

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 membership³, 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, without placing 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 Reference 16436
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.