

# PCT Cluster Implementation Guidance

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# PCT Cluster Implementation Guidance

**Prepared by Improvement and Efficiency Directorate**

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## Context

1. The 2011/12 Operating Framework describes the next stage in managing today's challenges and the creation of the new NHS. It sets out the conclusion that it will not be possible to retain effective management capacity in all PCTs until their abolition in 2013, presenting unacceptable risks to quality and financial management. In response, current PCTs will be retained as statutory organisations, in order not to add further to disruption from reorganisation, but there will be consolidation of management capacity, with single executive teams each managing a cluster of PCTs. These new clusters are not statutory bodies, nor are they permanent features of the landscape, but they are necessary to sustain PCT capability and enable the creation of the new system.
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.
3. This implementation guidance sets out:
  - Further guidance on the establishment of clusters by June 2011;
  - More detail on the functions of the clusters through 2011/12 and 2012/13;
  - Accountability arrangements;
  - HR guidance to support staff affected by the formation of clusters;
  - Advice, developed jointly with the Appointments Commission, on non-executive issues related to clusters.

## Establishment of Clusters

4. SHAs will lead the process of creating effective clusters (including the resolution of any issues associated with their establishment) and ensuring they deliver in 2011/12, after which the NHS Commissioning Board will support and hold them to account through to the proposed abolition of PCTs in March 2013.
5. The starting place for the establishment of PCT clusters varies widely across the country. In the North East, arrangements with single executive teams supporting a number of statutory PCTs have been in place for some time. In London, there is a well established process of grouping PCTs under sector leadership. In most other parts of the country, sub-regional groupings of PCTs exist to some extent.
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.

9. SHAs will ensure that there is a transparent and appropriate appointment process for cluster Chief Executives and executive teams. There will be national oversight of this process. The NHS Top Leaders programme will be available, as appropriate, to provide support to individuals as candidates and appointed cluster teams.
10. SHAs will ensure that clusters are able, at the earliest opportunity, to be involved in and take on responsibility for integrated plans for 2011/12, QIPP plan implementation, consortia development and support and commissioning issues associated with the FT pipeline.
11. Critically, SHAs will also ensure that clusters are able to take on the requirements for securing quality through change that will be set shortly by the National Quality Board and for promoting the Equality Delivery System as developed by the National Equality and Diversity Council. SHAs and clusters should also ensure that all statutory duties, including for example safeguarding, equality and diversity and information governance, are handled clearly, explicitly and effectively through the new arrangements. This includes paying due regard to the provisions of the Equality Act 2010, which aims to ensure that all public bodies within the health service comply with principles of equality.
12. The DH will conduct a detailed assurance process early in 2011/12 to ensure the arrangements set out above are secure.
13. There is already experience and good practice to draw on in the establishment of single executive teams covering more than one statutory body. The experience of the North East over a number of years is an invaluable source of learning to colleagues in the rest of the country. The Local Authority IDEA (Improvement and Development Agency) website contains good practice advice on the experiences of local authorities sharing executive arrangements and can be located at [www.idea.gov.uk/idk/aio/14197204](http://www.idea.gov.uk/idk/aio/14197204)

## Cluster Functions

14. The following table sets out cluster functions, their relationship to PCT boards and GP consortia functions and how they will change through the coming two years:

		2011/12	2012/13
Delivery of Integrated Plans	Clusters	By June 2011 oversight and management of 2011/12 PCT level plans  Oversight of FT pipeline input from PCTs	Development and delivery of 2012/13 integrated plans  Input to FT pipeline sign off with commissioning intentions
	PCTs	Local implementation under cluster guidance of 2011/12 plans  Development, under cluster guidance, of 2012/13 plans	Local implementation under cluster guidance of 2012/13 plans
	Consortia (including commissioning support arrangements)	In line with state of development, increasing ownership of implementation of 2011/12 plans  In line with state of development,	In line with state of development, increasing ownership of implementation of 2012/13 plans

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		increasing role in creation of 2012/13 plans	Leading role in creation of 2013/14 plans
Direct Commissioning	Clusters	<p>By June 2011 oversight and management of 2011/12 contracts and delivery of Operating Framework requirements</p> <p>Negotiation of 2012/13 contracts</p>	<p>Oversight and management of 2012/13 contracts and delivery of Operating Framework / mandate requirements</p> <p>Support GPCCs in negotiation of 2013/14 contract</p> <p>Negotiate and prepare oversight arrangements for services to be directly commissioned by NHS Commissioning Board</p>
	PCTs	<p>Agreement of 2011/12 contracts</p> <p>By June 2011 management of 2011/12 delivery as required by cluster</p> <p>Agreement and delivery of primary care contracts</p> <p>Annual accounts</p> <p>Input to FT pipeline sign off with commissioning intentions</p>	<p>Management of 2012/13 delivery as required by cluster</p> <p>Annual accounts</p> <p>Input to FT pipeline sign off with commissioning intentions</p>
	Consortia (including commissioning support arrangements)	<p>Involvement in negotiation of 2011/12 contracts</p> <p>As possible, management of agreed elements of 2011/12 contracts</p>	<p>As possible, involvement in negotiation and management of 2012/13 contracts</p> <p>As possible, leadership of negotiation of 2013/14 contracts</p>
Management and implementation of medium-term QIPP plans	Clusters	<p>By June 2011 ownership and leadership of cluster wide QIPP plans</p> <p>Ongoing management and updating of medium term QIPP plans</p>	<p>Ongoing management and updating of medium term QIPP plans</p> <p>Handover of QIPP process to GP consortia for 2014 onwards</p>
	PCTs	<p>Handover of QIPP plans to cluster</p> <p>As required by cluster leadership</p>	<p>As required by cluster</p>



		of service change elements required by QIPP plans	leadership of service change elements required by QIPP plans
	Consortia (including commissioning support arrangements)	Engagement with and ownership of local QIPP plans	As agreed with cluster, leadership of service change elements within QIPP plans  Development of QIPP approach beyond 2013
Oversight of closedown of PCTs	Clusters	Leadership of appropriate consolidation of capacity and capability across cluster	Work with NHS Commissioning Board and GPCCs to ensure smooth transfer of all residual PCT functions to new structure
	PCTs	Work with cluster on transfer of appropriate people and skills to developing arrangements	Work with cluster on transfer of appropriate people and skills to developing arrangements
	Consortia (including commissioning support arrangements)	Agree with clusters which individuals should be assigned to consortia to help their development	Once authorised increasingly employ staff directly including under TUPE arrangements
Enabling development of GP Commissioning Consortia and wider reform	Clusters	By June 2011 support of pathfinder development  Work with Provider Development Authority linking commissioning and QIPP plans to FT pipeline issues	Support of consortium development and, as required by the NHS CB, support to the consortium assessment process and management of residual issues in consortia formation  Work with Provider Development Authority linking commissioning and QIPP plans to FT pipeline issues
	PCTs	Handover of consortium development process to cluster arrangements  As required by cluster, support to consortium development	As required by cluster, support to consortium development
	Consortia (including commissioning support arrangements)	Local development work	Formal application and assessment processes
Supporting development of commissioning support for consortia	Clusters	By June 2011 ensure continual availability of commissioning capacity  Work with SHA commissioning support development team, consortia and other clusters to develop and begin implementation of organisational models for commissioning support  Work with clinical networks to identify and put in place role in developing commissioning landscape	Ensure continual availability of commissioning capacity  Work with NHS CB to put in place new organisational options for commissioning support

	PCTs	Support cluster in making people and systems available in support of commissioning	Support cluster in making people and systems available in support of commissioning
	Consortia (including commissioning support arrangements)	Engage with initial commissioning support offer  Engage in process for designing future commissioning support options	Make choices/place contracts for commissioning support
Governance	Clusters	Ensure all statutory duties of PCTs appropriately covered  Ensure cluster executive arrangements are consistent with agreed governance and delegation arrangements	Prepare handover of statutory responsibilities to NHS CB and GPCCs
	PCTs	Put in place Board Governance arrangements  Put in place Schemes of Delegation	
	Consortia (including commissioning support arrangements)	Understand and engage with local governance and scheme of delegation arrangements	Take on additional responsibility as they become statutory bodies with increasing budgetary responsibility devolved from outgoing PCTs
Maintain talent and support people through change	Clusters	By June 2011 lead process of supporting PCT staff in securing future through transition	Complete process of supporting PCT staff in securing future through transition
	PCTs	Support cluster in managing people transition As the employers of staff, abide by relevant employment legislation and good practice – eg in terms of consultation	Support cluster in managing people transition As the employers of staff, abide by relevant employment legislation and good practice – eg in terms of consultation
	Consortia (including commissioning support arrangements)	Agree with clusters which individuals should be assigned to consortia to help their development	Once authorised increasingly employ staff directly including under TUPE arrangements
Maintain relations with local government and other key partners	Clusters	Oversight of continuity of effective local joint working and engagement processes with patients, communities and seldom-heard and marginalised groups	Oversight of continuity of effective local joint working and engagement processes with patients, communities and seldom-heard and marginalised groups
		Oversight of development of Local Health and Wellbeing Boards	Work with developing Local Health and Wellbeing Boards
		Work with local public health and local authorities on development and use of Joint Strategic Needs Assessment	Work with local public health and local authorities on development and use of Joint Strategic Needs Assessment
		Ensure resilience of emergency planning structures	Ensure resilience of emergency planning structures

		Work with DH on creation of local elements of new public health service	Work with DH on creation of local elements of new public health service
		Work with DH and local partners on effective development of Healthwatch	Work with DH and local partners on effective development of Healthwatch
	PCTs	Maintain effective joint working arrangements and engagement processes with patients, communities and seldom-heard and marginalised groups	Maintain effective joint working arrangements and engagement processes with patients, communities and seldom-heard and marginalised groups and ensure effective handover to GP consortia and Local Health and Wellbeing Boards
		Plan for transition of public health functions to national Public Health service and local authorities	Transfer of public health functions to national Public Health service and local authorities
	Consortia (including commissioning support arrangements)	Engagement with joint working and commissioning arrangements as set out above	Strategic partnership with local government, LHWBs and other key partners

## 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.
18. Through to 31<sup>st</sup> March 2012 these clear lines of accountability will be exercised by SHAs through clusters. For 2012/13 it will be exercised by the NHS Commissioning Board through clusters.

## HR Issues

19. This guidance applies when appointing to the senior leadership posts that will operate at cluster level as identified in paragraph 6 above. This guidance should be read in conjunction with existing regional HR and Employment frameworks and, in line with good practice, its content and the detail of its implementation should be the subject of consultation with each Regional Social Partnership Forum.
20. Where established cluster arrangements and substantive appointments already exist in parts of the country, appointments will not be revisited as part of this national process, unless the SHA, in agreement with the NHS Chief Executive, deems that further change is required.
21. The legal advice obtained indicates that it is acceptable for SHAs who are leading this process on behalf of their PCTs to determine how pooling should operate. In deciding which pooling option to adopt the SHA should ensure that they consult fully with their PCTs, and Regional Social Partnership Forums.
22. As employers of the staff affected by these changes, PCTs should also undertake appropriate consultation with affected staff and their Trade Unions prior to implementing the processes set out in this guidance. PCTs will wish to facilitate requests for Trade Unions to meet across the cluster to enable them to respond in a co-ordinated manner.
23. The appointment process for the Chief Executive for each cluster will be either:
  - Stage1 All substantive PCT CEs within the cluster
  - Stage 2 All eligible staff within the region including substantive PCT CEs, the substantive SHA CE, all substantive SHA Directors, all relevant substantive ALB CEs who have elected for that regional pool
  - Stage 3 Open competitionOR
  - Stage 1 All substantive PCT CEs within the region or sub region
  - Stage 2 All eligible staff within the region including the substantive SHA CE, all substantive SHA Directors, all substantive ALB CEs who have elected for that regional pool
  - Stage 3 – Open competition
24. Any PCT Chief Executive who has been seconded out of their substantive role will be eligible to apply at Stage 1.
25. The panels for these appointments must be constituted in line with the NHS CE letter of 18 October 2006 (Gateway No 7246). The appointment panels should ideally include all constituent PCT Chairs but it is permissible for the Vice-Chair to represent them should

it be not possible for them to attend in person. Alternatively they may ask another of the constituent PCT Chairs to represent them. The SHA CE or their nominated deputy should be the assessor and a further assessor should be nominated by the SHA CE.

26. The appointments to all Chief Executive posts will be subject to national oversight.

27. Once the Chief Executives are confirmed, recruitment to the Director posts will take place with the pooling mirroring that for Chief Executives as follows either:

Stage 1 - All substantive PCT Directors and PCT CEs who were unsuccessful at Stage 1 (paragraph 23 above, and subject to paragraph 30 below) within the cluster

Stage 2 – All substantive PCT Directors / all substantive SHA Associate Directors within the region / all substantive ALB Directors opting for that regional pool.

Stage 3 – Open competition

OR

Stage 1 – All substantive PCT Directors all PCT CEs who were unsuccessful at Stage 1 (paragraph 23 above, and subject to paragraph 30 below) within the region or sub region

Stage 2 – All substantive SHA Associate Directors within the region / all substantive ALB Directors opting for that regional pool.

Stage 3 – Open competition

28. Any PCT Director who has been seconded out of their substantive role will be eligible to apply at Stage 1.

29. The panels for these appointments should be constituted in line with the NHS CE letter of 18 October 2006 (Gateway No 7246). The appointments panel should include a PCT Chair, the PCT Cluster Chief Executive, the appropriate SHA Director plus another agreed assessor (see also above in respect of PCT Chairs Panel membership)

- The appointments to all Directors of Finance will be subject to national oversight.
- When the Directors have been appointed third in line posts will be filled under current regional arrangements.

30. It is not the intention of this process to cause the redundancy of current PCT Chief Executives and Directors above and beyond what may be required to achieve running costs reductions. However, each case needs to be reviewed in the light of the individual circumstances and employers should take their own legal advice. Whilst the responsibility for handling any staff displaced as a result of these changes rests with

individual employers, SHAs will need to provide leadership to ensure that best practice is adopted. Alternative work could include senior roles in GP Commissioning Consortia (subject to their agreement), development of Commissioning Support, support to the development of the NHS Commissioning Board or oversight of key quality and statutory responsibilities.

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.
32. Beyond the advice on the creation of a single executive team, the management structure of the cluster and its constituent PCTs is a matter for local determination. As in this national guidance, we would expect cluster leaders to strike the balance between avoiding long and unnecessary internal reorganisation and ensuring that there is effective and sustainable capacity for delivering a complex agenda through to April 2013 within running cost limits.
33. Cluster arrangements are temporary and clusters are not statutory organisations in their own right. It is envisaged, therefore, that Directors will continue to be employed by their current organisation.
34. Once the functions and posts in the single executive team have been identified and the consultation commences, all affected CEs and Directors should be declared “at risk” and they will form part of the pooling arrangements described in this guidance. To enable the recruitment processes to take place in a timely manner it is recommended that consultation takes place as soon as practicable. There is also an expectation that the SHA will help co-ordinate these processes and ensure they are discussed at the Regional Social Partnership Forum.
35. The pay arrangements for PCT Cluster Chief Executives taking responsibility for a broader footprint across more than one organisation, is contained within paragraphs 27 and 28 of the VSM Pay Framework document. The Chief Executive base pay will then be used to determine the remuneration for the Directors. These arrangements will apply for the duration of the appointments. In line with HM Treasury oversight of public sector pay, any proposal to pay a salary that exceeds £142,500 will need their approval.
36. The SHA CE should ensure that arrangements are in place to support senior staff throughout these changes. They may also need to support PCT Chairs in their discussions with CEs about their future roles.
37. In addition to the formal HR advice and processes, it is important to set out the context in which all leaders are expected to work to support SHA and PCT staff in the change processes which lead up to their abolitions in 2012 and 2013 respectively.

38. One of the purposes of clusters is to offer a bridging structure to allow the change to be managed more effectively. Clusters will:

- Be actively supporting the development of GP Commissioning Consortia. This will include developing appropriate staff, those whose functions will move from PCTs to GP Consortia, eventually under TUPE provisions, so that they can best meet Consortia's future requirements;. Whilst staff cannot be directly employed by consortia until they are authorised and become statutory bodies, consortia may choose to have certain staff assigned to them to help and support them during the transition;
- Be directly charged with sustaining commissioning expertise through the transition and enabling it to be formed into effective commissioning support arrangements from which consortia can choose. This is likely to include the creation of social enterprises and joint ventures with the independent and voluntary sector. Again this will enable clusters to support appropriate staff in developing opportunities with these new bodies;
- Be working with the emerging NHS Commissioning Board on how it might structure its local interfaces for primary care commissioning, oversight and support of GP Commissioning and regional and national specialist commissioning. Whilst it is not yet possible to be precise about what form these will take it provides a further opportunity for clusters to support existing staff in potential moves to the new landscape.

39. All the appointment processes required for these changes should comply with the Equality Act 2010 and the principles of fairness with every effort being made not to lessen the representation of people of protected characteristics such as BME people and women in senior roles. It will be particularly important for the NHS to retain its expertise and intelligence on tackling health inequalities (including those arising from discrimination) during the transition. The SHA, in conjunction with its PCTs, should carry out an Equality Impact Assessment of these proposals.

## Board Issues

40. The role of the statutory boards of PCTs remains key. In making the change to cluster executive teams the right balance needs to be struck to retaining the statutory roles, challenge and oversight from individual boards with having streamlined arrangements that enable effective executive action.

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.

42. We expect clusters, working with their individual PCTs, to ensure that there is strong clinical leadership across the system throughout the transition. This includes managing the transition from involvement through PECs to leadership from GP Commissioning Consortia effectively. Whilst there has already been significant local change in many parts of the country on the function and composition of PECs, and this will continue, the creation of clusters should not lead to the unnecessary loss of local structures for clinical engagement and leadership.



# APPENDIX A

## Advice on non-executive issues

### 1. Context

- 1.1 The *NHS Operating Framework 2011/12*<sup>1</sup> explains that Primary Care Trusts (PCTs) have a critical role in the NHS over the coming years. However, there has to be some rationalisation of their management structures to secure the capacity and flexibility needed to enable them to function effectively during the transition period leading to the full implementation of *Equity and Excellence; Liberating the NHS*.
- 1.2 PCTs will remain as statutory bodies, but there will be a managed consolidation of PCT capacity through the creation of PCT clusters across all regions of the NHS by June 2011. The PCT Cluster Implementation Guidance to which this advice is attached sets out the functions that clusters will be expected to undertake during the transition period, which includes oversight and management of contracts and Operating Framework requirements, developing the capability and capacity of local GP commissioning consortia and ensuring effective leadership of cluster-wide QIPP plans.
- 1.3 Each cluster will have a single Executive Team and will also need to put in place effective governance structures which will deliver the proper handling of statutory business, decision making and accountability through the individual PCT boards.
- 1.4 Appropriate governance structures will be determined locally and different models may be implemented in response to local circumstances. On 1 December 2010, an amendment to the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 came into effect, removing the disqualifying criteria for 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. This provision to make dual appointments can support the arrangements for PCT clusters, enabling Chairs and non-executives to discharge their functions across a number of statutory PCT boards if required.

### 2. Purpose

- 2.1 In his letter of 15 December 2010 to all NHS Chief Executives in England, Sir David Nicholson, NHS Chief Executive, explained that the detail on the governance arrangements and the process for forming clusters would be set out in January 2011<sup>2</sup>. This advice note has been prepared jointly by the Appointments Commission and the Department of Health and sets out the key principles that should be followed in establishing governance arrangements of PCT clusters to support effective delivery of statutory functions. The advice also sets out the implementation arrangements PCTs will need to take into account when establishing their preferred governance model.

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<sup>1</sup> The Operating Framework for the NHS in England 2011/12, Department of Health, paragraphs 2.11, 2.13 and 2.14

<sup>2</sup> Equity and Excellence: Liberating the NHS – Managing the Transition and the 2011/12 Operating Framework, 15 December 2010, Page 7

- 2.2 PCT boards will need to take the lead in designing appropriate cluster governance structures and this advice should be used by PCT boards to guide their consideration and agreement of such arrangements. SHAs will assess proposals against the principles set out in section 3. Where the Appointments Commission is involved in making decisions about the public appointments affected by any cluster proposal, these principles will guide those decisions.
- 2.3 The advice is not prescriptive about the governance structures that PCTs should put in place and is designed to facilitate the establishment of effective governance models with sufficient flexibility for local organisations to adopt or adapt the model that best meets their local needs. Various models and options are presented for local organisations to consider. Other models may be agreed as long as they comply with the principles set out in section 3.

### 3. Principles

- 3.1 Set out below are the principles that should underpin local arrangements for designing a governance model for a PCT cluster board and its implementation.
- 3.2 In agreeing the governance model for the PCT cluster, local organisations will be expected to demonstrate how these principles have been met.

#### 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<sup>3</sup>, 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.

PCT Care Trust and PCT Care Trust Plus boards are subject to additional statutory requirements which must continue to be met as part of a cluster arrangement. A PCT Care Trust or PCT Care Trust Plus board must continue to contain at least one non-executive nominated from each relevant local authority. In addition, the single executive team within a cluster where there is one or more Care Trust must contain an individual who has experience of the health-related functions of the local authority or authorities covered by the Care Trust.

**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

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<sup>3</sup> Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 (SI 2000/89)

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.

### 3.5 Implementation principles

**Clear decision-making** – where possible local boards should agree the arrangements and the roles board members will take to sustain good governance and an appropriate mix of skills and experience. If possible, governance arrangements should be agreed before or at least at the same time as establishing the single executive team. The relevant Appointments Commissioner will need to agree the NED Board structure if changes to statutory appointments are envisaged.

**Timely** – The approach should facilitate and be responsive to the timescales set out in the *NHS Operating Framework* for the creation of PCT clusters by June 2011 and should minimise the level of disruption involved with implementing the arrangements to limit potential distraction and diversion from PCT / cluster board core functions.

**Fair and transparent** – Chair and non-executive appointments to the statutory PCT boards will continue to be the responsibility of the Appointments Commission and will need to be underpinned by a fair and transparent process that can command public confidence, whilst meeting the needs of the locality.

#### 4. PCT cluster governance options

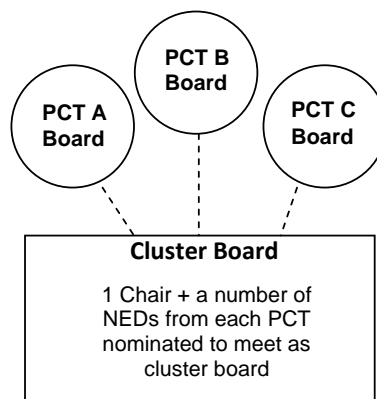
- 4.1 The exact configuration of PCT clusters will vary depending on local situations. A model that works well in one area may not work in another. There are a number of local factors that should be taken into account to inform the design of the cluster governance arrangements. These include:
- the size of the cluster
  - the number of constituent PCTs involved
  - geographic and demographic issues
  - relationships with and input from GP commissioning consortia
  - relationships with local authorities
  - current arrangements that are working well within and between local bodies
- 4.2 With this in mind, there are a number of potential governance models, or variations thereof, that localities may wish to consider. Some example models are set out below. The number of PCT boards in each option is for illustrative purposes only and could be varied depending on local circumstances.

##### **Model 1**

###### Design

- 4.3 A 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.

###### Diagram



###### Operational issues

- 4.4 It will be important that robust Schemes of Delegation are in place that set out what functions the cluster board will carry out on behalf of its constituent PCTs and what functions will be retained by the PCTs. The role of the non-executives that do not meet on the cluster board would need to be established and could include liaison with local stakeholders or supporting the development of GP consortia. There would also need to be an open and transparent process for identifying an individual to act as the cluster board Chair.

Potential advantages

- Retains a distinct local non-executive focus on the cluster board.
- Promotes retention of existing non-executives, their experience and expertise at a time when strong leadership, independent scrutiny and continuity of local knowledge will be important.
- This nomination-based model would require minimal resources to establish and would limit the level of upheaval as it would not be necessary to seek resignations or terminate appointments of office holders. However, once the cluster is operational, there may be a higher workload for the executive team in servicing the PCT boards depending upon the meeting cycle agreed.

Risks/impact assessment

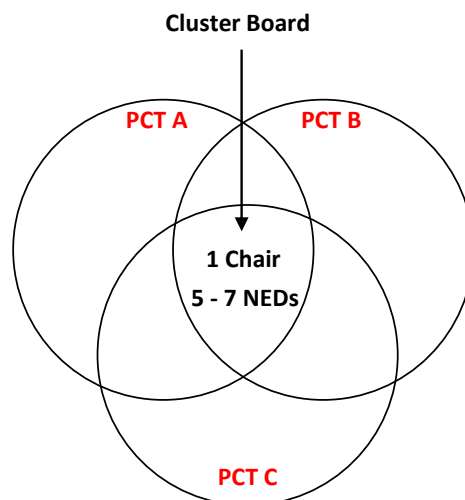
- Could present a barrier to swift and effective unitary board decision-making.
- The Chairs and non-executives that do not serve on the cluster board would continue to receive full remuneration although the required time commitment involved may be reduced depending upon the other duties they undertake.
- The PCT boards involved would need to work together effectively to support effective action by the single executive team.
- The cluster board could be difficult to manage due to a potentially large number of non-executives and their locality focus, depending on the number of PCTs involved and non-executives nominated from each board.

**Model 2**

Design

- 4.5 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.

Diagram



### Operational issues

- 4.6 While this provides the clearest unitary governance structure, it will be important that the cluster board ensures that it continues to meet the obligations of each individual PCT (see section 5.5).

### Potential advantages

- Symmetry with single executive team arrangements and would minimise the complexity of the management task and executive workload.
- Supports a unitary approach to the cluster board that would promote swift and effective decision-making.
- Cluster board size makes it easily manageable.
- Supports the objective of reducing PCT management costs.
- Clear lines of accountability.

### Risks/impact assessment

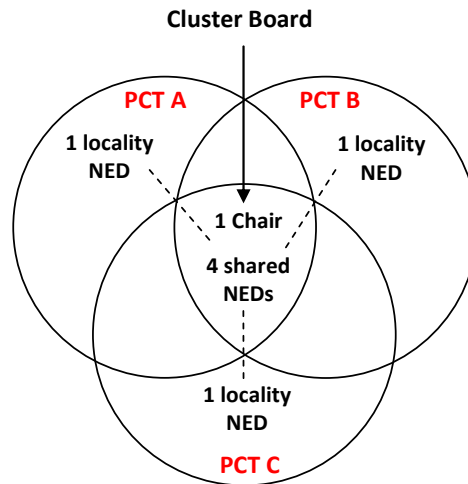
- Loss of a large number of non-executives, their experience and expertise at a time when strong leadership, independent scrutiny and continuity of local knowledge will be important.
- Potential impact on diversity levels, particularly women and BME.
- Loss of links with localities.
- While the initial workload involved in setting up this model could be high, for example conducting ring-fenced competitions and resignations or a termination process for NEDs not appointed, there could be a resource pay-off down the line, reducing the executive workload in comparison with the other models due to the clear and unitary nature of the cluster board.

## **Model 3**

### Design

- 4.7 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.

Diagram



Operational issues

4.8 This model would enable flexibility around how the PCT boards operate within the cluster, providing scope for the retention of some PCT level focus. There could also be flexibility around the way in which Audit Committee arrangements operate. Each constituent PCT could have its own Audit Chair serving as one of the locality non-executives, or alternatively, one Audit Chair could be appointed to all the constituent PCTs.

Potential advantages

- Retains a distinct local non-executive focus on the cluster board.
- Provides flexibility in terms of the overall size and composition of the cluster board.
- Promotes retention of existing non-executive skills and experience.
- Provides the flexibility to appoint a separate Audit Chair for each constituent PCT board which could be beneficial when completing separate audit accounts for each constituent PCT board.

Risks/impact assessment

- Depending on the configuration of locality and shared non-executives, the model could lead to a large number of locality-based non-executives being appointed which could increase the complexity of the management task and present a barrier to swift and effective unitary decision-making.

**Model 4**

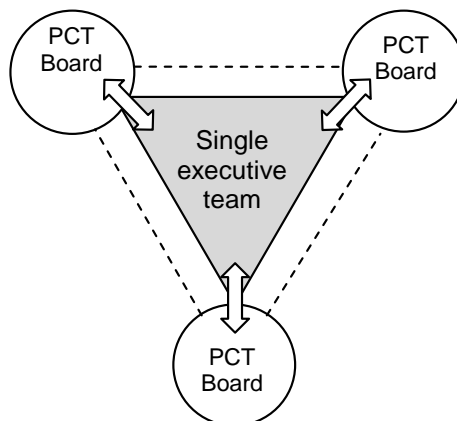
Design

4.9 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.

### Diagram



### Operational issues

- 4.10 It will be important that individual PCT Chairs work together closely to agree common issues. It will be important that the boards co-operate effectively in making the arrangements work and in developing practical measures to facilitate the smooth operation of the cluster arrangement such as holding all board meetings on the same day, adopting the same or a similar governance committee structures within constituent PCTs and establishing clear processes that can be used to resolve situations where individual PCT boards take different decisions on cluster issues.

### Potential advantages

- Retains a strong and distinct local non-executive focus.
- Retention of Chair and non-executive skills and experience at a time when strong leadership, independent scrutiny and continuity of local knowledge will be important.
- No appointment or termination issues for Chairs and non-executives. Should Chairs or non-executives leave, dual appointments could be considered.
- Flexibility to develop into Model 1.

### Risks/impact assessment

- Potential to generate significant workload for the single executive team and a complex management task as the executive team would need to attend and service separate board meetings for each PCT.
- Could present a barrier to swift and effective decision-making within the cluster, particularly if disagreement arises between two or more PCT boards about cluster-wide issues.
- The PCT boards involved would need to work together effectively to support effective action by the single executive team.



## 5. Implementation arrangements

### *Managing the transition*

- 5.1 The NHS has benefited enormously from the contribution made by independent Chairs and non-executive directors and their skills and expertise will be of particular value in ensuring the continuation of robust independent scrutiny and providing constructive support to cluster executive teams. For example, the existing non-executive knowledge of GPs, providers and local authorities in their areas means they are well placed to support the local delivery of QIPP, GP commissioning consortia and supporting the development of relationships with GPs and local authorities. It will be important that Chairs and non-executives are engaged in the design and implementation of clusters and that their contribution and dedication to securing a successful transition to the new arrangements is recognised, respected and valued.
- 5.2 All cluster boards should have a Chair and non-executive team with the right mix of skills, experience and competencies. These should be reflected in clear criteria and due process should be followed to populate cluster boards to ensure fairness and transparency. Depending upon the governance model chosen, this could be through either mutual agreement following consultation with Chairs and non-executives and overseen by the relevant Appointments Commissioner, an interview process or a paper-based assessment, taking into account performance in appraisals.
- 5.3 If the model adopted makes this necessary, discussions should take place with those office holders that do not have a continuing role within the adopted governance model to identify whether they can make any other alternative contribution locally or whether their resignation will be required. The Secretary of State for Health has the powers, delegated to the Commission, to terminate an office holder's appointment if it is not conducive to the good management of a trust for that person to continue to hold office. Regulations stipulate that a Chair or non-executive whose appointment has been terminated is disqualified from being appointed to an NHS trust for two years. Therefore, the termination of appointments would be used only as a last resort if mutual agreement cannot be reached.

### *Accountability arrangements*

- 5.4 To ensure that there is clarity both for the individuals concerned and the wider public, all Chair and non-executive appointments will continue to be made to the relevant PCTs within a cluster as statutory entities, rather than to the cluster board.

### *Scheme of delegation, reservation of powers and Standing Orders*

- 5.5 Non-executives will need to satisfy themselves that clear Schemes of Delegation are in place that set out the functions that the cluster board will exercise on behalf of each constituent PCT and how the Board will perform each of these functions in respect of each PCT, as well as those functions that the constituent PCT boards will discharge independently as distinct statutory bodies and the arrangements that will be put in place to support this. Schemes of Delegation should be underpinned by the respective functions set out for clusters and PCTs in the PCT Cluster Implementation Guidance. For example, individual PCT boards will continue to be responsible for publishing

separate annual reports and a final set of accounts. Schemes of Delegation should also describe how the statutory PCT Board will hold the Cluster Board to account for effective delivery of its delegated functions.

### ***Remuneration***

- 5.6 The remuneration for PCT Chairs is based on the weighted population covered by the PCT. Where a single Chair is appointed to all constituent PCT boards and undertakes chairing responsibilities across the cluster, the remuneration calculation will be based on the combined population size covered by the constituent PCTs. This approach is in line with pay arrangements for chief executives undertaking shared responsibilities across organisations as set out in the VSM Pay Framework. Non-executive directors will be remunerated at their current level.

### ***Managing vacancies***

- 5.7 While it is the intention to produce sustainable models up until April 2013, ad hoc vacancies may arise. Where a vacancy arises, an assessment should be made whether to fill it. This will include considering whether as a result of the vacancy, the PCT will have the skills necessary in the non-executive team to enable it to meet its obligations and whether it can meet statutory requirements, such as the quoracy requirements. Where this is not the case, a dual appointment of a Chair or non-executive director could be considered.