BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Tuesday, 29th November, 2011

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Eleanor Jackson, Anthony Clarke, Bryan Organ, Kate Simmons and Sharon Ball

52 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

53 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

54 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Loraine Brinkhurst had sent her apology to the Panel.

55 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

There were none.

56 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

57 ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

There were none.

58 CONTRIBUTOR SESSION ON PROPOSED CLUSTERING ARRANGEMENTS BETWEEN NHS BATH AND NORTH EAST SOMERSET AND NHS WILTSHIRE

The Chairman informed the meeting that the contributors will address the Panel according to the Day Schedule (attached as Appendix 1 to these minutes).

The Chairman invited Jeff James (NHS BANES and NHS Wiltshire Chief Executive) to address the Panel.

Jeff James took the Panel through his summary of the PCT Cluster Implementation Guidance summary, Shared Operating Model for PCT Clusters and the letter from

Jim Easton (National Director for Improvement and Efficiency) issued on 29th September 2011 (all these documents attached as Appendix 2 to these minutes).

Councillor Hall said that Jim Easton said in his letter that 'key principles of model 2 are adopted by all PCT clusters, by December 2011 or, exceptionally, by a date agreed with the SHA' and asked what constitute 'exceptional'.

Jeff James responded that the SHA should give an answer on what constitute 'exceptional'. Jeff James surmise was that the SHA felt there was no particular need to keep the PCTs separate hence why the deadline is moved to December 2011.

Councillor Clarke said that he questions what the SHA is trying to achieve here considering that the relationship between the Council and PCT in BANES is different than the one between Wiltshire Council and their PCT.

Jeff James said that part of the argument for clustering arrangements is to speed up the work between the Councils and Clinical Commissioning Groups and put the PCTs away as they, PCTs, will demise in April 2013.

Councillor Jackson commented that for this area we have a very good model of Council's integration with the PCT. As a result of that the Health Scrutiny worked well with and for both organisations. Councillor Jackson also said that there is a mismatch between BANES and Wiltshire and expressed her concern that the new setup will not have the same standards across (i.e. waiting/referral times difference, etc.).

Jeff James responded that absolutely nothing will stop Health Scrutiny to express their views, or scrutinise, the new setup although Health Scrutiny will not be in the position to contend non-executive appointments on the new board. Jeff James also said that there are differences between BANES and Wiltshire but he will be committed to honour and respect both areas.

Councillor Hall said that her concern was that the Council appeared to have inferior role in these arrangements and not consulted on these issues but expected to act as per requirement.

Councillor Clarke agreed with Councillor Hall and said that he criticise the decision made on the higher level and not on the local level. The Panel has the right to put forward views of the people they represent.
Jeff James responded that clustering will not change legal issues in the Council and Members will still be able to represent their constituents.

The Chairman said that the biggest issue for this authority is that we are merging with another authority that is not quite into the PCT integration like we are.

Jeff James replied that nothing in the letter from Jim Easton says that joint commissioning should end with the PCT clustering.

The Chairman thanked Jeff James for his statement.

The Chairman invited Malcolm Hanney (NHS BANES Chair) to address the Panel.

Malcolm Hanney declared the interest as he is the NHS BANES Chair and also BANES Councillor.

Malcolm Hanney said that the December 2011 deadline is too early and it will be impossible to start with clustering from that date. The issue about model 2 governance option is not about a single chair and single executive team; it is in fact about the proper basis of the partnership. There is also no issue about differences in BANES in Wiltshire but there is an issue about the list of executives operating on cluster level and omission of people, such as Ashley Ayre, who should be the part of the new board. There need to be a lot of understanding and consultation on different issues hence why April 2012 should stay on as the deadline.

From this point Malcolm Hanney read out his statement (attached as Appendix 3 to these minutes).

The Chairman commented that lots of issues would need to be considered in preparation for the new cluster board.

Malcolm Hanney responded that there is a need for a thorough discussion on what will happen until April 2013 and beyond that date (after PCTs demise). There is also a need of the thorough discussion as some people do not understand the scale of the partnership.

The Chairman said that the main complication is that we have integrated services and asked how Wiltshire received that.

Malcolm Hanney confirmed that we have joint staffing (i.e. Ashley Ayre) set under Section 113 Agreement and that makes situation here much more complex.
Malcolm Hanney said that he will meet with the SHA and NHS Wiltshire Chair to discuss these issues further.

Malcolm Hanney said that he will send a copy of the letter, which he will write to the Leader of the Council after the meeting with the Strategic Health Authority on 30th November, to the whole Panel.
Malcolm Hanney concluded by saying that it is important that discussions between BANES and Wiltshire continue in order to understand the guidance on cluster arrangements.

The Chairman thanked Malcolm Hanney for his statement.

The Chairman invited Ashley Ayre (Strategic Director for People and Communities) to address the Panel.

Ashley Ayre said that his starting point is to protect local arrangements and also to provide the best for patients and public. The Council expressed their reservation to the Strategic Health Authority deadlines as it might undermine what we have locally, including what local Clinical Commissioning Group what to do with the Council in near future. In Wiltshire things might be different and they might have different relationships between their Council, PCT and their Clinical Commissioning Group.

Ashley Ayre asked the Panel also to bear in mind policies and financial issues within the Council.

Ashley Ayre said that his role is to develop a new structure and he recognised that the change is inevitable. Mike Bowden (Active Director for Service Development) had been seconded for 18 months by the Council to think about the structure of the new department which would also provide the support to the colleagues in the PCT.

Ashley Ayre also said that there were very good a discussion locally between the Council, PCT and the Clinical Commissioning Group and that there is a good will from all sides to provide the best outcome.

Ashley Ayre informed the Panel that the amount per head that the Clinical Commissioning Group will work with is £25 per head.

Jeff James added that the current PCT costs per head are £37.

The Chairman thanked Ashley Ayre for his statement.

The Chairman invited Jayne Pye (BANES Local Involvement Network) to address the Panel.

Jayne Pye referred to the letter sent by Diana Hall Hall to Sir Ian Carruthers (Chair of NHS South of England) on 3rd November (Appendix 4) and the reply from Charles Howeson (Vice-Chair NHS South of England) on 23rd November this year (Appendix 5).

Jayne Pye said that, as long they get the service, our community do not care who is providing the services to them. Jayne Pye also said that the LINk do not want to lose the good working relationship with the Council and PCT.

The Chairman thanked Jayne Pye for her statement.

The Chairman invited Dr Ian Orpen (Chair of the BANES Clinical Commissioning Group) to address the Panel.

Dr Orpen referred to his briefing (Appendix 6) submitted in advance of the meeting which includes his letter to John Everitt (Council Chief Executive) dated 2nd November.

The Chairman thanked Dr Ian Orpen for his statement.

The Chairman thanked the contributors for their statements and invited the Panel Members to comment.

Councillor Organ said that the Council worked hard for a very long time to be integrated with the PCT and December deadline for cluster arrangements is too short. Councillor Organ asked that the deadline should be April 2012.

Councillor Clarke said that the Panel did not want to undermine on-going process but there are clear differences between BANES and Wiltshire PCTs. Councillor Clarke also did not agree that cluster arrangements should start as of December 2011.

Councillor Jackson agreed with the statements from Councillors Organ and Clarke and added that there is a cross party disapproval of December deadline.

Councillor Hall said that she also did not agree that cluster arrangements should start as of December 2011.

The Chairman concluded that December deadline for cluster arrangements is quite unreasonable and disruptive.

The Panel unanimously **AGREED** with the following:

The Wellbeing Policy Development and Scrutiny Panel heard from a range of contributors on proposed clustering arrangements between NHS Bath and North East Somerset and NHS Wiltshire at their meeting on Tuesday 29th November 2011.

The Panel made the following **RECOMMENDATIONS**:

1. The Panel did not support the conclusion of the NHS Management Board that the key principles of model 2 PCT cluster governance must be adopted by December 2011. The Panel did not agree with the 'top down' approach from the NHS Management Board when a local decision of April 2012 had been mutually agreed between both NHS Bath and North East Somerset and NHS Wiltshire.
2. The Panel felt that the deep integration between the Council and NHS Bath and North East Somerset and the Clinical Commissioning Group's commitment to continuing these partnership arrangements in the future qualified as exceptional circumstances to allow deferral until April 2011 to allow the complexities of future working arrangements to be properly established.
3. The Panel asked Malcolm Hanney to send a copy of the letter, which he will write to the Leader of the Council after the meeting with the Strategic Health Authority on 30th November, to the whole Panel.

Appendix 1

Appendix 2

Appendix 3

Appendix 4

Appendix 5

Appendix 6

The meeting ended at 7.50 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Wellbeing Policy Development and Scrutiny Panel
29th November 2011at 5.30pm
Brunswick Room

Contributors Session –

To consider the context for the proposed clustering arrangements of NHS Bath & North East Somerset and NHS Wiltshire and the related implications for:

- **Our current arrangements in the form of Bath and North East Somerset's Health and Wellbeing Partnership and joint commissioning arrangements**
- **Future organisational arrangements with the Clinical Commissioning Group and proposed Commissioning Support Units**

Meeting structure and timings

Time	***Item***
5.30	• Welcome & Introductions by the Chairman, Councillor Vic Pritchard • Standard agenda items
5.35	• Presentation from Jeff James (BANES and Wiltshire NHS Chief Executive) • Q&A with the Panel
6.35	• Statement from Malcolm Hanney (NHS BANES Chair) • Q&A with the Panel
6.50	• Presentation from Ashley Ayre (Strategic Director for People and Communities) • Q&A with the Panel
7.50	• Statements/briefing from Diana Hall Hall (BANES Local Involvement Network) and Dr Ian Orphen (Clinical Commissioning Group) • Q&A with the Panel
8.20	• Members of the public and Councillors. Panel can ask factual questions.
8.35	• Conclusion. Panel to make recommendations/resolution/proposal (if any) in public.
8.45	Meeting ends.

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Department of Health Policy and Practice guidance on PCT Clusters

PCT Cluster Implementation Guidance
Gateway Reference 15520
Issued 31 January 2011

Context

2. The creation of clusters is intended to:
   - Sustain management capacity, and a clear line of accountability, providing greater security for the delivery of current PCT functions in terms of statutory duties, quality, finance, performance, QIPP and NHS Constitution requirements through to March 2013;
   - Provide space for developing GP Commissioning Consortia to operate effectively;
   - Provide a basis for the development of commissioning support arrangements, allowing current commissioners and new entrants to develop a range of commissioning support solutions from which consortia and the NHS Commissioning Board can secure expert support;
   - Similarly, provide space for new arrangements with Local Authorities, and particularly Health and Wellbeing Boards to develop;
   - Provide a mechanism to enable high quality NHS staff to move to new roles in consortia, commissioning support arrangements and the NHS Commissioning Board, including minimising unnecessary redundancy costs;
   - Support the provider reform element of the transition particularly in terms of ensuring progress with the FT pipeline through commissioning plans.

Establishment of Clusters

6. Each SHA has therefore been asked to take the necessary steps to ensure that, as at June 2011, sensible clusters of PCTs exist which have the following features:
   - A single Chief Executive, accountable for quality, finance, performance, QIPP and the development of commissioning functions across the whole of the cluster area;
   - Supported by a single executive team for the cluster. This must include a Director of Finance to ensure effective financial management, a director with responsibility for the full range of commissioning development and medical and nurse directors to ensure clinical engagement and leadership. From these and any other cluster director posts, there should be clarity about personal leadership for in year performance and medium term QIPP delivery, service quality and safety, communications, and informatics. Local Directors of Public Health will not be consolidated at cluster level, in order to support the transfer of this function to upper tier local authorities. Further detail of the transitional processes associated with creating the new Public Health landscape will be published separately;
   - Be sustainable until the proposed abolition of PCTs at the end of March 2013;

7. We expect that the geography of clusters, where not already clearly established is likely to be based on existing sub-regional arrangements, although SHAs have indicated that there may be some exceptions to this to reflect specific local circumstances or patient flows. The formation of clusters is designed to give space to emerging consortia to take on responsibility for commissioning so, clusters must not be on the same footprint as GP commissioning consortia, so where very large consortia are proposed this may affect cluster geography. Cluster configuration will be signed off by the NHS Chief Executive.
8. For new clusters, SHAs will ensure that key partners, and particularly GP commissioning consortia, local authorities and NHS providers have been engaged in discussion on the nature of cluster development in their area, in terms of geography, functions and how they will support the development of more local commissioning and partnership arrangements through GP commissioning consortia and Health and Wellbeing Boards. Current information received from SHAs suggests there will be around 50 clusters nationally.

Accountability Arrangements

15. Following appointment, the cluster Chief Executive will be confirmed as the Accountable Officer for each of the constituent PCTs by the Boards concerned. He or she will be expected to exercise the full range of responsibilities associated with being the Accountable Officer.
16. Whilst allocations, and accounts will remain at PCT level, with critical roles for the individual PCT Boards, the managerial processes for monitoring and holding to account will be exercised through the cluster Chief Executive.
17. Boards will retain their full range of statutory accountabilities and will have a clear agreement, adopted by the Board, of which of those are being exercised through the cluster arrangements, and which are being retained at PCT level.

HR Issues

31. The appointment of cluster Chief Executives needs particularly careful handling where jointly appointed PCT Chief Executives/Local Authority Directors exist. Again we do not intend that either the appointment or non-appointment of such a person to a cluster Chief Executive position should automatically lead to the dismantling of effective joint PCT/LA appointments prior to 2013. The SHA, cluster, PCT and Local Authority should work together to identify how best to sustain joint working arrangements, and the development of new joint working structures, including, as appropriate, the retention of such jointly appointed posts. Equivalent considerations should be given to joint appointments at PCT Director Level.

Board Issues

41. We have been working with the Appointments Commission to identify good practice and implementation options which strike this balance, and their guidance is attached in Appendix A. It sets out:
    a. Key design principles for board arrangements in support of clusters;
    b. A number of suggested options for the operation of board arrangements;

c. Identifies how, in the context of these approaches, a range of practical issues can be tackled, including appointments and terminations, schemes of delegation and appropriate use of the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment Regulations 2010 which removes the disqualification contained in the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 which prevented an individual serving as a Chair or non-executive of one PCT from being appointed and serving as the Chair or a non-executive of another PCT at the same time.

Appendix A Advice on Non Executive Issues

3.3 Governance principles

Comply with statute –PCTs will continue as separate statutory entities with no statutory mergers of PCTs. As a result, the governance arrangements for PCT clusters must enable PCT boards to continue to comply with their statutory requirements. In line with regulations for PCT board membership[3], each board must continue to have in post a non-executive Chair and a minimum of five and not more than seven non-executives. Following an amendment to the regulations, Chairs and non-executive directors can now be shared across PCT boards. Each PCT board will also need to continue to include members with a suitable range of experience and skills for that PCT, as would usually be the case. PCT boards will need to continue to publish a separate annual report and set of accounts.

Operational context - Whatever governance structure PCT clusters put in place, it is critical that it enables the effective and efficient discharge of the specific functions and responsibilities of both the cluster board and of the individual PCTs (including their legal requirements) that are set out in the PCT Cluster Implementation Guidance, withoutplacing disproportionate demands on the single executive team. Governance arrangements will also need to be appropriately aligned with the requirements set out in the HR Framework for managing the transition.

Supports the executive team - Consideration should be given to the potential impact that the governance arrangements being considered will have on the single executive team that will be required to manage the arrangements, particularly around the demands they will place on the executive team in terms of the complexity of the management task and the workload that will be involved.

3.4 Design principles

Effective – the arrangements should demonstrate that boards can continue to provide effective strategic leadership, independent scrutiny, constructive challenge and transparency in decision-making. The constituent PCT boards will remain as statutory bodies and appropriate consideration will need to be

given and arrangements made to enable them to continue to exercise these and the specific responsibilities set out in the PCT Cluster Implementation Guidance, either through the cluster board or by meeting separately.
Proportional and cost-effective – the approach should be simple, avoid unnecessary bureaucracy and support the Department of Health's target to reduce management expenditure, while at the same time ensuring that it provides the necessary stability and resilience needed to sustain the arrangements effectively until April 2013.

Locally determined – the design of the governance arrangements should meet the local need and situation and have the support of stakeholders, such as GP consortia and local authorities.

PCT Cluster Governance Options

Model 1
PCT cluster board is populated with a Chair from one of the constituent boards and 'cluster' non-executive director(s) nominated by each PCT. Each PCT would delegate relevant functions to the cluster board. The number of cluster non-executives from each PCT can vary according to local circumstances.

Model 2
A single Chair and set of non-executives meet with the single executive team on the cluster board to discharge the respective statutory functions of the constituent PCT boards. All of the PCT boards involved in the cluster would have an identical Chair and non-executive team, with the same individuals being appointed to all of the PCT boards.

Model 3
A single individual chairs the cluster board and is appointed to all the constituent PCT boards, but the non-executive team is comprised both of a person or persons appointed to all constituent PCT boards, described in the diagram below as 'shared NEDs' and a person or persons appointed specifically to an individual PCT ('locality NEDs'). The number of shared and locality non-executives can vary according to local circumstances, but the requirements for a minimum of five and maximum of seven non-executives to be appointed to each PCT board must be met.

Model 4
PCT boards form into a cluster arrangement but continue to operate with their own Chair and non-executive team, but share a single executive team. Individual PCT boards would work together to identify and agree the common issues for all boards within the cluster and what are individual PCT issues. Each constituent PCT board holds the single executive team to account for its individual as well as the cluster issues.

Shared Operating Model for PCT Clusters
Gateway Reference16436
Issued 28 July 2011

10. As set out in the PCT Cluster Implementation Guidance, published in January 2011, governance arrangements for Clusters should comply with statute, fit the operational context and be locally determined. However, in ensuring that these arrangements fit the operational context Clusters will need to pay particular attention to **ensuring that governance arrangements are effective, but do not place disproportionate demands on the single executive team**. We are aware that some models currently in use are placing significant demands on executive teams and this is an issue that will require further consideration.

12. We also expect **Clusters to continue to maintain and build strong working relationships with local government**. This includes, where possible respecting pre-existing local joint working or joint appointments, and appropriately involving local government in developments or refinements of Cluster arrangements. It includes supporting CCGs to develop their own joint working arrangements with local government and to engage in the development of health and wellbeing boards. It also includes working with local government to implement the new arrangements for public health.

PCT Cluster Governance
Letter from Jim Easton National director for Improvement and Efficiency
Gateway reference 16713
Issued 29 September 2011

I am writing to set out the conclusions of the NHS Management Board following our recent discussions on the governance arrangements of PCT Clusters. Many of you have contributed to those discussions and I am grateful for those contributions.

The Management Board was guided by two objectives:

i) supporting the direction of travel for reform, in particular whilst allowing for effective management of the transition, providing space and support for CCGs and Local Authorities to begin establishing the local relationships that will, subject to legislation, be the bedrock of the new NHS commissioning system;

ii) having governance arrangements with absolute clarity about responsibility and accountability and which are efficient and effective.

On this basis we have concluded that, of the four governance models that were originally described for PCT clusters, model 2 is the most effective model. Many PCT clusters have already adopted or are adopting this model and we strongly welcome this. Indeed, it is the model which has been adopted by the SHA clusters. A number of other clusters have effective governance arrangements which incorporate the key features of model 2.

SHAs have been asked to ensure the following key principles of model 2 are adopted by all PCT clusters, by December 2011 or, exceptionally, by a date agreed with the SHA:

- a single board meeting transacting, as far as is practicable, the board business of all of the constituent PCTs;
-a single executive team with single chief executive;
-a single individual as chair of the cluster, therefore excluding shared or rotating arrangements.

SHAs will be working with you and the Appointments Commission to establish the implications of this for your organisation and any necessary further action.

Wellbeing Policy Development and Scrutiny - 29 November 2011

In July 2005 Bath & NE Somerset Council and NHS Bath & NE Somerset agreed to proceed with an integration project which now covers Children's Services; Adult Social Services, Health and Housing; and Public Health. Integration has been supported on a cross party basis within the Council and by key stakeholders including LiNK and local clinicians. Over the period since July 2005, B&NES has been at the forefront of partnership working with consequential benefits to the residents we serve.

Earlier this year the Joint Provider Social Enterprise (Sirona) was established and transfers of businesses and 1,700 staff were effected by 1 October 2011. It is one of the few joint Social Enterprise providers, one of the very few that includes children's services (community paediatrics and Lifetime) and the only one in the South West that includes public health. The Council and PCT worked very hard to meet challenging Department of Health (DH) timelines while ensuring, as best we were able, the involvement and support of our staff groups, GPs and other professionals and the local community.

In 2006 there was serious concern that the important link of coterminosity may be severed by combining NHS B&NES within a larger Greater Wiltshire (that was the term actually used in the Council report of 30 March 2006) or Avon PCT. In the end the Government recognised the importance of coterminous working between PCTs and local unitary authorities and NHS B&NES continued as an independent entity. It is unlikely that integration would have progressed in the way it has if NHS B&NES had been part of a larger PCT and it is noted that Council / PCT relationships are much weaker in neighbouring areas including Wiltshire.

The NHS is currently the subject of major transition. This can be seen locally with the establishment of Sirona, the development of Clinical Commissioning Groups (CCGs), PCT Clustering, the development of Commissioning Support Organisations (CSOs) with geography and activity still to be determined, the transfer of public health to local authorities (although it is already part of the partnership and under the Health & Wellbeing Partnership Board) and with heavy financial pressure on the PCT (and the Council) and on related management capacity.

On 29 September 2011, the DH issued a letter to PCT Cluster Executives indicating that (unless exceptionally agreed by the Strategic Health Authority) each cluster should have, by 1 December 2011, a single executive team, a single board meeting transacting as far as is practicable the Board business of constituent PCTs, and a single Chair of the Cluster.

NHS B&NES and NHS Wiltshire had already reached agreement to have a common Chair and Non-executive Directors by 1 April 2012 and in order to assist in a managed transition I had indicated that I would stand down as Chair on that date. However, over the period to 1 April 2012, critical decisions need to be made including on the balance of what is done locally and what is done at a cluster or CSO level and what that will mean for the Partnership, our joint staff and our community. The personal and organisational relationships will be critical during this period as Council, CCG, PCT, Cluster and the local community explore and determine the best way forward.

Following discussions with and representations by the Council, the CCG and LiNK and, following a two week local 'pause' agreed by the SHA to consider how best to progress, I wrote to the SHA on 4 November 2011 requesting that NHS B&NES be an exception to the

DH 'guidance' and enclosed copies of letters from the Leader of the Council and from the CCG and LiNK. My cover letter and an enclosed governance paper I had also prepared were used to support the case for a deferral until 1 April 2012. (There are a number of governance issues affecting the ability to create a single executive given current PCT Regulations and related Directions) irrespective of the criticality of having regard to the Partnership arrangements. I await a formal response from the SHA and will be meeting with them tomorrow. After that I will be able to respond more fully to the letter I have received from the Council and / or determine if further representations may be appropriate.

The PCT recognises that it is in a partnership with the local authority which the CCG wishes to continue through to 2013 and beyond, that there are business and employment issues that need to be discussed and resolved in terms of any proposals for, and prior to any implementation of, a single executive and a single board meeting at Cluster level. The clustering arrangements must reflect the local situation and agreements and recognise the significant involvement of senior Council executives in the management of the joint businesses including through the Health & Wellbeing Partnership Board (which has overall responsibility for the monitoring and implementation of the Partnership's businesses). We believe that the nature and extent of the Partnership is such that an exception should be considered by the SHA to give sufficient time to work through the matters of principle the Council and others have raised and determine the practical mechanisms to manage the joint businesses going forward recognising the strength and value of the Partnership.

I shall be pleased to answer any questions.

Malcolm Hanney

Malcolm Hanney
Chairman
NHS Bath & NE Somerset
29 November 2011

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Sir Ian Carruthers
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3 November 2011

Dear Sir Ian

B&NES and Wiltshire PCT Cluster - Joint Commissioning

The Bath & North East Somerset Local Involvement Network has now been working with NHS B&NES and B&NES Council for over three years, and has during this time been impressed by the commitment of these bodies to the implementation of Joint Commissioning arrangements across the health and social care sectors. We are convinced that this very close partnership is of great benefit to service-users and carers in both sectors, and that it must not be lost as a result of NHS reorganisation.

We have been concerned already at the possible threat to these joint arrangements that may arise from the removal of community services in B&NES to a new Social Enterprise. We are even more concerned at the threat that may come from the clustering of the B&NES and Wiltshire PCT's. It seems to us that the latter is very far behind B&NES in the practical implementation of and the very strong commitment to joint commissioning, and we fear that a new PCT Cluster will have to compromise between the positions of the current PCT's, leading to a dilution of commitment to joint commissioning in our area. We are, of course, also aware of the recent resignation of the Chief Executive of NHS B&NES, which could lessen the impact of the PCT's legacy in this important area.

The LINk would be grateful for any comments the SHA can make on this, and for some reassurance that the valuable work done and structures evolved in B&NES for Joint Commissioning will not be lost as clustering arrangements are implemented.

Yours sincerely,

Diana Hall Hall
Chair, Bath & North East Somerset LINk

cc. Dr Ian Orpen, Chair,B&NES CCG
Cllr Vic Pritchard, Chair, B&NES Wellbeing Policy Development & Scrutiny Panel
Cllr. Malcolm Hanney, Chair, NHS B&NES

NHS
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23 November 2011

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Dear Ms Hall Hall,

Thank you for your correspondence setting out your views on the Board governance arrangements for the NHS Bath and North East Somerset and NHS Wiltshire Cluster. Your views are very helpful.

We are disappointed that both organisations could not reach a joint view on the best way to meet the governance arrangements set out by the Department of Health.

Given the majority of Primary Care Trust clusters now have the right arrangements in place, it is vital we meet with both organisations to agree a way forward on how they will meet national NHS policy.

Once we have met with the organisations, we will ensure that you are kept up to date with progress.

Once again, thank you for sharing your views.

Yours sincerely

Charles Howeson
Vice-Chair
NHS South of England

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B&NES Wellbeing Policy Development and Scrutiny Panel
Contributors Session
29th November 2011

B&NES Clinical Commissioning Group Briefing

The B&NES Clinical Commissioning Group (CCG) made clear its views that the very short time scale for board merger by 1st December represented an unwanted distraction as we considered how best to configure the CCG to face the huge challenges ahead. It was obvious to us that the local arrangements of partnership with the council gave us different options and opportunities to other emerging CCGs given the degree of existing integration and collaboration. It was our belief to take full advantage of this required sufficient time to avoid the risk of unwittingly undermining existing arrangements that might be otherwise in the interests of the council, public and the CCG.

The CCG had been consulted about, and were happy with, the1st April date for a board merger agreed between NHS Wiltshire and NHS B&NES.

So I wrote the following letter (dated 2nd November) to John Everitt as part of a wider submission to the Strategic Health Authority from the B&NES Council, NHS B&NES and LiNK. This summarises effectively the views of the CCG.

Dear John

You have asked for confirmation of the views of the Clinical Commissioning Group with regard to the DH proposals for a single board and single executive for NHS B&NES and NHS Wiltshire by 1 December 2011. These comments are provided in the context of our plans for maintaining and developing the close partnership with the Council and as members (2) of the Health & Wellbeing Partnership Board which we have been pleased to have joined and been warmly welcomed by our Council colleagues.

It is very apposite to consider the reasons why an early board merger is not appropriate for B&NES as I leave the National Association of Primary Care (NAPC) conference in Birmingham. We have heard from a wide range of speakers including:

- *Sir David Nicholson*
- *Andrew Lansley*
- *Dr David Colin-Thome OBE, recently retired National Director for Primary Care at the DH*
- *Professor Steve Field, Chair of the NHS Future Forum*
- *Sophia Christie Chief Executive Birmingham East on secondment to DH as Director of Alignment and Coordination*

There was a very strong theme running through the meeting regarding the imperative of good, close and supportive relations with your local authority. Andrew Lansley noted that a year ago Health and Wellbeing Boards had been only a concept, but there were now 132 across the country. He also stressed the role of the new tariff structure due to be announced shortly to facilitate integrated commissioning of services.

Nigel Edwards, senior fellow at the Kings Fund and former Policy Director of the NHS Confederation, said that the reforms will deliver a strong National Commissioning Board and potentially strong localities. The latter though, is not a given and will require CCGs to make it happen: fundamental to this will be the relationship with the council as well as the public, through the Health and Wellbeing Boards.

Both Steve Field and David Colin-Thome confirmed the view of the vital importance of HWB in personal conversations we had with them. The latter has firsthand experience of what the Partnership has delivered locally from his attendance at the Sirona Workshop day last week.

It has been our experience that the joint approach has delivered key benefits to us locally and this is noticeable not only in Sirona's existence as joint provider of Health and Social Care, but by what it

help deliver even before it became a Social Enterprise. The DTOCs (Delayed Transfers of Care) in B&NES are less than 1% as opposed to over 5% in Wiltshire in the most recent figures from the RUH monthly quality scorecard. DTOCs rates have been consistently low for BANES over the last 12months, and this is in no short measure due to the integrated approach we have taken with our Local Authority and community provider and the effective partnership working that has been developed. This joined up approach is one the key ways of delivering the enormous challenges we have ahead of us and reflects our almost unique position with the existing Partnership and HWB. We are aware that neighbouring local authorities look to BANES as a good example of partnership working and are keen to learn from our experience and success in achieving what we have.

It also needs to be acknowledged that there are already established formal contractual arrangements of senior managers between the LA and NHS BANES and the current timetable of clustering does not take adequate account of the need for consultation with regard to the changes.

There was a lot of discussion about the role of clusters being customer focused and responsive to the requirements and requests of CCGs as they start to develop into intelligent clients for commissioning support. To that extent, one might reasonably argue that clusters have a responsibility to respond to what their constituent CCGs views are on an issue such as this. It is clear that at no point were we directly asked for our views about the proposed merger date (by the cluster executive).

Also, much was made of the choices that CCGs need to consider about what support they wish to obtain and where from. Local authorities were noted to be an obvious and significant potential alternative to clusters for obtaining support.

Given the additional general agreement from Andrew Lansley down, stressing the practical importance of integrated commissioning and delivery to reshape radically the models of care and the importance of the HWB and CCG relationship, it is crucial that we allow sufficient time to explore how this will impact on the CCG's plans for its commissioning support and where it chooses to get it from. We are also concerned that the other part of the cluster has yet to establish a close relationship and we would be concerned at the potential for major distraction for us a CCG and wider community, including the Council, over the coming vital 5 months, should an early merger take place. This period is likely to be pivotal as we flesh out the details regarding our commissioning structure and requirements.

For all these reasons outlined above, it remains the firm view of the CCG that a there is an overwhelming argument for a delay in board merger to April 2012 to take into account the peculiar local factors in play.

Best wishes

Ian

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