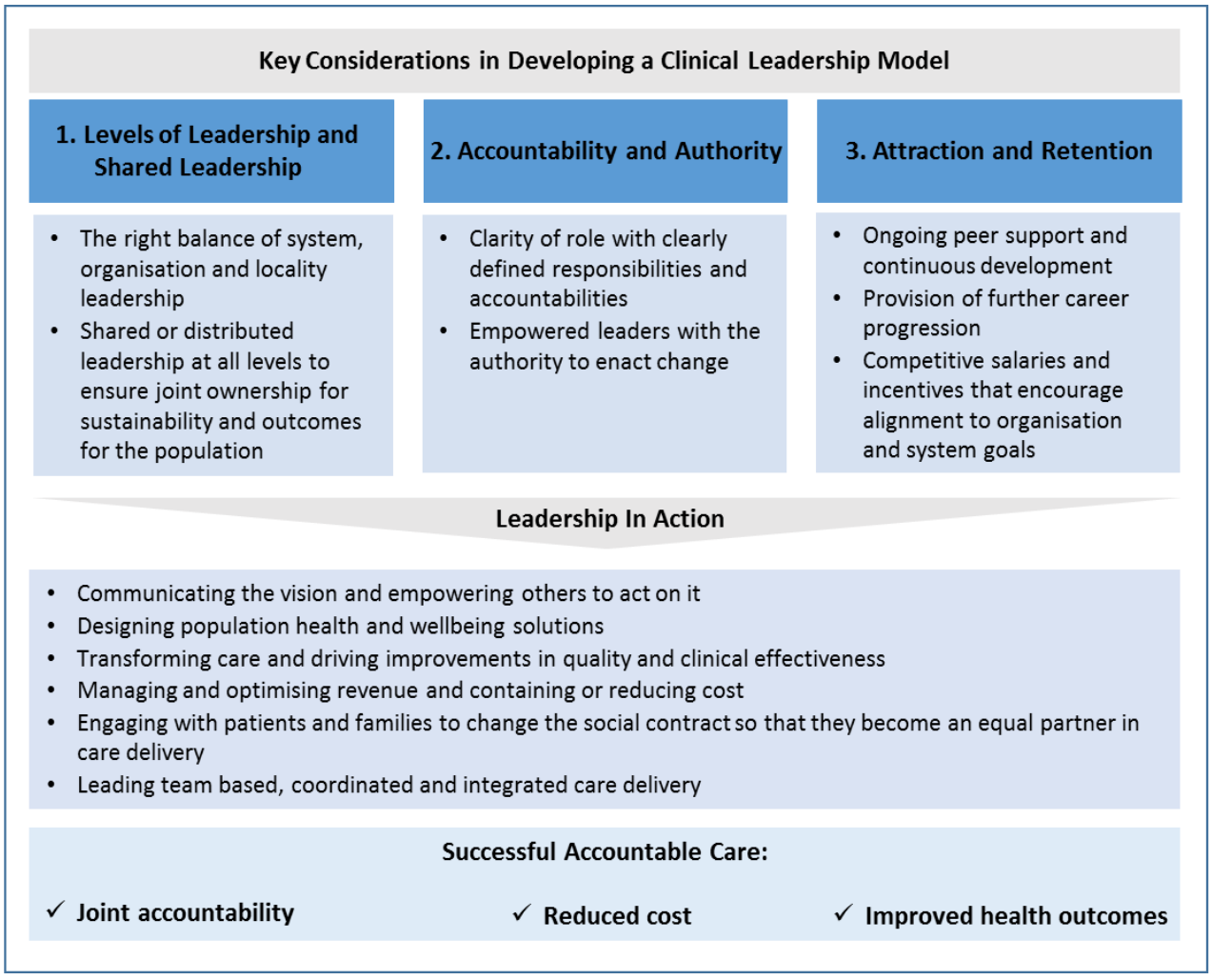
The definition helps to point us in the direction of the key factors that need to be considered to develop effective clinical leadership, both at an organisational and ever more importantly at a system level. With the advent of Sustainability and Transformation Plans (STPs), the requirement for effective leaders who possess the two distinct and interrelated attributes that make up a system leader is becoming increasingly important - ''i) collaborative and ii)cross boundaries – organisational, professional and virtual, therefore extending leaders beyond the usual limits of their responsibilities and authorities''.[2]

The following sections explore three key factors to be considered when designing the Clinical Leadership element of a Blueprint for accountable care:

1. Levels of Leadership and Developing Shared Leadership

In designing a clinical leadership model that supports transition to or delivery of accountable care, it is critical to consider the levels at which leadership needs to exist and the informal requirement for leadership.

Levels of Leadership - balancing system, organisation and locality level clinical leadership will be critical as accountable care is designed around a designated population, often within a defined geography.



[1] Department of Health (DH). *Our NHS, Our Future*: NHS Next Stage Interim Report. London: HMSO Cmnd; 2007

[2] http://www.leadershipacademy.nhs.uk/about/systems-leadership/

Clinicians play a critical role in the development and embedment of the vision, empowering others to act on it and working with partner organisations in a coalition, fostering strategic alliances.

They also play a vital leadership role in developing and implementing scalable models of care that integrate provision across organisational boundaries and settings to address the needs of the population and in developing the infrastructure and capabilities to support accountable care.

Ultimately, sustainable changes in ways of working will only be achieved by winning the hearts and minds of those delivering care. This is especially critical during transition when transforming primary care, so that it operates at scale acting with one voice as an equal partner in healthcare provision.

In developing leadership at all levels, consideration also needs to be made of the shadow system that operates – as in "every legitimate, official or consciously designed system (which is intended to be and is supposedly rational) there is a shadow system. The shadow system is where all the non-rational issues reside; e.g. politics, trust, hopes, ambitions, greed, favours, power struggles".[3]

Shared Clinical Leadership - alongside vertical leadership, shared or distributed clinical leadership at all levels within a system will be vital for accountable care to be effective. This will ensure joint ownership for the success and sustainability of the organisation or system and the outcomes for the population. This reflects how different members involved in team-based delivery exercise a leadership function whenever their area of expertise is needed, both clinically and in their broader contribution to quality improvement.

Clinicians also play a vital role in advocating for patients and in activating/engaging with them to re-balance the conversation/'social contract', so that they become an equal member of the care delivery team and take greater ownership for their own health and wellbeing.

> *"By the end of this Parliament we will have a million more over 70s, one third of them living alone. Yes the health and social care system must do a much better job of looking after them. But so too must all of us as citizens as well…..The best person to prevent a long term condition developing is not the doctor – it's you" (Jeremy Hunt, Speech to the Local Government Association annual conference, 2015)*

Shared leadership can be developed and nurtured in various ways including formal leadership training and coaching support for team members and investment in culture and behavioural change through developing a shared purpose for the team, a common view about how leadership should be engrained in day to day activities and ensuring transparency of team member objectives.

2. Attraction and Retention

There is an extensive list of barriers to clinicians embracing clinical leadership. These include: remuneration in comparison to undertaking clinical practice; perception by their peers; and challenges in balancing practice and a leadership role. So how do NHS organisations ensure that they attract the best and then retain them?

Peer Support and Continuous Development - anecdotal evidence suggests that clinicians can feel isolated and unsupported in their role. It is critical that peer support is built into leadership roles and that there is ongoing investment in their continuous development to enable them to undertake their role effectively. Central to this will be the development of strong commercial acumen and their ability to effectively influence and engage, leveraging their unique position to be able to effect colleagues and embed shared accountability for performance, financial results and most importantly patient outcomes. Providing training and development that addresses any gaps in skills and competencies when assessed against a credible leadership skills framework such as 'Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services' will make the role both attractive and supports getting the most out of leaders.

Career Progression – providing a career pathway needs careful consideration. Although historically advancement has been relatively limited, the breadth of opportunity is widening as the accountable care agenda and STPs evolve. Roles are required at multiple levels and across organisational and geographical boundaries – not only clinical leadership at board level in commissioning and provider organisations but also at a regional, city and locality level and across commissioners and providers supporting broader collaboration and system integration.

Remuneration - from first-hand experience in the NHS, pay and incentivisation is a sensitive topic, a word that clients do not wish to explore. This has been a key enabler in successful Accountable Care Organisations at both leadership and operational levels. With the evolution of accountable care, serious consideration should be given to competitive salaries and individual incentives that encourage clinical leadership alignment to

[3] Extract from Chapter 12 'Leadership and Systems' in The Search for Leadership: An Organisational Perspective, Triarchy Press

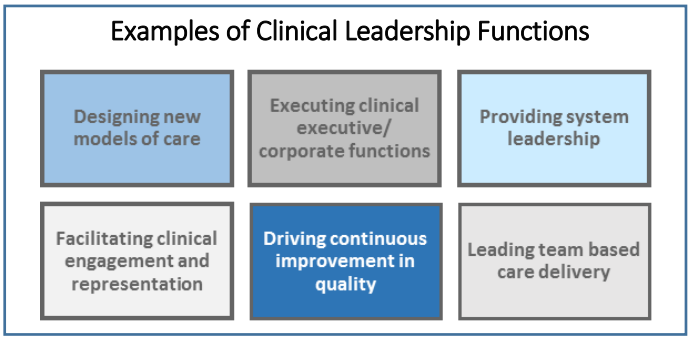
organisation and system goals, both in a commissioning and provider environment.

3. Accountability and Authority

Without a formal structure, there is no yardstick to assess whether the organisation or system is getting value for money and if leaders are effectively fulfilling their responsibilities. From experience, this is especially evident in the commissioning arena. Often roles are broad or ill-defined, with clinicians having endless autonomy but limited authority and accountability, and where there are unclear divisions between commissioning managers. This plays out through a lack of clarity about who should be providing direction and also clinicians feeling uncomfortable in challenging commissioning decisions. Coupled with over-bureaucratic governance and lengthy decision making, this can result in challenges to effectively engage with clinical leaders in commissioning decisions and in some circumstances results in leaders becoming disenfranchised with their role.

Accountability - roles should have clearly defined accountabilities, responsibilities and authority whilst avoiding being too broad to risk leaders having insufficient time to do their job. These need to be set within a formal performance management framework as is the case for all other employees, where regular coaching and feedback is provided to support and reinforce desired behaviours.

Authority - empowering clinical leaders with the authority to enact change will help maintain their energy and enthusiasm and embed a sense of ownership and worth. This will result in making them more effective in fulfilling their roles.



Take Time to Design the Right Model

Designing an effective clinical leadership model that supports both transition and a long-term model of accountable care is multifaceted. The above narrative seeks to bring some of the key factors to the surface for careful consideration. Is clinical leadership the only enabler? No, but in our opinion if you get it right it can be the difference between 'taking people with you' and 'implementation at pace' versus an uphill battle, where 'progress is slow' and there is 'continuous resistance'. So as a leader who aspires to develop a model of accountable care, take some time out and ask yourself and your peers three key questions:

- *What levels of leadership do we need in the system to move towards models of accountable care?*
- *How do we attract and retain these leaders?*
- *Are we clear what they will be accountable for and what authority they will have?*

Embarking on the journey to accountable care is no easy feat and requires significant collaboration, planning and patience. At Transforming Care, we have spent the last three years working with clients on system change: collaborative working between commissioners and providers; designing new models of care and supporting the move towards accountable care. We believe that with strong foundations of collaboration, effective clinical leadership and a commitment from health and care organisations within a system, the model can be a win-win for all involved – working together to design and deliver a sustainable model that meets the health and wellbeing needs of the population and improves outcomes.

To find out more and how we could help you in your journey, please contact Richard Cohen (Director) on +44 (0) 7833 161 711 or by email at richardcohen@transforming-care.co.uk.