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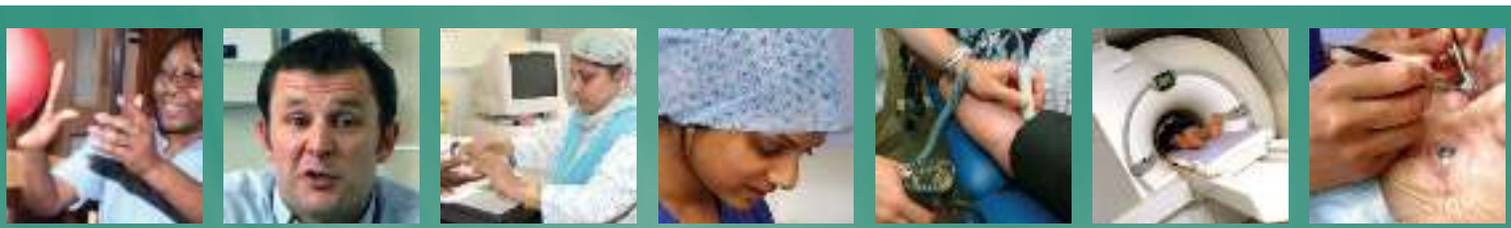

Fit to Lead

a review of the Primary Care Trust Professional Executive Committee

Fit to lead:

towards effective clinical leadership for PCTs

Contents

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Executive summary

1. This review of the PCT Professional and Executive Committee (PEC) was commissioned by the Department of Health and undertaken by the NHS Alliance. It is informed by the opinions and experience of primary care trust PEC chairs and members, chief executives and their management teams, health professionals and external stakeholders, all of whom contributed their views at short notice. The NHS Alliance and the Department of Health are grateful for their time and input.

2. All stakeholders agreed that the PEC needs to change. As well as reflecting the changing role of PCTs, which will become primarily commissioning organisations, contributors acknowledged that the old PECs exhibit variable success. The review, they said, should examine the factors that led to success and those that led to failure, so as to avoid the latter. It should consider not just the future function and role of the PEC, but how SHAs and the top levels of the NHS link with and support the new PEC and wider clinical leadership.

3. Evidence submitted to the review shows that there is no single 'right' model for the PEC. PCTs vary hugely in their population size, geography and health needs. Prescriptive advice from the Department of Health should be kept to a minimum, although guiding principles and facilitation are essential.

4. The new PEC should play a strategic role wherever it is able to add significant value. It should not be restricted to 'clinical' issues, not least because apparently non-clinical decisions may impact upon clinical delivery. Its key functions are encompassed by:

   - Setting and communicating the vision and strategic direction of the PCT
   - Commissioning and managing the market
   - Clinical effectiveness and clinical governance
   - Leading communication with partners and stakeholders.

5. All these depend upon integration and good relationships with the senior management team, and effective internal and external communication. The PEC and clinical leadership is about a style of working. Senior management members should see themselves as much a part of the PEC as the clinicians.

6. The new PEC is key in facilitating and driving practice based commissioning, especially in its early development. The PEC's role will change with time as PbC matures. Good communication with PbC commissioners and consortia will be essential but a challenge, particularly in the larger re-configured PCTs. The PEC will need to:

   - Link PbC into the broader PCT strategy and identify gaps in services
   - Encourage development of provision and patient choice
   - Champion health inequalities, health promotion and public involvement.

7. However, stakeholders agree that, just as PbC cannot replace the PEC, the PEC must engage in wider partnerships too: with local authority commissioners, secondary care, private and voluntary sector providers and others. Communication with patients and the public is an equally important role. Similarly, the PEC is not the sole repository of clinical leadership. That is needed at all levels: from PbC and provider organisations, through the PCT, SHA and the centre of the NHS.

8. There was wide agreement that the PEC should participate fully in decision making rather than being restricted to an advisory role. Stakeholders were unanimous that the PEC

needs to shed some of its broader roles so that it can focus on strategy and the core business of the PCT. They should be implementers and champions of innovation. Most felt it should be multi-professional but smaller: the most common proposals being 4 – 8 professional members. There was strong support for the view that it should retain a majority of practicing clinicians. Rather than representing a professional group, PEC members should be appointed on the basis of their likely contribution and skills, have clear job descriptions, key lead areas and tasks, and should be accountable for their delivery. Most felt that the PEC chair and either one or two professional PEC members should have seats on the PCT Board.

9. Despite widespread approval for decision-making authority, there were differing views on whether the PEC should retain its formal executive status. The majority wished the PEC to retain its executive position. Chief executives as well as clinicians were passionate exponents of its power to deliver strategy and innovation as well as clinical engagement and leadership. They argue that from this position they have also been able to facilitate practice based commissioning, providing strong support and ensuring the PCT's responsiveness to PbC needs. They would see the removal of the PEC's executive position as a fatal blow to their ability to deliver effectively, and would take it as a clear signal of the sidelining of strategic clinical leadership.

10. A minority argue that the executive power of the PEC has been an illusion and a distraction. It has led to PECs being over-whelmed and to poor relationships between clinicians and managers. A PEC freed up from executive responsibility would be better able to focus on its core business and deliver a strong strategic direction and framework for the PCT. It is possible that the term 'executive' has become associated with a requirement to encompass all executive functions (and the five-hour agendas lamented by more than one contributor) rather than retaining a more appropriate strategic focus.

11. It will be essential that issues around potential conflicts of interest and conflicts between commissioning and providing roles are resolved. Stakeholders said transparency was essential. Most often proposed were:

- management processes to minimise or remove conflicts of interest; or
- assessment of PbC projects and providers by a PEC sub-committee chaired by a non-executive director and excluding those who might have an interest;

12. Whatever local model is adopted, the PEC and wider clinical leadership will need support from SHAs and the Department of Health as well as their PCTs. Success will depend upon improved communications throughout the NHS and with partners – and upon cultural and attitudinal change at senior levels. It is likely to require new development and training for both managers and clinicians. These two groups have much to learn from each other. Learning should not be in only one direction.

13. Many stakeholders said the future of the PEC will depend upon establishing a clinical leadership career structure within the NHS.

14. Whilst investment in the PEC should be cost-effective, appropriately skilled and motivated clinicians should be properly remunerated. The role must be attractive and commitment to it must avoid loss of earnings at the least. Rates should be equal for all PEC members, reflecting the responsibilities of the post, not the profession of the individual. Reduced numbers mean that total costs are unlikely to increase.

Key Questions

1. Given recent developments and changes within the NHS (including the separation of commissioning and provision; the introduction of PbC and PbR, and the merger of some PCTs):
    - what should be the principles on which the new PEC is founded?
    - and what should be its key roles and functions?
2. How can effective manager/clinician working within the PEC (and more broadly) best be supported?
3. Should the PEC chair continue to be accountable to the PCT Board chair, and PEC members to the PEC chair, or should there be some other arrangement?
4. Should the PEC have executive status and powers or should it be limited to an advisory role?
5. How should the PEC work with practice based commissioners? How can conflicts of interest be best dealt with?
6. What should be the relationship between the PEC chair, PEC members and the Medical Director?
7. How might we judge if a PEC is successful? What specific outcomes or markers might we look for?
8. Should there be local flexibility in PEC structure and format? Are there key areas where parameters should be set, and if so, what are they?
9. Can or should the membership include potential for members from providers outside the PCT, such as the NHS acute sector and alternative secondary and primary care providers?
10. Should PEC members be appointed to the Board, and if so, how should their competencies be assured?
11. Should there be defined roles, responsibilities and competencies reflected in job descriptions for clinician members and the PEC chair? Who should decide these?
12. Are competencies more or less important than ensuring all clinician groups are represented?
13. How should the PEC work with other providers, local government, the voluntary sector, and patients?
14. How can SHAs and the Department of Health support the PEC and wider clinical leadership and engagement in primary care?
15. Is there a need for a clinical management and leadership framework or strategy and career structure for clinical leadership?
16. How can payment issues for PECs be resolved? What mechanisms for setting rates of pay would be effective?

How to respond

The full version of this document can be accessed at: http://www.dh.gov.uk/Consultations/LiveConsultations/fs/en.

It is also available to NHS Alliance members at www.nhsalliance.org or by emailing admin@nhsalliance.org

You can respond electronically or by hard copy. Please email pecreview@dh.gsi.gov.uk or post to:

PEC Consultation, Room 2N16,
Department of Health, Quarry House,
Quarry Hill, Leeds
LS2 7UE

We would be grateful for your response as soon as possible.

Foreword by Lord Warner

Report on Review of PCT's Professional Executive Committees (PECs)

Since PECs were established in 1999, their success as the "engine room" of the PCT has been variable. We have seen some excellent working where PECs and management teams have been able to function effectively supporting each other's skills to deliver benefits in effective use of resources and in innovation.

However, in other areas, the committee structure has added little value. Stakeholders have been telling us for some time that PECs need to change, to reflect the changing role of PCTs, and that the time is right for a review. We have listened to those concerns and this consultation document is the outcome of the review of PECs.

I have been clear that PECs, as a mechanism for clinical engagement in the new PCTs, are vital, but they must develop and evolve. How that might happen and what the future function of PECs might be will depend on the outcome of this consultation.

This document sets out our thinking so far which has been informed by the evidence collated by the NHS Alliance in conjunction with a wide range of external stakeholders. I am grateful to all those who have been involved in producing this document.

We are suggesting here a set of principles that PCTs need to use to establish the new PECs and posing specific questions on which we need your views.

I hope that you will let us have your views so that we can be sure that the future guidance is based on a robust evidence from stakeholders and is as flexible as possible to support local needs.

Lord Warner of Brockley
Minister of State for Reform

1. Introduction

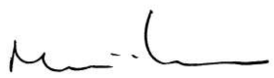
This report was commissioned by the Department of Health to review the roles and functions of the primary care trust Professional Executive Committee (PEC). For the NHS Alliance, it is the latest stage in a long term project to examine the future of clinical leadership and engagement, and to encourage more effective action at all levels to make that a reality.

Many PCTs have been thinking about and planning for a new PEC for the past six months or more. All are agreed that clinical leadership has a critical role in the new NHS – at least one PCT is to create a new Directorate of Clinical Leadership – that the PEC should be smaller and more focussed, and that appointments should be based on competencies rather than representative roles. It should be concerned with action rather than committee discussion, and a number have already adopted the NHS Alliance proposal that the PEC should be termed the Clinical Executive so as to emphasise that. There is a universal plea for flexibility for each PCT to develop its own functional framework and structure according to its local needs. Prescriptive guidance from the Department would not be seen as productive although guiding principles and facilitation are essential.

We are grateful to – and encouraged by – the large number of PCT chief executives, PEC chairs, external organisations and others who have contributed their views and experience at short notice. A number of PCTs and PECs have generously allowed us to reproduce their internal documents. Some responses come from individuals while others have been a joint response from a chief executive and PEC chair, or from the full three-at-the-top team, including the Board chair. One contributor emailed his response from the USA. Even though we asked for responses within only two weeks, a surprising number have consulted widely or agreed their contribution at meetings with colleagues and partners.

Particular thanks are due to the NHS Alliance internal reference group who have guided the production of this report, and to the External Stakeholders' Group convened by the Department of Health whose views and advice have been invaluable. We are encouraged, too, by the external organisations that have provided written contributions. Their considered and thoughtful criticisms of the old system are as helpful as their advice for the future.

The PCT Professional Executive Committee was intended to introduce primary care clinicians into the formal NHS management structures and to provide a focus for clinical leadership. It has had an uncomfortable infancy, but it is growing up fast and knows where it wants to go. Most importantly, it is here to stay.



Dr Michael Dixon

Dr Peter Reader.

NHS Alliance November 2006

2. The Need for Change

Throughout this first stakeholder consultation phase, we have found strong support for the need to review and restructure of the shape, form and purpose of PECs. Four areas in particular were highlighted as drivers for change:

- Structural and functional changes within the NHS
- The variable success of PECs in leading clinical engagement and innovation
- Relationships, power, influence and accountabilities between PECs and their management teams
- The positioning of clinical leadership within the broader NHS.

Underlying all of these is the focus on a patient-centred NHS. This is where the PEC has a vital role. As one contributor put it: "It is only by engaging front line clinicians that the true issues faced by our patients can be brought to the very heart of healthcare planning."

2.1 Structural drivers

The publication of Commissioning a Patient Led NHS (CPLNHS) in July 2005(1) reflected on the successes and failures of PCTs, and led a radical re-appraisal in relation to their size and their core functions. Whilst their key aims remain the same as those described in Shifting the Balance of Power, there was a different emphasis on how this was to be delivered. CPLNHS describes the PCT's main functions as:

- Improving the health of the community and reducing health inequalities;
- Securing the provision of safe, high quality services;
- Contract management on behalf of their practices and public;
- Engaging with local people and other local service providers to ensure patients views are properly heard and coherent access to integrated health and social care services is provided;
- Acting as provider of services only where it is not possible to have separate providers – and with arrangements for separating out decisions on commissioning from provider management;
- Emergency planning.[1]

This change in emphasis has moved the strength of focus on to achievement by strong and "intelligent" commissioning with a clear divide (and probably eventual separation into different organisations) of commissioning and providing.

This significant shift has been accompanied and driven by a host of other changes, including the growth of Foundation Trusts, the introduction of Payment by Results (PbR) and Practice Based Commissioning (PbC), and the use of a greater number of providers including the private sector: alternative providers might deliver secondary care, core primary care services and support for the commissioning function of PCTs.

The aim now is for improvements by innovation, efficiency, plurality of providers and competition. The ring for all of these is to be held by strong commissioning within larger PCTs that are co-terminus with Local Authorities.

A clear strategic direction for PCTs is provided in the White Paper: Our Health, Our Care, Our Say, with its requirement for robust health needs assessment of their communities, a focus on chronic disease management, care closer to home, and support for self care. Additionally it challenges PCTs to work more closely with a variety of partners to deliver improvements in health and wellness and the determinants of health. PCTs must manage this "health market" to deliver a shift in focus: a move

away from historical spend and models of care to new models that will deliver these aspirations while not producing destructive change in patient care during the transition.

Alongside these changes, the internal structures of PCTs have been challenged and reviewed by a national Fitness for Purpose process. This has examined the management and assurance processes within PCTs, focussing particularly on financial controls, sustainability, and commissioning. Against this backdrop it is essential that the structure and function of the Professional Executive Committee within PCTs should also be reviewed, and its role and the broader function of strategic clinical leadership strengthened and redefined.

2.2 Variability of success

The introduction of clinicians into formal management structures has resulted in both successes and failures. Despite the best efforts of many, there are historical professional attitudes and divides between clinicians and managers that have led to dysfunctional relationships in some PCTs.

At its worst this has resulted in clinicians remaining on the outside of their organisation trapped in a stagnant committee culture that has done little to forward commissioning or NHS and patient need.(2)

At the other end of the spectrum, PECs and management teams have been able to function extremely effectively, blending and supporting each other's skills to deliver quality and innovation(3,4,5,6,7,8). Similarly there are international examples that demonstrate that the development and application of clinical leadership at both strategic and front line levels can reap significant benefits in innovation and effective use of resources(9,10).

These benefits are delivered faster and beyond those that could be achieved without the presence of clinical leadership. It is vital therefore that we examine the structure and functionality of successful PECs. If we are to ensure universal effectiveness and added value, it is vital that we learn from their successes and disseminate their effective ways of working.

2.3 Relationships and Accountability Drivers

Since the introduction of primary care groups in the late 1990s, government policy has sought to develop and engage clinicians at all levels through the development of clinical ownership of NHS agendas, as well as clinical champions and clinical leadership. Strategic clinical leadership through the PEC and a broader clinical engagement (of which PbC is key but not the only part) are both vital and are mutually supportive. PECs and PbC represent two ends of the clinical leadership spectrum, and are not an "either/or" option. The PEC review represents an unprecedented opportunity to redefine, focus and empower them to deliver effective clinical engagement throughout the NHS. This will ensure the aspirations of the NHS to improve care for patients can be delivered efficiently and effectively.

Central to the delivery of this vision has been the relationship between clinicians and managers within PCTs and the broader NHS structure. This was recognised when PCTs were established and is reflected in early guidance.

From the Competency framework for PCT leadership – Department of Health, 2000

Leadership By Triumvirate

The leadership of the PCT is complex, depending as it does on the inter-relationship between the three key players. However, leadership by a team of three, although unusual, makes sense in this instance. Leading a PCT would always have been a challenge for one man or woman, even more so now in its much-enhanced role. PCTs, because they require a diverse range of leadership styles and approaches, present an ideal vehicle for leadership by a team. Although each role has a slightly different focus, the three people can pool their talents and agree their personal contributions in a

way that plays to their individual strengths. The model also ensures that all the functions of this complex organisation have a guardian and all the concerns of the stakeholders have a champion at the highest level in the PCT.

The three at the top should be considered as one team, a triumvirate, working together to meet the common goals and separately to make their unique contribution.[11]

Role of the Senior Management Team

A close working relationship between the Executive Committee of the PCT and its management team is essential. The management team of the PCT, accountable to the Chief Executive, is charged with ensuring the delivery of the decisions of the Executive Committee and Board. In addition to making recommendations to the Executive Committee, the management team will also provide the specialist advice and support that the Executive Committee will require to inform its deliberations and decision making.[11]

And from PCTs: Establishment, the preparatory period and their functions: Department of Health, 1999

PCT Governance Arrangements

The development of a mutual understanding and good working relationship between the lay board and its professionally led Executive Committee will be key to the success of a PCT.

... this relationship will need to be developed individually within each PCT and should form a clear part of the development programme within each organisation. … Crucial to the effective internal working relationships of the new PCT will be the leadership given by three key players: the Chair, the Executive Committee Chair and the CE.

… The Chair of the Executive Committee is responsible for the operational performance of the PCT. The Chair of the PCT Board has overall responsibility for the PCT and in this capacity the Executive Committee Chair is accountable to the Chair of the PCT Board.[12]

The PEC was to be positioned at the very heart of PCTs and key in driving vision, direction and leadership. The PEC and executive were meant to be one senior management team – blending together their different skills and strengths in the common goals of better patient care and improved health.

Unfortunately this marriage of clinician and manager has not always been happy or comfortable and, in some cases, has resulted in fractured and dysfunctional relationships within PCTs[13]. Too often clinical leadership has been weak, poorly developed or has simply not raised its game beyond historical professional representational debates.

Elsewhere it has been obstructed or sidelined by management action which has stifled opportunities for innovative development. This has led to the loss of the mutual benefit that has been realised by many others, and also to a further loss and disaffection in the broader NHS management and clinical communities.

This is not to blame one group or another, but to accept the different starting points of both clinician and manager. It has been a huge and difficult task to shoulder the burden of setting up new organisations while developing these intimate working relationships and power balances.

These issues need to be tackled openly and head on. As well as function and structure, the PEC review represents a real opportunity to undertake this and a chance to examine the educational, cultural and development needs for both clinical leaders and senior managers, learning from those many PCTs that were able to overcome obstacles to deliver an effective and innovative leadership force.

2.4 The positioning of clinical leadership within the broader NHS

With a move to larger more strategic PCTs, it is appropriate to reflect on how PECs might be brought into more effective engagement with Strategic Health Authorities (SHAs) and the DH.

The 3 pin plug of PCTs (Chair, chief executive and PEC chair) attempting to engage with the 2 pin socket (Chair and chief executive) of the NHS above them. has long been a source of frustration.

It has been seen by many as contributing to the disjunction that has often been encountered between high level policy and the frontline of the health service. SHA meetings where PCT Chairs and chief executives only have been invited, excluding the PEC Chair, have often symbolised this manager/clinician divide.

Similarly, in the early years of PCTs, written communication from the Department was addressed to the Board Chair and chief executive only, again appearing to exclude the PEC chair. These approaches have added to the isolation of the PEC and so undermined and strait-jacketed clinical leadership, leaving it constrained in its ability to exert expertise, influence and authority at all levels.

3. PEC Function, Purpose and Accountabilities

3.1 Function, role and purpose

Rather than a power house of leadership, innovation and strategic direction, many contributors to this document said the PEC has "become bogged down in the day to day minutia of the PCT" or had turned into a "committee for rubber stamping". Some said that, with the advent of Shifting the Balance of Power, PECs were destined to fail.

Yet in successful PCTs, there has been a retention of focus within the PEC. It is integrated with the senior management team in strategic direction setting and closely involved in innovative redesign or priority setting. (14, 15) The ability of managers and clinicians to draw on each other's different but mutually supportive skills, and blend the mix of influence, power and accountability, is evident – and breeds mutual respect that nourishes further success.

Stakeholders are unanimous that the PEC needs to shed some of its broader roles so that it can focus on strategy and the core business of the PCT. Lambeth PCT, for instance, says: "Agenda setting for the PEC will be more rigorous. 'Rubber stamping' items will in future be for 'information' only – not for discussion." The PEC must strike a careful balance: staying in touch with the broad picture whilst not becoming overwhelmed by it, yet it must be ready to turn its hand to any significant strategic issues that the PCT faces.

There is wide agreement that the PEC should be setting the pace and agenda for the PCT, providing clinical leadership and working jointly and equally with the senior management team. The PEC should set the over-arching framework, direction and environment within which other elements of the NHS – such as commissioning, PbC, plurality of providers – can deliver a first class patient centred service. A good example of this is the commissioning cycle where the new PEC would:

- Lead on direction setting and identification of need;
- Work with the SMT, public heath, local government, PbC and other partners;
- Provide input into local strategic partnerships;
- Ensure that all necessary elements are brought together and aligned in a timely manner in the Local Delivery Plan.

3.2 Commissioning, providing or both?

With the development of a clear divide between commissioning and provision, some PCTs have considered whether there is a need for a commissioning or a providing PEC, or whether different structures were needed for each. Most have concluded that the PEC should serve the PCT in its entirety, but needs to ensure that it considers its own provided services as robustly as alternative providers. The majority recognised that clinical leadership would exist within provided services too, from senior clinicians within those services.

A small number of stakeholders suggested the formation of a "Provider Board" to oversee and deliver the PCT provider services. This would function as an organisation within an organisation to ensure separation between the commissioning and providing functions. Often this Board would be chaired by a non-executive director with membership including a dynamic mix of senior managers and front line clinicians intended to drive development and innovation. The PEC (and the commissioning PCT) would relate to it in the same manner as other independent providers.

3.3 PEC functions

Stakeholders identified four key groups of PEC functions:

Vision and Strategic Direction

- Giving short, medium and long term direction and vision

- Clinical leaders and influencers – champions of transformational change
- Translators of policy for other clinicians
- Highlighting health promotion and disease prevention needs in planning
- Support to SHAs through primary care expertise
- Championing Patient and Public Involvement and Local Community Engagement
- Ensuring links with key partners including local government
- Succession planning for clinical leadership
- Providing organisational memory

Commissioning and Managing the Market

- Supporting financial balance
- Supporting strategic commissioning – overall direction, and also larger scale and specialist commissioning
- Helping to tackle unscheduled care issues from a strategic focus
- Providing a strategic direction for commissioning primary care
- Being clinical champions and innovation leads for key areas
- Making recommendations to the Board on PbC and other commissioning decisions, providing clinical and organisational scrutiny
- Ensuring alignment and coordination across localities and PbC groupings
- Ensuring services do not become fragmented through plurality of providers
- Ensuring health inequalities remain a key focus
- Helping manage competition and facilitate appropriate collaboration across providers: managing and developing the health market
- Providing recommendations to the Board in all clinical areas

Clinical Effectiveness and Clinical Governance

- Providing clinical contract management
- Championing clinical governance issues generally across the PCT
- Facilitating lean mechanisms for independent contractors to monitor and deliver Standards for Better Health
- Being champions of NSFs, NICE and Standards for Better Health
- Providing clinical scrutiny of service innovation: safety, quality and appropriateness
- Ensuring qualitative as well as quantitative assessment of commissioning and PbC outcomes
- Making recommendations to the Board from assessment of aggregated qualitative data
- Being custodians of clinical appraisal and performance

Leading communication with partners and stakeholders

- Acting as champions of the PCTs strategy and vision, while facilitating others to contribute to their development

- Developing joint strategies with local authority partners for social care
- Working in partnership with social care commissioners and providers (including local authority, voluntary sector and independent providers).
- Encouraging and facilitating practice based commissioning, using a developmental approach rather than stifling or controlling.
- Maintaining strong links with all frontline health professionals
- Linking with secondary care providers, managing competition and partnership together through good and clear communication.

Many contributors spoke of the need for local variation in these roles and their relative importance within and across PCTs. Needs would vary significantly, depending on local issues such as PCT size and the maturity of PbC. It was important to see the PEC as part of a spectrum of clinical leadership that included and spanned national leaders, PbC, and leadership within provider services.

Equally, today's solutions should not be seen as fixed and immutable. For example, as PbC becomes more competent and takes on a larger block of commissioning, so the leadership role of PECs for PbC will change although not disappear. Similarly it is inconceivable that new strategic challenges will not impact on the NHS in future. This is particularly likely as the providers' market develops. Stakeholders said it was critical to develop structures and functions within PECs (and other layers of clinical leadership) that could evolve, develop and be flexible as the need arises.

3.4 Accountabilities

The PEC is by statute a sub-committee of the Board, and its powers are delegated. Stakeholders said:

- The PEC chair should be accountable to the PCT chair.
- Clinical PEC members will be accountable to the PEC chair, possibly with the support of the CEO.

There was substantial agreement that lack of clarity about the role of PEC members had been a contributory factor in PECs that had been less successful. All contributors, including external stakeholders, said there is a need for clear job descriptions and that the appointment of PEC members should be based on competencies. Contributors said:

- PEC members are there to perform a function and deliver a work-stream with outcomes, not just to sit on a committee.
- All PEC members should have clearly defined job descriptions with associated competencies, key lead areas and tasks.
- Appointments should be made by interview against these defined roles and competencies.
- They are not representatives of their profession, although the wealth of knowledge of their particular professional background and perspective that they bring with them is valuable.
- PEC members should be accountable for their personal delivery.
- All PEC members should have regular meetings with the PEC Chair (or the PCT Chair in the case of the PEC Chair) to review progress on agendas, as well as an annual appraisal of performance. This appraisal should support a personal development plan (PDP) to assist the PEC member in the delivery of their roles.

- As with all employees, persistent failure to deliver key objectives or work-streams should result in a review of employment and suitability in the post.

3.5 Management roles for clinical leaders

While many said it was important that PEC members should have relevant management skills, stakeholders also felt they should provide significant added value in areas such as leadership, communication, and innovation. They should not become Mark 2 NHS managers. This has been highlighted in published evidence(6,7,16) and is considered in more detail in sections 5 and 6 of this document.

3.6 Should the PEC remain part of the PCT Executive?

Existing guidance makes it clear that the PEC is part of the executive of the PCT. PEC members and the SMT should work together to support the delivery of the PCT functions. This is a different arrangement from the more traditional NHS management model and certainly there are inherent tensions within it – not least that of the PCT CEO being the accountable officer for the organisation. Nevertheless, DH guidance has emphasised the tri-partite leadership model for PCTs(11,12) and subsequently the NHS Alliance has explored what characteristics have allowed PCTs to be successful.(14,15) Following the publication of CPLNHS, there has been some debate within PCTs and elsewhere as to the appropriate role and powers of the PEC.

From PCTs that have a history of delivering innovation, effective leadership and "added value" across their communities, chief executives and PEC chairs alike are convinced that their success demonstrates that the effective way forward is for the PEC to remain part of a joint executive management team. The new Liverpool PCT, for instance, says: "A strong 'Three at the Centre' culture will be re-established between the Board Chair, PEC Chair and Chief Executive. Their role will be to deliver collective cohesive leadership to the PCT". East Riding PCT agrees: "… the partnership between clinicians and managers must be visible and synergetic and built on mutual respect, support and understanding of the challenges faced, so that the necessary changes can be brought about together."

These managers and clinicians are passionate exponents of the power of this model to deliver strategy and innovation as well as clinical engagement and leadership. They argue that from this position they have also been able to be effective facilitators of practice based commissioning, and they welcome PbC as the natural strengthening of clinical engagement at the frontline. They are clear that PECs should be decision making and deliverers, not just advisors. They would see the removal of the PEC's executive position as a fatal blow to their ability to continue to deliver effectively, and they would take it as a strong signal of the sidelining of strategic clinical leadership. They also feel that the sidelining of PECs in some other PCTs has been a significant reason for failure. A limited advisory role has restricted these PECs to agendas decided by management rather than their being mainstream in the business of the PCT.

Exponents of the opposite view argue that the executive power of the PEC has been an illusion, and in reality has been a distraction. They say that it has led to PECs being over-whelmed by the breadth of the organisation's functions and that the tensions that power sharing has created have added to the poor relationship between clinicians and managers. One chief executive said: "PECs have been very variable across the country, but in only a very few cases we can honestly say they have been good value for money".

This small group argues that a PEC freed up from its executive power would be better able to focus on its core business, enabled to deliver a strong strategic direction and framework for the PCT and

good relations with the senior management team and Board.

Those who disagree claim this would require a significant shift at all levels of NHS management culture to be successful, and say that the lessons of recent practical experience demonstrate that, unless clinical views have significant statutory power behind them, they are all too easily subsumed by other imperatives. Work carried out by the NHS Alliance over the past eighteen months suggests that, in some PCTs, the term 'executive' has been interpreted to imply that all executive functions should be considered by the PEC rather than its more appropriate meaning of having decision making authority, whether that is applicable to some or all functions.

Whichever approach is adopted, stakeholders make it clear that the PEC can be successful only as an integral part of the PCT and needs the same level of support as any other.

3.7 Administrative support for the PEC

Many stakeholders commented on the importance of appropriate administrative support for the PEC. All PEC members, particularly the PEC chair, will need secretarial support to deliver their functions effectively. In the case of the PEC chair this may be a shared PA with the chief executive, and for other PEC members this may be possible through the executive support services as there will be much mutuality of work-streams and agendas.

3.8 Relationships with PbC

Practised based commissioning will be a powerful mechanism for engaging frontline clinicians in innovation and delivery of a quality patient focussed service. Much hope rests on its ability to generate service redesign and to realise the aspirations of the White Paper: Our health, our care, our say, with its focus on a shift of care closer to home, chronic disease management and on health as well as illness. The relationships between PbC and the PEC and PCT will be key to whether this is delivered or not.

Some stakeholders have suggested that the need for PECs has been largely removed by the advent of PbC. Others say this is largely to ignore the broader need and role for strategic clinical leadership that the post-CPLNHS world will require, particularly with the development of a healthcare market within the NHS. Both the PEC and PbC represent and deliver clinical leadership and engagement, but do so at different points on a continuum. Both are needed and both would be less effective without the presence of the other.

Stakeholders recognised that the role of the PEC in relation to PbC would vary depending on the experience, skills and confidence of local GP practices and therefore it should be flexible, organic and allowed to evolve. Common themes of what it should include were:

- Ensuring that PbC plans for innovation, service redesign and contract review are encouraged and enabled.
- PECs' experience and leadership will be required to help develop and deliver PbC in many areas, but care taken that support should be facilitative and developmental rather than restrictive and smothering.
- Linking PbC developments into the broader PCT strategy and setting key parameters within which developments should be considered.
- Championing health inequalities, health promotion and public and patient involvement.
- Ensuring delivery of quality and clinical governance to PbC developments.
- Interpreting aggregated outcomes and quality from PbC data and making recommendations to the Board.
- Encouraging provider developments as

well as commissioning and demand management.

- Challenging GPs to look beyond GP issues and ensuring multi-professional involvement.
- Identifying strategic gaps in services
- Managing and developing the market and encouraging an environment of choice and plurality of providers.

3.9 Communication between PEC and PbC

Good communications between PECs and PbC groupings will be essential but challenging, particularly where the reconfigured PCTs are geographically large. This will be required to:

- Facilitate the functions listed above;
- Ensure roles and accountabilities between the two groups are effectively delivered and maintained;
- Support the PEC in maintaining effective strategic communications across the PCT area;
- Ensure the balance between overall strategic direction and locality needs.

Stakeholder responses have produced a number of suggestions as to how this communication can be managed. All agree that there is no one model that will suit all. PCT size, PbC locality size and existing networks will all play a role in developing the final structures. Imposing inflexible models would have a negative impact, stakeholders say. The most commonly suggested models were:

- Formal locality commissioning groups (LCGs) who meet informally and formally with the PEC. The LCGs are variously funded from the PCT directly, from local DES's or from projected savings.
- Lead PbC clinicians having formal or co-opted membership on the PEC.
- PEC members having a formal link with individual PbC localities
- A separate committee of PbC leads supported by the PCT that links formally with the PEC.

Whatever model is locally adopted in each PCT, it will be important to ensure that it delivers:

- Excellent communication.
- Adequate two way linkage between the strategic and the locality needs.
- Appropriate accountability frameworks to ensure key projects and support are delivered.
- Solutions to probity issues relating to PEC and PbC members being both commissioners and providers.
- Where PEC GP members are also PbC leads, ensuring that PbC focus does not derail or subsume the strategic agenda of the PEC

3.10 Conflicts of interest and the PEC

Stakeholders raised three key issues:

- Clinical PEC members might be both commissioners and providers of services. This is particularly so of the GP members who could hold PbC budgets and might also be debating the use of a provider service in which they had a holding.
- The conflict of interest issues can affect both commissioning and providing decisions. In each instance both PEC members and PbC clinicians may be making or recommending decisions when they have a vested interest in the outcome.

- All stakeholders had highlighted a role in strategic commissioning as a key function of the PEC. Most also said the PEC role and PCT delivery would be significantly weakened if it were to be excluded from all PbC discussions and recommendations. At the same time, the Board would need to find and fund an alternative source of clinical advice relating to PbC developments if it is not to be the PEC. Given the large size of some PCTs, it might be difficult to find an alternative group of clinicians who do not have the same conflicts of interests as the PEC members themselves.

The issue of conflicts of interest in primary care is not new. For example, the investment GPs are prepared to make into their practices has a direct effect on their earnings. Nor are these issues restricted to clinicians. Almost all contributors felt strongly that managing them should not prevent PEC input nor cause excessive bureaucracy.

Many said that the key would be transparency: "The PEC should lead on clinical monitoring of all contracts with providers including PbC, the PCT's provider arm, Acute Trusts, Independent and the Voluntary sectors. There must therefore be clear lines of accountability with transparent contracting arrangement where GP Practices are both providers and commissioners."

Solutions recommended by contributors are:

Management processes to minimise conflict of interest issues, appropriate particularly to the assessment of PbC commissioning plans:

- Clear declarations of interests by all PEC members.
- Appropriate chairing and running of meetings such that those with an interest are excluded from the debates relating to their own PbC practices' developments.
- Exclusion from PEC membership any clinician who is a key player in a significant provider organisation.
- Explicit statements to the Board from the PEC when recommendations are made, making it clear where conflicts of interest have lain, but also how they have been dealt with.
- Management members of the PEC should ensure balance to the debate and, if necessary, raise concerns.
- The PEC is, or should be, multi-professional and so other clinicians would be expected to perform a similar function.
- When the Board receive recommendations from the PEC, they make an informed and separate decision. They must acknowledge conflicts of interest that may have arisen within any matter coming to them for consideration and make it clear how they are confident these have been dealt with.

Assessment of PbC projects by a subcommittee of the PEC, often felt appropriate for decisions on provision:

- Chaired by a Non-Executive Director and recommendations passed directly to the Board. Its members would be drawn from senior PCT management, clinical PEC members and perhaps other non-PEC clinicians. Selection and appointment to this sub-committee would need robust processes and potential conflicts of interest would need to be managed as above.
- Exponents of this approach also suggest that it has a second benefit: the PEC would not be involved in what is potentially a large volume of non-strategic work. This would seem to support the

general direction of making the PEC a more strategic body. It was proposed that the PEC would set the framework by which the sub-committee reached its decisions and should receive appropriate reports from it. The PEC would then remain an active player in PbC and could still be involved in other areas relating to PbC.

Assessment of PbC projects by the PCT senior management team only:

- Recommended by only a small number of stakeholders, this is a similar proposal to the PEC sub-committee, but goes further in excluding all risk of conflict of interest by clinicians. It would also exclude any detailed clinical advice, expertise and involvement in key decisions of the PCT in relation to making recommendations on PbC schemes.

3.11 Links to other Networks

The PEC will need to be effectively linked to local and national networks. It is likely that PEC members will work in support of specific agendas where their expertise can be used, but that these will generally be at a more strategic level than in the earlier PEC. Once again contributors put forward a number of options. These are often affected by local factors including historical links, level of integration with local government, geography, local health needs, and proximity of local providers and specialist services. The new PCTs and SHAs have been established so recently it would be difficult to give clear direction on how such links would be best served. Indeed most suggested that a degree of local variation may be entirely appropriate. Issues to consider are:

Lead commissioner arrangements;

- Larger strategic commissioning networks such as the Pan London Board;
- The need for strong links to other key partners such as local government, involvements in Local Area Agreements and the voluntary sector
- Focussing on areas where a PEC member can add real value
- The need to address health and health inequalities.

3.12 The role of a Medical Director

Not all stakeholders mentioned a medical director, and not all PCTs currently employ one. Of those that did there were three models generally described:

- A full or part time employed medical director, part of the PCT management team and invariably a member of the PEC
- A PEC member – usually the PEC chair – taking a defined role as medical director, paid additionally for this but usually on a part time basis
- The PEC chair acting up as a medical director when need arises

The majority of stakeholders who raised this issue said that a PCT's duty of quality, clear standards through NSFs and NICE, together with the Healthcare Commission's Standards for Better Health, all pointed to the need for a clearly defined medical director role within all PCTs. In keeping with the strategic model preferred by most respondents, they felt that it should be the function of the PEC to define the role, framework and principles that the medical director should operate within. These would be drawn from the guidelines already mentioned along with other useful documents from the GMC, other regulatory bodies and NCAS guidance.

Once the role is defined, stakeholders recommended appointment to this post would be by interview against a defined skill set, and any successful candidate would be an employee of the PCT. The Medical Director should be a member of

the PEC either as a core management team member or co-opted.

A few respondents suggested that, with the advent of clearly defined job descriptions for the PEC members, the medical director might perform the role of the PEC chair. A substantial majority of respondents rejected this outright as it runs counter to the model of clinical PEC members' accountability: it would make the PEC chair accountable to the CEO through the medical director line management structure. Others objected that the two roles would become confused. They suggested it would be hard, or even create a conflict of interest, for a transformational clinical leader also to be involved in the day to day management of GP performance issues. Additionally, in the new larger PCTs the time requirement for the role is likely to be substantial.

Questions

1. Given recent developments and changes within the NHS (including the separation of commissioning and provision; the introduction of PbC and PbR, and the merger of some PCTs) what should be:

a) The principles on which the new PEC is founded?

b) Its key roles and functions?

2. How can effective manager/clinician working within the PEC (and more broadly) best be supported?

3. Should the PEC chair continue to be accountable to the PCT Board chair, and PEC members to the PEC chair, or should there be some other arrangement?

4. Should the PEC have executive status and powers or should its role be advisory?

5. How should the PEC work with practice based commissioners? How can conflicts of interest be best dealt with?

6. What should the relationship be between the PEC chair, PEC members and the Medical Director?

7. How might we judge if a PEC is successful? What specific outcomes or markers might we look for?

4. PEC Structure and Format

All contributors were clear that the structure of the PEC was in need of updating to reflect the new functions and larger PCTs. Most felt that the old PECs had been too cumbersome, in part through striving to reflect or represent the communities they served, and this had added to their limitations. In the post-CPLNHS world, the majority accepted the need for them to be cost effective as well but emphasised the need for local flexibility.

4.1 Membership

The majority of responses consistently agreed that the PEC should be smaller, even though that might mean that not all professional groups are represented. Membership should include:

- The PCT CEO, director of finance and director of public health as core management team members (although the DPH could also be classed as a clinical member)
- Four to eight clinical members
- One or two local authority members.

Within the broad structure:

- The PEC chair must be a practicing clinician, carrying a caseload.
- Clinical professionals should make up the majority of members.
- Clinical membership should be multi-professional.
- Clinical members may be independent contractors or professionals from the PCTs managed services.
- All clinical members should be practicing professionals with a caseload.
- Membership should be based on competencies.
- PEC members should hold the respect of their clinical community.
- A broad range of professionals should be present, but competencies rather than professional background is key (explored further in section 5).
- Other management staff might also be core PEC members; these might include the medical director, director of commissioning and director of nursing.
- In all cases, membership should reflect local circumstance and need.

Other principles underlying this selection were:

- Local flexibility should be encouraged so as to reflect the enormous differences in size, needs, environment and populations, and consequently no rigidly defined model should be imposed.
- Guidance should allow other staff and clinicians to be co-opted onto the PEC (if necessary, for a time limited period) where specific pieces of work requiring their skills were to be carried out.
- There was some debate as to whether director clinical professionals could be clinical PEC members. Some stakeholders felt that this would ensure a good level of competency, while many others said that the directors' skills would be available to the committee anyway, that the practicing clinician input was vital and that the process of interview would ensure only appropriately skilled people were successful in getting on to the PEC.
- Quorum issues need to be defined.

Many contributors – including the BMA's General Practitioners' Committee – acknowledged the importance of retaining a multi-professional base.

Professional bodies representing allied health professionals, dentists, nurses, and pharmacists all put forward convincing arguments why their professions should be represented on the PEC. However one PCT that has already set about creating a more focused Clinical Executive told us: "Inevitably not all professional groups will find that they have one of their number on the Executive – and much lobbying is taking place."

A balance needs to be struck between multi-professionalism and the benefits that brings, with maintaining a size that is functional and able to operate in a focused way. Equally importantly, the PEC represents one part of the spectrum of clinical engagement within a PCT rather than the sole means for professionals to be engaged. Many of PCTs that are already setting up interim PECs have addressed that: "The membership is going to be reduced but resources will be put into more clinical involvement outside the PEC."

Similarly, the inclusion of unitary authority/ representation was viewed as essential: "to contribute to shared services discussion, joint strategies and planning for holistic health and social care development."

4.2 Flexibility

All contributors were agreed on the need for flexibility. Guidance should establish principles but not impose rigid solutions. As one put it: "Prescriptive advice from the Department of Health will not aide the necessary evolution of the PEC. There is no single 'right' model." A chief executive put it more strongly: "If we really are modernising the NHS it's time we stopped reaching for 'committees' and certainly time we stopped wasting money on civil servants writing six pages of membership regulations for them."

4.3 Developing relevant competencies

If PEC membership is to be based on clear job descriptions, with appointments made on the basis of competencies – and we have seen no exceptions to that view – then there will be a need to establish appropriate professional development programmes. Some PCTs are already actively involved in this. One told us: "Clinical engagement is no longer enough and clinical leadership can be provided through this mechanism."

However, clinical leadership is a relatively new idea that requires more attention than it has generally received in the past. It is a critical issue, examined in more detail in sections 5 and 7 of this document.

4.4 A place for other members?

A small number of stakeholders suggested that the PEC should embrace clinical membership from a broader church than GPs and other primary care professionals. It could include members from secondary care or other provider organisations. They argue that the inclusion of PCT provider professionals already locks in a commissioner/provider tension and so it does not matter that other providers might be at the PEC table. Indeed they suggest that this would give the PEC a broader strategic base from which to lead the healthcare of its community and may help foster collaborative working on patient pathways that bridge different sectors or providers. They felt it may also help organisations to hold competition and cooperation in the same hand – a skill which is often attributed as key in running a successful business. Where this approach is adopted, the PCT would need to ensure that employers would enable their PEC members to be free to contribute to the PEC on an equal basis with their colleagues, in availability and time.

4.5 PCT Board Membership

Virtually all stakeholders felt that PEC membership on the PCT Board was important. Most suggested a membership of 1-3 clinical PEC members. Commonly these were:

- PEC chair.

- One or two other clinicians (ideally, at least one a different profession from the PEC chair) perhaps including a lead for clinical governance or other main PCT work-stream.
- At least one of these Board members should be a GP.

Just as a package of competencies is required of PEC members, those who serve on the PCT Board should be able to offer the requisite skills for that function too. The selection process for non-executive directors has recently been tightened to ensure that Boards have the skills to function effectively. Where necessary, PEC Board members should have access to training in order to fill their roles effectively.

This will assist in facilitating a fuller understanding between PECs and Boards and will add further to the strength and dynamic of the three at the centre. The PEC chair should be an ex-officio Board member, but selection by interview may be appropriate for other PEC members.

4.6 Time commitment for clinician PEC members

Proposed time commitment for clinical PEC members varied across responses, and reflected different needs relating to local circumstances. Again, it is likely that local discretion is the best way forward rather than a centrally imposed model. However all clinician PEC members must retain at least one day of patient-facing clinical commitment in order to keep them bedded in the day to day issues of patient care. Proposals varied from:

- 2.5 to 4.0 days per week for PEC chairs
- 0.5 to 2 days per week for PEC members

A number of stakeholders expressed concerns about the balance of time for the PEC chair in large PCTs. It will be difficult to carry out the PCT role effectively while retaining a meaningful clinical caseload.

4.7 Structure of work

One of the main criticisms of PECs has been that they have become embedded in a stagnant committee culture. Conversely, in successful PECs this was not the case. Here, PEC members worked through a variety of mechanisms to deliver leadership, engagement and innovation. Local geography and needs will dictate exactly how each PCT and PEC approaches their task but many of our stakeholders suggested some or all of these must form part of this:

- Formal PEC business meetings
- Seminar meetings
- Away day or visioning sessions where more intensive work on strategy can be undertaken, as well as team building and goal sharing between the clinical and management teams
- Sub-committee work on key topics
- Work specifically aligned with the management lead for an area
- Meeting and working with other partners
- Work and meetings to link with PbC
- PCT events or meetings to engage the broader health community and the public
- "Walking the patch".

Questions

8. Should there be local flexibility in PEC structure and format? Are there key areas where parameters should be set, and if so, what are they?

9. Can or should the membership include potential for members from providers outside the PCT?

10. Should PEC members be appointed to the Board and, if so, how should their competencies be assured?

5. Competencies and Appointments

At the formation of PCGs and then PCTs, clinical executives were generally formed from enthusiastic volunteers. As PCTs matured it became clear that this approach was not adequate and that PECs needed to be made up of dynamic individuals with specific skills to carry out their complex task. One PCT summarised the the universal view: *"Appointments should be filled by a process of assessment and interview against clearly defined criteria."*

Updating the selection and appointment of PEC members has already been addressed in some PCTs. One that has recently appointed members to its new interim PEC says: *"There is a real sense that we have recruited credible leaders who can see the possibilities and opportunities presented by the new commissioning agenda to really change the system and improve patient care."*

In the same way, managers working closely with PECs – and with PbC – will also require leadership skills that will equip them to work across a spectrum of professional groups. This must not be neglected.

5.1 Competencies

Many stakeholders felt that a poor level of appropriate skills amongst some PEC members had contributed to their poor performance. The focused strategic role, together with functions such as developing innovation and managing the market, requires professionals who, rather than representing their own professional constituency, can draw on their professional perspectives and blend them with other skills including leadership. Stakeholders said what is required are hybrid clinician/managers/leaders who would bring a mix of skills to the table. Successful PEC members – and particularly some notable PEC chairs – are highly skilled strategic thinkers with strong leadership and facilitation skills. Incorporating those skills with their knowledge of day to day patient care, produces a powerful force for innovation and delivery.

All PECs need to be made up of such individuals, and defining the competencies of the successful is the first step in appointing and developing others. These skills can be loosely divided into core management skills and "added value" competencies. Both are important for managers and clinical PEC members, but the latter need to be particularly skilled in the "added value" set to ensure that they are bringing more than mere duplication of existing management expertise.

5.1.1 Added value competencies.

Many of these reflect leadership and transformational change skills which are a core added value skill. In many ways these define "clinical leadership".

- Ability to demonstrate leadership, inspire and enthuse others and able to develop both leadership and follower-ship in others;
- Ability to work from both a strategic and a coal face view point and to find solutions that marry the two often different focuses and needs;
- To be a conduit for translation between government and the broader NHS, and between clinicians and managers. Being able to demonstrate the drivers and necessity for change;
- Enthusiasm for working with colleagues from different professional backgrounds, whether managers or clinicians, in a partnership manner, valuing each other's skills and jointly delivering objectives;
- Being able to recognise key influencers and involve them;
- Managing the triangle of accountability, leadership and management by sharing these roles and blending them as a team – each adopting the needed role as appropriate and having clear expectations of what each is delivering;

- Holding collaboration and competition together at the same time in order to develop the NHS market;
- Understanding that innovative and potentially radical solutions may need to be found – the ability to think outside the box;
- To be ambitious on behalf of their organisation, and prepared to challenge other clinicians' or managers' practice and thinking across primary and secondary care. Clinical leaders can make things happen, or be respected – but not always loved;
- An interest in improving patient care from a systems perspective as well as at individual patient care level, together with an ability to work in both environments and bring the learning from one into the other;
- Ability to think beyond their own professional viewpoint.

5.1.2 Management competencies and personal characteristics

- A good understanding of NHS policies;
- Excellent communication skills;
- Time management;
- Ability to plan and structure work;
- An understanding of financial issues and resource management;
- Negotiation skills;
- Inclusive of others;
- Chairing meetings;
- Willing to support and develop others;
- Ability to prioritise and blend competing interests;
- Team player – ability to listen, learn, reflect, challenge and lead others;
- Able to manage and direct others;
- Open to new challenges, innovation and learning;
- To have integrity and to hold the respect of the local community;
- Resilience;
- Willing to walk the patch.

A job description and person specification for PEC members can be prepared from these lists of competencies. A useful example from Liverpool PCT can be found in Annex Three, together with detailed consideration of competencies from several PCTs.

5.2 The PEC chair

The job description and person specification for the PEC chair will be based on similar competencies as those for the PEC members but with a stronger focus on strategic and leadership skills. In particular it will need to address:

- Support to the PCT chair (and CEO);
- Delivering a cohesive leadership and strategy as part of the three at the top/centre leadership structure with the PCT chair and CEO;
- Ability to bring the lay, clinical and executive teams and perspectives together at the centre of the PCT and coordinating them to drive forward change;
- Lead the work of the PEC in engaging in visionary discussions and decision making in order to drive transformational change in the local health services;

- Ability to cope with the uncertainty that the developing market will bring and lead others through it;
- Ensuring that the spectrum of clinical leadership including PEC, PbC and other mechanisms work in a joined up and cohesive manner drawing strength, support and direction from each other, but remaining within the framework of direction and standards of the PCT;
- As part of the three at the top/centre leadership, ensuring communication and engagement with key stakeholders including NHS, patients, local government, voluntary sector and the plurality of providers.

5.3 Selection processes

The selection process should be more rigorous, stakeholders agreed. This is in keeping with the need to define expectations, accountabilities and management of the roles in a similar way to other senior or executive posts.

All replies were supportive of appointment to the PEC by interview against a job description and person specification. Many responses from both chief executives and clinicians indicated that it was important to have some GP membership of the PEC, but they said there should be no set quotas for particular professional groups.

A number of responses drew attention to the need for PEC members to hold the respect of their local clinical community. Some responded to this by suggesting that prospective PEC members should be supported in their application by a nomination from one or more related professionals.

Once appointed, lead areas and interests will need to be discussed with each PEC member and linked to the PCT's needs for its agendas to be serviced by a clinical lead. This may also be explored in the interview process. It may be that, for some, this will require specific educational objectives and learning. From this, job plans and objectives can be developed from which regular reviews and appraisals can be carried out consistent with usual management practices.

5.4 The interview process

When PCTs were created from PCGs, members of the PCG board were frequently involved in the appointment of the PCT CEO. They then in turn interviewed for prospective PEC members along with the PCT chair and often another professional representative such as the LMC. Suggestions reflected these experiences, although in this instance PCT Chairs and CEOs will already be in post.

In general an interview panel of 3-4 was proposed, reflecting the three lead groups in the PCT leadership structure. Suggested members were:

- PCT CEO;
- PCT Chair;
- For this first appointment process for the new PEC, a former PEC member, ideally a PEC chair (from one of the pre-reconfigured PCTs where there has been a merger);
- Another professional representative with relevant experience.

5.5 Selection of the PEC chair

The majority of respondents supported the current practice where the PEC chair is appointed by the PCT chair following recommendation of the clinical PEC members. This may require a secret ballot if there is more than one candidate. Stakeholders were clear that the prospective PEC chairs should undergo a rigorous assessment, probably by interview, to ensure they are competent to undertake the role. A small number of stakeholders suggested that the CEO should have a more formal

role as he or she will have to work closely with the PEC chair as part of the three at the top/centre relationship.

A small minority suggested that the PEC chair should be appointed first by interview so that they could then be involved in the selection of the other PEC members. This would appear to cause potential difficulties with the majority of stakeholders who wished the PEC chair to have the confidence of the rest of the PEC.

5.6 Length of tenure

Most responses suggested a defined tenure for PEC members of between 2-4 years, similar to current arrangements. Many also suggested that membership tenures should be staggered in order to avoid the possibility that all of the PEC might leave at the same time. This would ensure a degree of continuity and enable new members a period of time to settle into their post with the support of more experienced members.

Other stakeholders suggested the more radical option of PEC appointments being treated in the same way as other senior management posts with no set term of office. PEC members would be allowed to stay in post until they wished to stand down or their performance was substandard. Many stakeholders highlighted the lack of career structure as one of the factors that had held clinical leadership back. For some, the insecurity of a short tenure in the PEC prevented them from taking a more positive career step into the role.

By providing more job security and by recognising the PEC role as a substantive career appointment in this way, a number of stakeholders felt that this would encourage clinical leadership as a realistic career choice with a sustainable future. PEC members would be more likely to invest time and effort into skills development. It would allow those attracted to such a course early in their professional career to see clinical leadership as a viable choice. Within this option there would be other decisions to be made: would the PEC chair appointment still be time limited, for instance?

Virtually all stakeholders agreed that clinical PEC members would be required to step down from their PEC post in the event that they no longer carried a clinical case load and so were not practicing clinicians.

Questions

11. Should there be defined roles, responsibilities and competencies reflected in job descriptions for clinician members and the PEC chair? Who should decide these?

12. Are competencies more or less important than ensuring all clinician groups are represented?

6. Connecting for Delivery

For PECs to be powerful deliverers of clinical leadership and engagement it will be essential that they are connected in a functional and effective way both internally and externally. Communication runs through all of areas of the PEC's work and is highlighted in sections 3 and 5.

6.1 Internal connections

Delivering and communicating strategic direction and vision is a key PEC task. The PEC and management team must be visible leading forces within the PCT. Clear priorities, direction and outcomes running through all PCT work-streams are central to good communication. In many PCTs, the PEC has had a low profile and action is needed to address that, The importance of joined up clinical leadership and management needs to be signaled by the working practices of the senior team, how the decisions are implemented and the visibility of the people involved. The clinical PEC members working in close concert with members of the PCT management team should do much to assist with this, as will engaging clinicians at all levels.

More traditional mechanisms of aligning staff work objectives such as staff meetings, briefings and newsletters will play a part too, and allow the senior team to be more visible and approachable. Some PCTs are more innovative. Lambeth, for instance, plans a PEC website, linked to the main PCT website, that will illustrate the work of individual PEC members as well as overall progress and future plans.

6.2 Maintaining a local connection

There will be particular challenges for some of the new, larger PCTs that have resulted from recent mergers where there will be a need to bridge the gap between front line commissioners – as well as other local clinicians including those in PCT provided community services – and a geographically distant primary care trust.

We have been encouraged to see that a number of PCTs are already addressing this issue. For instance, one told us that their model: "… suggests a small clinical exec, which could come from a range of clinical backgrounds appointed against a job description and a competency framework. There would then be a 'second tier' of clinicians in specific, targeted posts with lesser time commitment and support for development into a more senior role." Another told us they had: "… already set about creating a Clinical Executive Committee with a more devolved network of local groups. We do not intend to delay this development."

Groups such as these will have a formal link to the PEC who should ensure a balance between overall strategic direction and locality needs, together with the involvement of all relevant professional groups and contact with local providers.

6.3 External stakeholders and partners

The PCT will have a large number of important external stakeholders and partners and all responses suggested that the PEC should play an important role in engaging with them. There will be practical problems in some of the larger PCTs that have drive times of an hour or more to cross from one side of the area to another. PEC members, with their limited time commitment, may find that more than a quarter of a day is spent in traveling. Pressures of work will present obstacles. Nevertheless, PEC members will act as emissaries, key leaders of pieces of work, champions of certain groups and facilitators of engagement. Communications with other stakeholders (particularly PbC and those concerned with social care) was flagged up as one of the PECs main functions and so this area has been explored in section 2 on roles and functions of the PEC. Ensuring close working with these groups will help key messages be transmitted both up and down these conduits and help the PEC be both visible to the front line, but also in touch with it.

Delivery of the health agenda and the reduction of health inequalities will require particularly close relationships with local authority and voluntary sector partners. Stakeholders made special mention of these two groups in their contributions.

Local authorities have become expert in commissioning high quality and cost effective care services from not for profit and for profit providers. NHS commissioners should grasp the opportunity to learn from them.

In many areas of the country, local government has recently re-organised adult social care into community directorates so as to make achievement of the green and white paper objectives easier. Local authority partners represent a considerable potential resource to support primary and secondary prevention. Contributors have referred to commissioning learning and leisure opportunities, community safety measures, helping people back into work, volunteering and older peoples networks.

It will be important that the PEC is supported in this task and so adequate administrative support to all PEC members, particularly the PEC chair is essential.

6.4 Connections with the Strategic Health Authority and the Department

A substantial number of stakeholders said that connections with SHAs and the Department of Health are immensely important but underdeveloped and neglected. Many talked of "communication up the line" (particularly to a fellow clinician who might better understand their concerns) being blocked. Most said communication with SHAs and the Department is invariably one way.

PEC chairs and members particularly talked of important SHA meetings to which only chief executives and PCT chairs were ever invited. This was experienced as destructive and appeared to exclude their insights and skills. Perhaps unintentionally, it sent a strong message to them – and indeed other clinicians – of disregard for their input and expertise. Many stakeholders spoke the need for this situation to be reversed. One asked: "Should PCTs be the only NHS organisations with a PEC?" Another pointed out: "It is important that clinical PEC members are able to work at SHA level, recognising that strategies of the SHA may well impact on services available to the local population."

However some SHAs have been more ready to encourage clinical leadership: "In the South West we have already had a PEC Chair's committee, which engaged with the Strategic Health Authority. There is a need for clinical engagement to continue to a national level."

While further work needs to be undertaken, suggestions from contributors included:

- PEC chairs to be included in all high level PCT meetings and communications with the SHA
- A lead PEC chair, representing all PECs within an SHA are who could regularly attended SHA meetings where issues or strategy relevant to PCTS were to be discussed
- Regular meetings with all PEC chairs and senior SHA staff
- The examination of SHA structures to see if clinical leaders and engagement could be bound into the structure in a similar manner to that for PCTs
- The formation of Clinical Standards Boards within SHAs that would have PEC clinical input and could examine and support agendas such as shared commissioning or ensuring the uniformity of standards across a large number of providers.

6.5 National issues for clinical leadership

Stakeholders suggested a similar disjunction with clinical leadership at the level of the Department of Health too: "Currently there appears to be a lack of clinical connection between national clinical leaders and PEC clinical leaders. The reduction in the number of PCTs may provide an opportunity for PEC and national clinicians to liaise more directly. This

should improve the dissemination of national clinical policy, but also potentially allow more local contribution to policy development."

Whilst they acknowledged the presence of the Chief Medical Officer and the Tsars, many contributors saw these roles as analogous to the medical director, and as being outside core DH decision making. Certainly they felt them to be distant and inaccessible. There is a need for an accessible core of skilled senior clinical leaders within the Department to help support and direct policy so that the benefit of the clinical perspective could be brought to bear at this level too. However, solutions are feasible: "All PEC Chairmen should have protected time for contribution to SHA and National strategy discussions. These discussions should aim to be as inclusive as possible and use modern communications media whenever physical attendance at meetings is not vital."

Gaps in clinical leadership communications at senior levels were mentioned by some as a reflection of the lack of a clinical leadership career structure within the NHS and an additional reason for the lack of interest in it from many clinicians, particularly doctors.

Current clinical leaders feel disenfranchised and under valued by the senior echelons of the NHS. They say how difficult it is to invest significant resources of time and training into a post which was likely to be time limited; for which there was little job security (three years' appointment to PEC); for GPs at least poorer paid; for others often unappreciated by their line management, and which appeared to have no career trajectory. "Above the PEC Chair there is a glass ceiling, with no route upwards. This really does need to change," one stakeholder said. Most clinical leaders enjoy the role because of its combination of clinical, leadership and management skills: they do not necessarily aspire to be directors or chief executives. They felt the skills they can bring to higher NHS leadership are as yet unrecognised and that there is a growing need for this to be resolved – even more so in the new world of the NHS market. They call for a clear NHS clinical leadership structure and career pathway.

Resolving these issues is critical to the future success of clinical leadership. Few clinicians will see the PEC as a viable option in their own careers if they are not. As one contributor put it: "The only real way to ensure clinical engagement is to ensure that the role is worthwhile, that PEC members really have an opportunity to shape things for better for the future and that their time, input and efforts are rewarded, not just financially but in terms of other incentives, including consideration of a career structure for such people."

Questions

8. How should the PEC work with other providers, local government, the voluntary sector, and patients?

9. How can SHAs and the Department of Health support the PEC and wider clinical leadership and engagement in primary care?

10. Is there a need for a clinical management and leadership framework or strategy and career structure for clinical leadership?

7. Financing and Training the PEC

7.1 Payments to PEC members

The PEC should be cost-effective, but equally remuneration will need to be adequate to attract an appropriately skilled membership and to reflect the responsibilities that the new more accountable role brings. Perceptions of poor pay and inequality of pay for PEC members has dogged PCTs since their inception. That has resulted in many professionals, particularly GPs, finding it hard to justify giving up time to take up the roles. Similarly some PCTs have not paid the PEC allowances to their employed staff members, classifying it as part of their normal role. This is a nettle that must be grasped and dealt with.

Most stakeholders said:

- The pay must reflect the responsibility and importance of the posts, both to adequately reward this and to attract good candidates;
- It must be equal for all members, except the PEC chair who should receive a higher rate of remuneration in recognition of the greater responsibility of the role;
- PCT employed PEC clinicians should receive equal pay to other PEC members for their PEC commitment. Their clinical leadership role should be valued for what it is and not seen as part of their current job;
- Adequate backfill arrangements should be in place for all PEC members including PCT employed clinical staff;
- That there may need to be a degree of variation in rates between PCTs as the size of PCTs and roles would vary hugely, possibly by linking PEC pay to CEO salaries (see below)
- PEC members should be paid a pro-rata salary. This would allow the PCT to agree variable time commitments from PEC members where individual members had particularly onerous portfolios or tasks that required additional time commitment above the norm. Variations should be locally negotiated. This should be interpreted as the flexibility to pay PEC members more for more time consuming tasks, as opposed to less for more minor roles.

Whilst stakeholders recognised this would mean PEC members would be more expensive individually than those currently in post, costs would be balanced by the decrease in numbers in individual PCTs and, because of mergers, a substantial decrease overall.

Remuneration levels might be set by:

- Linking PEC pay to chief executive's pay similar to the system currently in place for senior managers. For example the PEC chair might be paid at 90 - 100% of the chief executive's salary, whilst PEC members might achieve 80% which would put them on a par with their senior management colleagues;
- Linking the PEC pay to the relevant current clinical senior professionals' pay scale;
- Backfill payments should reflect the current market rates;
- Payments should be reviewed annually and appropriately uplifted.

7.2 Training

Many stakeholders said a lack training opportunities for PECs had resulted in much of the variability of the quality of PECs, their ability to take up effective leadership roles and poor relationships with the management team. They felt that training opportunities offered to PEC members had been patchy, and frequently linked to achieving specific NHS targets rather than focusing on assessing the

training and development needs of individuals. Others felt that available training available had focused on the clinicians and perceived need for managerial skills rather than looking at the PEC as a broader team and involving the management team. Managers and clinicians are trained in separate silos, a practice that does nothing to help them understand each other or work together once qualified. Stakeholders and PCTs that had been successful in bringing their teams together to function effectively had focused considerable time and resources on this issue and had seen training and joint personal development as key priorities for the organisation. The need for such efforts were highlighted in early DH guidance at the formation of PCTs:

PCTs: Establishment, the preparatory period and their functions: Department of Health,1999(12)

PCT Governance Arrangements

The development of a mutual understanding and good working relationship between the lay board and its professionally led Executive Committee will be key to the success of a PCT.

... this relationship will need to be developed individually within each PCT and should form a clear part of the development programme within each organisation.(12)

Successful organisations had supported this work in a variety of ways:

- Early joint away days to define both what the PCT stood for and its priorities;
- An ongoing programme of such events to support team building and to continuously update on changes in the NHS, work streams, direction and shared priorities;
- Mentoring opportunities for lead individuals such as the chief executive and PEC chair;
- Support for attending educational events including those on leadership and management skills;
- The pro-active sharing of generic skills contained within national initiative opportunities across the wider PCT;
- Regular supportive management meetings to review progress on work, appraisal and the development of learning needs.

Many stakeholders called for a strengthening and prioritisation of educational opportunities for PECs particularly around the areas of leadership and transformational change. Some training in generic management skills might be necessary, particularly for newer PEC members and those leading in PbC. PEC members should embrace these opportunities and be prepared to commit some of their personal development time, as well as commitment from the PCT to make them available. Importantly these stakeholders also stressed the vital need to include senior management in these opportunities, and highlighted the power of joint learning through supported development and problem solving together. Some stakeholders drew attention to the disparity that currently exists between primary and secondary care and commented that educational resources and clinical leadership structures are much more highly developed in hospitals than elsewhere in the NHS.

These observations have a sound backing from organisations such as the British Association of Medical Managers (BAMM) which has championed the agenda for many years. More recently these have been echoed by both the NHS Institute for Innovation(6) which has called for "a strategy for medical management and leadership including the design of a coherent competency framework". Medical professional bodies such as the Royal College of Physicians, agree. In their work "Doctors in Society"(17) they call for training for doctors in leadership and management as well as a greater commitment to research into these important areas.

It is encouraging that many PCTs are already addressing this. Annex Three contains a number of examples of training strategies currently being planned or implemented.

Questions

11. How can payment issues for PECs be resolved?

12. What mechanisms for setting rates of pay would be effective?

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