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Joint Response from the Association of British Dispensing Opticians, the Association of Optometrists, the College of Optometrists and the Federation of Ophthalmic and Dispensing Opticians

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Consultation on a Review of PCTs' Professional Executive Committees (PECs)

1. Introduction

The role of the PEC has been questioned for some time. It was intended to be the “engine room” of the PCT and to lead the PCT Board in detailed thinking on priorities, service policies and investment plans. The clinical majority on the PEC was meant to ensure that the views of health professionals shaped the activities of the PCT, but these objectives were never fully met. It would seem that the majority, if not all PCTs, are agreed that clinical leadership has a critical role in the new NHS, that PECs should be smaller and more focussed and that appointments should be based on competencies rather than representative roles. In addition, that the PEC should be concerned with action rather than committee discussion with a number already adopting the NHS Alliance proposal that the PEC should be termed the Clinical Executive, to emphasise its new nature. There is a universal plea for flexibility for each PCT to develop its own functional framework and structure according to local needs. Prescriptive guidance from the Department would not be seen as productive although guiding principles and facilitation are essential. Against this background we offer our comments below.

2. The need for change

In keeping with the stakeholders who took part in the review stage of this consultation, we agree that the PEC not only needs to adapt to reflect the changing role of PCTs, which will now function primarily as commissioning organisations, but to shed its broader concerns so that it can focus on the strategy and core business of the PCT. In doing this, it is paramount that it also places a high priority on developing strong relationships with front-line clinicians.

Clinicians and managers will be expected to work together to take joint decisions on commissioning and we support the suggestion that PEC members be given specific roles and be expected to work with specific directors in order to be involved in key decisions. It is highly important that the clinical PEC members are also closely allied to all practising frontline clinicians contracted to deliver services by the PCT so that work carried out with managers and key decisions are made from a fully-informed base. This has not been the case in the past and has led to many missed opportunities in redesigning services appropriately.

3. PEC function, purpose and accountabilities

Practice based commissioning may have a significant effect on how the PEC functions – some stakeholders take the view that the need for PECs has been largely removed by the advent of PbC. This is unlikely to ever be the case as the PCT will require an expert ‘conscience’ to assure its Board and its commissioners that the commissioning which takes place is clinically appropriate and in line with the overall aims of the PCT. This will be a big responsibility for the new PEC. Whatever the outcome of this new dynamic, the PEC ought to maintain clear lines of communication with commissioning groups and consortia, perhaps by establishing a sub-committee to deal with them, to ensure that its commissioning policy remains within the PCT’s overall strategic plan.

The possibility of conflicts of interest has been raised since clinical PEC members might be both commissioners and providers of services. This would certainly be so of GP members, for example, who could hold PbC budgets and might also be debating the use of a provider service in which they were involved. The obvious way of dealing with such contingencies is transparency i.e. clear lines of accountability with declarations of interest by all PEC members.

4. PEC structure and format

We would go along with the general consensus that there should be no single “right” model for PECs because of the wide variation in PCT sizes and demographics. However there is still a need for guiding principles and facilitation from the Department of Health, which is duly recognised. We would wish the PEC to have a multi-professional base whilst retaining a majority of practising clinicians.

We are persuaded that it would not be possible to have representation from each consortium on the PEC – that would mean that potentially there could be no limit to the size of a PEC. Besides, one of the responsibilities of the PEC will be to scrutinise consortia submissions and assess them in line with the PCT’s healthcare delivery strategy. We would, however, wish to see all the contractor professions including optometry represented. Bringing in non-medical, clinical professionals is particularly valuable in giving a more rounded clinical view on issues. This echoes what has been stated in many of the review responses - that clinical engagement is crucial to the success of any PCT.

5. Competencies and appointments

We support a more rigorous selection process for appointment to the PEC by interview against a job description and person specification and welcome the views from chief executives, PCT Chairs and clinicians which state that there should be no set quotas for particular professional groups as there was in the past e.g. for GPs.

That having been said, only those candidates with a good understanding of the broad field of NHS and private healthcare and who can demonstrate that they can meet the demands of the new NHS in terms of leadership, communications and innovative thinking, will make the difference that is required within the restructured PECs.

The question “Are competencies more or less important than ensuring all clinician groups are represented” is therefore a difficult one. We would suggest that ensuring all the contractor professions were represented would be a reasonable objective, given that many of the candidates would require an element of training and guidance anyway to help them to fit into the NHS environment. Successful PEC members have always appreciated that the business of the PCT is not about advancing their own agenda. A combination of operational knowledge and a strategic view is what is important, especially now under the new arrangements.

It is clear from the review responses that PEC members should hold the respect of their local clinical community i.e that prospective PEC members could be supported in their application by a nomination from one or more related professionals. We would suggest that candidates might also be supported or nominated by their local statutory committees e.g. a Local Optical, Dental, Medical, and Pharmaceutical Committee. Certainly the local committees should actively engage with the PEC and invite members to their meetings to ensure that there is active feedback and engagement between community practitioners and the PCT.

In the past, PEC members have not generally been scrutinised or held accountable for delivering objectives. We think that the introduction of an appraisal and performance review system for each member would make the PEC more effective in delivering objectives. It is vital when considering competencies that this is not just seen as an aspiration at the outset but an ongoing developmental framework. We would like the establishment of a formal structure of continuing training both in general NHS matters but also in leadership qualities.

6.Connecting for delivery

Good communications is at the heart of any endeavour. We would agree with the view that although connections with PCTs, SHAs and the Department of Health are extremely important, they are often underdeveloped and neglected. Suggestions for improvement usually involve the introduction of improved methods of communication within the NHS infrastructure itself. We would like to suggest that formal structures are established to facilitate communications between the NHS and its contractor professions e.g. Local Optical Committees. This is a statutory body charged with representing the optometric/optical profession at a local level. If primary health care is to be developed to cater for the needs of local populations and to transfer more care out of hospital into the community, then dialogue with the grass root professionals involved in the delivery of that healthcare, can only help PECs/PCTs to provide the service that is required. If the correct candidates are selected for the PEC positions, these will have been selected, in part, for their communication skills and therefore we would expect them to automatically engage with the professional bodies.

7.Financing and training for the PEC

We agree that perceptions of poor pay and inequality of pay for PEC members has dogged PCTs and that it is something which needs to be dealt with, particularly if PCTs are to attract highly motivated and skilled individuals to become members of PECs. We also feel strongly that the fees paid, whatever they might be, should be equal for all members, except of course for the PEC chair who should receive a higher rate of remuneration given the role's greater responsibility.

We also agree that the lack of training opportunities for PEC members was a contributory factor to the variability of PEC performances. Where training was provided, it did not concentrate on developing the skills and needs of the individuals concerned. Tackling this problem will, in large part, facilitate greater involvement and efficacy within the newly restructured PECs.



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