SHA CLUSTERING – NHS MANAGEMENT BOARD DECISIONS

At the start of the listening exercise, we confirmed that because of the pause in the legislative process, the changes planned for April 2012 – including the abolition of Strategic Health Authorities and the full establishment of the NHS Commissioning Board – would need to be delayed until at least July 2012. Having given further consideration to this issue and to the Future Forum's advice, we have concluded that changing accountability arrangements during the financial year would present a significant risk to operational grip and financial control, particularly as 2012/13 is the second year of the QIPP period.

Therefore, we need to keep SHAs in place as a vital linchpin in our system until the end of March 2013. The NHS Commissioning Board and other new national bodies will take up their full accountability and financial responsibilities from 1 April 2013. This approach avoids changing accountability arrangements and splitting the NHS cash limit during the financial year and, therefore, offers a more stable platform for transition.

However, we also recognised that we are already seeing real pressures on the resilience of SHAs, with a significant number of senior posts either not filled or covered through secondments. This is not sustainable for another 20 months. All of this pointed to the need to cluster SHAs. This is the best way both to ensure structural stability, and to manage within affordable running cost budgets.

Having made this decision, we concluded that it was better to move to the new arrangements quickly, and so we decided to move to clusters on 3 October 2011. We chose this timeline because:

- it allows us to make the changes before winter and the operational pressure that produces,
- we can embed these arrangements in time for the next financial year when things are likely to be even more challenging, and,
- the lessons from PCT clustering show that once a decision is made to cluster it is better to implement it quickly.

At the same time as making the decision to move to clusters, we made four other decisions. First, that there will be four clusters. Second, that one of the four will be London. Third, that we will not cut across existing SHA boundaries. And fourth, that we will work with the other national bodies (such as CQC, Monitor, the NHS Trust Development Authority and so on) to align our sub-national boundaries.

In order to progress this work further, we identified six workstreams to develop more detailed proposals on geography, structure, governance, HR processes, national arrangements and development. The NHS Chief Executive, Sir David Nicholson, asked Bill McCarthy to integrate the different workstreams and produce an over-arching report for the NHS Management Board. Bill convened a panel including the NHS Medical Director, Chief Nursing Officer and Ian Cumming to test the proposals and in particular to ensure that our approach would maximise our ability to maintain quality and safety during the transition. The panel applied three tests in pulling together the proposals of the various workstreams: quality, including safety; performance and delivery; and coherence.

Following this work, we have now made further decisions across the different workstream areas:

- Geography: The four SHA cluster areas will be as follows:
    - London
    - North (comprising of North West, North East and Yorkshire & Humber)
    - Midlands (West Midlands, East Midlands and East of England)
    - South (South West, South Central and South East Coast)

  These four areas will also provide the initial footprint for the NHS Commissioning Board's commissioning sectors from April 2013. However, presently SHA clusters will continue to work out of all current SHA offices. As the recent *Developing the NHS Commissioning Board* document set out, the bulk of the Board's staff will be distributed in locations across the country and we will encourage flexible and remote working. So there will continue to be offices in many different parts of the country both during the transition and beyond.

- Structures and operating model: There will be a single cluster executive team made up of the Chief Executive and at least three other Executive Directors. We will be consulting on the top-level structure of the SHA Clusters. Director posts will reflect operational needs and local priorities and will be agreed by the Chief Executive and Board in discussion with the NHS Chief Executive. Where needed, we will retain senior capability in current SHA locations under the direct management of the SHA Cluster CE and other Directors.

  Nationally consistent processes, aligned to PCT processes at PCT cluster level, should be put in place for SHA Clusters by the end of the year at the latest. These will cover emergency planning, quality and safety, performance management, workforce planning, medical recruitment, support for Foundation Trust applicants, educational reform, commissioning development, and communications.

  SHA Clusters will work within the 2011/12 running cost limit for SHAs which will remain at the same levels rolling forward into 2012/13.

- Governance: Each cluster will have a single shared Board replacing the existing SHA Boards, and consisting of a Chair, eight Non-Executive Directors, Chief Executive and at least 3 Executive Directors. Existing SHA Chairs who are not appointed to the Chair of the new cluster will become Vice Chairs. At the first meeting of the new Board, a comprehensive handover report for each current SHA should be received.

- Quality and safety: The transition to the new system will be actively managed with appropriate surveillance of quality issues. There will be formal handover arrangements between accountable officers and executives which should specifically cover quality and safety through transition.

- HR processes: Through consultation on the HR processes with individuals, in partnership with Trade Unions, there will a fair and reasonable HR process followed. The first phase will deal with recruitment of Chairs, Chief Executives, Non-Executives, an a number of core Executive Directors and critical operational posts by 3 October 2011. This will include identifying a leads for winter planning in each cluster area, and a lead for quality including safety, to be in post by 3 October 2011. Simultaneously, Senior Responsible Officers for the new national bodies (NHS Commissioning Board, NHS Trust Development Authority, Public Health England and Health Education England) will be confirmed or appointed.

- National arrangements: The NHS Management Board will be re-constituted during October 2011 to include the four Cluster Chief Executives, Senior Responsible Officers for the new national bodies, and the relevant DH leads. The National Quality Board will continue to operate to ensure a robust framework and approach to sustaining quality during transition. The Chief Executive of the NHS will continue to be responsible for the set up of all the new national bodies within the NHS, with the Senior Responsible Officers (and subsequently the Chief Executives when appointed) being accountable to NHS Chief Executive until April 2013 at which point their accountability will shift to the DH.

- Development: Personal development support for all Cluster Chief Executives and Directors will be provided through the NHS Top Leaders programme. We will also expect the new Boards to go through Board development to help them to establish themselves in their new roles.

It is a big challenge for us to put in place these arrangements whilst we continue to operate for another year. But we can be confident that staff will continue to give this their full support and commitment in the interest of the NHS and the patients that we serve.

14 July 2011