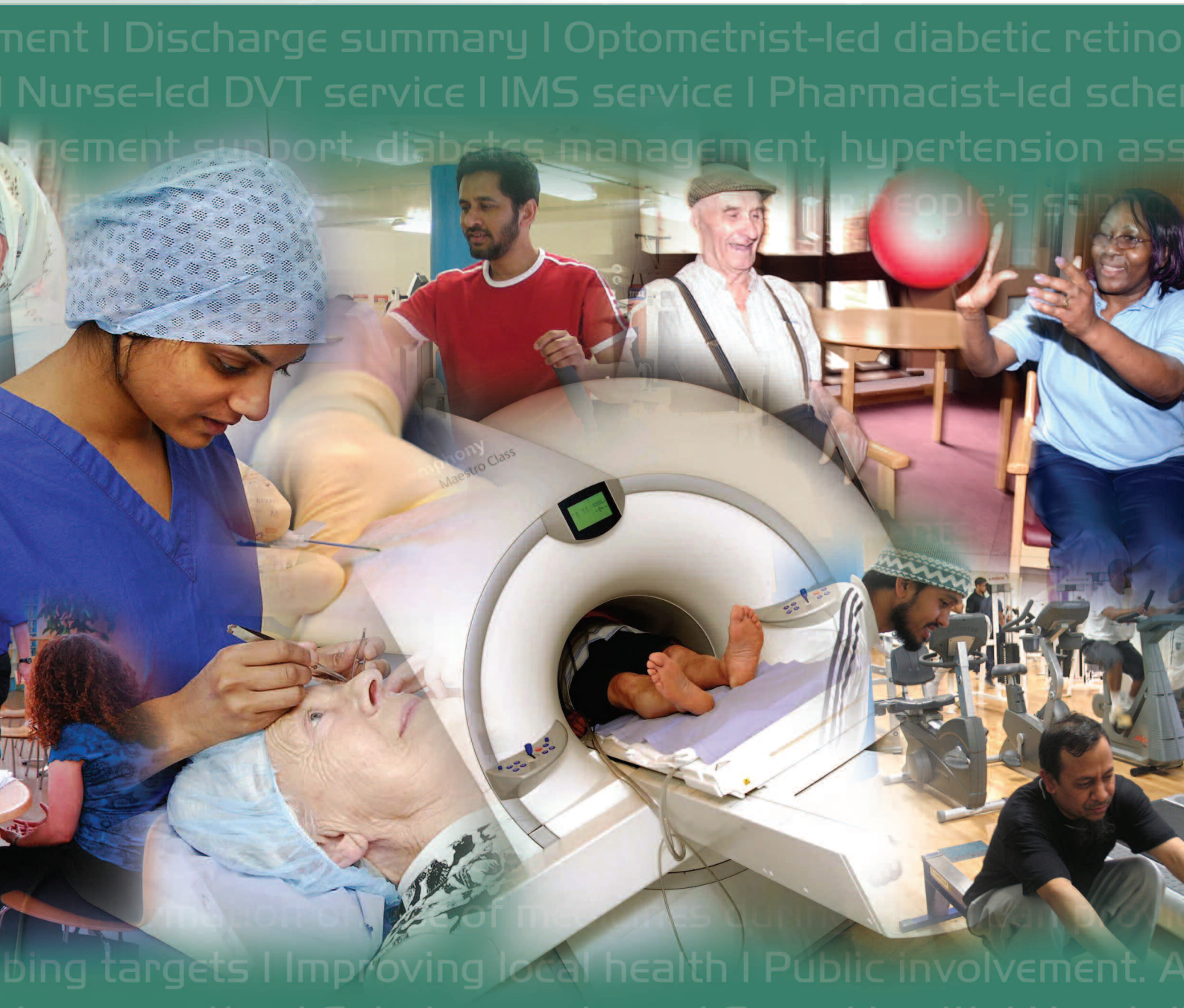
The future of strategic clinical leadership in commissioning and primary care

An **nhs alliance** *Discussion Document*



The Future of Strategic Clinical Leadership in Commissioning and Primary Care

An NHS Alliance discussion document

Dr Peter Reader
NHS Alliance members and networks

This paper should be read in conjunction with:
The future of clinical leadership in primary care and PCTs,
NHS Alliance January 2006

Contents

Foreword

The NHS is entering a new era. It is an opportunity to correct some of its current imbalances - between commissioner and provider, between primary and secondary care, between localism and centralism and between competition and partnership.

If NHS reforms are to have any meaning or impact then a rebalancing of the relationship between clinician and manager is also long overdue. Full clinical engagement and leadership is not an option in the new world. It is a dire necessity. Managers as well as clinicians are saying so.
For many years the NHS has tried to do without it and the outcome has been entirely predictable. We have seen frontline clinicians standing on the touchline, who do not identify with local or national NHS aims, who feel disempowered and who view everyone outside their personal domain as "them". The result has been a virtual paralysis in the implementation of policy. That is what needs to change.

Practice based commissioning has been seen as an answer to this clinical engagement conundrum. But by too many as the only answer.

This document focuses particularly on the issue of strategic clinical leadership within PCTs and the future role of PCT clinical executives and clinical chairs. As the focus moves to primary care and commissioning, the engagement and leadership of these clinicians will be as crucial as that of clinicians at the frontline involved in practice based commissioning, and also those working more centrally in SHAs and the Department of Health. Indeed, these PCT clinician leaders will be the glue that enables practice based commissioning to work, while ensuring that national priorities are met.

In the old order of things, those clinicians and the PCTs that they work within would simply have waited for the next piece of Department of Health guidance. In the new way of things, it is surely more appropriate that a leading body of respected clinicians should point the way. That is precisely what this document does.

On 29th June 2006, thirty or so of the most respected PEC chairs and PCT clinicians met at the Royal Society of Medicine to discuss the future of clinical leadership and engagement. Three weeks later they have written, printed and published this significant addition to work on the role of the clinicians in the new NHS. It is a shining example of implementation and delivery by determined, committed and focussed clinicians. Dr Peter Reader, the editor of this work and NHS Alliance national PEC chair network facilitator is to be congratulated on a timely piece of work that will inevitably lead to major NHS change. Change that has been long awaited by clinicians but which is equally welcomed by every forward thinking manager, who understands the issues and wants to have a fuller and more effective relationship with his or her clinicians. This new era could well be the NHS's best yet.

Dr Michael Dixon
Chair NHS Alliance
July 2006

Executive Summary

Since the publication of Commissioning a Patient Led NHS (CPLNHS) in July 2005, there has been active debate not just on the structure of PCTs and their function, but on the future of strategic clinical leadership within commissioning and primary care. Some have argued that the Professional Executive Committee (PEC), the current vehicle of strategic clinical leadership, has failed and that the advent of Practice Based Commissioning (PBC) renders the PEC obsolete. Others, including chief executives and chairs of many successful PCTs, say they could not imagine how the new PCTs could operate without a PEC.

Based on more than a year working with its multi-professional networks to review the work of PECs and their strategic role, the NHS Alliance concludes that:

- The PEC in its current form is no longer fit for purpose and should be reviewed
- Strategic clinical leadership remains an imperative if PCTs are to deliver NHS reforms
- That can best be provided through a formal structure within the PCT, not dissimilar to the present arrangements.

The PEC has given the NHS a cohort of highly developed clinicians with significant skills in strategic thinking and planning. Their management and people skills are coupled with clinical expertise, local knowledge and on-going experience of caring for patients.

This unique skill set is vital to lead PCTs and ensure intelligent and powerful commissioning. It is also crucial in delivering patient-centred, joined-up and cost effective services rather than a confused melée.

PBC alone cannot replace strategic clinical leadership: it is too small in scale and must focus on service delivery for relatively small populations. Nor is it an adequate substitute for full clinician engagement which must take account of all professional groups, including nurses, allied health professionals, pharmacists and others.

The new PEC – perhaps called a Clinical Executive – should be smaller and more focussed. It will have key strategic roles in creating the PCT's vision and strategic direction, commissioning, clinical effectiveness, ensuring local clinician engagement, probity and accountability. Issues around conflicts of interest are capable of being addressed.

The roles described above cannot be carried out effectively by medical directors alone, nor by clinical reference groups although both may have a significant contribution to make.

In larger PCTs particularly, there will be a need to bridge the gap between a distant organisation and front-line practice based commissioners. The NHS Alliance recommends a new tier of strategic clinical leadership, the Area Commissioning Forum.

Within the new primary care based NHS, PCTs will need to ensure that they share their primary care specialist skills with SHAs, and SHAs must become more skilled in understanding the primary care landscape.

Introduction

The NHS Alliance has long championed the role of multi-professional clinical leadership and engagement within the NHS. Since its early beginnings in the commissioning multi-funds that arose out of fundholding, its ideas and membership have grown. We have been part of the process that has seen clinical engagement and leadership develop and evolve as NHS reforms have moved through first Primary Care Groups (PCGs) and then Primary Care Trusts (PCTs).

The publication of *Commissioning a patient led NHS (CPLNHS)* in July 2005[1] reflected on what PCTs had achieved and led a radical re-appraisal in relation both to their size and their core functions. Whilst their key aims remain the same, the method by which they are delivered has shifted the strength of its focus on to achievement by strong commissioning, with a clear divide (and probably absolute separation into different organisations) of commissioning and providing.

This significant shift has been accompanied by a host of other changes within the NHS, including the growth of Foundation Trusts, the introduction of Payment by Results (PbR) and Practice Based Commissioning (PBC)[2 & 3], the greater use of the private sector and, most recently, its use to deliver core primary care services. The drive now within the NHS is for improvements by innovation, efficiency, plurality of providers and competition; with the ring for all of these being held by strong commissioning within larger PCTs that are co-terminus with Local Authorities.

Against this backdrop the internal structures of PCTs are being challenged and reviewed. A national *fitness for purpose* exercise is being undertaken. It is therefore appropriate that the structure and function of the Professional Executive Committee (PEC) should be reviewed at this time.

In January 2006 the NHS Alliance published a discussion document[7] reflecting work undertaken through its professional networks on the implications of the early stages of the changes described above. *The future of clinical leadership in primary care and PCTs.* laid out the case for the success of many PECs, defined the attributes that had allowed them to be so and suggested a future structure for strategic clinical leadership both to deliver its role, but also to support the development of PBC.

Since then the networks, particularly the PEC Chair network, have continued this work, most recently including a workshop held at the end of June 2006. The outcomes are presented here and lay out why and how strategic clinical leadership can continue to deliver significant benefit to a modern patient centred NHS.

Indeed we would go as far to suggest that without powerful and integrated strategic clinical leadership, the NHS reforms risk fragmentation of services and will fail to deliver any real changes or benefit.

The Need for Strategic Clinical Leadership

The NHS Alliance has long championed the benefits that engaged and positive clinical leadership can deliver[4, 5], as have others[10], not least the Audit Commission[6, 11]. There are now many nationally known examples and it is widely acknowledged that where there is good clinical leadership and engagement then there is effective service modernisation and innovation.

Financial governance too depends upon good clinical engagement at a senior level with ownership by clinicians of key management and financial decisions. The Audit Commission, in its recent report: *Learning the lessons of financial failure in the NHS*[11], points out that lack of clinical engagement in core management processes is a significant factor in organisations that have incurred major deficits.

Unfortunately the benefits of clinical leadership have not been universally achieved. Where it is under-developed there tends to be a disjunction between clinicians and management and greater traditional clinician tribalism. This is not a reason to reject clinical leadership, but should serve as a spur to strengthen it through:

- acknowledgement of its key role by senior NHS professionals
- its greater integration into NHS management fabric, and
- professional development opportunities.

Some see PBC as the next step in clinical leadership. They argue that the role of the PEC has been superseded and replaced by PBC. This is a narrow view of what strategic clinical leadership already delivers and misunderstands the challenges that lie ahead for the NHS in delivering the current reforms. PECs have served a variety of purposes over the lifetime of PCTs. Now they are in need of refocusing to deliver the next phase of NHS Reforms effectively.

The apprenticeship of PEC work has produced a cohort of highly developed front-line clinicians who possess significant skills in strategic planning and thinking. Their management and people skills are coupled with their knowledge and ongoing experience of caring for patients in their clinical roles.

In the post CPLNHS world of plurality of providers, contestability and strengthened commissioning, this exclusive mix of skills and insights will be vital to lead PCTs, and to hold together the ring of commissioners and providers as well as tensions that will naturally ensue out of this. This role is crucial to ensure the NHS provides patient centred, cost effective and joined up services, rather than a confused melée.

There is no other group that can deliver such a unique blend of skills and perspectives to the NHS. PBC will be too small in scale, certainly for many years, and the historical lessons of large scale commissioning from the Health Authority era teaches us that there is a long way to go to achieve intelligent commissioning. Too often, large NHS organisations that lack clinical leadership have rubberstamped the same contract with an uplift, or tried to shift large chunks of care without changing the shape of what is delivered within it.

Intelligent and powerful commissioning is not just about size, but transformational change as well. Strategic clinical leaders are ideally placed to facilitate the development of real commissioning by bringing their clinical insights to bear on the process and by building the bridge between the two ends of the commissioning spectrum - PBC and strategic - to support the delivery of real change right across the system.

The Roles

The shift in PCTs to a stronger focus on the core business of commissioning, their increased size, the advent of PBC, and plurality of providers, all call for a reappraisal of the roles of the PEC. It is clear that it needs to shed some of its broader roles within the PCT. Instead it should focus on supporting strategic development, bringing its clinical management skills to bear on the dual challenges of strengthening commissioning and managing and developing the new healthcare marketplace.

The new PEC also has a key role in supporting corporate probity and bringing clinical scrutiny to key decisions. In order to achieve this the PEC will need to retain some structural continuity for itself within the PCT. It cannot be diluted down to a simple clinical reference committee or one or two clinical directors. The new PEC - perhaps with a new title such as *Clinical Executive* - must be a visible and structural reference point within the PCT and its processes, not dissimilar to the current arrangement. The new PEC or clinical executive chair and members must have clear roles and accountabilities within the organisation and equivalence with the chief executive and other senior managers.

The PEC must change. It must be updated to reflect its more focussed role. It is also clear that the reconfiguration process of PCTs must reaffirm and strengthen the commitment to the *three-at-the-top principle* as it is this equal partnership working between managers, clinicians and non-executive directors that has underpinned the success clinical leaders can deliver.

Clinical leaders are not arguing for preservation of the PEC, but for a strengthening of their role within the organisation that means they can bring the full strength of their skills and unique contribution to bear. It is time for strategic clinical leadership to become truly mainstream within the NHS management structure rather than being wheeled out when it suits a convenient agenda.

Key roles for the PEC will be:

Vision and Strategic Direction

- Giving short, medium and long term direction
- Providing organisational memory
- Maintaining relevance to strategic local issues and needs
- Highlighting health promotion and disease prevention needs in planning
- Translators of policy for other clinicians
- Being clinical leaders and influencers - champions of transformational change
- Succession planning for clinical leadership
- Support to SHAs - by primary care expertise

Commissioning

- Supporting financial balance
- Supporting strategic commissioning - overall direction, larger scale and specialist
- Ensuring health inequalities remain a key focus
- Helping to tackle unscheduled care issues from a strategic angle
- Being clinical champions and innovation leads of key areas

- Supporting the developing of practice based commissioning - developmental, not stifling or controlling
- Ensuring coordination across localities and PBC groupings
- Ensuring services do not become fragmented through plurality of providers
- Helping manage competition and facilitate appropriate collaboration across providers

Probity

- Making recommendations to the Board on PBC and other commissioning decisions - clinical and organisational scrutiny
- Providing recommendations to the Board in other clinical areas
- Championing Patient and Public Involvement and Local Community Engagement

Clinical Effectiveness

- Providing clinical contract management
- Being champions of NSFs and NICE
- Providing clinical scrutiny of service innovation - safety, quality and appropriateness
- Championing clinical governance issues generally across the PCT
- Being custodians of clinical appraisal and performance

Accountability

- The PEC chair will remain accountable to the PCT chair
- Clinical PEC members will be accountable to the PEC chair
- All PEC members will have key lead areas and tasks and be accountable for their delivery in a similar manner to the rest of the management team

Key attributes that PECs possess to support delivery of these roles are:

- Multi-professional teams, representative of the variety of NHS professionals, whose members see themselves as integral to the wider team rather than present just to represent their profession.
- 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.
- 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.
- 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.
- 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.

The Structure

The new PEC, by whatever name, will continue to need to meet as a committee and have a structure. The frequency of these meetings will need to fit the new strategic role, and local needs.

The strength of successful existing PECs is derived in part from their multi-professional make-up (clinicians from different professions and managers) and the fact that it meets as a group of equals to debate and decide issues, direction and strategy. To define the PEC as nothing more than a group of singular individuals is to deny the strength of this group dynamic, integrated into the PCT organisation.

This is one of the many reasons that it cannot be simply replaced by clinical directors or a clinical reference committee. Given the key importance of strategic clinical leadership within the NHS and the next stage of the reforms, to argue that the PEC structure is no longer required is akin to suggesting that PCTs do not require a chief executive or a senior management team.

The Alliance has already put forward its ideas on the new clinical leadership structures[7] within reconfigured PCTs and suggested the renaming of the PEC as the Clinical Executive to reflect its clearer strategic role, tighter remit and equivalence with the senior management team.

It proposes:

- The maintenance of the three-at-the-top relationship (and its introduction where existing PCTs failed to implement *Shifting the balance*
- A smaller membership (probably 5-8 clinicians and 3-5 senior managers)
- Multi-professional clinical representation
- Accountability of the new PEC chair to the PCT chair
- Appointment of the new PEC by interview against a defined skill set
- Interviewers to include the PCT chair, chief executive and at least one clinician including whenever possible the out-going PEC chair
- Appointment of the new PEC chair by the PCT chair following recommendation by the whole new PEC membership
- Clinical new PEC members to be practising clinicians
- Clear roles for each member
- Regular appraisals for all clinical new PEC members by the PEC Chair (possibly jointly with the CEO as required)

- Personal development plans and support
- Flexibility in time commitment to reflect roles and career aspirations
- Clearly defined salaries. This is required to overcome the inequity between different clinical professions currently. New PEC members should be paid as clinical leaders and as befits the responsibilities they are shouldering, not on the basis of their historic professional background.

The NHS Alliance has also proposed the formation of Area Commissioning Forums (ACFs) within the large reconfigured PCTs[7]. Some commentators have described these as a "second tier" of clinical leadership, but this is to place a negative interpretation on their need and function. PBC has been acknowledged as delivering most benefit when delivered across a locality, and so it will be essential to have some form of structure to coordinate practices, clinicians and their plans across these smaller areas.

Particularly within the larger PCTs it will be essential to have lead clinicians and supporting commissioning management. They will need to have clear roles and accountabilities, linked in to the new PEC and PCT, both to support the delivery of the work, but also to ensure the balance between overall strategic direction and locality needs.

Seen in this light ACFs are key structures that will enable PBC to grow and flourish to deliver key PCT and local objectives.

Whilst we have described the structures which we believe are essential for effective delivery of local clinical engagement and strategic clinical leadership, the NHS Alliance has also been at pains to stress the importance of local flexibility. Clearly the needs of a large PCT will be very different to that of a small one.

The size and membership of the new PEC, and the size and presence or absence of ACFs, will be highly variable. Local PCTs and clinical leaders must have freedom to deliver structures that suit their individual needs. But strategic clinical leadership must always be present in a powerful and effective form.

Other key issues

A Role for Clinical Directors and Clinical Reference Groups

In the current debate, it has been suggested that the PEC role could be equally well carried out by clinical directors or by a clinical reference committee made up of local clinicians. The NHS Alliance would reject these options on the following grounds.

Clinical directors are directly employed and line managed by the PCT. Frequently they do not carry a clinical caseload. Additionally clinical directors deliver important and full time PCT responsibilities: clinical governance, accountability for professionals' performance and management of staff. That means they are poorly placed to carry out the new PEC function. Within the larger reconfigured PCTs, these roles will be more demanding and many of them sit uneasily with that of the PEC. For example, a medical director might find it hard for to carry the torch of innovation in one hand while performance managing GPs with the other.

For PEC members, on the other hand, it is the maintenance of the clinical day job, their place in the local NHS and their independence that gives them credibility with their local clinical colleagues - and enables them to introduce challenge and innovation within the PCT.

Existing and new PECs have an important function in improving and maintaining local clinical engagement. Being of the PCT yet simultaneously outside it, with all the understanding of frontline issues that only personal experience can deliver, allows them to win hearts and minds. Clinical directors are constrained by their employment and rarely achieve the same credibility.

Similarly the very fact that the PEC is a cohesive group of different clinical individuals adds a strength that other more traditional clinical management managers do not have access to.

The converse is true of clinical reference groups who would sit too far outside the structure and leadership of the PCT to deliver any of the influence and support that strategic clinical leaders within the new PEC can and should. However, such groups may have particular discrete roles.

In summary clinical directors perform key roles within a PCT and can add to and support the richness that the PEC can deliver. Similarly, clinical reference groups could perform useful roles as independent reference resources particularly in cases where difficult conflicts of interest exist. However neither of them can replace nor deliver the strategic clinical leadership that will be vital to the new PCTs. Clinical leadership needs to be built in to the structure of the PCT or it will again become nothing more than the polite fiction it was in the not too distant past.

Conflicts of Interest and the PEC

It has long been an issue for PCTs that the PEC is made up of local clinicians, perhaps particularly GPs, who have local practices that may gain by their own decisions. The advent of PBC has thrown this into much starker relief. It has led to expressions of concern about the sustainability of the PEC structure within the reconfigured structures[8]. Clearly as PBC develops, the new PEC may be required to make recommendations to the Board on service developments related to practices in which the PEC GPs are partners. In time this may include significant amounts of money or other resources including staff.

It is very important that these concerns are aired and due debate and consideration given to them. Appropriate mechanisms must be in place to deal with them. However it is important to remember that this position is nothing new and since the inception of PCTs this has been the case. These potential difficulties have been dealt with by clear processes and procedures which will need to remain in place and be more explicitly highlighted when considering PBC plans. These are:

- A requirement for 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 developments affecting their own practices.
- 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.
- Membership of the PEC includes PCT professional managers who can ensure balance to the debate and raise concerns over conflicts of interest if they feel they are not being adequately dealt with.
- The PEC is multi-professional and so these other clinicians perform a similar role to the management members.
- Finally whilst the Board will receive recommendations from the PEC, it is vital that 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.

Whilst PEC GPs may have the most obvious conflicts of interest, it is important to recognise that there are other conflicts of interest that are already in place within PCTs or may develop over time. These include:

- Where the PCT provides services and these are bidding for a new development.
- Where a PEC manager runs a service that is involved in or at risk as a result of a new development.
- Private providers that become involved in commissioning support.
- GPs as PBC commissioners and providers of primary care.

It will be impossible to remove all conflict of interests from within the PCT system, and it would therefore be a mistake to remove or downgrade PECs simply on the basis of these concerns. They can be dealt with by transparent management mechanisms and the benefits that strategic clinical leadership are too important to be lost.

Strategic Clinical Leadership and Practice Based Commissioning

Some believe that the advent of PBC has largely removed the need for a PEC. As has already been stated, this is to largely ignore the broader need and role for strategic clinical leadership that the post CPLNHS world will require. The new PEC and PBC equally represent and deliver clinical leadership and engagement, but do so at opposite ends of the spectrum. Both are needed, but each is less effective without

the presence of the other, particularly so in the world of choice and plurality of providers.

In these early days of PBC, the experience and leadership of the new PEC will be required to help develop and deliver it. The new PEC will also serve other key roles such as linking PBC developments into the broader PCT strategy. The new PEC will be key for championing health inequalities, health promotion and public and patient involvement, and ensuring delivery of quality and clinical governance to PBC developments. As PBC matures, the new PEC will have important roles in encouraging provider developments as well as demand management, challenging GPs to look beyond GP issues, identifying strategic gaps in services and encouraging multi-professional involvement.

In summary the position of PEC members as both strategic thinkers and 'coal face workers' will make them well placed not only to encourage PBC, but also to challenge it when required, and link it into the broader PCT aspirations and goals.

Links to Strategic Health Authorities

The Alliance has long lamented the fact that the *three pin plug* of PCT management links into a *two pin socket* at Strategic Health Authority (SHA) level and above. At the same time, the NHS has historically been secondary care centric in its thinking. This disjunction has been acutely felt by primary care organisations. The latest direction of NHS modernisation[9] calls for a change in this with a shift to providing patient centred care closer to patient's homes, plurality of providers and using hospitals as a base for treatment only when that care can not be provided in another setting.

PCTs therefore need to ensure that they share their primary care specialist skills with SHAs and give clear messages about direction and needs. In return SHAs must become more skilled in understanding the primary care landscape, what it can deliver and what their role is in relation to it.

This will be best achieved by ensuring good strategic clinical leadership is enshrined within SHA management structures. There are a number of ways that this can be achieved, but at the very least there should be regular involvement of PEC Chairs at 'top table' planning and discussions. There should be no more meetings limited to PCT chairs and chief executives, excluding the clinical chair - the third pin of the plug. More ideally this should also be achieved by employment and empowerment of appropriately skilled clinical leaders within their structures.

Conclusion

The reconfiguration of PCTs must be used as an opportunity to review, strengthen and refocus the roles of the PEC. It is clear there is a need to strengthen and empower clinical leadership within the NHS so that it can provide a golden thread from the coal face of patient care right through to senior policy making and implementation. Within the new commissioning PCTs and in the new NHS environment of patient choice, plurality and PBC/PbR; strategic clinical leadership has a key role to play and is vital to the realisation of the NHS reforms.

Bibliography

1. *Commissioning a Patient Led NHS.* Department of Health, July 2005.

2. *Practice Based Commissioning: technical guidance.* Department of Health, Feb 2005

3. *Practice Based Commissioning: achieving 100% coverage.* Department of Health, May 2006.

4. *Can do!* NHSAlliance, 2004

5. *Fast forward.* NHS Alliance, 2005

6. *Quicker treatment closer to home.* Audit Commission, 2004

7. *The future of clinical leadership in primary care and PCTs.* NHS Alliance, January 2006

8. *Commissioning in the reformed NHS: policy into practice.* Health Services Management Centre, School of Public Policy, University of Birmingham with the NHS Alliance, March 2006

9. *Our health, our care, our say.* Department of Health, February 2006

10. *Learning from Kaiser: developing integrated care in the NHS.* Professor Chris Ham. Health Service Journal, July 2006

11. *Learning the lessons of financial failure in the NHS.* Audit Commission, July 2006.

NHS Alliance - Goodbody's Mill - Albert Road - Retford - Notts - DN22 6JD
Tel: 01777 869080 - Email: office@nhsalliance.org - Website: nhsalliance.org

Published by the NHS Alliance, July 2006

Designed and Printed by
Clere Design & Print.
www.clere.uk.com