SECTION THREE

THE BOARD AND PEC ROLES IN PROVIDING STRATEGIC LEADERSHIP

This section considers:

- clear and appropriate clinical governance structures
- leadership roles of the CEO, Chair of the Board and of the PEC
- the relationship between the Board and the PEC
- the balance between corporate and clinical duties and responsibilities
- the need for effective and energetic strategic leadership
- translating clinical governance into a reality across the entire PCT community.

Responsibilities and challenges

Clear, consistent, and confident strategic leadership from the Board and the PEC is an essential pre-requisite to purposeful engagement with the PCT clinical governance agenda.

'We must lead change as well as manage it. We need leadership in setting out the vision and working with and through people to achieve it.'

Department of Health, 2002

The overall functions and responsibilities of PCTs are set out in the *PCT (Procedure and Administration Arrangements) Directions 2002*. These revoke the *Primary Care Trust (Functions) Directions March 2002* in the light of the disappearance of Regional Health Authorities and the establishment of SHAs.

The challenges facing PCTs, together with the additional commissioning and other responsibilities transferred from regional and local authorities, make it essential that Boards and PECs demonstrate a firm grasp of a complex and rapidly evolving clinical governance agenda; this must be achieved alongside a firmly grounded discharge of the broader duties and responsibilities of 'integrated governance'.

In order to do so, the Board and PEC need to have a common and explicit understanding of the PCT's 'core purpose' i.e. who it exists to serve and why it exists. The nature and the sustained quality of the relationship between the Board and PEC is utterly vital to the effective functioning of the PCT. An ongoing two-way flow of 'intelligent information' between them is essential if they are to keep on top of the rapidly evolving NHS and local agendas. This requires the investment of time in face-to-face interaction as well as 'smart' forms of written and IT supported information exchange.

Key learning from the pilot programme

Given the unique nature of their governance arrangements, the following are the key strategic leadership success factors for PCTs:

- the calibre of the 'three at the top' and the quality of their collaborative working
- the pro- active management of the Board/PEC interface, with the investment of time in face-to-face discussions and debates and the on-going two way flow of intelligent information so that there is clarity and consensus about their respective roles and functions
- the extent to which the NED's role is understood and valued
- the clarity and transparency of clinical governance structures, roles and responsibilities
- the capacity and the calibre of a middle management tier that can operationalise existing strategies and free senior executives to concentrate upon strategic development.

The section on the Board and PEC roles in Providing Strategic Leadership was the highest scoring of all sections with a score of 6 on the progress scale (range 4.5 to 7.3).

Although the more recently formed PCTs scored this section on average lower than their older peers (as they did every section), the difference on this section was relatively small. The 25 PCTs that were under a year old when they completed the questions scored an average of 5.9 while the remainder scored an average of 6.1.

The majority of those providing the first and most visible line of leadership, the 'three at the top', enjoyed the confidence of their Board and PEC colleagues. However in a significant number of PCTs one or two members of the PEC expressed, in their answers to the questions posed, significant dissatisfaction with, or disaffection from, the leadership. In a much smaller number of cases this dissatisfaction was far more widespread and signalled fundamental concerns about the overall leadership of the PCT.

A number of the Boards and PECs in the pilot had worked hard to develop a genuine sense of mutual understanding and consensus among members the Board and PEC. This required the regular investment of scarce time, and a willingness to discuss and debate basic and fundamental issues about the PCTs purpose and key roles without becoming bogged down in the micro-complexities of the operational or fiscal agenda. The result was an impressive level of commitment to a clear, common and prioritised agenda for quality assurance and for improvement.

One vital by-product of this was a clear and common understanding of what is meant by 'reasonable assurance' – a vital pre-requisite to the effective corporate functioning of a governance structure, since this represents the benchmark against which a Board and PEC's decisions will be tested if they are ever contested in law (see below).

The majority of PCTs had begun to foster consensus between the Board and the PEC but, due to the budgetary and other pressures associated with the creation of a new organisation, the additional commissioning and other responsibilities, or target-led pressures, they had either not been able to give sufficient time to collaborative working or had not recognised its fundamental importance.

In these cases, although quality was actively on the PCT's agenda, that agenda was still cluttered and, to some extent, less than coherent – with persistent uncertainty about the respective responsibilities and contributions of the Board and the PEC.

In a few cases no effective relationship had been formed between the Board and the PEC, with the very real danger that there were divergent or non-aligned agendas. Some Boards seemed to have been pre-occupied with fiscal and corporate matters to the virtual exclusion of quality and clinical concerns, just as a small number of PECs had singularly failed to take control of the clinical quality agenda or to provide effective leadership to the PCTs professional communities.

In most cases non-executives were making an important and highly valued contribution to the work of the PCT. A number of them showed an outstanding grasp of the complex issues confronting the local PCT and were making major strategic contributions to overcoming these challenges.

In a significant number of cases, however, the questionnaire revealed very divergent opinions about whether 'due weight' was being given to the views of non-executives. Sometimes these concerns were expressed by non-executives who did not feel that their voice was welcome or influential. In other cases PEC members, in particular, felt that too much importance was attached to non-executive perspectives. In all of these cases it was clear that there had been no proper and collaborative exploration and discussion of the duties and responsibilities of non-executives, so that no clear consensus had been generated. Left un-addressed this would have undermined the overall effectiveness of the Board and damaged its collaboration with the PEC.

In some PCTs the respective roles and responsibilities of the PEC and of the Clinical Governance committee were unclear, as was the differentiation between the role of the PEC Chair and the designated Clinical Governance lead. This was not merely an issue of structure, but sometimes reflected more complex misunderstandings about the nature of clinical governance and its connection to the core business of a PCT. This concern has been reinforced by a number of CHI PCT reviews that have identified a lack of simplicity and clarity in formal clinical governance arrangements.

Finally, it is clear from the work with the pilot PCTs that the scale and scope of PCT responsibilities are not always matched by their middle management capacity. Often indeed it appears as if a variant of the 'inverse care law' is being applied. The availability of middle management capacity tends to vary inversely with the need for it in a particular PCT. This was sometimes most evident in those PCTs that had been most recently formed and in those serving some of the most deprived and therefore most complex and needy local communities.Where this is the case two opposing dangers are present.

The first is that senior managers will be so overwhelmed by micro-operational pressures that they will have no opportunity to reflect or act strategically. Important and longer-term considerations will be overwhelmed by the urgent and the immediate.

The second is that clear and sometimes elegant strategies will be formulated, but there will be no capacity available to 'manage them into reality'. Both of these phenomena are frequently noted by CHI in their reviews of PCTs and the acute sector.

The Boards and PECS of PCTs must therefore be attentive to the organisation's middle management capacity and capability and, where necessary, must have the courage to invest in its development.

Locating clinical governance within the overall context of 'integrated governance'

'Governance' describes the overall systems of accountabilities and assurances that must be put in place within an organisation to ensure that it discharges its functions legally, ethically and effectively. The Board has corporate responsibility for regularly monitoring and scrutinising the behaviour of the organisation to be certain that

- these systems operate effectively
- key objectives and outcomes are being persistently and energetically pursued across all of the aspects of an NHS Trust's (NHST) roles and responsibilities.

The duties of Boards and Professional Executive Committees have recently been brought together for the first time in one concise document, produced by the Department for Health and the Appointments Commission.

This document emphasises not only that the governance duties placed upon the Boards of NHSTs must be exercised in relation to all key functions, but also that these duties must not be seen as ends in themselves but as a means to securing improvements in the quality and in the value for money that is delivered to local communities.

To this end it, also emphasises the dangers of implementing clinical, corporate, fiscal, information and research governance as separate and unrelated strands of activity, rather than as interconnected facets of a holistic system of control and quality that are underpinned and brought together by controls assurance processes.

In other words, integrated governance embraces all of the systems and processes by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services, and in which they relate to the wider community and partner organisations.

All of these systems will, in the future, be subject to one integrated form of scrutiny by the new Commission for Health Audit and Inspection.

The Government has laid down a number of Governance Standards that define the corporate duties and functions that a Board must discharge.

'There are clear accountability arrangements in place throughout the organisation;

The Board identifies the needs of stakeholders on an ongoing basis and determines a set of **key objectives and outcomes** for meeting these needs, including **how it meets its duty of quality.**

The Board ensures there are proper processes in place **to meet the organisation's objectives and secure the delivery of outcomes**.

The Board can demonstrate that it has done its **reasonable best to achieve its objectives and outcomes**, including maintenance of a sound and effective system of internal control.'

CASU, 2002

A full explanation of these standards is on the Controls Assurance Support Unit website (see Resources, below). Because, within NHSTs, some accountabilities are discharged directly by the Chief Executive in her/his capacity as the 'Accountable Officer', they and the Audit Committee have a crucial role in ensuring that the annual 'Statement of Internal Control' (SIC) accurately and fully encompasses all of the risks to which an organisation is or may be exposed and demonstrates that effective systems and processes are in place to manage and minimise these risks.

REFLECTION

What evidence is there to suggest that these Governance Standards are familiar to all members of the PCT Board and PEC?

It is important that all members of the Board keep these standards under active and explicit review. All NHSTs must ensure that integrated governance agendas are aligned. The Board must therefore strike an appropriate balance between attention to its fiscal and corporate responsibilities and to the specific safety, quality and transformation agendas and issues encompassed by 'clinical governance' and 'research governance'. Its duties in relation to 'information governance' straddle all of these domains since, as the new Commission for Health Audit and Inspection makes clear, 'intelligent information' should underpin all of the decisions reached by those who govern organisations (this is explored more fully in sections 7 and 9).

The development of the concept of clinical governance was itself a means to ensure that NHSTs placed quality at the very heart of the Board agenda.

'NHS Boards should focus even more time on clinical issues, to use the clinical governance framework as a brand, a promise to deliver quality across all clinical; services and to benchmark themselves against the best.'

Department of Health, 2002

So far as PCTs are concerned, the creation of the Professional Executive Committee (PEC) provides structural assurance that clinical issues will receive systematic and sustained scrutiny and that its regular reports back to the Board will keep clinical governance issues at the forefront of the organisation's integrated governance agenda.

Strategic leadership of clinical governance – maintaining 'balance'

Boards and PECs need to maintain a complex set of balances in the way in which they approach the clinical governance task.

Maintaining a balance between fiscal and quality concerns

Perhaps the most obvious balance relates to managing the tension between available financial and other resources and the extent of need.

'PCTs will never have enough resource to do all they are called upon to do and therefore the Board needs to agree the parameters within which the difficult choices are going to be made; they also need to be explicit about what takes priority and what doesn't. As part of the modernisation/innovation agenda, we are encouraging positive risk management rather than lowest common denominator management and this needs to be grasped if clinical governance is to move forward.'

Eddie Kinsella, 2002

Financial matters inevitably and necessarily form one important focus of the Board's attention and scrutiny – particularly where a PCT (or the health economy of which it is a part) has an inherited or recurrent deficit.

'We need to extract the best value from every pound .... We must be prepared to challenge behaviours, change old practices, be creative and take uncomfortable and difficult decisions.'

Department of Health, 2002

This is particularly important for PCTs given the new scale, the scope and the complexity of their financial responsibilities and accountabilities.

'For the first time the NHS knows the funding it will have available in each of the next three years; PCTs will take responsibility for 75% of the expenditure of the NHS; over the next three years the average increase is almost 31% in cash .... We must work across NHS organisations and with local authorities to pool our resources and plan services together wherever possible; look at new options for delivering services... challenge ourselves and each other to be creative and bold, just doing more of the same won't deliver.'

Crisp, 2002

It is also essential that Boards stay abreast of the emerging financial agenda – and consider the medium- to long-term implications for the PCT of possible or likely changes. *Reforming the NHS Financial Flows:Introducing Payment by Results* – a consultation and guidance document about changes to the way funds will flow through the NHS – sets out the next steps on the financial reforms announced in *Delivering the NHS Plan*. It provides important information for Boards and for all NHS finance, planning and commissioning staff.

REFLECTION

How balanced is the Board agenda between financial and clinical issues? What evidence exists to support your views?

Important as these considerations are, it is essential, if the Board and PEC are to discharge their statutory duty of 'quality', that attention to issues of finance, of financial balance and of corporate governance do not override or exclude attention to clinical concerns.

While it would appear from ongoing studies of NHS trusts that they are largely achieving the corporate accountability agenda, there is rather more room for improvement in the long-term developmental agenda of clinical governance.

Maintaining a balance between national and local priorities

Boards must also maintain the important balance between responsiveness to national and to local priorities.

'There is a tension between the demands of national policies and targets and the need for PCTs to address local issues and priorities..... Ninety percent of PCT board and PCT executive committee chairs wanted more opportunities to focus on local health needs and service development priorities.'

National Primary Care Resource and Development Centre, 2002

It is partly in response to this concern that the new Secretary of State has set out his vision for a more localised NHS:

'PCTs are local organisations whose sense of direction is looking outwards to their locality not upwards to Whitehall ....There will be clear national standards for public services applicable to everyone irrespective of where they live and of their ability to pay ...Within these standards front line staff must have the authority over how the service is delivered in their locality. ...To succeed in delivering services in the modern world, power over the experience of how those services are delivered needs to reside locally. This stress on the local management of local services is a vital part of localism.'

Reid, 2003

Not least with the advent of the new Commission for Health Inspection and Audit and with the reconsideration of the current basis of organisational 'star ratings', there will be a gradual reduction in targets and a refocusing of them so that there will be enhanced opportunities for PCTs and other local NHSTs to strike a more appropriate balance between national and local priorities, and to see their ability to strike this balance reflected in the way that their overall performance is judged.

REFLECTION

What evidence is there to indicate that a balance is maintained between attention to issues of safety and quality of current provision and attention to potential new forms of service provision?

Maintaining a balance between attention to safety and attention to improvement and transformation of services

Equally importantly, Boards must balance the need to pay attention to assuring and improving the safety and quality of existing care with the need to think creatively and imaginatively about new forms and models of care that would map more closely against the needs of the communities that they serve.

Not surprisingly, the controls assurance aspect of clinical governance is more developed than quality improvement but over time this will need to change.

'We must strike a difficult balance between planning for a future service whilst managing the problems of the one we have – looking for both short term service improvements and long term health improvements.'

Department of Health, 2002

Hitherto, in the face of the pressure to address some of the glaring shortcomings in quality that were uncovered by clinical governance, the balance has tended to fall on the side of 'safety'. The National Audit Office has recognised that:

'The controls assurance aspect of clinical governance is more developed than quality improvement.'

National Audit Office, 2002

Without in any way lessening the emphasis upon existing safety and quality this balance now needs to be redressed.

Maintaining a balance between attention to the intra organisational components of clinical governance and attention to the duty of quality in relation to commissioned services

In parallel with this, Boards must balance the attention they pay to the ownership and component elements of clinical governance within the boundary of the PCT with an engagement with their local health economy – so that their individual and corporate view looks outwards to the local health community as well as inwards to the PCT itself. They must have explicit regard to the quality of the services that they commission and subcontract alongside an equal commitment to the quality of the services that they provide. They cannot set one standard for the services they commission and subcontract and a different standard for the services they provide.

'The inherent tensions in the leadership role include:

- managing the balance between accountability for standards of governance and risk management while fostering creativity and innovation on the ground.
- focusing on the big picture while keeping a handle on the significant detail
- working in partnership outside the organisation to develop services in a collaborative way – while retaining a sharp accountability for leading their own organisation.'

Department of Health, 2001

Integrated Care Pathways, Networks and National Service Frameworks – the new clinical governance challenge

In order to manage the entire patient journey and the totality of the care experience more effectively, national and local initiatives alike are fostering the development of new and integrated patterns and models of provision that cross historical organisational boundaries. Progress in this area is vital. First, and foremost, this responds to the concerns of patients themselves about the discontinuity and lack of integration that characterise some of the care that they receive within the overall health and social care system. Equally, it will enable the PCT to prepare for the focus of scrutiny that will be developed by the new Commission for Health Audit and Inspection.

'The assessment must address three central matters:

the quality of care received by patients;

the quality of patients' experiences, particularly along the pathway between organisations and services;

and the quality of organisations and their capacity to produce improvements in services.'

CHI, 2003

The work of the Cancer Networks, of the Primary Care Collaboratives and of local implementation actions in relation to NSFs have all demonstrated the progress that can occur when organisations and clinicians come together in partnerships that seek to re-conceptualise, to map and to flexibly manage the total experience of care – in all of its complexity.

These new forms and models of care are tangible and concrete expressions of clinical governance in action. They present a challenge to develop partnership-based governance arrangements that ensure that accountabilities, leadership responsibilities, financial flows and reporting arrangements are all explicit and clear.

'Increasingly services are provided in networks and PCTs and SHAs alike need to become network organisations bringing in people and groups to work with them on tasks. Partnerships and alliances will become as much the currency of management of the future as the governance of individual institutions.'

Department of Health, 2002

Coping with co-incident challenges

Running as a core theme through all of these activities must be:

- a sustained commitment to pro-actively involving patients and local communities in all aspects of the work of the PCT
- fostering within the PCT staff community a positive and empowered culture in which commitment to patient safety and commitment to innovation co-exist and mutually support each other.

'Good leadership empowers teamwork, creates an open and questioning culture, and ensures that both the ethos and the day to day delivery of clinical governance remain an integral part of every clinical service.'

Halligan and Donaldson, 2001

A Leadership Qualities Framework sets out the qualities to which all NHS leaders should aspire if they are to cope with the diverse and complex nature of the challenges they and their organisations face. The qualities include a range of social, cognitive and performance skills, clustered into three categories: personal qualities, setting direction and delivering services. This framework provides a useful checklist not just for individual leaders within NHSTs but also for Board and PEC communities, so that they can assure themselves that taken together they have a balance of all of these requisite qualities. In order to discharge their complex statutory duties efficiently and effectively and to provide the strategic leadership demanded by the clinical governance agenda, the Boards and PECs of PCTs need to perform not only as individuals but to function well as 'working groups'.

REFLECTION

What evidence exists of the extent to which the Board and PEC keep their own performance under active critical review?

'It is the sum of the individual directors' abilities, their shared perception of the role of the board and the fusion of that board into an effective whole that distinguishes a mediocre board from one that can add long term strategic value.'

Tricker, 1997

In other words the performance of the Board and PEC needs, periodically, to be an item on the Board and PEC agenda. The discussion and debate that ensues needs to be actively informed by the views of the local community and of the PCT's own professional and support staff community.

Developing vision and explicit priorities

There is much that could potentially be done. Boards and PECs need to engage in an active dialogue with patients, staff and other key stakeholders in the local health economy. This will enable them to identify a clear vision for the future of the PCT: a clear understanding of overall purpose and direction of travel that brings coherence and focus to all the actions and activities of the organisation.

'In failed transformations, you often find plenty of plans and directives and programs, but no vision.'

Kotter, 1997

They then need to agree a realistic number of strategic priorities – priorities that reflect the key national concerns sat out in the Planning and Priorities Framework (2003 –2006) and at the same time embrace those of local people.

'Under-performance in a health organisation is often due to its board lacking a coherent strategic direction for the organisation itself and for the clinical care it provides.'

Wall et al., 2002

They then need the confidence and the persistence to pursue these priorities. The guidance emphasises the importance of

'**... constancy of purpose**, keeping the programme on course and not being deflected from the goals that the organisation has set itself.'

Department of Health, 1999

Boards and PECs must also ensure that they have in place processes that ensure that real, sustained and evidenced progress is made in turning these strategies into coherent systematic and effective action. CHI has expressed the concern that, in some organisations, there is a lack of communication and understanding between strategic and operational levels. The overwhelming majority of its reviews of PCTs, as well as of the acute sector, have raised concerns about communication between operational and strategic levels in relation to particular components of clinical governance.

'The Board recognised the need to shift their focus of Clinical Governance to making a demonstrable difference to clinical outcomes within managed frameworks i.e. moving from 'talking to doing'.

Carmarthenshire NHS Trust, 2002

REFLECTION

What evidence is there of a clear 'vision' for the PCT?

Does this 'vision' shape services and impact directly upon the provision of care?

The role of the PCT Board

The Board of every NHS organisation carries the final overall corporate accountability for its strategies, its policies and its actions.

'The corporate role of the Board is clearly set out in the Codes of Conduct and Accountability issued by the Secretary of State in April 1994.'

Corporate Governance Framework for Primary Care Trusts: Index, August 2001

This guidance specifies the duties of the Boards of PCTs:

'
- to ensure effective financial stewardship through value for money, financial control and financial planning and strategy
- to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation
- to appoint, appraise and remunerate senior executives
- to ratify (on the recommendation of the executive committee) the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them

- to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary
- to ensure that the executive committee leads an effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.'

Corporate Governance Framework for Primary Care Trusts: Index, August 2001

The guidance also makes clear the distinctive characteristics of PCT strategic leadership structures.

'The Boards of PCTs are expected to discharge these functions differently from those of other NHS bodies. PCT Boards should concentrate on the first four functions: for the latter two the Board's role is to oversee the work of the professionally led PCT executive committee and to consider proposals or initiatives generated by or on behalf of the PCT executive committee.'

Corporate Governance Framework for Primary Care Trusts: Index, August 2001

In no way does this exclude or absolve the Board from engagement with the clinical governance agenda. Rather it creates a specific grouping, the Professional Executive Committee, through whose focussed activities this agenda can be professionally led and embedded in all aspects of the PCTs clinical activities so that outcomes can be reported back to the overall Board on a regular basis.

'The PCT Board has overall responsibility for the PCT providing an external perspective and links with the local community through its lay members. It also has responsibility for performance management, ensuring that the organisation follows the agenda for investment and reform set out in *The NHS Plan*. The Board also oversees the work of the PEC.'

Westminster Primary Care Trust, 2002

In the light of the changing and expanding remit of PCTs, greater flexibility has been granted to them to determine locally the nature and composition of the Board and of the PEC through changes to the 'PCT Membership and Procedures Regulations'.

'Within a more flexible regulatory framework, PCTs now have greater freedom to decide their executive Committee composition and to make changes to the Board composition without seeking the approval of the Secretary of State for Health.'

Reid, 2003

Although much has changed in relation to the scale and scope of PCT duties and responsibilities in the intervening months, the Department of Health has issued useful guidance to PCTs: *Primary Care Trusts: Establishment, the preparatory period and the functions*, available at www.tap.ccta.gov.uk/doh/coin4.nfs

Although it was clear from the pilot that many PCTs Boards had, from the outset, taken seriously their overall duty of quality and their responsibility for clinical governance, in a significant number of cases the Board agenda had been dominated by financial or other corporate concerns, almost to the exclusion of clinical issues.

REFLECTION

What evidence is there to suggest that the role of the PCT Board is clear to all of its members and to the PEC members?

Is the role of the Board clear to the PCT community as a whole?

In these cases not only PEC members but especially those with Clinical Governance leadership responsibilities felt both isolated and vulnerable, particularly because they had a firm grasp of the risks that were being run, not least in the face of the prospect of CHI clinical governance reviews.

In the majority of such cases, the pilot programme has been able to redress this balance, not least by sharing with the members of Boards and PECs the outcomes from current PCT CHI reviews, the consequences of adverse review and the developmental agenda that confronts Boards in preparing for the inspection and audit regime that will be introduced by the new CHAI.

The role of the PEC

The work of the PEC needs to be clearly focussed on generating and fostering active engagement with all staff and with patients and the local community so that clinical priorities are owned in common by the patient and the professional community.

' The Executive Committee is where the detailed work of the Trust is carried out. The Committee guides the Board on detailed thinking on priorities, service policies and investment plans.'

Reid, 2003

The PEC must ensure that these clinical priorities become the focus for systematic and continuous improvements in quality (without allowing these priorities for improvement to deflect staff from a sustained commitment to the safety of existing provision).

' The PEC has a strong clinical focus in the way it conducts business and has a close working relationship with its working and partnership groups.'

Westminster Primary Care Trust, 2002

This differentiation of primary focus between the Board and the PEC has been viewed, by some professional commentators, as being potentially problematic – at least while these new structures are being tested out in practice.

' PCTs also have a professional executive committee, and tension between the two is to be expected as each works out its area of responsibility.'

Beenstock, 2002

The precise nature of these arrangements needs to be given concrete form at local level to enable local initiatives and solutions to emerge.

REFLECTION

Is the role of the PEC clear to all of its members and to the Board?

Is the role of the PEC clear to the wider PCT community?

Is the relationship between the PEC and the Board harmonious and unambiguous?

Does the composition of the PEC fully reflect the professional diversity, knowledge and expertise of the PCT community?

What evidence is there to support your views?

'We came up with the concept that instead of the executive committee being the engine room, it is the navigation room. It is more about considering the objectives coming up from the grass roots and the centre and deciding what are the local priorities. Then setting that course out and ensuring the organisation delivers....We have got different strengths and experiences, different personal skills, we actually complement one another and respect each others' boundaries. Through the culture we have created we have got effective working relationships among the three different groups. That ensures an organisation which is responsive to local needs while delivering the central agenda.'

Dr Peter Melton, PEC chair at North East Lincolnshire PCT, 2002

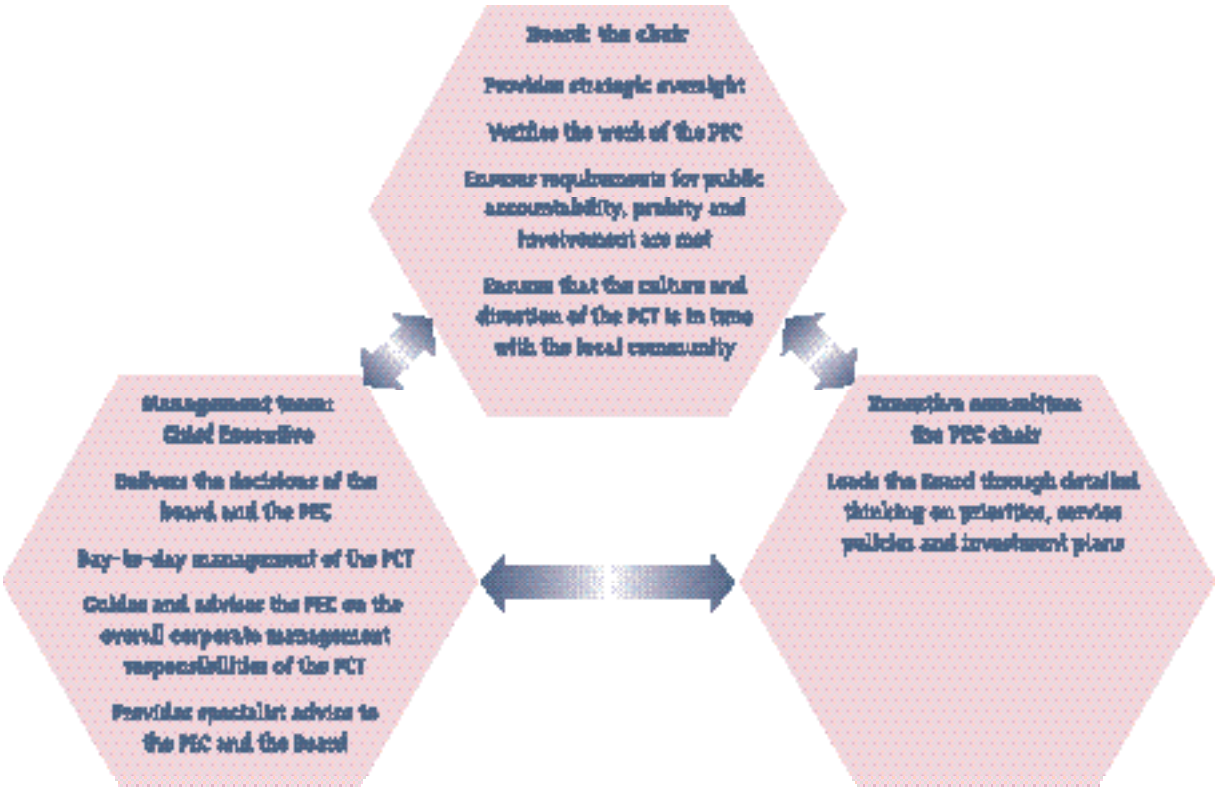
Many examples already exist of the ways in which PECs are working harmoniously and productively with Boards and with the PCT's executive officers.

'A close working relationship between the PEC and the PCT's Senior Management Team is essential. The PEC and the management team are collectively responsible for the leadership and management of the PCT, bringing together clinical and managerial perspectives.'

Westminster Primary Care Trust, 2002

It is clear from the pilot programme that the quality of the relationship between the Board and the PEC is one of the most vital determinants of overall progress in relation to clinical governance and quality. Notwithstanding the enormous pressures upon the individuals that make up both groups, the investment of time in coming together on a regular basis to share and exchange views about the current and future issues and agenda for the PCT is an essential pre-requisite to organisational success.

The Competency Framework of PCT Leadership is available on the NatPaCT website. It provides further details concerning the general duties of the Board and the PEC as well as specific duties of key posts and post-holders. It also includes the following helpful diagram.



The 'three at the top'

In all organisations the clarity and the quality of the relationship between a Chair and a Chief Executive is crucial to effective functioning.

'The role of the CEO and chairman is vital. The ability to work closely together with an understanding based on trust and a clear appreciation of each others role and responsibilities is vital.'

Tricker, 1997

The structure of PCT's governance arrangements, however, gives rise to a unique tri-partite relationship at the top of the organisation – that between the Chair of the Board, the Chair of the PEC and the Chief Executive.

'In a sense, PCTs have three leaders, each one appealing to different constituent parts of the organisation.'

Beenstock, 2002

Where relationships between Boards and PECS have evolved productively and harmoniously, it reflects on the nature and quality of the relationship that has been forged between this triumvirate who share the responsibility for facilitating effective co-ordination and collaboration.

REFLECTION

Is there evidence to indicate that the 'three at the top' work effectively together?

Do they share their thinking with others effectively? Who do they consult – and how often? Is there an explicit mechanism for consultation?

How open are they to the contributions and ideas of others?

'The key to success in the tri-partite scheme is personal working relationships. You cannot say the model will fail or succeed, it's the way in which you work with people that makes it a success or not ... It's about our collective working style not just my personal approach. We try to ensure the PEC chair is a fully participating member of the PCT board and of the management team. PEC chairs may well feel excluded from day-to-day management issues but we try to ensure that the PEC chair is fully involved in management team business. We also have regular post-board meeting reviews to pick up any issues that might have emerged. We make efforts to work together rather than end up in opposite corners.'

Bob Smith, Chief Executive of Newcastle PCT, 2002

Boards and PECs need to form a cohesive and mutually supportive team. This team should be inclusive and welcoming of the views and participation of others so that it does not become a closed clique, detached from the main body of the PCT community. The quality of the open dialogue between the Board and the PEC, and between them and other members of the PCT community, will significantly impact upon the quality of the distinctive culture that emerges over time in all organisations.

It was clear from the pilot that, in those organisations that were making the least progress, there were often profound differences of judgement and emphasis between the 'Three at the Top' – differences that had often not been recognised or, if recognised had not been directly addressed, until they were identified through the feedback process.

The Chief Executive Officer

The CEO is the named 'Accountable Officer' within the overall accountability framework of the NHS. The CEO signs off the Statement of Internal Controls and the Annual Clinical Governance Reporting Statement.

'PCT chief executives need the ability to connect with a variety of constituencies, the capacity to set a direction and to ensure targets are met, plus willingness to act as a buffer between central demands and local aspirations.'

Beenstock, 2002

The CEO, as the head of the executive arm of the PCT, has a major responsibility for ensuring that all the Board's strategies are implemented, and that the work of the PEC is supported and facilitated. The CEO has a duty to ensure a continuous flow of information and intelligence to the Board so that all decisions are informed by accurate and comprehensible information; the CEO must share with the Board, at the earliest opportunity, any significant risk to the achievements of any of the organisation's strategic priorities or objectives.

Specifically in relation to clinical governance, in collaboration with the Chair of the PEC and with the PEC itself, the CEO is responsible for ensuring that:

- there is clarity and cohesion in the establishment of clinical governance priorities
- purposeful action is initiated and sustained to translate these strategies into systematic reality
- progress is actively monitored and reported back (through the PEC and other appropriate structures) to the Board itself.

The effective discharge of this role demands both a breadth and a depth of professional management expertise, including the following:

'
- Self belief
- Self awareness
- Self management
- Drive for improvement
- Personal integrity
- Setting direction
- Vision
- Intellectual flexibility
- Political astuteness
- Drive for results
- Leading change
- Holding to account
- Empowering others
- Strategic influencing'

NHS Modernisation Agency, 2001

While it is, as yet, too early to say with certainty how CEOs in PCTs, in particular, feel about the issues and challenges that confront them in providing effective leadership to the clinical governance agenda, across the NHS as a whole an interesting and balanced picture is emerging.

' Chief executives see clinical governance as having been moderately successful, and having brought about real changes within NHS trusts in the way that clinical quality and performance issues are addressed. They indicate that NHS boards are now better informed, that quality is higher on the corporate agenda, that clinicians are more accountable for the quality of care that they provide, and that cultures and attitudes have become more receptive to the ideas of clinical governance and more willing to tackle However, chief executives are cautious about over claiming – few of them regard clinical governance as a complete success, and many cite barriers and problems which have inhibited progress, most notably resource constraints, staff and organisational cultures and attitudes, and the wider pace of organisational change in the NHS.'

(National Audit Office, 2002)

REFLECTION

Does the CEO provide leadership to the organisation?

Is he or she visible and well-known within the PCT and the wider community?

How is he or she supported?

What evidence is there to support your views?

REFLECTION

Does the Chair provide effective leadership to the Board?

Is the Chair an assertive and articulate spokesperson on behalf of the Board?

Are Board meetings well organised and well chaired?

What is the culture of the Board? Are they role models for the rest of the PCT?

Are all members of the Board, including the non-Executives encouraged to contribute fully to debates?

What evidence is there to support your views?

It was absolutely clear from the pilot programme how great was the load that was carried by PCT CEOs and by their executive team. Because of the highly demanding nature of the responsibilities and tasks of PCT senior managers, Boards (and not least the Chair and non-executive members) need to keep this workload under active review, and to ensure that the developmental and the support needs of CEOs and senior executives are recognised and addressed, so that they are enabled to develop and then sustain their performance at an optimum level.

The Board Chair

The Chair is responsible for leading the board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole. Because of her/his crucial contribution to the success of the PCT, the Chair's performance will be appraised annually by the Chair of the SHA.

'It is the Chairman's role to:

- provide leadership to the board
- enable all board members to make a full contribution to the board's affairs and ensure that the board acts as a team
- ensure that key and appropriate issues are discussed by the board in a timely manner.
'

Corporate Governance Framework for Primary Care Trusts: Index, August 2001

The Chair not only brings structure to the Board's deliberations, but also has a vital role to play in fostering a culture within the Board itself. This culture should be reflective, collaborative and honest; it should not respond defensively to dissent but view it as a stimulus to reflection and learning, and as an exercise of the Board's duty of scrutiny. This 'just and open culture' sets the tone for the rest of the PCT. It enables mistakes and near misses to be shared, lessons learned and learning shared with others in and beyond the PCT. This cultural tone starts with the Board as an example to the rest of the PCT.

'The key to [good governance] isn't structural, it's social ... a virtuous cycle of respect, trust and candour.'

Sonnenfeld, 2002

These qualities characterised the culture of the majority of PCT Boards and PECs in the pilot. In only a small minority of cases was there evidence of disharmony and dissatisfaction within or between the Board and PEC. In these, it was generally the case that the PCT Chair had failed to grasp and master his or her duties and responsibilities and so had not earned the respect of the Board and PEC colleagues.

The PEC Chair

The qualities and facilitative style of the Chair need to be mirrored in those employed by the Chair of the PEC. He or she needs to develop a Professional Committee that is genuinely representative of the PCT community and functions well as a working group.

'The challenge is to build a balanced group with the appropriate set of talents and to create a board level climate in which they will all be utilized to the full.'

Tricker, 1997

The Chair and PEC colleagues have a key role in ensuring that all professional groups within the expanding PCT community (general practitioners, nurses, dentists, pharmacists, optometrists, AHPs and all other professional staff) feel actively engaged with the clinical governance agenda. All members of the community must see this as a support to their professional duty of care to their patients – not as a bureaucratic or administrative imposition.

It is important to recognise that, as the National Tracker Survey revealed, PEC leads or leads for individual clinical disciplines within PCTs, sometimes feel isolated, overstretched and unsupported. Effective clinical governance implementation will not be possible without clinician 'champions' who can shape and carry forward the agenda. In taking on key organisational roles, clinicians may have 'stepped outside' some of their local support structures, and be seen by colleagues as 'part of the problem'. These key individuals must be provided with sufficient time for personal development and for the development of support networks.

The National Primary Care Development Team's (NPDT's) Clinical Leadership Initiative is an important contribution to this agenda and offers clinicians expert support and training to develop higher level skills not only in quality improvement itself but also in leadership for quality improvement.

It was clear from the pilot how great is the commitment and investment of the overwhelming majority of PEC chairs. Many of them provide exemplary leadership to their professional communities and exemplify all that has long been best in the traditions of UK healthcare, allied to an open-minded willingness to innovate and to embrace constructive change. Set against this were a very small number who viewed their role primarily as being to act as a defence block between the constituent general practices and the PCT. Perhaps unsurprisingly, in these cases, there tended to be a significant degree of cynicism and detachment that was common to a number of PEC members.

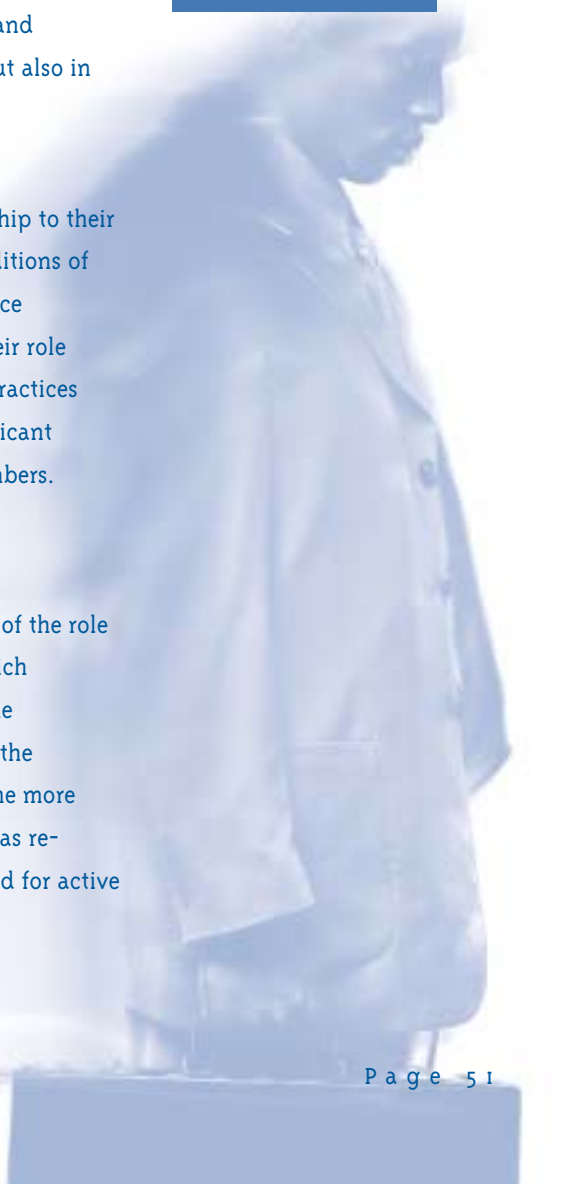
REFLECTION

Does the PEC Chair provide effective leadership to the committee?

Is the PEC chair an assertive and articulate spokesperson on behalf of patients as well as on behalf of the professions?

Is the PEC chair adequately supported in her/his role?

What evidence is there to support your views?



The role of non-executives

In the last few years, increasing emphasis has been placed upon the centrality of the role of the non-executive directors within NHS organisations. The Higgs review (which reported in January 2003) was specifically set up to review both the role and the effectiveness of non-executives in all forms of UK organisation. Building upon the foundation laid by *Cadbury* (1992), *Greenbury* (1994) and *Hampel* (1998) and the more recent conclusions of the Bristol Royal Infirmary (BRI) inquiry the *Higgs Code* has re-emphasised the need for forthright independence, for appropriate expertise and for active scrutiny.

'In our view, non-executive directors have a crucial role to play as representing the public interest in the conduct of the trust's affairs. They must be people with a high level of ability and experience in the leadership and management of organisations ... they should have a commitment to public service.'

Bristol Royal Infirmary Inquiry, 2001

Within the NHS, the duties of the non-executive have been summed up by the Appointments Commission under the acronym SAGE:

Steward
Advocate
Guardian
Excellence

'The Audit Commission has identified three characteristic tensions in the role of a non-executive:

1 They are part of a corporate team and should be supportive of the chairman and chief executive, but they also act as a counterbalance to the power of chairmen and chief executives.

2 A good team spirit is essential to the efficient operation of the board but non-executive directors have a particular role in monitoring the performance of executive directors, which has the potential for conflict.

3 It is generally accepted that non-executive directors should contribute to the development of the strategy and should not usually become involved in the detailed running of the organisation, which is the province of executive directors, but in monitoring the implementation of the strategy, non-executive directors need to be drawn into some discussion of operational issues. Further, if there are serious operational problems, the independent judgement of non-executive directors may be needed to help the board find a solution. The dividing line between strategic and operational issues is by no means clear-cut.'

The Appointments Commission

The non-executives in PCTs need to possess both the confidence and the competence to manage these tensions so that they are able to fulfil their key functions to:

- scrutinise and challenge the actions of the PCT
- ensure a strategic direction is set that balances national priority against local need
- ensure policies stay focused on the PCT's core purpose and key outcomes
- represent views of patients and be aware of the rights and responsibilities of users
- be aware of the rights and responsibilities of staff.

'Non-executives on NHS boards are expected to bring their independent judgement, expertise and their community perspective to bear on the issues facing the board. You will be able to question and probe the executives so that the board can make sound and well informed judgements and act as a corporate team.'

The Appointments Commission

Non-executive directors on the boards of PCTs play a vital role in representing the overall interests of the public at large: they must not represent only special or factional interests. Non-executives are drawn from a variety of backgrounds – business and commerce, education and other public sectors; they must use their independence and experience of the world outside the NHS to make a contribution to all the trust's work. Non-executive directors need to be actively engaged in framing strategy and policy.

'People who fulfil non-executive roles contribute to the development of organisational strategy; provide the necessary support for executive directors and managers to tackle and resolve issues to take the organisation forward.'

The NHS Confederation, 2002

They also need to play a stronger role on behalf of their communities and to be pro-active advocates for change by posing challenging questions to themselves and to the organisation. Non-executive directors can ask themselves the following questions.

'Do you ensure that the interests of people using the service come first and that services are run for service users?

Are you able to visit the frontline services and facilities in your organisation on a regular basis? And if you can't, how do you know what's going on?

Do you tackle your ambassadorial role as patients' advocate in a pro-active way?

Do you seek the views of patients and carers and ask questions of the board from their perspective?

Do you represent the interests of your organisation to the local community?

Do you seek views from groups in the community before their issues become public complaints?'

The NHS Confederation, 2002

Non-executive directors are also required to make use of their independence in scrutinising and challenging the current performance of all aspects of the organisation.

'It is fundamental to the non-executive role – to be one step removed and able to challenge what is being said and discussed at board level and to provide constructive criticism before the board reaches its collective decisions.'

Dr Roger Moore, Chief Executive of the Appointments Commission

They must ensure that they are informed and empowered, so that they can perform this role diligently. Where non-executives fail to fulfil these duties, or are prevented from doing so, tragic consequences can result.

'**Lessons for non-executive directors from the Bristol Inquiry**

Non-executive directors can be prevented from exerting their authority by 'not being let in on issues' at senior executive level.

Lack of sound knowledge about trust activity can lead to an inability to challenge chief executives' or executive directors' views.

Role objectives may not be clarified and communicated. There was:

- variation in the roles played by non-executives on the board
- variation in the expectations held of non-executives
- a lack of clarity and direction for the role.'

The NHS Confederation, 2002

REFLECTION

Is there evidence to suggest that the contributions of non-executives are welcomed and heeded?

What support is offered to non-executives for their personal development?

What evidence is there to suggest that they adequately represent the local community in terms of their experiences, their expertise and their backgrounds?

Because their performance is so important to the effective functioning of Trusts, the NHS Appointments Commission has established an annual appraisal system for non-executives. Each non-executive will be assessed against objectives set by the Chair; these objectives will focus on their roles as steward, ambassador and guardian.

'We hope the performance review system will help the whole organisation get better value from its non-executive members, that they will give even better service to the board and therefore the organisation. The nurse at the sharp end should feel she can have more confidence in the board that is making decisions about her organisation.'

Dr Roger Moore, chief executive of the Appointments Commission

It was clear from the pilot study how vital was the contribution of effective and empowered non-executives. It was equally clear that in a number of cases non-executives did not believe that due weight was attached to their views, and that their questions and contributions were not welcomed by executive Board members or by their PEC colleagues.

Where this was the case it generally proceeded from a lack of clarity within the Board and the PEC about the nature and the scope of the non-executive role. In a number of cases there had been no explicit discussion about the role with the result that mutual misunderstanding, and the distrust that stems from it, had become rife. The feedback process provided one vehicle for such discussions and underlined the importance of pro-active action by a PCT to ensure that genuine consensus is reached about the non-executive role and contribution.

Structural arrangements for clinical governance

In addition to ensuring that they have an active and effective PEC, the Board is responsible for ensuring that an appropriate Clinical Governance Lead has been appointed. There must also be clarity in respect of the relationship and the respective duties and responsibilities of this post-holder and the PEC Chair.

Over and above these requirements, there is no one set of prescriptive clinical governance structural arrangements laid down for PCTs. This means that local structures can reflect and respond to local circumstance and need. The membership of a clinical governance committee, for example, should be sufficiently broad to reflect the composition of a particular PCT's professional and staff community, and will often have non-executive membership.

Boards and PECs must comply with the most recent regulations laid down in relation to the function and accountabilities of Executive Committees of the PCT.

The Primary Care Trust (Functions) Directions 2000 dated 31st March 2000 have been superseded by the Primary Care Trust (Procedure and Administration Arrangements) Directions 2002 in line with the National Health Service Act 1977.

The scope and restrictions on the functions of Executive Committees are defined as follows:

'2 Subject to direction 3 (see below) the functions of an Executive Committee shall be:

a) to prepare proposals for the Trust's policy development, strategy or priorities for consideration by the members of the Trust;

b) to exercise, on behalf of the Trust, the functions delegated to the Committee pursuant to regulation 10(1)(d) of the Functions Regulations;

c) to provide advice to the members of the Trust in relation to the exercise of functions by the Trust;

d) to provide advice and assistance to medical practitioners for whom the Trust is the relevant Primary Care Trust for the purpose of facilitating the exercise of the functions of the Trust;

e) to otherwise assist the Trust in the exercise of its functions.

3 Restrictions on the exercise of functions by Executive Committees

a) An Executive Committee must exercise its functions in accordance with any other directions given by the Secretary of State, the appropriate Strategic Health Authority or the Trust.

b) An Executive Committee must exercise its functions in accordance with any restrictions or conditions imposed by the Trust and in exercising its functions must have regard to any guidance given by the Secretary of State with respect to corporate governance in Primary Care Trusts.

c) An Executive Committee must prepare and send such reports, and supply such information, to the Trust as the Trust may require.

In determining which functions are to be delegated to its Executive Committee a Trust must have regard to any guidance given by the Secretary of State with respect to corporate governance in Primary Care Trusts.'

Department of Health, 2002b

The clinical governance committee's lines of accountability and terms of reference need to be transparent, as does the relationship between the duties and functions of this committee and the PEC. Whatever the nature of the specific arrangements, these need to be:

- clear
- understood by the staff community as a whole
- effective in translating policy into practice.

The arrangements must ensure active monitoring of clinical work in progress and ensure a free flow of clinical governance information within and across the PCT community.

In particular they must ensure that information regularly and systematically tracks its way through the PEC to the PCT Board.

'**Clarifying reporting arrangements**

Organisations should ensure that they have appropriate mechanisms in place to deliver routine board reports on progress made in implementing clinical governance. These reports should reflect guidance and look to both the short and medium term.'

Department of Health, 1999

In their reviews of PCTs in particular CHI have often asked Trusts to develop greater clarity and greater simplicity in their overall clinical governance arrangements since it has become clear to review teams that PCT staff are themselves sometimes far from clear about divisions of responsibility and who does what so that, at the most basic level, they are not sure who to tell if they have a concern about the safety or quality of a particular service or activity.

Precisely because of the overall complexity of the duties and functions of PCTs, the greatest possible simplicity and clarity should be sought in terms of the local structures for clinical governance that they put in place.

Important as these structural arrangements are, they must never be viewed as an end in themselves.

Some NHS trusts still see the achievements of clinical governance at trust level in terms of systems, structures and processes – which though important and very necessary to the objective of improving patient care, are not necessarily sufficient in themselves to ensure that the objective is achieved.

The Commission for Health Improvement (CHI) has also frequently drawn attention to the importance of ensuring that these structures actually work. In doing so, it has found that almost half of all Boards reviewed to date did not receive information in relation to clinical governance that would enable them to be strategic and proactive.

'Reports to the board will be an important part of the accountability mechanisms that underpin clinical governance. The nature, range and importance of the clinical governance issues which are taken to the board will be crucial to the development of the whole programme within the organisation, to the local media, the public, and to the health organisation's partners. The more substantial and searching the issues the board discusses, the more it will be concluded that the organisation has a clear sense of direction on clinical governance and is taking it very seriously.'

Department of Health, 1999

REFLECTION

Is the clinical governance lead adequately supported to discharge his/her responsibilities?

Is there clarity of role and function between him or her and the PEC chair?

Are the structural arrangements for clinical governance clearly understood in the PCT community at large?

Do these arrangements provide a free and purposeful flow of clinical governance information across the PCT community?

What evidence is there to support your views?

Judging the performance of Boards and PECs

There is always a delay between the development of strategic priorities and any measurable change in the outputs and outcomes an organisation can achieve. The length of time will be influenced by the overall size, geographical dispersal and complexity of the organisation. It is important to note that the performance of a PCT Board and PEC will ultimately be judged by the evidence of these outputs and outcomes.

'Board members and their organisations need to demonstrate the successful implementation of clinical governance by showing that:

- users and carers believe that they are well cared for
- all staff feel included, listened to and empowered in their roles
- all staff understand and 'own' clinical governance
- there is an integrated strategy for the implementation of clinical governance
- the board have patient safety and service quality at the top of their agenda
- they identify and act on the areas of most concern to the organisation
- there is clear evidence of significant improvement in organisational performance.

NHS Confederation, 2002

PCTs must gather evidence, proactively and systematically, of work in progress in translating clinical governance into a system-wide reality – and of the staged progress that proceeds from that work.

The importance of this is reinforced by the new Commission for Health Audit and Inspection's emphasis upon 'intelligent information':

'CHAI will review the effectiveness with which providers use information in clinical and managerial decision-making;

CHAI will put the information it obtains into the public domain, and help members of the public to interpret it appropriately;

CHAI will use this information as the objective evidence on which to base its judgements'

CHI, 2003

REFLECTION

Does the PCT routinely gather evidence of the successful implementation of clinical governance?

Could you access this evidence?

Priorities for action

Now that you have finished reading through this section, please identify three key priorities for the PCT in relation to the strategic leadership of clinical governance.

1

2

3

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Appointments Commission www.nhs.confed.org/nexus/welcomepack/collective.htm

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Wall et al 2002

Westminster Primary Care Trust 2002. *The Boardroom*, www.westminster-pct.nhs.uk/boardroom

Resources

Commission for Health Improvement – CHI's aim is to improve the quality of patient care in the NHS
www.chi.nhs.uk

Controls Assurance Support Unit (CASU)
www.casu.org.uk

Department of Health – access all Department of Health information through their website:
www.doh.gov.uk

The Experience of Primary Care Clinical Governance Leads
www.nhsalliance.org

Financial reforms – information on proposed financial reforms can be found at:
www.doh.gov.uk/nhsfinancialreforms/financialflowsoct02.htm

The Modernisation Agency is a valuable source of information. You can access the different strands of the Agency through the website at:
www.modern.nhs.uk

National Clinical Governance Support Team (CGST) runs a series of programme to support the implementation of clinical governance 'on the ground'
www.cgsupport.org

NHS Appointments Commission including *Governing the NHS: a guide for NHS Boards*
www.modern.nhs.uk/nhsboards

NHS A Leadership Qualities Framework – sets out the qualities to which all NHS leaders should aspire
www.nhsleadershipqualities.nhs.uk

National Institute of Clinical Excellence – the NICE site contains details on the Institute, its ongoing work programmes, the methodology and processes it uses, the guidance it has issued to date, copies of all press releases and the minutes and papers from its Board meetings
www.nice.org.uk

The National Primary and Care Trust Development Programme – the NatPaCT team helps PCTs with organisational development.
www.natpact.nhs.uk

NatPaCT has completed the first phase of its work on emergency care. This is available at
www.natpact.nhs.uk/news/index.php?article_request=294

The National Primary Care Development Team – NPDT helps to address access and service improvements for patients. www.npdt.org.uk

Planning and Priorities Framework 2003-2006
www.doh.gov.uk/planning2003/2006/index.htm
www.doh.gov.uk/nhsfinancialreforms/financialflowsoct02.htm

Revised functions and responsibilities of PCTs are set out in PCT (Procedure and Administration Arrangements) Directions at:
www.doh.gov.uk/nhsreformact/pctprocedure.htm

Rating the PCT's current stage of development

Please rate the PCT's current stage of development in relation to the following questions.

Remember to use the Response Sheet provided for your answers.

3.1	To what extent do the Board and PEC share an understanding of 'reasonable assurance'?
3.2	To what extent do the Board and PEC function effectively together?
3.3	To what extent is due weight given to the views of non-Executive Board members?
3.4	To what extent have the Board and PEC established clear clinical governance structures of operational delegation and accountability?
3.5	To what extent do the Board and PEC discharge their duty of care to the PCT community?
3.6	To what extent overall, does the PCT have effective leadership?