

# **Delivering the Transforming Community Services Programme in NHS Eastern and Coastal Kent**

## *Recommendations on the future of the PCT Provider*

September 2009. Version 0.7.

### **Executive Summary**

The Department of Health (DH) programme Transforming Community Services was established following the publication of the *DH Operating Plan 2009/10* and the *NHS Next Stage Review, High Quality Care for All*. The PCT Board established the Shaping Community Services (SCS) Programme Board to corporately oversee the implementation of the Transforming Community Services work locally.

This paper details the work undertaken and sets out some recommendations on the future of Eastern and Coastal Kent Community Services (ECK-CS). Much of this paper is focused on the work undertaken to transform services in order to improve quality, productivity and ensure ECK-CS is business ready, in its own right.

The production of the Community Services Commissioning Strategy and the ECK-CS Five Year Integrated Business Plan are integral milestones in this Programme. These documents set out the vision and principles for the development of community services over the next five years including a strong commitment to equality and the embracing of diversity as an employer, and within our commissioning and provision. Primarily these principles will ensure community health provision is available to all, regardless of age, sex, disability, gender, race, ethnic origin, religion, belief or sexual orientation.

The assessment of organisational options has also been part of the Transforming Community Services Programme since it was launched nationally. However the NHS Chief Executive wrote to all Strategic Health Authority (SHA) and Primary Care Trust Chief Executives on the 30<sup>th</sup> July 2009 to focus Primary Care Trusts (PCTs) on delivering “responsive, personalised, productive services of a consistent high quality, embedded within a coherent approach to Quality Innovation Productivity and Prevention,” rather than on organisational structures. He also stated that PCTs do not now have to make a definitive decision about organisation form in October 2009.

However, before this letter at the end of July, a significant amount of work had been undertaken regarding organisational models, especially ensuring engagement with staff, so it is appropriate to begin our assessment of these models within this paper. However our thinking around organisational models will continue to develop as the Commissioning Strategy and Business Plan are implemented.

This paper recommends that Direct Provision remains the model of delivery for ECK-CS in the short to medium term, but acknowledges that the PCT corporately needs to support the autonomy and ambition of ECK-CS and allow the PCT as a commissioner to concentrate on its World Class Commissioning responsibilities. To do this it is recommended that the PCT will continue to strengthen its internal governance to further separate ECK-CS under the umbrella of the PCT, ensuring that becoming a stand alone provider, external to the PCT, is a viable long term option.

It also recommends that although there remain uncertainties around the Community Foundation Trust and Integrated Care Pilot models the PCT and ECK-CS should work with the SHA and DH to support the development of these models as their transition and implementation paths become clearer.

The PCT Board are also asked to ratify the ECK-CS Terms of Reference in Appendix 1.

## **1.0 Introduction**

- 1.1 The PCT Provider, NHS Eastern and Coastal Kent Community Services, (ECK-CS) has been evolving since the PCT was established in 2006. In February 2007 the PCT Board agreed to set up a programme to develop the capability and service models within the PCT Provider. In March 2008 the PCT Board agreed revised internal governance and management arrangements to enable the PCT Provider to become an arms length provider and in April 2009 ECK-CS was assessed as Business Ready to operate as an Autonomous Provider Organisation.
- 1.2 This paper details the work that has been undertaken as part of the local implementation of the national Transforming Community Services Programme and sets out some recommendations on the future of ECK-CS.

## **2.0 Context**

- 2.1 The DH programme Transforming Community Services was established following the publication of the *DH Operating Plan 2009/10*, the *NHS Next Stage Review, High Quality Care for All*, and the partner publication, *Our Vision for primary and community care*, which made a public commitment to creating modern, responsive community services of a consistently high standard. It reaffirmed the central importance of services in the community in delivering the national vision of integrated, personalised care outside of hospital and made quality the organising principle of the NHS. Quality improvement is a key deliverable of both the national and local community services programmes.
- 2.2 The DH Transforming Community Services Programme includes work streams focused on clinical transformation (including the strengthening of clinical skills and leadership and the development of pathway based transformational guides) and business transformation (including the implementation of a national standard contract and the World Class Commissioning of Community Services).
- 2.3 The *DH Operating Plan 2009/10* made it clear that "PCTs should ensure that their operational provider services are fit for purpose and able to perform effectively alongside all other providers" and that "by April 2009, provider services should be in a contractual relationship with their PCT, providing sufficient separation from Commissioning roles to avoid potential conflicts of interest".
- 2.4 In January 2009 the DH published *Enabling New Patterns of Provision (ENPoP)* which set out a framework and timetable for PCTs and SHAs to use to guide local delivery and decision making. It is focused on ensuring an effective internal separation of PCTs and guides PCTs in how to make decisions about future organisational form setting a deadline for agreeing future organisational models of October 2009. It also sets out requirements to strengthening the commissioning of community services.
- 2.5 Since the publication of *ENPoP* the NHS Chief Executive has written to all SHA and PCT Chief Executives on the 30<sup>th</sup> July 2009 to reiterate that the Transforming Community Services Programme should be focused on delivering "responsive, personalised, productive services of a consistent high quality, embedded within a coherent approach to Quality Innovation Productivity and Prevention". He states this is the "over-riding priority for community services" and not organisational structure. He also states PCTs do not now have to make a decision

about organisation form in October 2009 but that each SHA will set out a locally derived process that meets two key criteria:

- Readiness and capability to transform services, set within a robust approach to delivering Quality Innovation Productivity and Prevention.
- The strength of local leadership.

2.6 To this end we have focused much of this paper on the work undertaken to transform services from a commissioning and providing perspective but recognise that a significant amount of work had been undertaken regarding organisational models, especially ensuring engagement with staff, so it is appropriate to begin our assessment of organisational form in Section 8.0.

### **3.0 Scope**

3.1 The PCT Board established the Shaping Community Services (SCS) Programme Board to corporately oversee the implementation of the Transforming Community Services work locally. It is chaired by the PCT Chief Executive and has executive and non-executive membership from the PCT Board and the Community Services Management Board.

3.2 The core objectives of the SCS Programme Board are:

1. The PCT, as a commissioner, will ensure it has the capacity and capability to commission services in the community that effectively drive down health inequalities, deliver the best clinical outcomes and ultimately meet the health needs of our local communities.
2. The PCT, as a commissioner, will define service requirements and improvements that build on the strong community services that already exist locally.
3. The PCT, as a commissioner, will commission services that improve access, increase the scope of services provided in the community, ensure consistent quality, increase the personalisation of care and offer choice to people, where and when this is most appropriate.
4. The PCT, as a provider of care, will assess the viability of its services, better understand its business plan for the next five years, and put plans in place to develop a high quality workforce that has the right skills and competencies to deliver the services in the community to empower them to improve patient care and focus on quality.
5. The PCT, as a provider of care, will ensure their services are sustainable, efficient and offer value for money and begin measuring and benchmarking their performance against national and international best practice.
6. The PCT, as a corporate body, will make an informed decision on the future organisational model(s) for the services it currently provides through NHS Eastern and Coastal Kent Community Services.

3.3 Achievement of these objectives will ensure that the PCT is able to effectively determine its commissioning intentions for services in the community and commission those services and ECK-CS effectively, whilst ensuring that ECK-CS is able to operate an effective provider in its own right. It will also allow the PCT corporately to make a decision about the future

organisational model and assess whether ECK-CS meet the two criteria outlined by the NHS Chief Executive in his July letter.

- 3.4 Although the Programme Board is focused on the six objectives stated above the Programme can be defined into six wider areas with Engagement encapsulated within all areas. This is shown in Figure 1 below:



Figure 1: Key Parts of the Shaping Community Services Programme

- **Business Readiness and Governance**

- 3.5 Prior to April 2009 much work was undertaken to enable ECK-CS to meet the requirements of the *DH Operating Plan 2009/10*. This focused on ensuring strong governance and financial arrangements in place so that ECK-CS could operate autonomously from the PCT on an equal footing with other providers. A formal Management Board of ECK-CS was established as a committee of the PCT Board and the governance and management arrangements strengthened to operate effectively. On the 24<sup>th</sup> April 2009 the South East Coast SHA determined that “as a result of this assessment I am happy to confirm that ECKCS is substantially business ready in line with the Operating Framework requirements”.
- 3.6 A new Lay Chair has been appointed from the 1<sup>st</sup> August 2009 and three additional Lay Members have been in place from 1<sup>st</sup> September 2009. Alongside this a Managing Director role is now in place which together with the Associate Directors, Lay Members and two PCT Non-Executive Directors will form a constituted Community Services Board as a PCT Board Committee from 1<sup>st</sup> October 2009.
- 3.7 The chart overleaf shows the reporting relationships between the PCT Board and its Committees, and the ECK-CS Board

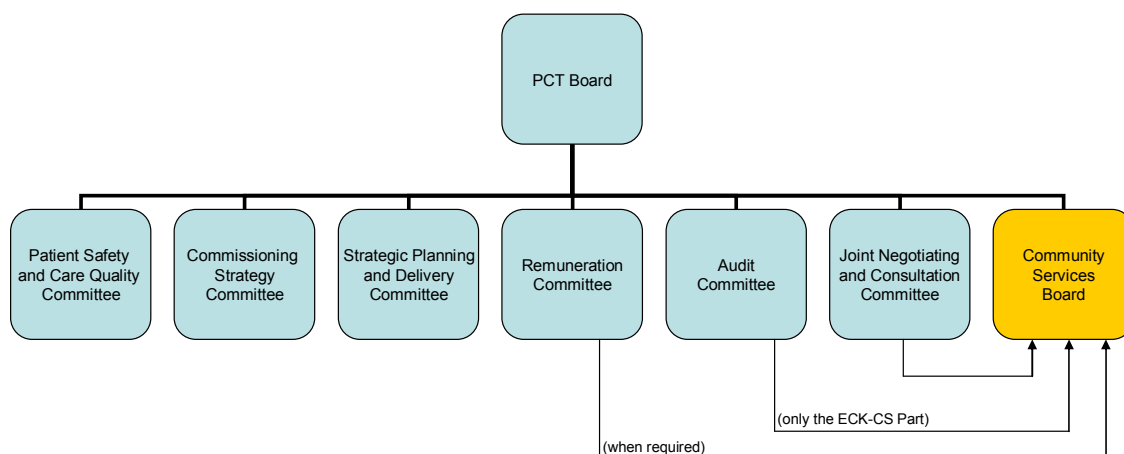


Figure 2: PCT Committee Structure

Further work will continue to ensure that these governance arrangements evolve and develop as the arrangements for a future organisational model mature.

3.8 • **Contracting and Commissioning**

The *DH Enabling New Patterns of Provision* guidance makes it clear that the transformation of community services can only happen if services are commissioned effectively in line with World Class Commissioning principles and that consistent contracts are applied to services in the community. From the 1<sup>st</sup> April 2009 the PCT contracted with ECK-CS through the national contract which provides consistent terms and conditions to all community providers across the country. Also Lead Commissioners have been developing a Community Services Commissioning Strategy which sets out the commissioning intentions up to 2013 and for the first time starts to describe the landscape of community provision within the Eastern and Coastal Kent area. This is described in more detail later in the paper.

3.9

• **Quality, Performance and Productivity**

Quality has been at the heart of ECK-CS' development from its establishment and it has a strong quality and safety governance structure, mechanisms and culture through the organisation. It has now registered in its own right with the Care Quality Commission and is performance managed by the PCT and assessed by regulators like any other provider. The PCT is currently part of a national pilot to test the DH Quality Framework for community services which include testing quality indicators which will be in place nationally from April 2010.

3.10

ECK-CS has initiated a large scale productivity programme called 'Brainwave vs Tidalwave' which drives aims to drive productivity through local innovation and quality improvement projects. This is an exciting development which aims to ensure ECK-CS prepares effectively for the downturn in NHS finances through a focus on quality and innovation.

3.11

• **Clinical Visions, Models and Skills**

ECK-CS has undertaken work in this area as an enabler to the Five Year Integrated Business Plan. The work is based on the conviction that the only way to build a strong

3.12 provider organisation is to have strong products and services that meet patients' and commissioners' needs. Clinical leadership, workforce planning, skills development and designing the right delivery models are imperative to success. Much effort has been put into really engaging staff and clinical leaders within ECK-CS, at a strategic and operational level in influencing the organisation of services to deliver effective clinical outcomes and offer the best patient experience. This is described in more depth later in the paper.

- **Five Year Business Planning and Infrastructure**

3.13 ECK-CS has used the outputs from the Clinical Visions, Models and Skills area to develop a clinically driven Five Year Integrated Business Plan that sets ambitious visions and underpins those visions with effective clinical models, proper workforce planning, the right infrastructure development and robust financial planning. Due to the change in financial climate ECK-CS will need to make clear within the plan its revenue assumptions, and where possible, gain acceptance to these by their commissioners. It will also test those plans through sensitivity and scenario planning, to ensure ECK-CS can be a sustainable and viable commercial organisation in the long term.

3.14 The PCT has invested significantly in ensuring both the commissioning and providing parts of the organisation have the right infrastructure to succeed. The DH guidance, *Enabling New Patterns of Provision* sets out arrangements with which PCTs must protect assets and the interests of taxpayers, and ensure the provision of safe, fit for purpose buildings. It states that estate "should not normally transfer to providers". To this effect it has been agreed that the clinical delivery property that the PCT owns or leases will be retained by the PCT as Commissioners and in October the management of this property will move from ECK-CS back to the PCT within the Assurance and Strategic Development Directorate.

3.15 This change will ensure that commissioners can ensure best value and really utilise estate in the best interests of patients and in alignment with the PCTs commissioning intentions. This establishes a landlord/tenant relationship between the PCT and ECK-CS and applies to those buildings currently owned and leased by the PCT for the provision of clinical services. This relationship will be established with all providers of services from PCT buildings through Memoranda of Occupation linked to service contracts. In line with national guidance the PCT as owner of the estate is developing a Commissioners Investment and Asset Management Strategy. This is a new approach to developing an Estates Strategy and promotes an alignment between PCTs commissioning strategies and its plan for the future of its estate. This will be published in April 2010.

3.16 With regards to the IT infrastructure ECK-CS will retain ownership of desktop assets and has a dedicated support contract in place with the Kent and Medway HIS. The PCT will retain ownership of networks and control access onto the NHS networks, ensuring both information governance and technological standards are maintained. This will be developed further during 2009 and 2010.

- **Information and Pricing**

3.17 It has been widely recognised that access to good information about clinical delivery in community services is poor and that block contracts with community providers do not help providers themselves or commissioners understand what is being delivered or how each provider is performing. The DH published *Currency and Pricing Options for*

*Community Services* in January 2009 which sets out how PCTs need to move the contracting of community provision, over the coming years, from block contracts to cost and volume contracts and ultimately to a payment by results type framework.

3.18 The failure of the Local Service Provider contract for the Southern Cluster as part of the National Programme for IT has led to significant delays in the deployment of a community information system. Currently the three community providers in Kent are pursuing a joint procuring of such a system whilst the DH and Connecting for Health explore the possibility of procurement under an ASCC contract. The aim is to have procured and implemented a community information system through the route that offers the best solution, in 2010. This will revolutionise the quality and availability of data both for clinicians to use during their care but also for providers and commissioners to use to performance manage their services.

3.19 In tandem with this the Community Contracting department within the PCT are leading some initial pilots of cost and volume contract and payment mechanisms, in shadow form, for some community services, starting with those that currently have access to an adequate information system. Over the next two years this will ensure the PCT can move ECK-CS from block contracts to a more sophisticated activity and payment model.

3.20 In preparation for these developments significant work is being undertaken to understand the makeup of ECK-CS income especially in understanding the total cost for each service including overheads and indirect costs. Strong financial footings are essential and this continues to be a priority during the rest of 2009/10.

- **Engagement**

In undertaking the work described, specific and appropriate engagement has been undertaken.

3.21 Within ECK-CS this has included engagement with staff around the service visions and development of the five year Business Plan. 26 staff engagement sessions were held between February and August 2009 with 940 staff attending.

3.22 Each session was tailored to reflect the Shaping Community Services journey and included opportunities to update staff on the progress to date, gaining input into the ECK-CS purpose, values and service visions and gathering suggestions for how to further develop services over the next five years. There was also opportunity for staff to understand each of the organisational options and ask questions and provide comment on each of their preferred options.

3.24 Engagement with Staffside has also been positive with the Chair of the Staffside a member of the Shaping Community Services Programme Board and Community Services Management Board. They have been actively involved in these work streams and the JNCC have received updates on the Programme at each of its meetings.

3.25 Another area of engagement within ECK-CS has been raising awareness of the national Right to Request mechanisms. The 'right to request' is a commitment set out within the *NHS Next Stage Review*. It entitles primary and community care staff to put a business case to the PCT Board to set up independent social enterprises and to have their case considered. If approved, the PCT will support the development of the social enterprise and award it a contract to provide services, still free at the point of

delivery. To date no services or staff have initiated their 'right to request'.

3.26 Within the PCT as a commissioner, the development of the Community Services Commissioning Strategy has involved engagement with all parts of the commissioning organisation. Specifically Practice Based Commissioning, Social Care and Primary Care have been engaged and communicated with and the Patient and Public Engagement Team have set up events with Kent LINK for local people to influence the strategy.

### **Commissioning Community Services**

The Shaping Community Services Programme has three commissioning-led objectives.

4.0

In order to achieve these objectives a Community Services Commissioning Strategy has been developed. It is part of a suite of strategies that underpin the PCTs Strategic Commissioning Plan (SCP) for 2008-2013. These include strategies for elective care, urgent care, maternity services, long term conditions and end of life. The Community Services Commissioning Strategy will sit alongside these as a vehicle for the delivery of the SCP.

4.1

4.2

4.3

The Community Services Commissioning Strategy is not purely a strategy for services provided by ECK-CS but encapsulates all the current and future services it is intended should be provided outside of major (acute) hospital settings and is supported by a strong commitment to ensuring access to all, regardless of age, sex, disability, gender, race, ethnic origin, religion, belief or sexual orientation.

4.4

In delivering the Community Services Commissioning Strategy, the Commissioning Strategy Committee agreed the direction of travel, expectations and timetable for delivery of the Strategy in July 2009. Since then there has been consultation with Practice Based Commissioners and stakeholders and wider consultation events with the public and patients, which has been supported by the Kent LINK. The final Strategy will be submitted to the Commissioning Strategy Committee in October for ratification. However, the strategy has been sufficiently developed to allow its draft outputs to inform this paper.

4.5

The current community provider landscape includes ECK-CS, other PCT's Provider arms, EKHUFT, KMPT, Kent County Council, General Practices and private and voluntary sector providers. There are Integrated Care Pilots being developed and Section 75 agreements between health and social care. The Primary and Community Nursing Strategy integrates community nursing directly with primary care. The Community Services Commissioning Strategy will bring together the commissioning of all the elements of community care into one integrated approach and will enable the development of quality provision through a plural market of providers.

4.6

Both the Strategy and the ECK-CS Business Plan have been written against five agreed Department of Health priority areas for community care. These have been developed for both adults' and children's services:

- Long Term Conditions and Rehabilitation
- End of Life
- Acute Services Closer to Home
- Promoting Health and Wellbeing
- Mental Health



4.7 In developing the Strategy commissioners have defined some strategic commissioning principles for community services. They have also specifically identified the key commissioning principles, outcomes, requirements and the potential impact on the service provider market for each service area.

### **Strategic Commissioning Principles**

5.0 Within the Strategy there are six key principles that will drive the commissioning of community services. These are:

- 5.1
- Deliver more services in local community settings, ensuring they promote personalisation and independence and are responsive to patients
  - Use analysis of local health and social care needs to inform commissioning that will address and reduce inequalities
  - Improve the integration and communication across community care and all other health and social care providers
  - Increase patients' and health practitioners' knowledge of services available in the community to enable them to make informed choices and referrals
  - Increase the focus on education and prevention through health and well-being services.
  - Ensure that clinically-led quality, safety, efficiency and value for money are at the heart of all community services through a focus on the delivery of measurable outcomes

5.2 These Strategic Principles and the underlying detail for each DH priority area will enable the delivery of all the commissioning objectives of the Transforming Community Services Programme, specifically the objective which requires the PCT to define service requirements and improvements that build on the strong community services that already exist locally.

### **Community Services Five Year Integrated Business Plan**

6.0 The Shaping Community Services Programme has two objectives specific to ECK-CS. In order to achieve these objectives ECK-CS conducted five key pieces of work.

6.1 Firstly it assessed the viability of its services by conducting an analysis of its portfolio. This allowed ECK-CS to understand the makeup of its services, the way in which they interact and identify any services it feels could be at risk from its own business perspective or from an assessment against commissioning intentions. It has also allowed it to build an internal Operating Model.

6.2 Secondly it has used the intelligence gathered from the first exercise to create 5 year visions for each service linked to the DH service areas described previously. This has enabled the organisation to set some ambitious targets, drive its business development capability and empower strong clinical leadership at all levels.

6.3 Thirdly it has put quality improvement at the heart of its operations and made productivity and innovation a key part of its development for the long term. It is also bolstering its performance management mechanisms and embedded a high performance culture at both strategic and

6.4 operational levels, in line with its contracted and corporate responsibilities.

6.5 Fourthly it will publish, to the first formally constituted Community Services Board in October, its Five Year Integrated Business Plan produced from the clinically led developments described above. It will aim to show ECK-CS as a sustainable, commercially viable organisation that offers quality and value to the patient and the commissioner.

The key overriding principles for ECK-CS can be summarised as:

- 6.6
- Further integration of our services to deliver continuous quality improvement, a strong and embedded commitment to ensuring equality, and embracing diversity, and a better and more consistent patient experience.
  - Focus on what we do best, become more productive and expand existing services where appropriate.
  - Develop and win new services (focusing on reducing acute demand and developing services that would have traditionally been provided in acute settings).
  - Expanding our service delivery to other areas by responding to the commissioning intentions of commissioners other than NHS Eastern and Coastal Kent.

6.7 Finally ECK-CS will align its infrastructure, support and corporate services with the clinical visions and ambitions so that the clinical services in their current and future state are appropriately supported by proper workforce, financial, infrastructure and corporate planning.

6.8 In meeting the second provider-led Shaping Community Services Objective it continues to be an ambition for ECK-CS and the other PCT Providers it works closely with to be able to benchmark their performance against each other. It will use the introduction of the national quality indicators as the first stage in this development.

### **Alignment between Commissioning and Provision in Community Services**

7.0 Alignment of this kind is not a one off event but part of a continuous cycle of development for both the commissioner and providers. It is important to ensure, at this critical stage, that there is an alignment in intentions but it is equally important to understand the mechanisms that are in place to refresh priorities and developments over time, as both the Commissioning Strategy and ECK-CS Business Plan are live documents.

7.2 In aligning the current intentions of both the Commissioning Strategy and the ECK-CS Business Plan both representatives from ECK-CS and Lead Commissioners met during the summer to bring together their draft plans. A key area where this was particularly successful was Long Term Conditions and Rehabilitation. The PCTs commissioning principles for Long Term Conditions and Rehabilitation focus on strong integration across multi-disciplinary teams, greater independence and well being for both carers and patients with a greater focus on self care and moving rehabilitation services closer to home.

7.3 ECK-CS has set ambitions that will improve patient care in this area and supports these commissioning principles. An example of this include ECK-CS' aim to create a Long Term Conditions Integrated Health and Social Care Team that works in partnership with social care and is integrated with primary care. The service model will bring together nursing, therapy and medical practitioners who will focus on patients with long term conditions. They will ensure seamless care between professions and organisations whilst supporting patient

independence and reducing hospital admissions.

7.4 Another example of alignment is Health and Well-Being. The PCTs commissioning principles in this area focus on personalising services to the needs and choice of the individual. There is a focus on sexual health, for which ECK-CS intends to be a market leader, smoking and healthy weight.

7.5 In order to support these intentions ECK-CS aims to extend its general practice provision in this area including vascular services and lifestyle clinics with a focus on 'at risk' men. Extending provision in dental health will also support PCT ambitions both at a general and specialist dental level. ECK-CS also has an aim to work with sports and fitness groups targeting prevention of musculoskeletal injuries and at the other end of the spectrum aims to extend its provision in Weight Management and Obesity services for adults and children. The development of a Sexual Assault Referral Centre as a joint venture with Kent Police is a specific ambition as well as more targeted work with the Lesbian, Gay, Transsexual and Bi-Sexual Community.

7.6 Whilst there is alignment between the commissioning intentions of NHS Eastern and Coastal Kent and the ECK-CS Business Plan it must be made clear that the PCT commissioning principles include a desire for increased plurality of provision for example in the area of Long Term Conditions and the intention to review the specification and provider landscape for a number of service areas such as Adult Speech and Language Therapy and Physiotherapy. Where there are currently known implications for ECK-CS these areas have been subject to more robust sensitivity analysis in the ECK-CS Business Plan.

7.7 This picture will not be uncommon across the provider landscape. There will be services in all parts of the health system that are subject to commissioning led review or market testing. It requires providers to develop strong sensitivity analysis and scenario planning to understand the implications of loss and gain in revenue to its overall business model. As the commissioning cycle is implemented for each service area changes to the provider landscape will manifest themselves in a variety of way. These include:

- Services being market tested and procured by commissioning
- Natural modernisation and service improvement by either the commissioner or provider
- Pathway based commissioning that adjusts the way services are organised,
- Providers moving away from an area of provision outside of their mandatory services
- The 'Right to Request' mechanism.

ECK-CS recognises this within their Business Plan and gives confidence that their overall business model can flex to natural service movement.

7.8 Ensuring ongoing alignment will require continued focus and there are now mechanisms in place to support this. Through operational performance meetings which cover all service areas, ECKCS and its commissioners are able to evolve and develop services to meet changing needs, including discussing service innovation and developments at a strategic level. In addition ECKCS will participate in groups led by commissioners that bring together providers from across a pathway to integrate processes and ensure seamless provision. This will ensure an ongoing alignment between the developing Business Plan of ECKCS and the strategic commissioning plans of commissioners.

7.9 There is also public health and patient experience intelligence gathered by the PCT which is available to ECK-CS and other providers to support their ambitions and enhance the delivery of PCT commissioning intentions. Market Analysis completed by the PCT will also inform

7.10 procurement plans in the future. These mechanisms provide confidence that alignment will continue as the Commissioning Strategy and ECK-CS Business Plan are implemented.

### **Organisational Options**

8.0 One of the core principles of the Shaping Community Services Programme is to drive service transformation, patient experience improvement and not specifically focus on Organisational Models. Over the last year many options have been tested in various forms by PCTs across the country. As described earlier, PCTs are no longer required to make an organisational decision in October 2009 but a significant amount of work had been undertaken in the PCT before this requirement was put in place. Therefore it is appropriate to show the work that has been undertaken and begin our assessment of these models below.

8.1

The DH *Enabling New Patterns of Provision* sets out nine organisational options:

- 8.2
- Direct Provision
  - Community Foundation Trust
  - Social Enterprise
  - Vertical Integration
  - Horizontal Integration with Local Authority
  - Partnership Arrangements
  - Integrated Care Pilots
  - Primary Care Contracts
  - NHS Contracted Arrangement / Services provided on behalf of a PCT by a third party

8.3 There is no nationally prescribed model and all options have advantages and disadvantages. It is not a requirement that the whole provider arm follows the same organisational model. Most of the models above can be applicable to the whole organisation, to individual services, or even groups of services that have proven synergies for patient care delivery; however no model is mutually exclusive from another.

8.4 Work has been undertaken within ECK-CS to determine where synergies exist across services provided by ECK-CS and how these synergies can be further developed for greater patient benefit. This has significantly influenced the overall operating model for ECK-CS, as part of the development of the Business Plan, and supports the synergies between both adult and children's services.

- **Assessment of Models**

It is appropriate to look at how the nine organisational models listed above could be applied to ECK-CS.

8.5 Two of the models above (Partnership Arrangements and Primary Care Contracts) exist currently within Eastern and Coastal Kent and will continue to form part of the rich picture of contractual models used across the health economy. However they do not provide a solution to the overall organisational model for ECK-CS as the examples below show they are best applied to specific services and pathways in a way that delivers the right benefits to patients.

8.6

- **Partnership Arrangements**

Partnerships are a key part of the purpose and vision of both the PCT and ECK-CS. It features heavily in the SCP and the values of ECK-CS and will remain a key priority

- 8.7 across the health system in Eastern and Coastal Kent.
- 8.8 There are many partnerships in operation; both formal and informal and support patients across organisational boundaries and enable seamless care provision, especially across different sectors. There are Section 75 arrangements in place with both Adult and Children's Social Services including the Learning Disabilities Community Teams which enable integrated care provision and multi-disciplinary working.
- 8.9 The Community and Primary Nursing Commissioning Strategy has partnerships at its core and integrates community nursing into primary care, supporting general practice in the management of patients with long term conditions, palliative care and wound care, for example.
- 8.10 Both the PCT and ECK-CS have explicit reference to partnerships in their strategies and regardless of the overall organisational model recommendation a strong component to the future of community services will be partnership arrangements.
- 8.11 • **Primary Care Contracts**
- 8.11 Although Primary Care Contracts are not the principle contracting route for community services, they are used to contract with primary care providers across the health economy. ECK-CS have seven PMS contracts for the general practices they manage. These contracts are being reviewed currently as part of a PCT Board decision in January 2009 to move the contracting to S-PMS contracts. ECK-CS as part of its clinical visions work has given notice to the PCT for one of its practices which the PCT contracting team is processing.
- 8.12 Whilst Primary Care Contracts will continue to be used to contract primary care services across the health economy, they are not an appropriate form of contract for community services as a whole. A national community contract is already in place and will be utilised regardless of organisational form.
- 8.13 The model described as 'NHS Contracted Arrangement / Services provided on behalf of a PCT by a third party' offers a wider solution than the previous two models and is described below.
- 8.14 • **NHS Contracted Arrangement / Services provided on behalf of a PCT by a third party**
- 8.14 It is possible to contract between NHS organisations for the delivery of services on behalf of each other. Local examples of this include the delivery of EKHUFT and Medway Outpatient Services within Community Hospitals, administered and managed by ECK-CS through inter-provider contractual arrangements. Also Adult Speech and Language Services and Dietetics and Nutrition Services are provided to the patients of EKHUFT under contract to ECK-CS. These are sub-contractual relationships between providers.
- 8.15 These mechanisms offer providers and commissioners flexibility to contract appropriately. They will continue to be used to increase capacity and capability in particular services.
- 8.16 With regard to more detailed contractual arrangements, Regulation 10 of the NHS (Functions of Strategic Health Authorities and Primary Care Trusts) and Administration Arrangements Regulations 2003 (SI 2003/2375) enables a PCT to: (a) delegate provider functions to a committee or employees of the Trust; and (b) enter arrangements under

which the provider functions are delegated to another PCT or a joint committee. Also Section 21(2) of the NHS Act 2006 enables a PCT to provide community services for another PCT under a commissioning arrangement.

8.17 These regulations therefore allow for the PCT to enter into a contract with another PCT or NHS organisation to provide the services that are currently provided directly. There are test cases within the South East Coast SHA and across the country. However they do not offer a long term solution and can be subject to detailed competition/collaboration processes. Due to the size of ECK-CS as the fifth largest provider in England it will not offer value to the PCT or patients to move the responsibility (but not the overall accountability) further away from the PCT Board.

8.18 It should be recognised that the PCT Board will still remain accountable for the services but the management of those services will be delegated to a third party outside of the PCT's direct control. There have been no specific requests or enthusiasm for an outward transfer of ECK-CS, however the PCT must be ready to respond to requests for an inward transfer of another PCT Provider. In preparation for this a risk based partnership framework is being developed corporately for the PCT and will be published in the Autumn.

8.19 Due to reasons described above these three models should not be subject to more detailed assessment as an overall organisational model for ECK-CS. This does not exclude them from future assessment for individual services as the Commissioning Strategy and ECK-CS Business Plan are implemented but are not appropriate at this time.

The remaining six models can be applied as an overall organisational model and are relevant for a more in depth analysis.

## 8.20 **Assessment of Models against Criteria**

9.0 The Shaping Community Services Programme Board agreed a process with which it would assess relevant organisational options. Once the alignment between the Commissioning Strategy and the ECK-CS Business Plan had been reviewed the PCT must take a corporate view of appropriate future organisational model(s).

9.1 It was agreed that the following ten criteria will guide the assessment of the corporate risk and benefit of each remaining model:

- 9.2
1. Effect on quality of service delivery
  2. Effect on staff
  3. Effect on risk and reputation of the organisation
  4. Effect on Service Continuity
  5. Financial implications of transition and sustainability
  6. Ability to allow synergies between services
  7. Ability to be flexible in a changing NHS market
  8. Sustainability and resilience in the long term
  9. Viability in the current economic climate
  10. Ability to promote patient choice

9.3 The following matrix describes the remaining six organisational models, progress made nationally against this model and the main corporate risks and benefits for the PCT, for each model, guided by the ten corporate criteria.

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Direct Provision	<p>Although not seen as the long term solution the DH is keen for PCTs to focus on service transformation rather than organisational form in the medium term.</p> <p>National guidance on governance arrangements for PCT Providers gives opportunities to progress internal separation further to operate as two separate organisations within one umbrella organisation.</p>	<ul style="list-style-type: none"> <li>- Conflicts of Interest's may still exist and these need to be managed appropriately.</li> <li>- Could be seen internally and externally as not being ambitious enough in delivering transformation.</li> <li>- ECK-CS have a desire to be a standalone provider in the long term.</li> <li>- Potential loss of momentum on the journey to separation and progress onwards could get diluted.</li> <li>- The ECK-CS Business Plan is ambitious and requires ECK-CS Board to have the ability to make strategic long term decisions that may be different to that of the PCT.</li> <li>- Commissioning decisions that impact ECK-CS may be delayed or stopped if there is a corporate impact on the PCT.</li> <li>- Potential not to be sustainable and resilient in the long term so the potential for organisational change continues.</li> <li>- A service level agreement imposed by PCT as commissioner would have no legal enforceability (PCT cannot contract with itself)</li> </ul>	<ul style="list-style-type: none"> <li>- The PCT can focus on service transformation and quality improvement rather than organisational change.</li> <li>- Staff can continue to deliver services without disruption, other than that generated by service developments.</li> <li>- The PCT does not have to finance large scale organisational change which supports the current economic climate.</li> <li>- Synergies within services and across services can be developed further as part of the implementation of the Commissioning Strategy and Business Plan.</li> <li>- Allows flexibility in the future as services are reviewed and commissioned. Allows services to determine their own path and the organisation can flex accordingly.</li> <li>- The Commissioning Strategy and Business Plan will have an opportunity be mid-way through implementation before organisational change. Also patient choice can be developed.</li> </ul>

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
<p>Community Foundation Trust (CFT)</p>	<p>Six Provider Arm Pilots have been established for over 1½ years and developing under guidance from the DH. KMPG have reviewed the capabilities of the pilots in Spring 2009 and highlight that there are still some challenges to be overcome with regard to capability, policy decisions and process agreement with Monitor. Two pilots are developing faster than the others and they are moving forward. First likely date of authorisation is Spring 2011.</p> <p>The DH asked for declarations of interest in April from PCTs that would be interested in pursuing a CFT path. Those declarations had to be assured by the SHAs. Around 30 declarations were made including that of this PCT.</p> <p>As this is a viable model for the provision of the existing complex organisation providing multiple services rather than only for individual services the PCT has put a declaration of interest to form a CFT into the SHA which has sent to the DH for processing.</p>	<ul style="list-style-type: none"> <li>- Uncertainties as to the viability and application path for community providers to become CFTs.</li> <li>- Asset light model needs further investigation nationally and with Monitor.</li> <li>- Would mean three large FTs within ECK area and could restrict patient choice.</li> <li>- Monitor processes and regulation is complex and restricts some freedoms.</li> <li>- Long transition and authorisation period with significant focus and time commitment required by ECK-CS Executive and Non-Executive Team.</li> <li>- Potential to focus more on finance than quality (although this is being addressed)</li> <li>- Cost of transition could be substantial.</li> </ul>	<ul style="list-style-type: none"> <li>- Staff engagement shows enthusiasm and a willingness to proceed to FT</li> <li>- Strong governance focus within FT authorisation provides assurance to the PCT</li> <li>- Strong local ownership and public engagement model that supports community ethos.</li> <li>- Provides a separate legal form away from the PCT, allows absolute autonomy for ECK-CS.</li> <li>- Would feel relatively seamless transition for staff as development is over a long period and service structures continue.</li> <li>- Synergies within ECK-CS can continue and prosper.</li> <li>- Allows ECK-CS to compete on an equal footing with other local and national FTs.</li> </ul>



Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
<p>Social Enterprise (SE)</p>	<p>Significant enthusiasm and energy at DH level for Social Enterprise formation. Seen as a springboard to innovation, clinical leadership and entrepreneurship which gives freedoms to NHS staff they don't have within the traditional NHS Structure, through the Right to Request process.</p> <p>Investment available nationally to support development of business cases and transition. Test cases have focused on small community focused models with no complete PCT Providers having made the transition, although some PCT providers are developing significant business cases to float off complete providers into this model.</p> <p>Few 'right to request's' have been made as there is still apprehension over the NHS pension within a SE model.</p>	<ul style="list-style-type: none"> <li>- Not a model that would support the straight transfer of ECK-CS in its current form.</li> <li>- Staff largely not enthusiastic about the model, although there are some small clinical services that may develop this further in the long term.</li> <li>- NHS Pensions guaranteed on transfer to the social enterprise but there are circumstances once in the enterprise that this is not the case.</li> <li>- All major staff-side organisations are advising staff against this model.</li> <li>- Largely untested model in the NHS. No large scale test cases to assess.</li> <li>- Economical climate could hinder long term viability.</li> <li>- Social Enterprise may not want to carry on with services that PCT would consider to be mandatory.</li> <li>- Could be public objection to the movement of services outside of the traditional NHS family.</li> </ul>	<ul style="list-style-type: none"> <li>- Separate legal entity away from PCT.</li> <li>- Supports innovation and clinical leadership.</li> <li>- Supports patient choice and plurality of provision.</li> <li>- Synergies in services can be maximised and supports strong integrated working.</li> <li>- Regulated by the Financial Services Authority and Care Quality Commission which offers assurance to the PCT.</li> </ul>

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Vertical Integration	<p>This form of integration focused on movement into secondary or primary care organisations.</p> <p>There are test cases in England that show PCTs moving their provider into hospital acute trusts, mental health trusts and into primary care.</p> <p>Most movement into hospital and mental health trusts are for fixed periods of time while services can be market tested, and are seen as holding positions, unless the said provider wins the business through procurement.</p> <p>Varying degrees of enthusiasm for the model given the national policy to move care out of acute into the community.</p> <p>Movement into primary care provision is more in line with national direction and integration with primary care is seen as more positive. (see Integrated Care Pilots)</p>	<ul style="list-style-type: none"> <li>- PCT may find it less easy to implement its plans to manage acute demand and develop care pathways which have no acute service elements when the provider provides both community and acute care</li> <li>- Potential for very large monopoly foundation trust provider – does not support patient choice.</li> <li>- Most acute providers do not have the experience of providing wide ranging community services.</li> <li>- There is a risk of asset/resource stripping to meet other key needs of the acute business.</li> <li>- Economies of scale lost and business continuity compromised when individual practices employ services.</li> </ul>	<ul style="list-style-type: none"> <li>- Whole care pathway solution</li> <li>- Potential financial incentives towards system efficiencies</li> <li>- Support integration between services</li> <li>- Terms and Conditions of staff remain the same (unless employed in primary care)</li> <li>- Supports economic climate</li> </ul>

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Horizontal Integration with Local Authority	<p>Where Local Authority boundaries match PCT boundaries there are national examples of where the PCT Provider and Social Services have formed integrated organisations, either through transfer of NHS staff into the Local Authority or through Section 75 agreements.</p> <p>Operationally there are significant barriers both from a cultural and technological perspective but the most successful integrations do show patient benefit.</p> <p>Joint posts at senior levels have also been appointed to, but mainly from a commissioning perspective.</p> <p>Section 75 agreements are used regularly for service specific partnerships.</p> <p>Care Trusts are not seen as an option for community services.</p>	<ul style="list-style-type: none"> <li>- Constitutionally complex in practice</li> <li>- Employment terms and conditions will vary between staff groups</li> <li>- Governance arrangements may be complex on a large scale</li> <li>- Different financial regimes and positions may hinder progress.</li> <li>- Accountabilities can be difficult to define.</li> <li>- Payment and charging issues may cause tensions in service delivery and design.</li> <li>- Cultures and working practices may be different.</li> <li>- May not be clinically driven and clinical leadership may suffer.</li> <li>- Frictions from two-system approach.</li> <li>- Kent Adult Social Services have just completed a large scale restructure bringing together commission and provision functions.</li> <li>- Enthusiasm for whole-scale integration is low but high for service level operational integration.</li> </ul>	<ul style="list-style-type: none"> <li>- Established and flexible model suitable for a large number of different applications/situations</li> <li>- Integration across organisational boundaries can preserve existing staff benefits, although secondment models can be complex and open to challenge.</li> <li>- Support integration agenda</li> <li>- Gives a locally shared vision of care out of hospital</li> <li>- Strengthens the use of pooled budgets, co-location and strategic planning.</li> </ul>

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Integrated Care Pilots	<p>This programme is designed to explore different ways in which health and social care could be provided. The aim is to look beyond traditional boundaries (e.g. between primary and secondary care) to explore new, integrated models.</p> <p>16 Integrated Care Pilots (ICP) were announced by the Department of Health.</p> <p>Two bids from the Eastern and Coastal Kent area were not accepted. PCT is supporting a local programme to develop these and further pilots.</p> <p>There is much enthusiasm for this model both nationally and locally.</p> <p>ECK-CS are partners in both local pilots.</p>	<ul style="list-style-type: none"> <li>- The model is in its infant stages and needs time to develop to fully understand benefits over and above current service provision models.</li> <li>- 3 year pilots mean that whole-scale move to this model will take time.</li> <li>- Economies of scale lost and business continuity compromised when individual practices employ services.</li> <li>- Contractual arrangements could be complex for the PCT.</li> <li>- Potential friction between whether these pilots become structural organisations or functional networks managed by a shared board.</li> </ul>	<ul style="list-style-type: none"> <li>- Patient focused and clinically led</li> <li>- Local models being development with ECK-CS involvement</li> <li>- As a functional rather than structural solution may be more readily realised.</li> <li>- Improved partnerships in care provision across health and social care sectors.</li> <li>- Better use of scarce resources and more effective and economic delivery systems</li> <li>- Method of Improving relationships, governance, risk management and innovation in specific delivery systems</li> </ul>

9.4 Taking into consideration the risks and benefits for each model, and the current progress nationally this matrix suggests that Direct Provision continues to have the best balance between risk and benefits. The other models should remain under consideration and be progressed if appropriate once the national and local picture becomes clearer.

9.5 Other than direct provision, establishing a Community Foundation Trust is currently the most viable option for the wholesale transfer of the existing service model whereas all other options would be better applied to individual or small scale services.

## 10.0 Recommendations

- 10.1 This paper set out to describe the local implementation of the national Transforming Community Services Programme. It has focused on service transformation and quality improvement but also assessed the corporate suitability to the organisational models that the *DH Enabling New Patterns of Provision* describes.
- 10.2 In conclusion the following recommendations are made to the PCT Board for ratification:
- The PCT Board are asked to endorse the significant work that has been undertaken in delivering the Transforming Community Services Programme to-date, within the PCT and ECK-CS.
  - Endorse the local approach to Transforming Community Services that focuses on making quality improvement and service transformation the organising principle for change rather than organisational form.
- 10.3 On the basis of the organisational model assessment and our focus on quality improvement and service transformation, a further seven recommendations are made:
1. Direct Provision will remain the model of delivery for ECK-CS in the short to medium term to allow time to transform local services and improve quality through the implementation of the Community Services Commissioning Strategy and the ECK-CS Business Plan.
  2. To support the autonomy and ambition of ECK-CS and allow the PCT to concentrate on its World Class Commissioning responsibilities the PCT will strengthen its internal governance to further separate ECK-CS under the umbrella of the PCT, with the intention it will be a standalone provider, external to the PCT, in the long term. It must also show during its journey to absolute separation that it can demonstrate best value, productivity and efficiency, alongside any other provider.
  3. Although there remain uncertainties around the Community Foundation Trust and Integrated Care Pilot models the PCT should support the development of these models as their transition and implementation paths become clearer. In the meantime ECK-CS should use the tools supplied by Monitor to develop its capability and capacity to operate as a commercially viable NHS business.
  4. To begin implementation of the Community Services Commissioning Strategy and ECK-CS Business Plan, once ratified, and recognise that this may mean discrete services that currently sit within the Direct Provision model are identified for more detailed commissioning or provider-led reviews. A programme of reviews will be shared between the PCT and ECK-CS and recommendations following any reviews will be subject to normal PCT Board agreed processes.
  5. The PCT should allow innovation and clinical entrepreneurship to prosper as ECK-CS continues to evolve, as well as continue to allow staff and individual services the opportunity to develop business cases that support the right to request principles to become a Social Enterprise or other organisational form.
  6. To undertake the SHA assessment, once determined, to assess PCT compliance against the two key tests outlined by the NHS Chief Executive in July 2009.

7. To stand-down the Shaping Community Services Programme Board in December 2009 following its work to further strengthen the current governance arrangements. It will then meet again in March 2010 for a one off meeting to review commissioning and provider progress and review any national developments. It will then report its review and any further organisational option recommendations to the PCT Board in May 2010.
- 10.4 The PCT Board are asked to ratify the following (See Appendix 1):
- Terms of Reference for the ECK-CS Board so that it has agreed Terms of Reference in place in time for the first public ECK-CS Board Meeting on the 2<sup>nd</sup> November 2009.

## 11.0 Next Steps

The PCT Board are asked to endorse the next steps:

- Ratification of the full Community Services Commissioning Strategy in October 2009 by the Commissioning Strategy Committee.
- Ratification of the ECK-CS Integrated Business Plan by the Community Services Board on the 2<sup>nd</sup> November 2009.
- Develop a risk based partnership framework that sets out the governance arrangements and approval routes for ECK-CS to enter into high level partnerships.
- Inform the SHA in their role of assurance, of our recommendations in line with national timescales and work with them and the DH on developing the Community Foundation Trust model and processes.
- Review the relevant governance documents to ensure governance arrangements are further strengthened and ECK-CS has an appropriate decision making abilities, autonomy and licence to act for all its functions and clinical and non-clinical services.
- Publish a PCT Estates Strategy in April 2010.
- The PCT as Commissioner and ECK-CS to agree the principles for any service reviews and identify any service areas that are likely to be reviewed over the coming year.
- Review of any further developments around the organisational model options to inform a further report to the PCT Board in May 2010.

**NHS EASTERN AND COASTAL KENT COMMUNITY SERVICES  
BOARD**

**TERMS OF REFERENCE  
(Version 7)**

**1.0 PURPOSE**

The NHS Eastern and Coastal Kent Community Services (ECK-CS) Board is a formal Committee of the Board of NHS Eastern and Coastal Kent Primary Care Trust (“the PCT Board”), and reports directly to it.

It has overall strategic and operational responsibility for the PCT Provider as an Autonomous Provider Organisation (APO).

ECK-CS will establish a robust governance framework to ensure that ECK-CS is run within the appropriate standards of probity, transparency and integrity.

**2.0 DUTIES**

The ECK-CS Board (“the Board”) duties are to:

- (1) Set the NHS Eastern and Coastal Kent Community Services Five Year Integrated Business Plan and Vision. It will ensure that the Strategic Objectives are met through integrated systems, processes and internal controls of business management and governance within ECK-CS.
- (2) Set Strategy and Policy for ECK-CS and ensure all services provided meet commissioning intentions, are performing well, are productive against commissioner and service user requirements, are of a high quality, safe, and are developed in line with the ECK-CS Strategic Objectives.
- (3) Ensure effective management systems within ECK-CS that safeguard public funds and implement the requirements of integrated governance.
- (4) Achieve value for money from the resources available to ECK-CS, using to best effect the funds available for providing healthcare.
- (5) Ensure that ECK-CS meets its statutory duties relating to equality and diversity, specifically as an employer and in the delivery of its services.
- (6) Approve and monitor the risk management programme for ECK-CS and ensure effective governance systems are in place, monitored through the ECK-CS Assurance Framework and ECK-CS Risk Register.
- (7) Make decisions based on recommendations from the Clinical Quality and Safety Committee, the Performance Management Committee, the Incident Management and

Learning Committee, the Infection Control and Cleanliness Committee, the Audit Committee, Remuneration and HR Committee, Joint Negotiating and Consultative Committee, and their own sub-groups.

- (8) Be responsible for the achievement of all relevant national requirements including NICE, National Service Frameworks (NSF), National Targets and the Care Quality Commission registration requirements, within ECK-CS.
- (9) Oversee the development of clinical and support services within ECK-CS.
- (10) Ensure the business of the ECK-CS Board is conducted in accordance with these Terms of Reference, the Scheme of Delegation, Standing Orders, Standing Financial Instructions and the statutory and legal obligations of ECK-CS.

## **2.1 In addition to the duties described above the ECK-CS Board has the following roles and responsibilities:**

### Equality and Diversity

Further to duty 5 above, the ECK-CS Board will:

- ensure that it does not approve or recommend strategies, policies, plans or initiatives without assessing their impact on the equality and diversity policies of ECK-CS
- ensure that its services are available to all who require them (as per referral/acceptance criteria), regardless of age, sex, disability, gender, race, ethnic origin, religion, belief or sexual orientation.

### Health and Safety

The ECK-CS Board will:

- provide leadership to health and safety across the organisation and receive assurance from the Health and Safety Group via the Clinical Quality and Safety Committee
- take action to ensure that it and its reporting committees meet their statutory duties in relation to health and safety
- ensure that it does not approve or recommend strategies, policies, plans or initiatives without understanding their impact on the health and safety policies of ECK-CS.

### Business Continuity and Emergency Planning

The ECK-CS Board will:

- ensure that ECK-CS can meet its statutory responsibilities under the Civil Contingencies Act 2004
- ensure that it can operate as required in the event of the emergency and/or when business continuity plans are activated.

### Information Governance

The ECK-CS Board will:

- take action to ensure it and its reporting committees act in line with the statutory obligations of the organisation in relation to information governance. Specifically:
  - the publication scheme in line with Freedom of Information requirements
  - data security requirements.



### **3.0 MEMBERSHIP**

The membership and composition of the ECK-CS Board shall be:

- (1) An Independent Lay Chairman appointed by the Appointments Commission for a specified time and who is designated as a Non Officer Member;
- (2) Three other Independent Lay Members appointed by the Appointments Commission for a specified time and who are designated as Non Officer Members;
- (3) Two Non-Executive Directors appointed to the ECK-CS Board by the PCT Chairman for a specified time and who are designated as Non Officer Members.
- (4) Six voting employees of ECK-CS (the "Officer Members") consisting of:
  - Managing Director
  - Associate Director of Finance
  - Deputy Managing Director
  - Associate Director of Nursing
  - Associate Medical Director
  - Associate Director of Quality and Performance
- (5) Non Voting Members:
  - Associate Director of AHP & Specialist Clinical Services
  - Associate Director of Business Development
  - Assistant Director of HR and Organisational Development
  - Chair of the Joint Negotiating and Consultative Committee
  - Any Other Associate / Assistant Directors as co-opted
- (6) The Chief Executive and the Director of Human Resources and Organisational Development of the PCT may also attend meetings if they so wish.
- (7) The ECK-CS Board may co-opt non-voting stakeholder members, such as the Local Authority and patient and public representatives. .

### **4.0 CHAIR**

The Lay Chair ("the Chairman") will be appointed independently of the PCT by the Appointments Commission and will be given responsibility for the chairmanship of ECK-CS

At any meeting of the ECK-CS Board the Chairman shall preside.

The Chairman and members of the ECK-CS Board may appoint one of their number, who is not an Officer Member, to be Vice-Chairman, for such period, not exceeding the remainder of his/her term as a member of ECK-CS.

If the Chairman is absent from a meeting or absent temporarily on the grounds of a declared conflict of interest, the Vice-Chairman shall preside. In the event of the absence of both the Chairman and the Vice-Chairman, those present shall select one non-officer member to act as Chair for the duration of the meeting.

The decision of the Chairman of the meeting on questions of order, relevancy and regularity and interpretation of the Terms of Reference, Standing Financial Instructions and Scheme of Delegation at the meeting, shall be final.

## **5.0 SECRETARY**

The Associate Director of Quality and Performance or their nominee shall act as Secretary to the Committee.

## **6.0 QUORUM**

No business shall be transacted at a meeting unless at least one-third of the membership including the Chairman (including at least one member who is an Officer Member and one member who is a Non Officer Member is present.

Those in attendance for an Officer Member but without formal acting up status approved by the Board may not count towards the quorum.

If the Chairman or member has been disqualified from participating in the discussion on any Matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

## **7.0 FREQUENCY**

Ordinary meetings of the ECK-CS Board shall be held bi-monthly in public at such times and places as the ECK-CS Board may determine.

## **8.0 NOTICE OF MEETINGS**

The Chairman of ECK-CS may call a meeting of the ECK-CS Board at any time.

One-third or more members of the ECK-CS Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

In advance of any meeting held in public, the ECK-CS Board will ensure that a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at ECK-CS Headquarters at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)

## **9.0 CONDUCT OF MEETINGS**

The ECK-CS Board shall be conducted in accordance with the provisions of the current PCT Board approved Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

### **9.1 Admission of public and the press**

The public and representatives of the press may attend all meetings of the ECK-CS Board, but shall be required to withdraw upon the ECK-CS Board passing the following motion:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

Guidance should be sought from the PCT's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

### **General disturbances**

The Chairman or the person presiding over the meeting held in public, shall ensure that ECK-CS business can be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The Chairman can require the public to withdraw from the ECK-CS Board meeting if continued interruption and disruption is causing unacceptable disturbance.

### **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the ECK-CS Board following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the ECK-CS Board.

Members and Officer Members or any employee of ECK-CS in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of ECK-CS, without the express permission of ECK-CS.

### **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Terms of Reference shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of ECK-CS or Committee thereof. Such permission shall be granted only upon resolution of ECK-CS.

### **Observers at ECK-CS Board meetings**

ECK-CS will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the ECK-CS Board meetings and may change, alter or vary these terms and conditions as it deems fit.

## **9.2 Voting**

Every question put to a vote at a meeting shall be determined by a majority of the votes of members present. In the case of an equal vote, the person presiding (i.e.: the Chairman of the meeting) shall have a second, and casting vote.

At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

If at least one-third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

If a member so requests, their vote shall be recorded by name.

In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to formally fill a voting member vacancy shall be entitled to exercise the voting rights of the Officer Member.

A manager attending the ECK-CS Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member.

An Officer's status when attending a meeting shall be recorded in the minutes.

### **9.3 Declaration of Interests**

ECK-CS Board members are required to declare interests which are relevant and material to their membership of the ECK-CS Board. All existing ECK-CS Board members should declare such interests. Any ECK-CS Board members appointed subsequently should do so on appointment.

Interests which should be regarded as "relevant and material" can be found in the current PCT Board approved Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions in place from time to time.

Any Member of the ECK-CS Board who comes to know that ECK-CS has entered into or proposes to enter into a contract in which he or any person connected with him has any pecuniary interest, direct or indirect, the ECK-CS Board member shall declare his/her interest by giving notice in writing of such fact to the ECK-CS Board Chairman as soon as practicable.

At the time ECK-CS Board members' interests are declared, they should be recorded in the ECK-CS Board minutes.

Any changes in interests should be declared at the next ECK-CS Board meeting following the change occurring and recorded in the minutes of that meeting.

During the course of an ECK-CS Board meeting, if a conflict of interest is established, the ECK-CS member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

The Managing Director will ensure that a Register of Interests is established to record formally any declarations of interests of ECK-CS Board members.

These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Register will be available to the public and the Managing Director will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

## **10.0 AGENDA AND SUPPORTING PAPERS**

In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

No business shall be transacted at the meeting other than that specified on the agenda.

A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman and Associate Director of Quality and Performance at least 15 clear working days before the meeting. Requests made less than 15 working days before a meeting may be included on the agenda at the discretion of the Chairman.

The Agenda will be sent to members six working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear working days before the meeting, save in emergency. The ECK-CS Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

## **11.0 MINUTES OF MEETINGS**

The names of the Chairman and Members present at the meeting shall be recorded in the minutes. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

Minutes shall be circulated in accordance with members' wishes and be made available to the public as required by Code of Practice on Openness in the NHS.

## **12.0 REPORTING**

The ECK-CS Board will report to the PCT Board on matters that the PCT Board retains corporate responsibility for, which includes strategic financial management, workforce information, health and safety reporting and the reporting of any decisions, risks or events which may impact on the ability of the PCT to perform its functions or adversely affect the reputation of the PCT which includes any major decisions on the future organisational structure(s) of ECK-CS or its constituent services.

The confirmed minutes and a report from the Managing Director will be presented to the PCT Board at each of its meetings.

## **13.0 APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**

The ECK-CS Board may appoint committees of ECK-CS.

ECK-CS shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

#### **14.0 REVIEW**

These Terms of Reference will be reviewed at least annually or sooner if there is significant change.

If for any reason these Terms of Reference are not complied with, full details of the non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of

the ECK-CS Board and PCT Board for action or ratification. All members of the ECK-CS Board and staff have a duty to disclose any non-compliance with these Terms of Reference to the Chairman as soon as possible.

Any variation of these Terms of Reference is subject to PCT Board approval.