



Shared Operating Model for PCT Clusters

DH INFORMATION READER BOX

Policy	Estates Commissioning IM & T Finance Social Care / Partnership Working
HR / Workforce Management Planning / Clinical	
Document Purpose	Best Practice Guidance
Gateway Reference	16436
Title	PCT Cluster Shared Operating Model
Author	Jim Easton
Publication Date	28 Jul 2011
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of Nursing, Local Authority CEs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Communications Leads, Emergency Care Leads
Circulation List	
Description	This publication supports the development of PCT Clusters to ensure they deliver their twin objectives of overseeing and accounting for delivery and supporting the development of the new system. It supports the move towards a more consistent way of operating in some areas as we move through transition and prepare for the establishment of the NHS Commissioning Board.
Cross Ref	PCT Cluster Implementation Guidance
Superseded Docs	
Action Required	N/A
Timing	
Contact Details	Improvement and Efficiency Directorate Department of Health Richmond House 79 Whitehall London SW1A 2NS
For Recipient's Use	

Shared Operating Model for PCT Clusters

1. The Operating Framework for 2011/12 announced the creation of PCT Clusters to secure the capacity and flexibility needed for the transition period. They will work as transition vehicles to:
 - Oversee and account for delivery; and
 - Support the development of the new system.
2. In January 2011, the Department of Health published PCT Cluster Implementation Guidance to assist the NHS in the identification and development of PCT Clusters. That guidance set out key responsibilities, structures and governance issues for Clusters.
3. Since then, the Department has agreed with Strategic Health Authorities (SHAs) proposals for 51 PCT Clusters covering England. We know there is significant variation, both between and within regions, in how Clusters are operating.
4. In some areas, this is desirable to allow the NHS to respond to local circumstances and priorities. However, there are also areas where consistency is needed, because;
 - there should be appropriate consistency of implementation on issues such as support for and development of clinical commissioning groups and ensuring QIPP delivery;
 - with the Clustering of SHAs, it will not be possible to sustain effective system management and development with 50 different operating models;
 - given the twin challenges of QIPP and modernisation, both operational and strategic risk are high and require best practice responses;
 - it is a lead in to the development of a consistent operating model for the National Commissioning Board (NHSCB), and;
 - the NHS needs to take account of policy developments following the NHS Future Forum's recommendations and the Government's response.
5. This shared operating model for PCT Clusters is being co-produced with the NHS. It sets out where there are processes or functions that all Clusters will need to perform and where it is important that there is consistency between Clusters.
6. This phase of the work to develop the model covers six initial key areas. Once these areas are settled, and Clusters are working to ensure they are operational, we will need to consider whether the model should be extended into other areas in a further phase of the work.

7. There are a number of high-level principles that our discussions with the NHS and stakeholders have identified as being important, these run through the shared operating model.
8. In **overseeing and accounting for delivery**, Clusters must keep in their minds that **they are collections of PCTs with a single executive team**. These teams must ensure that each PCT within their Cluster continues to meet its legal, financial and performance responsibilities and obligations. The Chief Executive for the Cluster is also the Accountable Officer for each PCT within the Cluster.
9. Each Cluster should identify and exploit opportunities to improve efficiency within their Cluster. This will require them to streamline and centralise some functions or processes. Clusters should be demonstrating leadership and proactively planning to deliver this as part of **ensuring their management arrangements are as efficient as possible** during the transition process. However, there is a balance to be struck as Clusters will need to ensure they have **sufficient management capacity so that accountability can be maintained**.
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.
11. Clusters have a crucial role in **supporting the development of the new commissioning system**. This role includes: the development of CCGs and being responsive to their requirements to enable full authorisation at the fastest pace possible consistent with their own commitment and readiness; developing commissioning support for them; preparation for the establishment of the NHSCB; the transfer of public health to local government and the establishment of health and wellbeing boards. Well-supported development of the new system can make a significant contribution to current delivery.
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.

13. This **Shared Operating Model supports, but does not supersede or replace previous key guidance or requirements**, for example the NHS Operating Framework for 2011/12. All requirements and responsibilities set out within that or in statute still stand. This includes requirements or responsibilities outside the six initial signature processes such as Informatics, Public Health or Workforce.
14. In particular Clusters are reminded that the Public Sector Equality Duty (Equality Act 2010) and specific duties (currently before parliament) apply to all NHS organisations listed in schedule 19 of the Act including PCTs until their abolition. Clusters should ensure that all constituent PCTs pay due regard to the Public Sector Equality Duty. Clusters will also have an important role in maintaining and strengthening action on health inequalities through out the transition. Subject to Parliament, the Health and Social Care Bill proposes new legal duties on health inequalities for the Secretary of State, the NHSCB and CCGs. PCT Clusters will be expected to ensure that local knowledge on inequalities their drivers and effective approaches to addressing them form part of their work to support the development of CCGs, Health and Wellbeing Boards and Strategies. A comprehensive strategic approach will need to be taken to ensure action is large scale and systematic, spanning their strategic vision, commissioning, finance and workforce functions as well as public health.
15. The new health and care system will be driven by shared leadership across local government and clinical commissioning groups, with health and wellbeing boards developing joint strategies to underpin local commissioning. CCGs will be the engine room of the new system but will require this shared leadership with local government as this will be critical to delivery of QIPP and to managing strategic and operational risk through the transition. We expect Clusters to **play a key role in developing this shared inclusive leadership**.
16. In making staffing changes to streamline delivery within Clusters, all appointment processes should comply with the Equality Act 2010 and the principles of fairness. Every effort needs to be made not to lessen the proportion of people with protected characteristics such as staff from BME backgrounds, disabled people and women in senior roles. It will be particularly important for the NHS to retain its expertise and intelligence on advancing equality and tackling health inequalities during the transition. The SHA, in conjunction with its PCTs, should carry out an Equality Analyses of these proposals.
17. The relationship between SHAs and PCT Clusters, and in particular how current SHA functions are to be carried out during the transition period, will be addressed through the work to Cluster SHAs. However our expectation is that SHAs will continue to hold Clusters to account for delivering their responsibilities and that PCT Clusters, and SHAs will continue to work together closely to ensure the NHS continues to meet patients' needs.

1. Integrated Finance, Operations and Delivery

18. The role of the Cluster is to facilitate the transition to the new system whilst maintaining financial control and service performance within PCTs and ensuring appropriate transparency for the financial position and financial management of each PCT.
19. The Cluster Chief Executive and Director of Finance should ensure that each PCT within their Cluster continues to deliver what is required of them through statute and other key documents, including the NHS Operating Framework for 2011/12. All the financial guidance and performance measures that currently apply to PCTs will continue to apply at PCT level, although Clusters will be responsible for ensuring each PCT's delivery and meeting its QIPP challenge. This includes the quality, resource and reform elements of each PCT's Integrated Plan.

Performance – Deliverables and Areas of Consistency

20. PCT Clusters are required to ensure that all PCT functions are fulfilled for the duration of their existence as statutory bodies. This specifically, but not exclusively, includes:

21. Ensuring delivery:

- Ensuring delivery within each PCT of Operating Framework requirements on quality, resources and reform, including headline and supporting measures;
- Monitoring contracts and holding providers to account against Operating Framework requirements and contractual requirements;
- Meeting the QIPP challenge by ensuring delivery of each PCT's integrated plan or the PCT Cluster's integrated plan, covering quality, resources, reform;
- Considering the scope for delivering greater quality or productivity improvements across PCT integrated plans and day-to-day delivery through the process of Clustering, whilst respecting legal and other PCT responsibilities;
- The Cluster must ensure that there are arrangements in place that meet the statutory requirements for each PCT, for instance on safeguarding children and adults.

22. Reporting and assurance

- Cluster Chief Executives must ensure there are processes in place to meet all in-year reporting for each PCT on headline and supporting measures in the Operating Framework, as well as all sit rep reporting (e.g. on winter) and ad hoc national assurance requests as necessary to support parliamentary accountability.

23. Robust planning

- Cluster Chief Executives must ensure that there are appropriate arrangements in place for effective planning for 2012/13, enabling

emerging CCGs to lead the planning round where they are ready and willing to do so. This includes undertaking needs analysis for their local population, identifying health inequalities, developing robust demand and activity assumptions, setting priorities and strategic vision locally. This planning will need to involve engaging Local Authorities and health and wellbeing boards to ensure plans align with the Joint Strategic Needs Assessment and emerging joint health and wellbeing strategies as they are developed. It will also include working with other stakeholders and leading any reconfiguration or service development required;

- Local planning will need to take into account NHS Operating Framework requirements, in order to secure SHA Cluster (and thus DH) sign off;
- The Cluster CE must ensure that there are appropriate arrangements in place to meet statutory and national requirements in relation to reconfiguration and service development.

24. Commissioning and contracting

- The Cluster CE must ensure there are appropriate arrangements in place for contract negotiation and agreement with providers for 2012/13 and must involve their emerging CCGs in such negotiations;
- The Cluster DOF must ensure that emerging CCGs are involved in agreeing contracts that go beyond the expected life of PCTs and Clusters;
- The Cluster should work to ensure arrangements are in place to ensure joint commissioning arrangements with local authorities are maintained, and further developed where appropriate through the transition.

Finance - Deliverables and Areas of Consistency

25. We expect PCT Clusters to ensure that all the functions of PCTs are fulfilled for the duration of their existence. This specifically, but not exclusively, includes:

- Holding service providers to account against Operating Framework 2011/12 requirements on service, quality and finance;
- Ensure delivery of QIPP within each PCT;
- The Cluster must ensure the capability and robustness of financial management and governance arrangements for constituent PCTs;
- PCTs remain, until their abolition, the relevant statutory body and accordingly, financial planning and reporting and the preparation and audit of statutory accounts will remain at the PCT level. Clusters will be responsible for the delivery of these matters, including ensuring the adequacy of appropriate counter fraud and audit committee arrangements;
- The Cluster Chief Executive and Director of Finance will sign the statutory accounts of constituent PCTs and be responsible for the audit opinions on these accounts;

- Allocations will continue to be made at the PCT level until their abolition and all resource transfers between PCTs, including PCTs within the same Cluster, should be agreed with the SHA Cluster;
- The Cluster is responsible for working with emerging CCGs in respect of financial planning and control to ensure strong financial management and the prevention of PCT deficits. The Cluster is responsible for ensuring all existing legacy debt issues are resolved in accordance with the requirements of the 2011/12 Operating Framework;
- The Cluster will be responsible for complying with all Departmental financial guidance issued that applies to PCTs, including running costs limits and their management (which are likely to be set at the aggregate regional level), the creation and management of the 2% recurrent funding headroom, the application of Payment by Results guidance and planned or ad-hoc information requirements;
- The Cluster must, through engaging emerging CCGs, continue to undertake effective planning for 2012/13. This will include needs analysis for their local population, developing robust demand and activity assumptions, tackling health inequalities, agreeing local priorities and Operational plan, working with Local Authorities and other stakeholders and leading any reconfiguration or service development required.

2. Commissioning Development

26. The success of the Cluster in commissioning development will be measured by the successful establishment of the new commissioning architecture, such that it can accelerate the delivery improvements in health and healthcare. Clinical leadership is at the heart of the new system, and Cluster management should aim to support and nurture clinical leadership through the emerging CCGs. This needs to include a clear ambition to deliver full authorisation of as many CCGs as possible by April 2013 wherever CCGs are ready and willing to achieve this.
27. To establish the new arrangements effectively, Clusters will need to create strong relationships with a wide range of players, including:
- Emerging CCGs – to support them in their journey to taking on full responsibilities for commissioning and local leadership of relationships with local authorities and patient and public groups;
 - With local authorities to support the development of effective health and wellbeing boards, future joint commissioning arrangements and robust arrangements for public health and health inequalities across the new system. Whilst clinical commissioning groups are coming into being Clusters will need to ensure that essential local knowledge is retained within the health community across the Transition;
 - With other Clusters to develop shared approaches to commissioning support;
 - With the new NHS Commissioning Board, when established as a Special Health Authority, in moving towards a single operating model for those commissioning functions which will rest with the NHS Commissioning Board from April 2013 (subject to legislation). Specific detail on this is set out in the final part of this section.

Clinical Commissioning Groups - Deliverables and Areas of Consistency

28. The aim is to provide sufficient support to enable clinical commissioning groups to be fully authorised without conditions by April 2013 if they wish. To support the delivery of this in 2011/12, Clusters should:
- Have a board-level director with overall responsibility for the development of commissioning;
 - Support emerging CCGs to prepare for the authorisation process aiming to ensure the support is such that all those CCGs who wish to, can be become fully authorised as soon as the process begins in the second half of 2012 (subject to the passage of the Bill);
 - Work with SHA Clusters in supporting prospective CCGs to find a configuration that will meet the likely legislative requirements;
 - Support all emerging CCGs to undertake a self-diagnostic, using the national tool (to be available at the end of July) or a recognised alternative;
 - Ensure that all CCGs have the mandated £2 per head support in place as minimum;

- Ensure that emerging CCGs have, in addition to the £2 per head cash resource, the appropriate management support either assigned directly to them or working across several groups to allow them to develop and take on delegated responsibility;
- Ensure that all GP practices are part of a CCG by April 2012 and facilitate discussions where practices are having difficulty defining CCG boundaries.
- Ensure that all emerging CCGs have a development plan in place, agreed with Clusters, including access to individual leadership development;
- Support all emerging CCGs to have appropriate earned autonomy/delegation of budgets, which can be reported and tracked through the Operating Framework indicators;
- Should facilitate discussions with HealthWatch, and local authorities to ascertain their support and contribution to supporting CCGs in delivering personal, fair and diverse commissioning services for individuals belonging to protected characteristics and those facing health inequalities. Clusters may need to support CCGs to understand and deliver on the Public Sector Equality Duty and the Equality Delivery System is a tool which is available for this.
- Ensure emerging CCGs have the opportunity to build up track record of delivery (eg. on QIPP, primary care, tackling health inequalities, relationships with local partners including participation in emerging health and wellbeing boards, patient engagement and public involvement) in preparation for authorisation;
- Support CCGs in leading the planning round for 2012/13 as appropriate;
- Support CCGs to ensure they are engaged early in the development of their local health and wellbeing board in shadow form during 2011/12 and that they are able to play a lead role in shaping the joint strategic needs assessment and joint health and wellbeing strategy;
- Support CCGs in engagement with critical aspects of provider development, and in particular the future for NHS trusts.

Commissioning support - Deliverables and Areas of Consistency

29. To ensure appropriate levels of commissioning support, Clusters should focus their attention on the following areas:
- Customer development and intelligent commissioning: Clusters should facilitate the development of CCGs, as intelligent commissioners and customers, and understand and articulate their needs;
 - CCGs should be centrally involved in the development of commissioning support models so that they can then become intelligent consumers of such support;
 - NHS development: All Clusters should support the development of affordable and viable models of commissioning support, taking account of the feedback from the recent stocktake of capacity and capability. This will need to be developed by working closely and collaboratively with emerging CCGs and in line with the national timetable.

Development should take account of the need to draw on services which are provided at scale and which maximise expertise and the need to develop effective local working arrangements with emergent CCGs;

- Financial analysis: Clusters should work through cost models to ensure their overarching strategic approach to commissioning support will be affordable;
- Clusters should facilitate a discussion with local authorities to ascertain their potential contribution to providing commissioning support for Clusters.

NHS Commissioning Board – Directly Commissioned Services

30. PCT Clusters will have a vital role in supporting convergence towards a single operating model for all direct commissioning functions of the NHS Commissioning Board (including primary care, specialised, military health and offender health commissioning). In particular, Cluster priorities should be agreed and running cost reduction decisions taken in light of future operating models where known. CCGs should be involved in developing a modus operandi for joint work in developing and improving local primary care provision.

31. More detailed information for PCT Clusters about the convergence to a single operating model for all aspects of commissioning that will become the direct responsibility of the NHS Commissioning Board is scheduled for publication in September. It is expected that this will also include information about the Board's proposed responsibilities for commissioning secondary dental services, and any public health services on behalf of Public Health England.

Deliverables and Areas of Consistency

Primary Care

32. The new system for primary care commissioning will form part of the single operating model of the NHS CB. This will include medical, pharmacy, optometry, and both primary and secondary dental care. This means that the variability of current commissioning arrangements at PCT level will not be a feature of the new system.

33. Clusters will have an important role to play in the development of the primary care commissioning model, as well as in ensuring a safe and proper transfer of responsibilities in 2013 through an agreed process of convergence.

34. To date work in this area has concentrated on:

- Function and task analysis of what happens now in PCTs, SHAs, DH and NHSE;
- Reviewing the work done as part of the world class commissioning programme;

- Communicating and building understanding of the concept of a single operating model;
 - Engaging with a broad network of clinical and managerial staff in SHAs and PCTs as well as with national stakeholder organisations;
35. The priority thus far has been on a safe transition but is now turning towards the design of a system which will ‘transform’ primary care in years to come. CCGs will play a crucial part in such transformation, delegated by NHS CB, and therefore need to be involved at an early stage in shaping the new primary care environment. Especially in areas such as quality improvement, reducing inappropriate variation, premises and information technology. Clusters will be expected to continue to support this and in particular the work being undertaken in the following areas:
- The commissioning system – including contracts with practices, performance of individuals, clinical advice, system alignment, role of clinical commissioning groups;
 - Primary care support and infrastructure functions – including premises reimbursement, occupational health services, primary care clinical audit, IT support;
 - Pay and rations – including the already national commissioning support organisations such as the BSA which processes dental and pharmaceutical payments and the future of FHS functions including GP payments and patient registration;
 - Functions, organisation design and structures – both central and local, discharged through clinical commissioning groups, local professional networks and potentially through commissioning support organisations;
 - Linking with other workstreams such as information and intelligence to ensure our information needs will be met by their design work; revalidation, responsible officers and performers lists ensuring that the design work supports emerging policy in these areas.

Specialised Services

36. The case for change for moving from separate and disparate arrangements for specialised commissioning has been well made and is generally supported by patient groups and the service alike. The move to national standardisation for access to services and standardisation of policies and specifications allows resources to be released to focus on the quality and effectiveness of what is being bought and the impact of this on treatment outcomes. Specific areas of consistency include:
- National convergence of commissioning from 1st April 2012;
 - Clustering Specialised Commissioning Group arrangements into the SHA Cluster footprint to support the move towards one operating model for specialised services;
 - Operating as a national team via SHA Cluster footprints, focusing on convergence of contracts, policies and service specifications.
37. The ‘transition’ phase of work is now almost complete and by the end of September we will need collectively to be in a position to know:

- What will be commissioned (subject to final approval by Secretary of State);
- The service standards and specifications (based where possible on NICE Quality Standards) against which they will be commissioned, including the identification of where convergence is not possible and a plan to manage this;
- The impact both financial and clinical of separating contract activity, specialised/non specialised, and local agreement as to how this should be managed and over what timescale.

Prison Health

38. PCT Clusters will have additional responsibilities in relation to managing the transition of offender health commissioning functions in line with emerging arrangements for the wider NHS.
39. Operationally, new arrangements have to:
- Be coherent with the NHS CB's direct commissioning responsibilities for primary care and specialist services, where there are areas of overlap such as Dangerous & Severe Personality Disorder;
 - Connect the NHS CB's direct commissioning of prison health with (i) the wider responsibilities of CCGs who will negotiate secondary care contracts accessed by prisoners and (ii) with Public Health England's drugs commissioning arrangements.
40. There are significant overlapping responsibilities and a wide range of interested and responsible parties, including the Ministry of Justice, National Offender Management Service (NOMS), Youth Justice Board and others.
41. PCT Clusters will need to ensure that offender healthcare is planned and commissioned to sustain an offender healthcare system that is built around the needs of the patient, and has quality and innovation at its heart. For this to happen, all parts of the system must work together. Specifically and as part of the quality and efficiency challenge, PCT Clusters should aim to deliver quality and productivity improvements to Offender Healthcare through the 2012/13 commissioning round.
42. For offender healthcare, development plans should be in place in readiness for the 2012/13 commissioning round. All plans should be supported by a refreshed health needs assessment and assessed for the impact of equality. As well as meeting the needs of the general offender population, specific consideration should be given to the following groups:
- people with mental health problems;
 - people with learning disabilities;
 - women;
 - children and young people (including those in Secure Children's Homes and Secure Training Centres);

- older offenders.

Military Health

43. PCT Clusters will need to ensure that military healthcare is planned and commissioned, taking into account proposed future commissioning arrangements for military health.
44. These can be summarised as follows:
- **Statutory Duties:** Subject to passage of the Health and Social Care Bill through Parliament, the intention is for current PCT duties in relation to health care for HM forces and their families (who are registered to MoD medical centres) to be transferred to the NHS CB who may delegate some of them to CCGs;
 - **NHS Funding:** the NHS CB will receive the secondary and community allocation for resident HM Forces, and the full allocation for families registered at military medical practices. This allocation will be managed collaboratively between the NHSCB and the MoD (Joint Medical Command);
 - **HM Forces:** Primary care remains the responsibility of the Defence Medical Services;
 - **Veterans:** Certain aspects of Veterans' Health Care may be commissioned by the NHS CB where these are usefully centrally managed and meet the specialised services criteria. Examples could include specialist mental health support and specialist veterans' prosthetics (subject to the Government response to the review recently undertaken by Dr Murrison and Armed Forces covenant);
 - **Non-standard care:** commissioning and funding of non-standard care by the Defence Medical Services will continue, including directly managed rehabilitation (e.g. Headley Court, Army Recovery Capability, and Regional Recovery Units).
45. Work is underway with SHA Armed Forces Networks, Defence Medical Services to establish an effective operating model for commissioning these services by September 2011.

3. Ensuring Quality (Effectiveness, Experience and Safety)

46. Organisational change can pose risks to the quality of services that are delivered. Whilst maintaining and improving the quality of services is first and foremost the responsibility of health professionals in provider organisations, all parts of the system need to work together to prevent failure as well as improving services and outcomes for patients. This includes PCT Clusters and CCGs. Such co-operation centres around making quality the 'organising principle' of the NHS.
47. The National Quality Board published *Maintaining and Improving Quality during the Transition: safety, effectiveness, experience* in March 2011. This confirmed that statutory responsibilities remain the same during the transition. The National Quality Board will be reviewing roles and responsibilities for maintaining and improving quality in the new system architecture. Clusters and CCGs will need to take account of this report , which is expected later in 2011/12.
48. In the meantime, Clusters have key roles in maintaining and improving quality, described below. PCT Clusters also need to be thinking about, and preparing to hand over and support, CCGs to take on their future roles with respect to quality. This includes taking account of the direction of travel focusing on improving health outcomes. It also includes preparing and maintaining legacy documents that can be shared with CCGs and further developed during the transition period leading up to formal handover of responsibilities.
49. Success for a Cluster is defined as assuring itself that the quality of commissioned services from all its providers (including those facilities providing services to vulnerable people) meet the necessary standards of quality specified in CQC registration requirements, standard contracts, professional guidance, the NHS Operating Framework and other relevant sources. Clusters need to continue to support the delivery of excellent patient care and drive improvements in health outcomes within available resources.
50. Through robust contract monitoring and the appropriate use of hard and soft intelligence, Clusters use the information they have about providers to play a vital role in detecting and preventing serious failures at an early stage. While it is for the CQC to make judgements on whether a provider is compliant with registration requirements, Clusters should be alert to opportunities to spot signs of non-compliance quickly and should inform the providers, the SHA and regulators as appropriate. The plurality of sources of information can also be used to identify areas where Clusters are performing well, and this good practice should be documented and handed over during the transition to new organisational structures.
51. A Cluster should ensure good clinical governance, patient safety frameworks and methods to capture and act upon patient experience and

feedback are in place, including ensuring their provider organisations are reporting incidents appropriately and implementing the learning from analysis of incident data. Clusters must look to foster a culture of open and honest co-operation and have a responsibility to proactively listen to and engage with staff, patients and the public to understand concerns and the experiences of their local populations.

52. Finally, Clusters should maintain a focus on quality improvement as well as quality assurance and ensure that proposals to meet the QIPP challenge the NHS faces either improve or maintain the quality of services provided. This includes ensuring that PCTs are not placing inappropriate restrictions (for example blanket bans) on patients' ability to access or be referred to any services.

Deliverables and Areas of Consistency

53. Deliverables and areas of consistency for Clusters include:

- Clusters must appoint a named Cluster board-level Director with responsibility for the three domains of quality (effectiveness, experience and safety) and establish clear lines of accountability through providers from the Board to the front line. This could be a joint medical /nursing director responsibility
- Establish Cluster board-level director responsibilities for the shape and size of the overall provider workforce. Their responsibilities are to include effective risk management and challenge of workforce plans, including sharing of best practice to mitigate risks / resolve issues, and quality assurance that the proposed changes have had sufficient clinical input and sign off;
- Clusters should ensure their providers can demonstrate they are using appropriate and safe workforce models which meet the criteria set out in the national workforce assurance framework (which is being developed for final publication in November 2011). At present this could include asking providers how they assure they have the right workforce configuration, what models they use, and when they last conducted a review;
- Clusters must ensure quality is maintained by constituent PCTs through their contract management procedures with providers, particularly where providers are proposing significant changes to service delivery;
- Clusters must have in place mechanisms for reviewing data on quality from relevant sources, including incident reports, CQC Quality and Risk Profiles, staff, patient and public feedback and quality indicators (including hard data from surveys, as well as other intelligence such as that received via PALs and complaints);
- Clusters must ensure their constituent PCTs continue to maintain robust systems and processes, with named individuals in each PCT responsible for receiving, disseminating and ensuring action is taken in response to relevant patient safety alerts, public health notices and MHRA drug and device alerts issued via the Central Alerting System;
- Similarly, Clusters must ensure constituent PCTs continue to maintain robust systems and processes to safeguard children and vulnerable adults, including board level leads, sufficient access to the expertise of

designated professionals in line with local needs, and robust arrangements for partnership work through Local Safeguarding Children Boards;

- Clusters must ensure they have due regard to planned collaborative reviews and risk summits and input to formal mechanisms led by CQC for bringing key partners together to share information and intelligence on risk. Planned Collaborative Reviews take place annually and bring together a wide range of organisations that hold information on quality and safety, including PCTs. Clusters should ensure their constituent PCTs continue to engage with the CQC on these. Triggered Risk Summits provide a mechanism for detailed discussion and assessment of risk in response to serious concern. Run by the CQC, Clusters must look to engage where necessary to support this process;
- Clusters must ensure that PCT responsible officers are establishing and maintaining appropriate policies and systems to: monitor doctors' conduct and performance, evaluate their fitness to practise, support doctors about whom there are concerns and underpin medical revalidation when introduced.
- Clusters must ensure their constituent PCTs continue to maintain robust systems and processes for handling patient complaints in accordance with regulations, including the requirement to produce an annual report on complaints. Clusters will need to ensure that such systems and processes are clear to patients and the public, and also that proportionate action is taken in response to individual complaints. Clusters will in particular need to ensure robust arrangements are in place to prepare for smooth transition of individual complaints casework (current and historic records) to new responsible bodies, paying particular attention to data protection issues;
- Clusters should ensure they have received legacy documents (as advised in the National Quality Board's report Maintaining and Improving Quality during the transition: safety, effectiveness, experience Part One – 2011-12), from their constituent PCTs, and ensure that they prepare, and keep up to date, their own Cluster wide legacy document ready to handover to SHAs and CCGs. The Cluster level legacy documents should provide an overview of quality across a geographical reach and based upon the individual legacy documents of each constituent PCT for that Cluster. As well as formal handover at the end of the transition period they should be used to develop capability and understanding in CCGs leading up to handover.
- Clusters will wish to involve and engage with Health and Well Being Boards and LINKs / HealthWatch as they develop commissioning strategies for service areas, and ensure that information and insight about people's needs and preferences are not lost during transition.
- In partnership with Local Authorities, Clusters will develop a quality framework for public health services for the shadow year, in preparation for transfer in 2013.
- Clusters will have an important role to play in supporting emerging CCGs to build upon and expand integrated commissioning with local authorities, and through this to promote integrated provision of services. Better joined up services will make an important contribution to improving quality and safety in particular at the interface between services.

- Clusters should be working with all commissioners (PCTs and emerging CCGs) to take heed of the direction of travel in relation to the national Outcomes Frameworks, including looking at the collection of data, equalities and inequalities dimensions, establishing baselines and publication of information where possible. They should support CCGs to set up their quality systems for measurement and improvement.
- Clusters should review and address issues of safety and quality for people with characteristics protected by the Equality Act. With the help of the CQC, the Equality Delivery System has been specifically designed to help the NHS fulfil this duty.

4. Emergency Planning and Resilience

54. PCT Clusters are expected to maintain the capacity of NHS Commissioners to carry out Emergency Planning and Resilience during the transition period. They are also expected to support the development of the new Emergency Planning and Resilience function within the NHS.
55. Two overarching principles have been applied to the development of the proposed operating model for how the NHSCB will deliver its EPRR duties:
- The NHS will have the lead responsibility and accountability for all incidents which require use of the NHS resource;
 - The implementation of the operating model is subject to further work to identify and secure appropriate resource.
56. The proposed model will support the NHS to maintain resilience during the transition period, but also start to form the sorts of relationships needed within the future landscape, in anticipation of the passage of the Bill. Subject to ministerial approval, the model will establish a robust and resourced structure which operates at all NHS levels, providing the Secretary of State with a direct 'line of sight' to local providers of NHS funded care. These plans will be considered in detail by the DH Executive Board and then the board of the NHS CB when it is established as a Special Health Authority in October 2011. This will allow the NHSCB to consistently lead the NHS response to any emergency or incident that has the potential to, or impacts on, the delivery of NHS services or requires the services/assets of the NHS to be mobilised at the most appropriate level:
- At a national level, it is proposed that the NHSCB will set a risk based national EPRR implementation strategy and planning structure for the NHS. It will also put in place a consistent national EPRR assurance framework for all providers of NHS funded care, to assure health care resilience;
 - At the sub-national level, it is proposed that NHSCB will commission, direct and assure the local EPRR structure to ensure delivery of the national EPRR strategy;
 - At the local level, it is proposed that the NHS CB will discharge its EPRR function via 38 Local Health Resilience Boards (LHRB) which will map onto existing Local Resilience Fora boundaries. The sub-national hubs of the NHS CB will be responsible for appointing a suitable local NHSCB lead who will chair the LHRB. Supported by a NHSCB funded team, this lead will have responsibility for local planning, assurance and response.
57. In order to achieve a successful transition of all EPRR functions into the NHS CB, EPRR structures will need to start to transition to new arrangements, with a sufficient lead in time for new systems and processes to fully bed in ready to go live in April 2013 when the NHS CB assumes full statutory responsibility.
58. For this to be successful, this will include the introduction of a consistent operating model for Clusters (both SHA's and PCT's), and to achieve the

timetable, whilst maintaining system wider resilience, there is a need to commence formalisation of existing processes currently fulfilled by health resilience sub-groups from October 2011

59. The following areas are to assist PCT Cluster board meet their responsibilities for EPRR, including obligation under the Civil Contingencies Act 2004, whilst moving towards April 2013.

EPRR Governance Issues

60. Where there is more than one PCT Cluster per LRF area, one PCT Cluster should be nominated as the lead for Emergency Preparedness within that locality. As far as practically possible, the PCT Clustering arrangements for representation should not cut across LRF boundaries. Where this does happen, both LRF's will need to be serviced.
61. Where a PCT Cluster will lead on Emergency Preparedness arrangements, it must be clear in Standing Financial Instructions that under emergency conditions, the on call Executive Director has collective authority to commit resource (fixed assets and spending) of other PCT organisations in the Cluster.
62. If not already included in the commissioning contracts, a Memorandum of Understanding should be agreed with all provider organisations covered by the PCT Cluster to ensure that under extreme condition the nominated PCT Director can prioritise the work of the provider(s) during times of emergencies. This will ensure that during a major incident provider organisations can have their strategic direction of the organisation refocused to ensure a collective, whole systems response to an incident.
63. When required to do so by the SHA, the PCT Cluster must contribute to, and be able to play a full part in, the response to a wider area emergency that may require the PCT Cluster to provide mutual aid. Under these circumstances, the PCT Cluster nominated Director will be responsible for coordinating the local health economies contribution to the mutual aid effort.
64. With SHA Clusters now coterminous with DCLG resilience hubs, it will be for SHA Cluster EP Directors to engage with DCLG resilience directors to ensure health contributes fully to the multi-agency strategic planning for significant and widespread incident.

Deliverables and Areas of Consistency

65. *PCT Cluster responsibility for planning:*
- Provide assurance using 24/7 response activities;

- Promote the developing relationship between community providers and local authorities with regards to emergency preparedness and response;
- Maintain a health emergency planning network, chaired by the Lead Director for EP, ensuring all NHS organisations in their area meet at least quarterly to agree health resilience issues
- The Lead Director represents any issues of relevance from this meeting to the Local Resilience Fora (LRF)
- Undertake assurance via a mapping exercise and where there are capacity gaps in PCTs, take measures to ensure coverage.
- Appoint/nominate a director who is responsible for health emergency planning; this person should report to the board regularly on local risks to either delivering health care, and/or the health of the local population.
- Maintain a sufficiently resourced and adequately trained health emergency planning team, that can manage the day-to-day preparedness work, and support the Director and Cluster PCT board.
- The nominated director will be responsible for representing the local health economy at the LRF. The nominated director will be supported on the LRF by the local HPA representative and a regional ambulance service director.
- Maintain a 24/7 on call rota that includes response and incident support that is available to the PCT Cluster executive team, but also to support provider organisations. This system must be exercised monthly.
- The Cluster PCT must ensure sufficient testing and exercising of communication plans in accordance with the 2005 DH guidance. This should include testing both in hours and out of hours.
- The nominated Director should ensure the local NHS contributes fully to any local multi-agency training and exercising programme, especially, but not limited to, exercises that are of a statutory requirement for local high risk sites, i.e. Nuclear Power installations, chemical plants, sports grounds licensing etc.

66. PCT Cluster responsibility for response

- Ensure a mechanism for local organisations (particularly LA, Police and Ambulance Trusts) to access through a single point of contact, NHS Primary Care and Community Services to ensure an appropriate local managed 24/7 response to a local incident;
- Ensure mechanisms are in place to support local system wide response, including cross boundary mutual aid for emergency response;
- Continue to maintain provision to provide local system management for routine capacity issues, diversion and winter pressures;
- The director on call must have clearly delegated authority to mobilise and direct the resources of any NHS organisations across their Cluster area (or area of responsibility when on call) during an incident across the local health economy.
- This executive authority can be used when necessary without reference back to others. (This senior level delegated responsibility is

critical if the on call director is required to attend the multi-agency Strategic Coordinating Group, or Gold Command)

- The PCT Cluster must maintain a capacity to provide 24/7 coordination to an incident via a suitably equipped control room for period of up to two weeks duration.

5. The Commissioning Elements of Provider Development

67. Clusters have an important role in supporting the delivery of the provider side reforms. It is important that Clusters are fully engaged in the provider development agenda to ensure effective partnership with current and future Foundation Trusts (FTs) beyond long-term contractual arrangements. Clusters will need to show leadership and make progress on implementing the Tripartite Agreements that have been signed up to by commissioners.
68. Clusters are also responsible for ensuring patients get an increasing choice of high quality services through the effective implementation of Any Qualified Provider and through the provision of support for successful Right to Request social enterprises.
69. Clusters are transition vehicles and outside of actions agreed in the Tripartite Agreements we are not expecting them to enter into agreements that pre-judge the future decisions of CCGs. Where agreements must be entered into for a longer period these should be planned and undertaken in partnership with emerging CCGs.
70. It is also important that Clusters exercise robust oversight of the failure regime within the Cluster geographical area of responsibility.
71. A single operating model is being developed for the enhanced DH central team and SHA Clusters to support a consistent approach to FT pipeline. When this has been finalised there will be a clearer idea of the transitional state and where responsibilities and accountabilities will lie in the system.

Deliverables and Areas of Consistency

72. Supporting the Foundation Trust Pipeline:

- Maintain an ongoing dialogue with aspirant FTs, supporting the commitments set out in the Tri-Partite formal agreements;
- Ensure support and sign-up to the activity levels agreed by both parties in NHS Trusts plans;
- Ensure NHS Trusts engage with and endorse provider strategies that support sustainable local healthcare, reflecting patient needs.
- Take actions to ensure appropriate providers and models of care are available to meet commissioning requirements;
- Support the development of Trust FT applications specifically with activity plans and overall health system strategies;
- Support Trusts in developing sustainable business models to achieve FT status;
- Provide support to NHS Trusts to ensure they are aware of the Equality Delivery System.

73. Effective implementation of Any Qualified Provider as set out in the Guidance published on 19 July 2011:

- Work in partnership with CCGs to develop an effective plan for implementing patient choice of Any Qualified Provider;
- Support and maintain free choice of providers of elective care.

74. Ensuring effective procurement and contract management:

- Promote good procurement practice and procure services in a manner which is consistent with DH policy; guidance and the law, ensuring compliance with the Principles and Rules for Cooperation and Competition;
- Ensure that all procurements are advertised on Supply2 Health;
- Ensure there is the capability to investigate challenges to procurement award decisions;
- Promote the development of currencies and tariffs locally;
- Monitor provider performance, driving improvement and cost reduction in support of the QIPP agenda including reconfiguration of services;
- Ensure contracts are in place for all service providers (and for contracts that go beyond the expected life of Clusters to ensure clinical commissioning groups are involved in agreeing them);
- Ensure registers held for contracts.

75. Provide oversight of the failure regime within the Cluster geographical area. Where failure regimes / plans for the restructuring of services affect more than one PCT area, ensure that:

- Plans are co-ordinated and agreed;
- Any contractual amendments reflected;
- The impact of the change is clearly understood (including cost) and considered with stakeholder groups including Local Authorities and the public;
- Commissioners retain the responsibility for ensuring the continuity of NHS services
- In discharging the above functions Clusters should continue to operate within the current failure regime in place for NHS Trusts and FTs, until introduction of the new failure regime.

76. Supporting the successful establishment of agreed Right to Request social enterprises:

- Providing oversight to ensure that Right to Provide requests, which are underpinned by sound business cases, are providing services that are consistent with commissioning intent.

6. Communications and Engagement

77. The NHS is modernising and trying to deliver more with tighter budgets, whilst ensuring patients and the public get better quality information about health services, and more say in decisions about their own care. At the same time the NHS has to become more accountable for the quality of the service it delivers, whilst still maintaining public confidence. All of this adds to up an unprecedented challenge and huge change.
78. During times of change high quality communication and engagement support is vital. Clusters, emerging CCG leaders and the system as a whole will be under more media and public scrutiny than ever and will need the right support, at the right time to communicate and engage effectively and rise to this challenge.
79. Substantial cost reductions during the past 18 months mean there are significantly fewer people and resource now delivering essential communications and engagement services across the NHS, and remaining staff are unevenly distributed.
80. In order to meet the challenges outlined above we must redesign our current communications and engagement service to ensure that all areas, not just some, are effectively supported in their communications and engagement needs whilst at the same time reducing costs and developing a resilient and sustainable service for the new commissioning system.
81. For these reasons, remaining communications and engagement resource will be realigned into a single, locally focused, nationwide shared service for communications and engagement.
82. Clusters and emerging CCGs will be supported by this new service. It will be locally based, locally focussed, locally led and locally responsive, backed up with support from a nationwide network of specialist expertise, flexible resource to support 'hotspots', and, where appropriate, 'do once' economies of scale.
83. It will ensure there is continued and consistent high quality local communication and engagement support and local delivery, based on an intimate local knowledge of the needs of the local NHS, but with additional support available through a nationwide infrastructure to maximise economies of scale and increase resilience.
84. The cornerstone of the service will be local communications and engagement leaders and local teams - the bulk of staff will be focussed on local delivery, directly supporting Clusters' and emerging CCGs' needs.
85. Communications and engagement leaders will be a dedicated resource for Clusters and emerging CCGs with the experience, knowledge and gravitas to plan, advise and ensure delivery of personalised communications and engagement.

86. They will be supported by a local team who will deliver Clusters' day to day communications and engagement needs including media and reputation management, intelligence gathering and briefing, crisis communications and communications for emergency planning, formal consultations, ongoing engagement and involvement, internal communications and staff engagement, and web communications among others.
87. Local leaders and local teams will have access to a nationwide network of specialists in their fields who can share best practice, coordinate activity nationwide on common issues, avoid duplication and obtain best value for money through economies of scale.
88. Clusters should remain focused on the need for high quality communication and engagement during transition, working with SHA Directors of Communication (DoCs) and emerging CCG leaders to engage with, and inform the development of, the nationwide communication and engagement shared service.
89. Clusters should ensure that arrangements are in place for effective staff engagement in accordance with the NHS Constitution including partnership working at regional and local level based on the principles of social partnership.

Deliverables and Areas of Consistency

90. PCTs have statutory responsibilities for communication and engagement and Cluster leaders must assure themselves that PCTs in their Cluster can continue to meet these statutory responsibilities effectively e.g:
 - Publishing accounts, holding AGMs, publishing plans etc;
 - Consulting, involving and engaging on significant changes to and decisions about the local NHS;
 - Providing information (for patients, on performance etc.) to facilitate the exercise of choice and to improve accountability;
 - Responding effectively to FOIs.
91. Cluster Chief Executives must work with SHA DoCs as well as emerging CCG leaders to help inform the development of the locally delivered nationwide shared service for communication and engagement during transition. The shared service will ensure that every area, not just some, benefits from high quality, locally focused, consistent, professional and resilient communication and engagement support during transition.
92. A wide-ranging engagement exercise will take place over coming months to inform the development of the communication and engagement shared service and Cluster Chief Executives, along with emerging CCGs leaders and communication and engagement staff are encouraged to participate in that exercise to ensure the service meets commissioners' needs, now and in the future.

93. Working with SHA DoCs Cluster Chief Executives, along with emerging CCG leaders, will help to inform the development of the shared service, ensuring local needs are articulated and can be met, and that there is appropriate consistency in the local element of service delivery across the country. To ensure consistency Clusters will be expected to work with SHA DoCs and emerging CCG leaders to agree what must be delivered locally.
94. Insight and views gathered through the engagement exercise will inform the final model for the shared service – this is expected to be published in the Autumn and a formal consultation with communications and engagement staff will be undertaken.
95. When the service is launched in April 2012, with initial arrangements starting to be put in place from October 2011, Cluster communications and engagement staff will become part of it and it will support Clusters and emerging CCGs through the remainder of the transition period.

Monthly Guide of Shared Operating Model Milestones

June 2011

- Clusters to have completed business review stocktake of commissioning support
- Establish Cluster board-level Director(s) with responsibility for quality, and the shape of the overall provider workforce, and establish clear lines of accountability from the Board to the front line

July 2011

- Clusters will ensure that 90% of practices are in CCG pathfinders;
- Clusters should ensure they have received legacy documents (as advised in the National Quality Board's report Maintaining and Improving Quality during the transition: safety, effectiveness, experience Part One – 2011-12), from their constituent PCTs by 11th July 2011

August 2011

- By August Clusters will have begun ensuring that a clear percentage of budgets are delegated to CCG pathfinders

September 2011

- Clusters to have undertaken patient engagement and have determined services of choice for Any Qualified Provider
- Clusters should ensure they prepare, and keep up to date, their own Cluster wide legacy document ready to handover to SHAs on the 5th September 2011
- Clusters/SHAs to begin phase II of commissioning support business review
- Clusters to have identified staff currently involved in directly commissioning primary care, specialised, prison health, and military services
- Clusters to have ensured current Prison Health Needs Assessments remain fit for purpose, and to have revised accordingly for use in the 2012/13 commissioning round
- Clusters to input into the development of a single approach to primary care contract performance management, for delivery by April 2012
- Clusters to have identified how they provide the services described in the draft national FHS schedule and the staff involved in this work. They should have established how they are linked into the national work and from this how they are moving to standardising their services across the Cluster to that described in the draft national specification. We envisage that by December 2011, to have achieved standardisation within the Cluster, and have clear plans for rationalisation where appropriate
- Clusters, in collaboration with their Specialised Commissioning Groups, to have used a single national algorithm to separate specialised and non-specialised elements of activity in every acute/mental health contract according to planned activity for 2011/12, allowing high-level financial risk management to take place on a contract by contract basis

- Clusters, in collaboration with their Specialised Commissioning Groups, to have identified all services that are currently commissioned by regional Specialised Commissioning Groups that are outwith the specialised commissioning national definition set (as defined by the national information algorithm) and migrate to these to Cluster/CCG commissioning responsibility
- Clusters, in collaboration with their Specialised Commissioning Groups, to have identified all services that are currently commissioned by PCTs but are included in the specialised service national definition set (as defined by the national information algorithm) and migrate these to Specialised Commissioning Group responsibility

October 2011

- All CCG pathfinders to have completed self diagnostic or recognised equivalent
- Clusters will have ensured that a clear percentage of budgets are delegated to CCG pathfinders, with a trajectory for future delegation
- All practices to be within an emerging viable CCG
- Clusters to have supported agreed Right to Request proposals to become successful establishments
- Clusters to have signed off priority Any Qualified Provider services with SHAs
- Establish regional communication and engagement hubs in line with SHA Clusters in October. This goes hand in hand with establishing interim management of the locally delivered, nationwide shared service in the Autumn.
- Clusters should have identified secondary care activity usage by prison and custodial services from new data flows and use it to inform commissioning plans
- Clusters to have separately identified prison health secondary contract activity by service (e.g. mental health, substance misuse, acute, etc); speciality/HRG; value; provider; in order to allow 2012/13 contracts to separately identify shadow NHS CB / CCG responsibilities
- Clusters to have identified secondary care activity usage by armed forces from new data flows and use it to inform commissioning plans
- Clusters to have separately identified Military Health secondary care activity by: service (e.g. mental health, substance misuse, acute etc); speciality / HRG; value; provider, in order to allow 2012/13 contracts to separately identify shadow NHS CB CCG responsibilities
- Specialised Commissioning Groups Cluster into the new SHA footprint

December 2011

- Clusters to have agreed with their prospective CCGs their do/share/buy options and their commissioning support requirements
- Clusters to have completed cataloguing existing contracts for primary care, prison and custodial health and offender health (i.e. GMS/PMS, GDS/PDS/orthodontics, local agreements and enhanced services for medical, dental, optical and pharmaceutical services) according to a national template setting out the broad contents of the contracts and their

state of readiness for handover to the NHS CB. And in addition Clusters to have completed a cataloguing of the primary care premises according to a national template to ensure that the NHSCB has a robust record of the current primary care estate²

January 2012

- January 2012 - Clusters to ensure its constituent PCTs, as listed in Schedule 19 of the Equality Act 2010, have published information and evidence to demonstrate their compliance with the Equality Duty, including information relating to employees (for organisations with 150 plus staff) thereafter at least annually³

March 2012

- Clusters to have completed the Commissioning Support business review phased process
- Clusters to be operating direct commissioning functions in line with an agreed shared operating model
- Clusters have mapped their specialised commissioning functions onto NHS CB future organisational structure
- Clusters to have supported CCGs to ensure they are actively engaged in the development of their local health and wellbeing board

April 2012

- Clusters to have started delivery of at least 3 Any Qualified Provider community and mental health services, working in partnership with CCGs
- Locally delivered, nationwide share communication and engagement service will be fully functioning
- Clusters to begin to move towards a single process for primary care contract performance management to ensure all are following the same process by April 2013
- Clusters to migrate staff to single specialised commissioning team
- By 6th April Clusters to ensure their constituent PCTs publish Equality Objectives³

May 2012

- Provide Cluster-level feedback on constituent PCTs' providers' Quality Accounts
- Clusters to ensure constituent PCTs publicly report on the incidence of "never events" as part of their annual reporting on quality

² This task is separate from but may inform overall quality legacy documents as described in section 3 'Ensuring Safety and Quality'.

³ Subject to Parliamentary approval (which is expected Autumn 2011).