Transitional PCT Governance arrangements for South East London PCTs and Bexley Care Trust (v20)

Contents

1. Introduction

1.1 NHS Operating Framework 2011-12

This paper has been informed by the Operating Framework 2011-12 issued on 15th December 2010 and the publication of PCT Cluster Implementation Guidance issued on 31st January 2011 by the Department of Health (Gateway reference 15520). It has also been informed by advice from Capsticks on the statutory requirements for PCT board membership.

Whilst current PCTs /Care Trusts will be retained as statutory organisations there will be a consolidation of management capacity, with single management teams managing a cluster of PCTs. These new clusters are not statutory bodies but are necessary to sustain PCT capability and enable the creation of the new system.

NHS London has indicated that this is the approach that will be taken throughout London, and are expecting proposals from South East London which broadly mirror proposals in other London clusters. These are based on there being a single executive team and a single Accountable Officer with as much business as possible being undertaken by six Borough-based Business Support Units (BSUs). These units would be overseen by local Clinical Commissioning Committees operating as subcommittees of each PCT/Care Trust Board, the whole overseen by the six PCT/Care Trust Boards operating jointly (the Joint Boards) with some common membership and a single Chair. The composition of local committees is for local determination: the assumption in this paper is that they will be chaired by Clinical GP Commissioner Leads (as PEC Chair) to pave the way for full delegation.

Cluster guidance states that the design principles for governance arrangements should be;

- Effective
- Proportional and cost effective
- Locally determined

And through their operation should;

- Result in clear decision making
- Allow timely consideration
- Be fair and transparent

The exact nature of governance arrangements are for local agreement but guidance includes a range of examples where;

- Individual Boards delegate a range of functions to a cluster Board

- A number of PCTs share identical Board membership forming a cluster Board
- A cluster Board is formed from a single Chair, shared NEDs and individual PCT NEDs ("locality" NEDS)

The following arrangements have drawn on these examples, been informed by arrangements being developed by other clusters in London, and modified and amended following consultation with members of existing South East London Boards to reflect the particular circumstances of PCTs and Care Trusts in South East London.

For reference, Appendix 1 summarises the functions of a PCT/Care Trust Board

2. Guiding principles

2.1 London PCTs will adopt "cluster" arrangements to fulfil their statutory functions

These arrangements will;

- Achieve the management cost savings targets
- Facilitate the transition to GP Consortia led commissioning arrangements
- Comply with the statutory duties of PCTs/ Care Trust

These arrangements need to take account of;

- The developmental nature of devolving responsibilities to GP Pathfinders
- The specific requirements for PCTs/Care Trust who have integrated arrangements in place with local authorities, including Bexley Care Trust whose Establishment Order includes the requirement for Bexley Council to appoint at least one borough-nominated non-executive director with full voting rights.
- The requirement to continue to manage and account for PCT/Care Trust performance at an individual PCT/Care Trust level

South East London PCTs/Care Trust will exploit the recently established principle of non executive directors being able to serve on more than one Board

The complement of NEDs will be altered so that;

- A single chair will serve all PCTs/Care Trust in South East London
- NEDs are appointed with a primary role for a specified PCT/Care Trust to retain local knowledge and accountability, with 6 acting as Vice Chairs of each of the 6 constituent Boards and 1 acting as Chair of all 6 Audit Committees.
- Voting rights are equally distributed

2.2 Arrangements should strengthen and not undermine local involvement of clinicians in understanding, leading and being accountable for commissioning decisions that serve the needs of local populations

For clinical commissioners to experience this empowerment:

- Clinical leaders will take key roles in the governance structures proposed
- Arrangements will be put in place to establish Local Clinical Commissioning Committees as formal subcommittees of each Board that have delegated responsibility for local commissioning budgets and existing arrangements for local delegation to clinical commissioners should continue. These committees will assume the responsibilities previously delegated to Professional Executive Committees that include developing local commissioning strategies and plans, ensuring maximum health gain for resources spent and delivery and performance against plans.
- Where cluster arrangements are in place to undertake specific commissioning functions other than those areas outside the scope of clinical commissioning, these functional areas will be managed as shared business service lines, accountable to the Local Clinical Commissioning Committees for their commissioning activities

2.3 Arrangements should retain local accountability

- A single accountable officer and financial officer in the central cluster team will manage within the resource limits set for each PCT/Care Trust and account to the Joint Boards separately against these resource limits
- To manage performance effectively there will be devolved delivery structures that support each PCT/Care Trust in meeting its statutory duties
- The cluster recognises that although financial accountability will be through a single accountable officer, the commissioning decisions and management actions necessary to influence performance will take place at a local level
- These arrangements will build capacity and understanding in local clinical commissioners in preparation for GP Consortia-led commissioning in PCTs where this is not already in place
- Each local Clinical Commissioning Committee will establish with the Joint Boards the areas that it will be commissioning for and will have formal agreement of the commissioning resource envelope for which it will be accountable. This will allow for continuation of existing levels of delegation to Clinical Commissioners where applicable
- This commissioning envelope will increase as the local commissioners move closer to fulfilling the requirements for full GP Consortia status
- This relationship will be formally agreed in each PCT/Care Trust Board's schemes of delegation with its Clinical Commissioning Committee

The statutory functions of the six current PCT/Care Trust Boards will be fulfilled by the six Boards operating jointly.

The majority of the Joint Boards' business will be transacted as one but should the need arise, for instance to agree an individual PCT/Care Trust's accounts, each Board would meet as an individual PCT/Care Trust Board. Likewise two or more of the individual Boards will be able to meet on an adhoc basis to consider issues that related to particular localities, communities or service providers, e.g. the Boards of Bexley Care Trust, Bromley and Greenwich PCTs might meet to discuss issues relating to South London Healthcare Trust.

2.4 Care Trust arrangements

Any joint arrangements need to take account of the individual variation in governance arrangements. The Establishment Order of Bexley Care Trust requires that at least one of the non-executive directors is nominated by the London Borough of Bexley with full voting rights.

2.5 Subsidiarity

The intentions of these governance arrangements are to ensure that PCTs and Care Trusts can continue to fulfil their statutory duties whilst enabling a smooth transition to the new system of GP led commissioning. During this transitional phase it is essential that local decision making should support ownership, understanding and engagement of local clinicians and that as much business as possible should be delegated to local Clinical Commissioning Committees.

Appendix 2 lists those functions that can be delegated by PCT/Care Trust Boards and work on schemes of delegation will enable local Clinical Commissioning Committees to indicate how much of these functions they wish to have delegated to them.

Appendix 3 lists those functions that cannot be delegated by the Trust Boards. It is anticipated that although local Clinical Commissioning Committees are unable to be delegated these tasks, they will undertake the significant majority of the planning, monitoring and assurance gathering that will enable Joint Boards to undertake these functions.

Appendix 5 shows the views from a group of Non Executive Directors on Schemes of Delegation and **Appendix 6** on Audit and Risk

3. Proposals for Joint Board arrangements

3.1 Board membership

Current regulations stipulate that the Board can have up to 7 Non executive members excluding the Chair and that non executive membership including the Chair should be in the majority.

3.1.1 Membership of Joint Boards

In addition to the Chair and Audit Chair, 12 non-executive directors will be appointed to serve on the six PCT / Care Trust Boards. By appointing two pools of six NEDS with one pool serving Lambeth Southwark and Lewisham and the second serving Bexley Bromley and Greenwich each Board NED membership will remain within the total permissible limit of 7, excluding the Chair. This arrangement enables each PCT / Care Trust to retain two non-executive directors and consequently increase continuity, local capacity and support to the Executive Team.

In order to comply with the terms of its Establishment Order one of the non-executive directors for Bexley Care Trust will be a nominee of Bexley Council. The implication of this is that two NEDs from the LSL pool will require cross-appointing to Bromley and Greenwich as the Local Authority NED cannot be cross appointed to those PCTs.

Five executive members will be common to all six Boards. In addition each Chair of local Clinical Commissioning Committees, expected to be the GP Commissioning Lead, and the Managing Director of each Borough Business Support Unit will make up the executive director complement.

Membership is shown in Diagram one.

Diagram One: Proposed Board membership

	Bexley Care Trust	**Bromley PCT**	**Greenwich TPCT**	**Lambeth PCT**	**Lewisham PCT**	**Southwark PCT**
Non executive members						
8	NED CHAIR					
	NED AUDIT CHAIR					
	NED Vice Chair (Bromley) NED Vice Chair (Greenwich) NED Vice Chair (Nominated by London Borough of Bexley) NED NED NED			NED Vice Chair (Lambeth) NED Vice Chair (Lewisham) NED Vice Chair (Southwark) NED* NED* NED* *(*2 NEDs from this group to be cross appointed to Br/Gr)*		
	Additional associate NEDs appointed locally as required					
Executive members						
7	Chief Executive (1 for 6) (accountable officer)					
	Director of Finance (1 for 6) (accountable finance officer)					
	Director of Public Health (1 representing 6)					
	Director of Development/Director of Operations (1 for 6)					
	BSU MD	BSU MD	BSU MD	BSU MD	BSU MD	BSU MD
	PEC Nurse	PEC Nurse	PEC Nurse	PEC Nurse	PEC Nurse	PEC Nurse
	Clinical lead*	Clinical lead*	Clinical lead*	Clinical lead*	Clinical lead*	Clinical lead*
[*NOTE – Clinical lead will be local PEC Chair]						
In attendance						
	Director of Nursing (tbc)					
	Director of Corporate Affairs					
	Others to be agreed					

31 members will be present at Board meetings, excluding officers in attendance (Chair, Audit Chair, 12 NEDs, 5 cluster executives, 6 BSU MDs and 6 Clinical Commissioning leads.)

One NED from each PCT/Care Trust will serve as Vice Chair to the Board and will play a key role in the sub-committee structures of each PCT / Care Trust.

3.1.2 Director of Public Health

Current regulations include the Director of Public Health as an executive member of PCT and Care Trust Boards. In the current proposals the DPH is shown as a single member.

Discussion will take place with existing PCTs/Care Trust and DPHs as to how to achieve inclusion of public health advice and representation of the six PCTs /Care Trust through this single place at the Joint Board meetings.

When the Board was meeting to transact the business of a single PCT /Care Trust the DPH role will be filled by the appointed DPH for that PCT. For joint business the cluster DPH will act as Board member but with other PCT/Care Trust's DPHs acting as named alternates.

4. Board Subcommittees

There will be the following board Subcommittees

- **Local Clinical Commissioning Committee (PEC)**
- **Joint Audit and Risk Committees**
- **Joint Remuneration and Employment Committees**
- **Joint Finance and Performance Committees (QIPP)**
- **Joint Quality and Safety Committees**

4.1 Local Clinical Commissioning Committees (LCCC)

4.1.1 Remit

The Board will establish a set of subcommittees, one per Borough, which will operate as a Clinical Commissioning Committee. It will fulfil the statutory duties currently delegated to Professional Executive Committees for developing and recommending commissioning intentions to meet the needs of local residents. Its clinical chair will be an Executive member of each of the Trust Boards. The sub-committee will be responsible for the day to day commissioning of the Trust and will operate within a scheme of delegation, accountable to the Joint Boards for an agreed commissioning budget. The Nurse

representative on the PEC will have a professional link to the Director of Nursing at the Cluster who will represent them on PCT boards.

The Joint Boards will, through the scheme of delegation, ensure that local Clinical Commissioning Committees have significant freedom to determine their membership and terms of reference and will be given responsibility for commissioning for local needs. The NED Vice-Chair, Clinical Commissioning lead and the Borough MD would form the local "three at the centre" that is the unique feature of PCT/Care Trust governance arrangements.

These three will be responsible for establishing and maintaining constructive relationships with key stakeholders in the local health economy including the local council, clinicians, elected politicians and local patients and residents.

Local Clinical Commissioning Committees will operate with at least the level of delegation currently operating within the individual PCTs/Care Trusts and this will be increased as and when the Committee seeks to take on more responsibility in accordance with the pathfinder trajectory.

More information on the business to be delegated to Local Clinical Commissioning Committees is attached with the notes from a Scheme of Delegation workshop at Appendix 5.

4.1.2 Membership

Membership of Local Clinical Commissioning Committees will be locally determined but the assumption is that it should be chaired by and include strong representation of clinical commissioners that will form GP consortia. The committee will ensure that there are robust local arrangements for the involvement of patients and the public and a wide range of clinicians in the work of the committee. Executive membership will be drawn from the local business support unit.

4.1.3 Responsibilities and accountability

The committee will be responsible for developing and recommending a commissioning plan that meets the health needs of local people to the Joint Boards.

The Local Clinical Commissioning Committees can establish such subcommittees and working groups as it deems necessary for the effective discharge of its duties but will retain its accountability to the PCT/Care Trust Board in the Joint Boards arrangement

The scheme of delegation for each Local Clinical Commissioning Committee will reflect the stage of development of local clinical commissioners and their appetite to hold

responsibility for delegated budgets. Where specific commissioning responsibilities are excluded from the remit of the clinical commissioners, the committee can nevertheless offer advice to the Joint Boards to guide commissioning decisions.

It should be noted that the Local Clinical Commissioning Committees cannot 'double delegate' and that whilst they are free to establish groups as required it must be the LCCC that takes any decisions.

4.1.4 Health and Well Being Boards

The legislative framework document for the Health Bill before Parliament confirms that Health and Well Being Boards will have a statutory footing and a core membership of GP Consortia, at least one elected member, the Director of Adult Social Care, Director of Children's Services, the Director of Public Health and HealthWatch.

It is anticipated that shadow arrangements will be in place early in 2011-12 and that local Clinical Commissioning Committees will have a key role in taking forward arrangements for these boards with local authorities, thus ensuring a strong link between the local NHS in transition and the Local Authority and others with an interest in the local health economy.

4.2 Joint Audit & Risk committees

The Audit & Risk Committees will operate as joint Audit and Risk Committees of all six PCTs/Care Trust. The single Chair of all six will be appointed from the existing NED Chairs of Audit who wished to be considered.

The Audit and Risk Committees' membership will be all NEDs from across the six PCTs/Care Trust, but with a quorum of the chair and one NED from LSL and one from BBG. All Executive Directors will be required to attend the Joint Audit and Risk Committees as requested by the Audit and Risk Committee.

The committees will for particular purposes, such as signing off an individual PCT's Statement on Internal Control, meet as the Audit and Risk Committee of an individual PCT/Care Trust. The joint Audit and Risk Committees will establish mechanisms for gaining assurance that robust internal controls were in place for discharging the duties of the PCTs / Care Trusts whether at cluster or local level and that issues that were identified as high risk to achievement of the organisations' objectives were escalated to the joint Audit and Risk Committees in a timely and appropriate manner. The committees will also be responsible for seeking assurance that all service changes pass the 4 reconfiguration tests whether at single borough level or cross borough level.

The Joint Audit and Risk Committees Terms of Reference will be the standard TOR from the governance handbook.

Assurance of Risk Management will be undertaken by reviewing the Board Assurance Framework/risk register from each Business Support Unit and the cluster directorates.

A working group of Audit Committee chairs has developed views on the role of the committee. Notes from this meeting are attached at **Appendix 6**.

4.3 Joint Remuneration and Employment committees

A joint Remuneration and Employment Committee will serve all six PCTs/Care Trust.

The Chair and membership will be all of the non-executive directors appointed to serve on the Joint Boards (excluding the Audit Committee Chair) including at least one NED from each original PCT / Care Trust Board.

4.4 Joint Finance, Performance and QIPP committees

Financial management, Performance management and progress against delivery of the QIPP plan will be reviewed by a separate finance, performance and QIPP committee where the LCCCs and Director of Finance and Resources will present their financial risks and controls. The Director of Performance will bring performance reports to the committee and escalate performance issues through this route to the joint boards. Similarly, progress in delivery of QIPP will be monitored through this committee and a summary reported to the joint board. The sector Director of Finance and Resources will develop a TOR for this committee to include a NED Chair.

4.4.1 Internal and External Audit

The sector Director of Finance and Resources will review the internal audit arrangements, rationalising contracts (if possible to a single provider) and making efficiencies where possible.

The programme for 2011/12 will be a risk based audit approach and the audit plan will be agreed by the joint Audit Committees at their first meeting.

4.5 Duty of Quality

The Joint Boards will establish a subcommittee to oversee the clinical governance framework for the six PCTs/Care Trust. This function was previously delegated to Professional Executive Committees and revised arrangements that are currently operating in local PCTs/Care trust reflect the separation of commissioning and planning

decisions from the quality scrutiny function. This committee could be chaired by the Medical Director and should draw on members nominated by local committees who have clinical governance expertise as well as staff with key governance roles across the cluster and the Business Support Units.

4.5.1 Cluster Joint Quality and Safety Committees (Assurance)

The function of this joint subcommittee will be

- To provide **assurance** to the Joint Boards that commissioned services are safe and high quality and that there are adequate plans in place to respond to issues of poor quality
- To establish and oversee the clinical governance framework for the South East London cluster to include patient safety, clinical effectiveness and patient experience
- To advise the Joint Boards on the management of clinical risk
- To oversee the procedures for identifying, investigating and learning for serious incidents and for safeguarding children and vulnerable adults
- To support a culture of learning and continuous improvement in healthcare services in South East London
- To receive reports from two subcommittees reviewing Issues of Concern from Primary Care Contracting

Membership

6 Non executive directors (3 LSL, 3 BBG)
Cluster Medical Director (s)
Cluster Nurse Director
Cluster Director of Public Health
Business Support Unit Clinical Governance lead clinician (x6)
Cluster Deputy Director of Integrated Governance

In attendance (as required): Business Support Unit Governance Manager (x6)

This committee will report to the Joint Boards and will also make recommendations to local Clinical Commissioning committees to support commissioning for quality.

4.6 Executive Meeting Arrangements

The Chief Executive Officer will establish a Management Board led through a Clinical Strategy forum, an Operations group that will manage the delivery of the integrated plan (including contract monitoring and quality) and a Transition group that will manage

change to the new commissioning system. Terms of Reference for these groups are under development.

4.6.1 Executive meetings – strategy and engagement

Two groups will provide advice on strategy and engagement and will provide the mechanism for developing and reviewing service change proposals against the four reconfiguration 'Lansley' tests (GP Support, Strengthened Engagement, Clinical Evidence and Patient Choice).

4.5.1 Clinical strategy forum

The clinical strategy forum would come together to determine, design and recommend service changes across more than one borough. Examples of this will be changes to cancer or vascular services or changes to King's Health Partners.

This group would be formed from the existing BBG Clinical Forum, whilst it is suggested that a similar LSL Clinical Forum be established and that the two groups meet together periodically to agree sector-wide clinical strategy. Membership will be drawn from GP commissioning leads, the cluster Nursing Director, Medical Director and other clinical members as required.

The forum will be responsible for reviewing service changes against the four reconfiguration tests, taking advice from the Stakeholder Reference Group, before reporting to the audit and risk committee for assurance purposes.

Membership

6 x GP Commissioning Leads
Cluster Director of Strategy
Cluster Medical Director
Cluster Director of Nursing
Cluster Director of Corporate Affairs (as required)

4.5.2 Stakeholder Reference Group

The Stakeholder Reference Group will evolve from the existing BBG Stakeholder Reference Group that has been successful in improving stakeholder engagement following A Picture of Health (APOH) and reviewing the programme against the two reconfiguration tests on patient engagement and Choice.

The group will be independently chaired and report to the Clinical Forum. It's aim will be to bring together key stakeholders including LINKs, Voluntary Sector representatives, Health Scrutiny Chairs, BME network representatives and the NHS (including a GP

representative) to review plans for engagement and to provide an informal setting for stakeholders to understand the changes to the commissioning system and to review communications and engagement plans for delivering the QIPP programme. It is proposed, that similar to the matrix for the quality and safety committee, LSL and BBG Stakeholder Reference Groups will meet separately, but will come together to meet as a cluster where there are strategic issues that will impact all six boroughs – for example changes to services across King's Health Partners.

Membership

Independent Chair (Peter Gluckman)
Cluster Director of Corporate Affairs
Cluster Director of Strategy (as required)
Clinical Forum GP representative
LINk Representatives
Heath Scrutiny Chairs
Voluntary Sector representatives
BME network representatives (arrangements tbc)
Providers as requested

Appendix 1 Functions of the Board

The Department of Health model form Standing Orders and Schemes of Delegation retains a number of functions to the Board. Whilst this is a model rather than a required form, the Board would need to be able to explain why it chose to depart from the standard model.

The model form Standing Orders and Schemes of Delegation state that the Board has six key functions for which they are held accountable by the Department of Health on behalf of the Secretary of State

1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy,

2. to ensure that high standards of corporate governance and personal behavior are maintained in the conduct of the business of the whole organisation,

3. to appoint, appraise and remunerate senior executives,

4. on the recommendation of the Executive Committee (PEC) to ratify 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,

5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary,

6. 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.

It notes that it is the Board's duty to:

1. act within statutory financial and other constraints;

2. for PCTs (and PCTs designated as Care Trusts), establish the Executive Committee;

3. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board or PCT Executive Committee and Standing Financial Instructions to reflect these;

4. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;

5. establish performance and quality measures that maintain the effective use of resources and provide value for money;

6. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;

7. establish Audit and Remuneration Committees based on formally agreed terms of reference which set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board."

Appendix 2 Issues which could be delegated to local borough-based subcommittees (Clinical Commissioning Committees)

- delivery of the Borough aspects of the QIPP and integrated delivery plan;
- delivery of the PCTs financial obligations at a borough level;
- ensuring best use of resources and QIPP delivery at a borough level;
- development of and support to GP commissioning development at a borough level;
- hold GP commissioners to account for any delegated responsibilities;
- inform the development of the CSP and Integrated Delivery Plan with partners, based on an agreed JSNA;
- making optimal linkages to health and well being boards and GP commissioning operating arrangements;
- development of joint commissioning at a borough level;
- oversight and performance management of operating framework deliverables at a borough level;
- delivering service and quality improvement at a local level;
- ensuring borough based statutory deliverables e.g. safeguarding are achieved;
- assurance mechanisms for ensuring Quality of Primary Care.

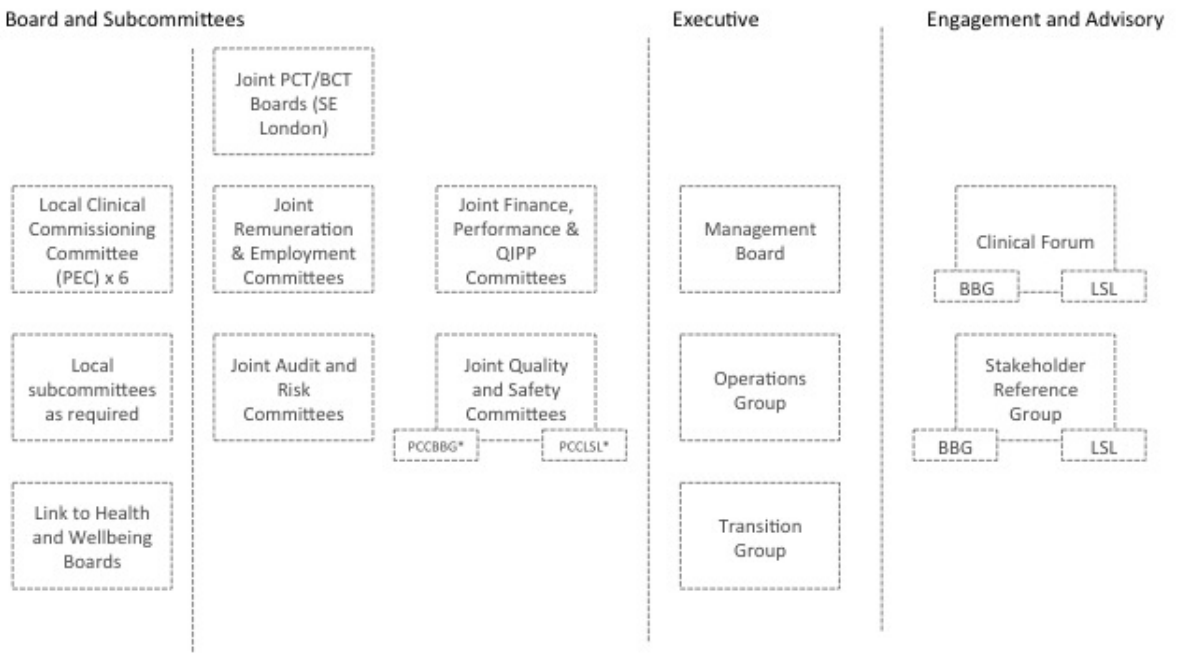
Appendix 3 Issues which only the Joint Boards can deal with

- overseeing the delivery of the single SE London QIPP and Operating Plan;
- decision-making on change programmes that have an impact across the cluster (e.g. potential reconfiguration or SE London wide models of care);
- achieving financial balance across SEL;
- oversight of planning for 2011-14;
- oversight and management of strategic risks;
- whole system performance management;
- market management / FT pipeline;
- tracking the delivery of SEL wide QIPP and change programmes;
- leadership to the organisational development and change implementation in preparation for the new commissioning system;
- adherence and delivery of the statutory PCT responsibilities;
- decisions on further delegation.

Capsticks have also provided a list of twenty four non-delegable statutory functions including responsibilities under various Acts (e.g. Mental Health Act 1983, Local Government and Public Involvement in Health Act 2007, Health and Social Care Act 2008). These are available on request.

Appendix 4

Proposed SE London PCTs and Bexley Care Trust Board and subcommittee structure



Please see following slide for more detail on board subcommittees

**Primary Care Contracting Issues of Concern*