Developing the PCT Cluster

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1. **Forward**

The NHS Chief Executive, Sir David Nicholson, has instructed Strategic Health Authorities (SHA) to arrange their Primary Care Trusts (PCT) into Clusters with specified managerial positions and accountabilities that subsume the accountabilities held by respective PCTs. This is legally possible even though the Clusters will not be incorporated bodies and each PCT will remain the legally accountable body until it is abolished in 2013 (if Parliament approves the current Health & Social Care Bill). The instruction is for the Clusters to be functional by June 2011 at the latest.

South Central Strategic Health Authority (SC SHA) and East Midlands Strategic Health Authority (EM SHA) and Northamptonshire PCT (Northants PCT) have supported the wish of Milton Keynes PCT (MK PCT) to be Clustered with Northants PCT. This preference for a MK PCT / Northants PCT Cluster has been supported by the emerging G.P. Consortia in Milton Keynes and Northampton.

In preparation for the Cluster arrangements, the transfer of lead SHA responsibility for NHS MK to East Midlands took place on 1 April 2011.

2. **Introduction**

This concordat represents ‘a meeting of minds’ and details how the two statutory organisations Northamptonshire and Milton Keynes PCTs will work together to manage and deliver the required changes set out in Department of Health (DH) documents and in the draft NHS Bill.

Legal advice has been sought to confirm that the way forward detailed within this concordat is appropriate.

The purpose of this document is to brief the two statutory Boards on the creation of a PCT Cluster given the current legislation and policy settings.

3. **Cluster Functions**

This Cluster Implementation Guidance (CIG) makes clear the functions of PCT Clusters:

- Delivery of integrated plans
- Direct commissioning (contracting)
- Management and implementation of medium term QIPP plans
- Oversight of closedown of PCTs
- Enabling the development of GP Commissioning Consortia and wider reform
- Developing commissioning support for Consortia
- Governance
- Maintain talent and support people through change
- Maintain relationships with local government and other key stakeholders
In addition to the above, there will also be a need to aggregate certain functions that will become part of the National Commissioning Board and to also take on roles that are currently being performed by the SHA.

4. Legal and Governance Issues

The role of the statutory Boards of PCTs remains paramount. In making the change to Cluster executive teams, the right balance needs to be struck to retain the statutory roles, challenge and oversight for individual Boards whilst having streamlined arrangements that enable effective executive action. During a period of significant change, there will be a need for the governance process to be less risk adverse and more ‘light touch’.

Importantly, Clusters are not merely PCTs working together as they will have a significantly different role with the planned closure of SHAs, working with the National Commissioning Board (NCB) once established, empowering and developing Consortia, sustaining financial balance and overseeing the delivery of the QIPP agenda.

The regulations governing PCT Board membership are the “Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000” (the “2000 Regulations”). In overview, these provide that:

- The number of executive Directors on the Board shall not exceed the number of non executive Directors (“non-officer members”)

- Total Board membership shall be a minimum of 10 and a maximum of 14 (with the Chair not considered to be a member).

In relation to PCT Board membership the CIG stipulates that, in line with its 2000 Regulations, each PCT Board must continue to have in post “a non-executive Chair and a minimum of 5 and not more than 7 non-executives”. The Appointments Commission will remain responsible for the appointment of these non-executives to the statutory PCT Boards.

The statutory PCT Boards must have the following Executive Directors: Chief Executive, Director of Finance, and also under the 2000 Regulations, each PCT Board must have the PEC Chair and a PEC nominee as executive directors and a DPH. One of these must be a Medical Practitioner and one a Nurse. As a clinician, an individual will be classified as a “professional member” of the PEC for the purposes of the 2007 Directions. The 2007 Directions provide, in effect, that a professional member, for these purposes will be the Chair and nominee, who can only be a member of a PEC if they provide or perform, or assist in the provision or performance, of services under the 2006 Act for the benefit of persons for whom the PCT is responsible.

SHAs tasked with forming the Clusters must acknowledge that the transition is being undertaken at a time of uncertainty owing to the relevant legislation not yet being in place. Therefore, to comply with statutory obligations and avoid potential legal challenge, some Clusters have been designed so that the Cluster Board
and constituent statutory PCT Boards actually meet at the same time. Such an arrangement enables delegation to be undertaken direct by the statutory PCT Board, avoiding any issues over lawfulness. This type of arrangement is considered within the potential 'models' as it maintains input from separate PEC Chairs and Nominees, as well as Directors of Public Health, thus fulfilling the need to look at local health issues.

Accordingly, in formulating the governance arrangements and proposals, PCTs and Clusters must make sure that the PEC Chair and the PEC Nominee, who it is anticipated will be a nurse, are not required to sit on a Board or executive committee where they do not provide or perform, or assist in the provision or performance, of services for the benefit of persons for whom the PCT is responsible. This will still mean that there are practical difficulties or complications where Clusters intend that the professional PEC member(s) should sit on more than one PCT Board. However, Clusters will need to make arrangements to make sure that appropriate clinical PEC voices are heard by the Cluster body.

Quorum requirements of PCT Boards will be set out in each PCT’s Standing Orders. The model standing orders provide that meetings will be quorate where one third of the members and the Chair (including at least one executive member and at least one non-executive member) are present. Each PCT should confirm that these standard form provisions apply to them.

The CIG indicates at paragraph 17: ‘[PCT] 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.’

The PCT, via the SHA, has received legal advice with regard to Clustering arrangements, and the implications for existing Boards and their associated Executive, Non Executive and Professional membership. The proposals within this paper present a pragmatic solution to the requirement to create the Cluster, whilst ensuring legal compliance.

An appropriate arrangement needs to be put in place for the “non-delegable” functions. The range of non-delegable functions is relatively diverse. In respect of one such function, that of child safeguarding, one group of PCTs which forms two separate Clusters have agreed to pool resources under a Memorandum of Understanding (MOU) and delegate the management function to a joint committee of the PCTs, hosted by one of the constituent PCTs. The respective statutory PCT Boards delegated the management to the Joint Committee of the PCT (JCPCT).

It will be important for there to be an understanding at both PCT Boards over which duties are to be performed by the Cluster so that effective delegation can occur and a clear agreement put in place.
4.1 **Appointments Commission view on “Statutory PCT Boards -v- Cluster Board”:**

The Appointments Commission will appoint a maximum of 7 NEDs plus a Chair to each statutory PCT Board. It is not possible for this number to be exceeded. The creation of the Cluster Board is therefore a “local issue” as long as the statutory Boards are competent and legal, then they can form the Cluster Board which must have an agreed scheme of delegation from the statutory PCT Boards.

Importantly, the Appointments Commission will only appoint to a vacant NED role and it is not therefore possible to make MK and NHSN NEDs joint appointments as this would exceed the no more than 7 NEDs (plus Chair) rule.

The only way of having the same 7 NEDs working across the 2 PCT Boards and the Cluster Board would be for all the current NEDs to resign. In such a situation the Appointment Commission would then ensure that a proper process was put in place to determine which seven individuals would be appointed to work across the 2 statutory Boards.

The remuneration for NEDs is set by the Secretary of State and the amount paid is not related to size of the PCT or complexity. The only appointment that is size related is that of the Chair with the Appointment Commission salary band being determined by population and size e.g. falling into one of five remuneration bands.

4.2 **The Cluster Board - Executive Roles**

The PCT CIG is prescriptive with regard to the executive roles expected on PCT Cluster Boards and must be followed. These are:

1. Chief Executive
2. Director of Finance
3. A Director with responsibility for the full range of commissioning development
4. Medical Director
5. Nurse Director

Existing PCT Boards remain statutorily responsible for Public Health until 2013 and Cluster Chief Executives together with Local Authority CEOs should develop a joint governance plan for Public Health to be in place by 2011. The guidance for the formation of PCT Cluster Executive Teams does not include Directors of Public Health. This reflects the future role of Directors of Public Health in Local Authorities and the crucial role they will play in local transfer arrangements and the development of their Local Health and Wellbeing Board.

However, the statutory PCT Board will need to obtain views from the Director of Public Health in order to comply with the 2000 regulations.
Similarly the statutory Boards will also need to retain a PEC Chair and nominee.

In summary:

- PCTs can have Joint Committees empowered by their respective Boards to exercise any function of the PCT.

- A PCT can delegate [almost] any function to another PCT but must avoid ‘double delegation’ i.e. PCTs must avoid a further delegation of delegated functions, whether through intermediary bodies/committees or otherwise.

- The exceptions and therefore “non-delegable” functions are listed in an attachment to the Capsticks advice.

- The number of executive Directors on the Board shall not exceed the number of non executive Directors (“non-officer members”).

- Total Board membership shall be a minimum of 10 and a maximum of 14 (with the Chair not considered to be a member).

- PCT Boards must have the following Executive Directors. Chief Executive, Director of Finance, and also under the 2000 Regulations, each PCT Board must have the PEC Chair and a PEC nominee as Executive Directors and a Director of Public Health. One of these must be a medical practitioner and one a nurse.

- The CIG requires the following Executive appointments to the Cluster Board
  1. Chief Executive
  2. Director of Finance
  3. A Director with responsibility for the full range of commissioning development
  4. Medical Director
  5. Nurse Director

- To avoid decisions being legally challenged PCT Boards need to be properly constituted.

- The CIG is guidance that needs to be followed but in a manner that recognises the current legislation.
5. The Cluster Board

5.1 Board Configuration

The CIG also considered a number of different design principles for Board arrangements to support Clusters. These are detailed below and have been amended to take account of some local circumstances. The comments on each model come from the following sources:

- Risk and impact assessment are copied from the CIG.
- Local interpretation

The models are:

**Model One** - A PCT Cluster Board is populated with a Chair from one of the statutory PCT Boards. The 5 Cluster Executive Directors would meet and be matched by 5 NEDs with the number coming from each statutory PCT. Each statutory PCT would delegate relevant functions to the Cluster Board.

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**Risks/Impact Assessment:**

- Could present a barrier to swift and effective unitary Board decision-making as there would be 3 Boards.
- 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.

- One Executive Team servicing three Boards with potential conflict between shared and local NEDs that would need to be managed.

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<tr>
<th>NHS MK</th>
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<tbody>
<tr>
<td>Chair</td>
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**Note:** Each Chair is at the Cluster with Chairing of meetings alternating between the two individuals. When not acting as Chair will be attending as a NED. Two NEDs are nominated from each statutory PCT to be on the Cluster Board Common Exec Team to all 3 Boards. The voting arrangements would need to be resolved to avoid a situation where the Executive Team at 8 or 11 individuals exceed the NED team.
**Model Two** - 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.

**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.
- This Model does not deal with the statutory requirement to have a PEC Chair, PEC nominee and DPH.

- This would require all of the current NEDs to resign so that the Appointments Commission could appoint up to 7 joint NEDs to vacancies on the statutory PCT Boards.
- This would be the simplest Model to adopt if the problems above could be resolved.
### Model 2

#### NHS MK
- Chair
- NED
- NED
- NED
- NED
- NED
- Chief Executive - VM
- Finance Director - VM
- Medical Director - VM
- Nurse Director - VM
- Director of Comm Dev - VM
- PEC Chair - VM
- PEC Nominee - VM
- DPH - VM

#### NHS Nhants
- Chair
- NED
- NED
- NED
- NED
- NED
- Chief Executive - VM
- Finance Director - VM
- Medical Director - VM
- Nurse Director - VM
- Director of Comm Dev - VM
- PEC Chair - VM
- PEC Nominee - VM
- DPH - VM

### Note:
Highlighted individuals in these roles occupy a position on each of the three Boards. The voting arrangements would need to be resolved to avoid a situation where the Executive Team at 8 or 11 individuals exceed the NED team. PEC Chair /PEC Nominee/DPH still needed on the Statutory PCT Boards.
**Model Three** - 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, 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 5 and maximum of 7 non-executives to be appointed to each PCT Board must be met.

![Diagram of PCT Cluster 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. (NB this concern does not apply in the example below).

- The potential conflict between shared and local NEDs would need to be managed.
- Builds upon Model One and could still result in there being 3 Board meetings but avoids the Executive potentially having to work to 2 Chairs.
Note: Single Chair covering all 3 Boards

Five to seven NEDs are appointed to both the statutory PCTs and sit on the Cluster Board
Exec Team appointed to both the statutory PCT Boards and sit on the Cluster Board
The voting arrangements would need to be resolved to avoid a situation where the Executive Team at 8 or 11 individuals exceed the NED team
**Model Four** - 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.

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 2 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.

- Creates a Cluster Executive rather than a Cluster Board and leaves the Executive working to 2 statutory Boards.
(Committee of the two statutory PCT Boards)

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- Chief Executive
- Finance Director
- Medical Director
- Nurse Director
- Director of Comm Dev

PEC Chair
PEC Nominee
DPH

PEC Chair
PEC Nominee
DPH

Note: Statutory PCT Boards remain with a single Executive Team. The voting arrangements would need to be resolved to avoid a situation where the Executive Team at 8 or 11 individuals exceed the NED team.

6. Option Appraisal

All the above models have advantages and disadvantages.

Model Three represents the ideal solution as it provides a single Chair with the same 5-7 NEDs being appointed to the two statutory Boards and forming the Cluster Board. A single, shared Executive Team will also be appointed. There will also need to be 2 DPH’s, 2 PEC Chairs and 2 PEC nominees.

7. Accountability Arrangements

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.

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.
Boards will retain their fully 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.

Through to 31 March 2012 these clear lines of accountability will be exercised by SHAs through Clusters. For 2012/13 this will be exercised by the NHS Commissioning Board through Clusters.

Summary

- The role of Clusters will be significantly different to that of the statutory PCTs.
- The DH and SHA required that Clustering happens quickly with a requirement for integrated plans in March and Board to Board meetings in April.
- The roles of the new Clusters are clearly set out in DH guidance.
- The executive roles for Clusters are determined nationally.
- The governance model, namely Model Four retains the two legal entities and creates a Cluster Executive team and creates a workable arrangement that will not be ‘ultra vires’ within the current legislation and policy settings.

8. Way Forward

- Once the Cluster Chief Executive is appointed, an Executive Team will be appointed.
- Arrangements will be put in place to appoint a single Chair and between 5 – 7 NEDs by the Appointments Commission.
- The aim is for the Cluster Board to be in place by early June.
- Lawyers will be asked to draw up an appropriate scheme of delegation as part of the revised governance arrangements.