DH Department of Health

Primary Care Trust Professional Executive Committees

Fit for the future

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For Recipient's Use			

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Foreword

I am pleased to be able to introduce new guidance for the Primary Care Trust Professional Executive Committee (PEC).

This document has been designed and drafted in close conjunction with a wide range of clinicians and managers, following a public consultation, “Fit to Lead, a Review of the PCT Professional Executive Committee” and I am particularly grateful for their support and advice through all phases of this review.

I firmly believe that successful clinical leadership is paramount if we are to deliver health reform. Clinicians need to have a much bigger role in the design and development of local services because they understand what patients want and how they can deliver it. This guidance presents an enormous opportunity to develop clinicians across all sectors to become drivers and leaders of clinical change.

For the PEC to be effective there needs to be a partnership between clinicians from a broad multi-professional background and managers. This partnership will ensure that decisions about the prioritisation of resources, the redesigning of services and better commissioning, including practice based commissioning are based on good evidence, represent good value for money and is what the public want.

Clinical leadership must not be a token gesture. It is the duty of all managers and clinicians to take responsibility for embedding clinical leadership and empowerment in their organisations so that we realise our vision for a national health service of the future.

Andy Burnham

Minister of State for Delivery and Reform

1. Introduction

1.1 This guidance follows the responses to the Department of Health public consultation on the document “Fit to Lead, a Review of the PEC”, which was conducted between December 2006 and February 2007. PCTs should consider this guidance when establishing their Professional Executive Committee (PEC) in time for new PECs to be in place by 1 October 2007.

1.2 Since Primary Care Trusts (PCTs) were established, although there has been little change to their overall core functions, there has been considerable change to the way they need to carry out these functions.

1.3 Most recently we have seen the introduction of Practice Based Commissioning (PBC) which requires strong clinical leadership, delegation of budgets to practices and commissioning decisions made by clinicians. PCTs are now tasked with making a reality of the recent White Paper “Our health, our care, our say” by developing more services closer to people’s homes. The NHS, having received substantial increases in investment, now needs to ensure services are configured in such a way that they are financially sustainable year on year.

1.4 To achieve the government’s aspiration there needs to be stronger emphasis on good commissioning.

1.5 Given the diversity that exists across PCTs in terms of their population size, demography and health needs, one of the principles of this new guidance is to move away from a prescriptive approach, to enable flexibility for PCTs to determine how PECs should operate according to local circumstances. In drafting this guidance, we have sought to strike a balance between advising on core principles, generic to all PECs and giving PCTs local discretion in the way they wish to structure and operate their own PEC.

1.6 The relationship between the PEC and PBC will be vital for effective delivery. Whilst the PEC is important in supporting the development of a vision and strategic direction for the PCT, PBC will be the main mechanism by which front line innovation and service reconfiguration are delivered. PECs and PBC represent two different but mutually supportive parts of clinical engagement and leadership that will be vital if PCTs are to commission high quality and effective services for patients.

1.7 We therefore expect the PEC will set the overarching framework, direction and environment for PBC and link PBC development to the PCT’s overarching commissioning strategy.

2. Guiding principles

2.1 By working within a set of guiding principles, PCTs will be in a position to realise the full potential of the “Three at the Centre” management arrangements. It will enable them to manage the triangle of accountability, leadership and management by sharing these roles and blending them as a team – each adopting the appropriate role and having clear expectations of what each can deliver.

2.2 The guiding principles set out below, are enshrined throughout this document and provide a strong framework for the various aspects of PECs described in the sections that follow.

The guiding principles for Professional Executive Committees

- PECs need to be patient-focused and promote the health and well being of communities, as well as addressing health inequalities.
- PECs need to be drivers of strong clinical leadership and enablers of clinical empowerment.
- PECs need to be decision-making and firmly part of the governance and accountability framework of the PCT.
- We fully expect PECs to reflect a range of clinical professions and the wealth of experience this brings.
- PCTs will have the freedom to determine how PECs operate according to local circumstances.

3. Roles and functions

3.1 The specific roles and functions of the PEC will need to be set and delegated by the PCT Board, together with the necessary authority to deliver them. Whatever the specific remit, we expect the PEC to provide the PCT with clinical leadership, working jointly and equally with the senior management team. However, this does not mean that all PCT management decisions need to reviewed and endorsed by the PEC. We need to move away from using the PEC to "rubberstamp" each decision to a position where the PEC's role in decision making is transparent and adds demonstrable value.

3.2 We have identified four key groups of PEC functions. However the roles and their relative importance within and across PCTs will vary:

- Support the PCT in developing their vision and strategic direction
- Commissioning and supporting PBC
- Clinical effectiveness and clinical governance
- Leading clinical communications with partners and stakeholders

More detailed roles and functions that might be given to PECs are described in Annex A though the list is not exhaustive.

3.3 It will also be necessary to develop structures that can support the delivery of these four key roles. These structures should be locally determined, fluid and evolving to meet future challenges as they arise.

4. Developing clinical leadership

4.1 For PECs to be successful now and in the future, we need to be continually developing the leadership potential of our clinical professionals. We know that where change has been successful, senior visible clinical leadership to drive through those changes in partnership with good management has been the critical success factor.

4.2 PCTs need to strengthen and prioritise development opportunities for PEC members. This includes proper training and mentoring support as well as in the areas of leadership and transformational change. Further advice can be accessed at www.institute.nhs.uk.

4.3 SHAs need to give consideration to:

- PEC chairs being included in all high level PCT meetings and communications with the SHA to reflect the three at the centre accountability arrangements;
- regular meetings between PEC chairs and senior SHA staff; and
- the role of the PEC as part of the performance management of PCTs.

5. Accountability

5.1 The PCT is an organisational entity with a number of statutory responsibilities delegated from the Secretary of State for Health. The PCT must establish a Board comprising a chair and members, which has overall responsibility for discharging the PCT's responsibilities. The PCT Board is able to establish a number of committees and delegate responsibility for delivery to these committees. The PEC is one such committee and should be firmly part of the governance structure of the PCT.

5.2 The PEC chair should be accountable to the PCT chair and should work closely with both the chair and the chief executive of the PCT. Other clinical PEC members are expected to be accountable to the PEC chair. All PEC members should have clear roles and objectives and the delivery of their work should be performance managed through regular meetings with the PEC chair (and chief executive where appropriate).

Relationship with Practice Based Commissioning

5.3 Subject to local discretion and delegation from the PCT Board, we would expect the PEC's role in relation to PBC to be:

- advising and contributing to the overall strategic direction for commissioning, including PCT commissioning of primary medical and dental care and, in relation to PBC, commissioning of all hospital based care covered by PbR, prescribing, community services and mental health;

- encouraging an environment of choice (including competition) through a plurality of providers, whilst ensuring that clinical governance and quality standards are met;

- ensuring that services are patient focused and that health inequalities, health promotion and public and patient involvement are a key priority;

- ensuring alignment and coordination across practices and PBC groupings and challenging GPs to ensure multi-professional engagement; and

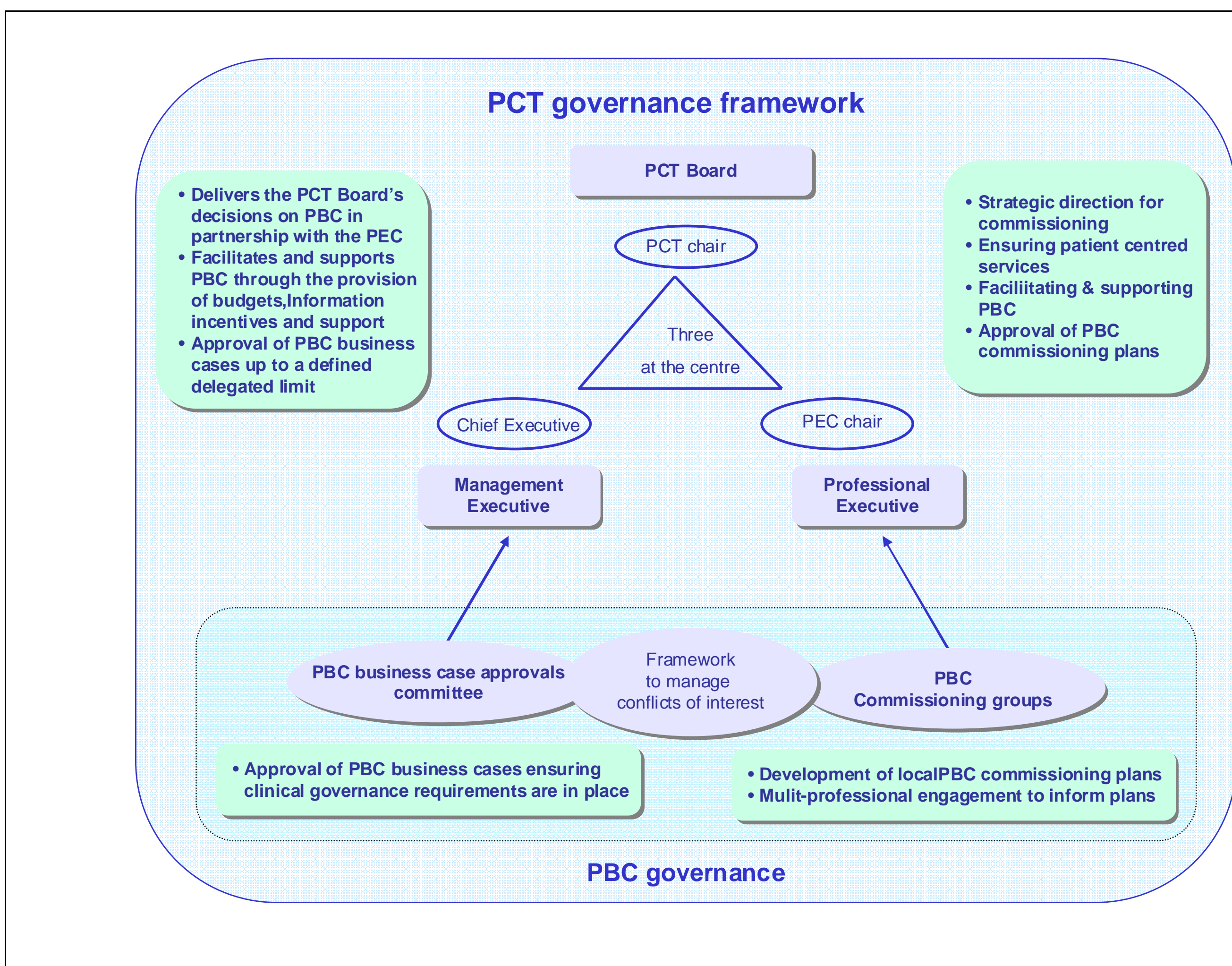
- approval on behalf of the Board of PBC plans and other commissioning decisions by providing clinical and organisational scrutiny based on data, analysis and evidence.

5.4 To achieve this, links and communications between PECs and PBC practices and groupings will have to be strong and effective. Once again this is an area where local flexibility and variation will be appropriate. Requirements will depend not just on geography, population size and need, but also on the maturity of PBC development. In areas where practices have little experience of managing budgets and service redesign then the support of the PEC will be invaluable in the start up phase of PBC. It will be important that this support is developmental and nurturing, rather than directive, and that it gradually withdraws as PBC matures.

5.5 Several models for effective PEC and PBC inter-relationships were put forward during the consultation and these are provided below as examples that can be used as local requirements dictate:

- formal commissioning groups which meet both informally and formally with the PEC;
- lead PBC commissioners having a formal or co-opted membership on the PEC;
- PEC members having a formal link with individual PBC commissioning groups; or
- a separate committee made up of PBC lead commissioners that links to the PEC.

Table 1: PCT Board sub committees and their role in PBC



Managing conflicts of interest between PBC and PEC

5.6 Whilst strong relationships between the PCT Board, PEC and PBC commissioning groups will be vital for effective delivery, a framework to manage potential conflicts of interest will also be necessary.

5.7 Given that some clinical PEC members will also hold commissioning budgets and be providers of services, robust governance arrangements to minimise conflict of interest issues within the PEC should exist, particularly in relation to the assessment of PBC plans and the approval of PBC business cases.

5.8 We therefore advise PCTs to clearly set out the PEC's role in relation to PBC and to take account of DH guidance set out in *Practice based commissioning: Practical Implementation (Nov 2006)*[1] which provides an accountability framework to help practice based commissioners and PCTs work effectively together and avoid any potential conflicts of interest. The key aspects to this framework are set out in the table below:

PBC governance and accountability:

Minimising conflicts of interest between PBC and the PEC

- there should be clear accountability to the PCT Board through a separately convened PBC approvals committee of the PCT which has clear delegated powers to approve PBC business cases and it should meet with sufficient frequency to ensure business case approval is timely (although small scale business cases may be approved by an executive director);
- clinicians on the PEC or other PBC approvals committee must exclude themselves from decisions where they might benefit financially, particularly to the assessment of PBC commissioning plans and business cases, though such individuals can provide advice, but not make the ultimate decision;
- management members of the PEC should ensure balance to the debate and, if necessary, raise concerns;
- there should be an explicit statement to the PCT Board from the PEC or other approvals committee when recommendations on PBC commissioning plans are made, making it clear where conflicts of interest have lain, but also how they have been dealt with; and
- all PBC related meetings (PEC or other) should be based on the principle of transparency, pragmatism and a common sense approach to managing conflicts of interest which minimises bureaucracy.

6. Structure and format

What should the membership of a PEC be?

6.1 A balance needs to be struck between multi-professional representation and the benefits that this brings, with maintaining a size that is functional and able to operate in a focused way.

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062703

6.2 Exact PEC membership therefore will be for local determination, but must be sufficient to be able to deliver the functions set out in section 3. The most common suggestion throughout the consultation was a number no greater than eight. We recommend that in considering the local structure, account should be taken of the following:

- membership to include PCT Board director(s);
- professional members should be practising clinicians, carrying a caseload;
- professionals should make up the majority of members;
- staff, clinicians and others (local authority representative, practice based commissioning consortia leads, secondary care clinicians, voluntary organisation representatives, patients) may be co-opted onto the PEC where specific pieces of work requiring their skills are to be carried out; and
- the PEC Chair should sit on the PCT Board.

7. Competencies and appointments

Recruitment principles

7.1 PCTs will need to develop a plan to appoint members and a chair to their PEC.

We recommend that:

- appointments should be made by interview against defined roles as set out in a job description;
- appointments should be made on the basis of suitability against a person specification and competencies;
- members should not be appointed to represent their profession;
- members should be considered as office holders;
- members should be accountable for their personal delivery of a defined and agreed set of objectives, plans and workstreams; and
- members should have regular meetings with the PEC chair (or the PCT chair in the case of the PEC chair) to review progress against plans, as well as an annual appraisal of performance. This appraisal should be supported by a personal development plan (PDP) to assist the PEC member in the delivery of their objectives.

Further detail on the person specification and competencies against which potential members should be assessed is contained in Annex B. Also included is a guide to the interview and selection process.

Length of tenure

7.2 We recommend that terms of appointment should be for local determination. Consideration should be given to PEC members being allowed to stay in post until they wish to take on another leadership role, stand down or their performance is deemed substandard (as in any other NHS management/leadership role).

7.3 We hope this will encourage clinicians with an interest in clinical leadership to see this role as a viable career option and give them the security to devote personal learning time to the development of the specialist skills required.

8. Remuneration

8.1 The Department is seeking to give PCTs greater flexibility on setting PEC remuneration to reflect local circumstances and it will say more on this in due course. In the meantime, PCTs need to comply with the existing framework for allowances and locum payments for PEC members.

Annex A

Detailed PEC roles and functions

- **Supporting the PCT in developing vision and strategic direction**
  - Giving short, medium and long term direction and vision
  - Clinical leaders and influencers – providing clinical ownership, delivery and championing of transformational change, strategic development and direction
  - 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**
  - Supporting financial balance and better
  - Supporting strategic commissioning – overall direction, and reconfiguration of clinical services, 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
  - Being directly involved in mechanisms to ensure delivery of PBC commissioning plans
  - Ensuring alignment and coordination across localities and PBC groupings
  - Ensuring services deliver high quality and patient focus when developing the market and competition
  - Ensuring health inequalities remain a key focus
  - Facilitating appropriate collaboration across providers: managing and developing the health market including the third sector
  - Providing recommendations to the Board in all clinical areas
- **Clinical effectiveness and clinical governance**
  - Providing clinical contract management expertise
  - Responsibility for clinical governance issues generally across the PCT to include commissioned and provider services, and independent contractors
  - Facilitating 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, revalidation and performance

- **Leading communication with partners and stakeholders**
  - Acting as owners and drivers of the PCT's 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).
  - Ensuring patient focus
  - Encouraging and facilitating practice based commissioning, using a developmental approach rather than being stifling or controlling.
  - Maintaining strong links with frontline health professionals
  - Linking with secondary care providers, managing competition and partnership together through good and clear communication.

Person specifications and competencies and a guide to selection and interview

Person specification for 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 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 along with other primary and secondary care providers to drive forward change;
- lead the work of the PEC in engaging in visioning discussions and decision making in order to drive transformational change in the local health services;
- ability to cope with the uncertainty that growing plurality in provision 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 centre* leadership, ensuring communication and engagement with key stakeholders including NHS, patients, local government, voluntary sector and the plurality of providers; and
- Lead in succession planning and development for clinical leaders and leadership

All PECs, both as committees and as individual members should be minded that an important role and function is to encourage and develop the next generation of PEC members and other clinical leaders at all levels.

Competencies

Management roles for clinical leaders

PEC members should have relevant management skills and should also provide significant added value in areas such as strategic thinking, leadership, communication, and innovation. It is vital that PEC members provide more than just management skills to the PCT but that their involvement adds significantly to the PCT’s management delivery capabilities.

We have therefore divided skills into “core management” and “added value” competencies. PEC members must be able to demonstrate skills or development potential under both headings.

Core management competencies

- 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;
- 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;
- Manage and direct others;
- Open to new challenges, innovation and learning;
- Have integrity and to hold the respect of the local community;
- Resilience;
- Willing to walk the patch.

Added value competencies

- Ability to demonstrate leadership, inspire and enthuse others and able to develop leadership in others;
- Ability to work from both a strategic and a front line 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;
- Understanding that innovative and potentially radical solutions may need to be found – to garner the evidence base - and to have ownership of these and to lead and support their development and implementation;
- To be ambitious on behalf of their organisation and the NHS, and prepared to challenge other clinicians' or managers' practice and thinking across primary and secondary care;

- 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.

A guide to selection and interview

Potential PEC chairs should undergo a rigorous assessment and interview, to ensure they are competent to undertake the role.

There may be an interview panel of 3-4 people, reflecting the three lead groups in the PCT leadership structure. Suggested members are:

- PCT CEO;
- PCT Chair;
- For the 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); and/or
- another professional representative with relevant experience.

For advice about appointments, please contact the Appointments Commission on 0870 240 3801.

Annex C

Timetable for implementation

Duncan Selbie's letter of 6 Sept 2006, explained the interim arrangements for PECs, pending the outcome of the review and formal consultation on the review findings.

With this publication of new guidance, PCTS now need to take steps to ensure that their PEC arrangements are fit for the future and in place by 1 October 2007.

The following is a checklist of actions for PCTs:

- Consider the roles and functions which the new PEC will be required to undertake, based on advice in the guidance;
- Consider competencies against which a new PEC chair and members can be assessed based on the skills necessary to effectively fulfil the roles and functions required;
- Convene an interview panel and agree dates for sifting and interview of candidates;
- Advertise PEC posts;
- Undertake a sifting exercise and pull together a shortlist of suitable candidates to interview;
- Offer posts to successful candidates, agree terms and conditions of appointment;
- Give notice to current PEC members as necessary;
- Consider how new PEC members will be inducted and establish mentors for PEC members. Consider training and development needs of new PEC members.
- Establish mechanisms to measure and feedback the effectiveness of the PEC within the PCT.

The current legislation governing PECs is contained in the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000/89[2] and the Primary Care Trust Executive Committee (Membership) Directions 2003[3].

These regulations and directions will be amended to reflect the new guidance in line with the 1 October 2007 timescale.

[2] www.opsi.gov.uk/si/si2000/20000089.htm
[3] www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle.

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