South East London

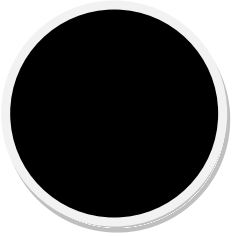
ENCLOSURE 1 – ENCLOSURE 7

NHS SOUTH EAST LONDON PCT/ CARE TRUST BOARDS

Thursday 19th May 2011, 3.00pm-6.00pm

Council Chambers,
Lewisham Town Hall,
1 Catford Road,
London SE6 4RU

TAB COLOUR INDEX



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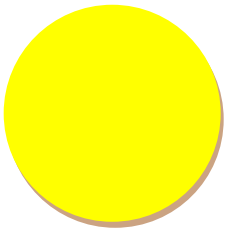

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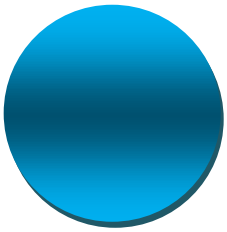

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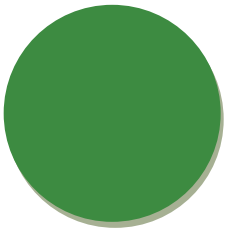

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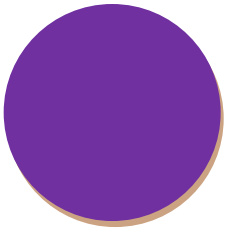

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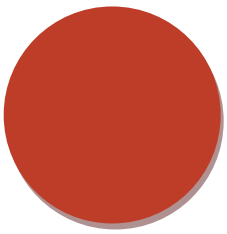

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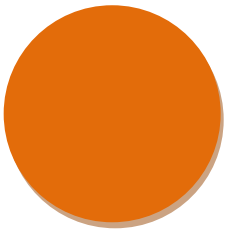

Southwark (Orange)

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

A meeting in Public, of the Boards of Bexley Care Trust, Bromley Primary Care Trust, Greenwich Teaching Primary Care Trust, Lambeth Primary Care Trust, Lewisham Primary Care Trust and Southwark Primary Care Trust will take place on **Thursday 19th May 2011, 3.00pm-6.00pm at the Council Chambers, Lewisham Town Hall, 1 Catford Road, London SE6 4RU.**

Board members are requested to send questions or clarification requests to the Board Secretary by 12.00pm on Monday 16th May 2011. Answers to these questions will be provided to Board members the evening before the meeting via e-mail and will be tabled at the meeting and appended to the minutes.

The public are asked to indicate to the Board Secretary any points of enquiry or questions they would wish to address with the Boards, three days before the meeting, please contact Jane Walker on 020 3049 4335 or via e-mail at jane.walker11@nhs.net.

Chair: Caroline Hewitt

AGENDA

AGENDA

	Time	Item	Papers	Presented by
BM/001/11	3.00	**Welcome & Introductions**		Caroline Hewitt
BM/002/11	3.05	**Apologies for Absence**		Caroline Hewitt
BM/003/11		**Declaration of Interests*** *Members should discuss any potential conflicts of interest with the Chair prior to the meeting*		All
BM/004/11	3.10	**Matters Arising not on the agenda**		Caroline Hewitt
SET-UP				
ACTION BY: All Boards				
BM/005/11	3.15	**Governance** • Governance Framework - Joint Committees - Standing Orders/Standing Financial Instructions/Scheme of Delegation • Adoption of the Principles of Public Life • Adoption of NHS SEL Boards' Contract • Adoption of lead officer roles • Indicative Corporate Risk Register	ENC 1 ENC 2 ENC 3 ENC 4 ENC 5	Simon Robbins

BM/006/11	3.30	**NHS SEL Business Plan & Corporate Objectives** To agree the Corporate Objectives and the NHS SEL Business Plan	ENC 6	Gill Galliano
BM/007/11	3.40	**Integrated Plan** To approve the integrated plan (full document available at http://www.selondonsector.nhs.uk/documents/608.pdf) and receive an executive summary identifying key risks and way forward	ENC 7	Gill Galliano
BM/008/11	3.55	**Emergency Planning & Business Continuity Policy** To agree the NHS SEL Emergency Planning & Business Continuity Policy	ENC 8	Dr Ann-Marie Connelly
SET-UP				
INDIVIDUAL ACTION BY: Bexley Care Trust, Bromley Primary Care Trust, Greenwich Teaching Primary Care Trust, Lambeth Primary Care Trust, Lewisham Primary Care Trust and Southwark Primary Care Trust				
BM/009/11	4.05	**Minutes of previous PCT Board meetings** To agree the minutes and action sheets from the previous Board meetings of: • Bexley Care Trust • Bromley PCT • Greenwich Teaching PCT • Lambeth PCT • Lewisham PCT • Southwark PCT	ENC 9	Dr Joanne Medhurst/ Pamela Creaven Dr Angela Bhan Annabel Burn Andrew Eyres Martin Wilkinson Andrew Bland
BM/010/11	4.15	**Pathfinder Development & Delegation** To agree the proposal for delegation to Local Clinical Commissioning Committees	ENC 10	Gill Galliano
BM/011/11	4.35	**Local Clinical Commissioning Committees** To agree the Terms of Reference of the Local Clinical Commissioning Committees (LCCC): • Bexley • Bromley • Greenwich • Lambeth • Lewisham • Southwark	(See ENC 1)	Dr Howard Stoate Dr Andrew Parson Dr Hany Wahba Dr Adrian McLachlan Dr Helen Tattersfield Dr Amr Zeineldine

AGENDA

10/11 YEAR END				
ACTION BY: All Boards				
BM/012/11	4.45	**Performance & Quality** To note the 2010/11 outturn performance position	ENC 11	Jane Schofield
11/12 ISSUES				
ACTION BY: All Boards				
BM/013/11	4.55	**Finance Report** To note the 2010/11 financial position, agree overall cluster budget, note impact of acute contract settlements, use of 2% non recurrent funding and QIPP programme. To delegate authority to the audit committee for adoption of accounts and sign off to Chair, Chief Executive and Director of Finance	ENC 12	Marie Farrell
BM/014/11	5.05	**Quality Report** To receive an update on key quality issues to be prioritised in 2011/12	ENC13	Dr Jane Fryer
BM/015/11	5.15	**London Review of Cancer Services** To receive an update on actions to be taken and any decisions to be made	ENC 14	Andrew Eyres
BM/016/11	5.25	**Pharmaceutical Applications Panel** To approve a proposal to establish a Pharmaceutical Applications Panel	ENC 15	David Sturgeon
11/12 ISSUES				
INDIVIDUAL ACTION BY: Bexley Care Trust, Bromley Primary Care Trust, Greenwich Teaching Primary Care Trust, Lambeth Primary Care Trust, Lewisham Primary Care Trust and Southwark Primary Care Trust				
11/12 ISSUES – FOR DISCUSSION				
BM/017/11	5.30	**BEXLEY CARE TRUST** To discuss progress on the QMS Campus Outline Proposal	ENC 16	Dr Joanne Medhurst/ Pamela Creaven
11/12 ISSUES – TO RATIFY CHAIR'S ACTION				
BM/018/11	5.45	**BEXLEY CARE TRUST** To ratify Chair's Action for the business case and transfer of £2.4 million to the Local Authority for social care	ENC 17	Dr Joanne Medhurst/ Pamela Creaven

BM/019/11	5.45	**LAMBETH PRIMARY CARE TRUST** To ratify Chair's Action for Lambeth PCT & Southwark PCT Community Services Integration with GSTT	ENC 18	Andrew Eyres
BM/020/11	5.45	**BROMLEY PRIMARY CARE TRUST** To ratify Chair's Action for Local Pharmaceutical Service Continuation of Designation	ENC 19	Dr Angela Bhan
ITEMS FOR INFORMATION ONLY The following items are for information only and will not be the subject of discussion at the meeting unless members indicate otherwise three working days before the meeting. Please contact Jane Walker on 020 3049 4335 or e-mail **jane.walker11@nhs.net**				
ACTION BY: All Boards				
BM/021/11		**Chair's Report**	ENC 20	Caroline Hewitt
BM/022/11		**Chief Executive's Report**	ENC 21	Simon Robbins
BM/023/11		**Director of Public Health Briefing**	ENC 22	Dr Ann-Marie Connolly
ANY OTHER BUSINESS				
BM/024/11	5.50	Any other business		
BM/025/11	5.50	To receive questions from the public (if time allows)		Caroline Hewitt
DATE OF NEXT MEETING				
BM/026/11		Thursday 21st July 2011, PART I 3.00pm-6.00pm, PART II 6.10pm-7.00pm, Venue to be confirmed		
BM/027/11		To consider a motion that the public should be excluded from the meeting while the remaining business is under consideration, as publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted.		Caroline Hewitt

*All Board members and senior employees of NHS SEL have the legal obligation to act in the best interests of each of the SEL PCTs and Care Trusts. Public service values matter in the NHS and those working in it have a duty to conduct NHS business with probity. All board members and senior employees are therefore expected to declare any personal or business interest which may influence, or may be perceived to influence, their judgement. This should include as a minimum, personal, direct or indirect financial interests.

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 1 **NHS SOUTH EAST LONDON GOVERNANCE FRAMEWORK**
DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development
AUTHOR: Oliver Lake, Director of Corporate Affairs
TO BE CONSIDERED BY: All
SUMMARY: This paper sets out the proposed South East London Governance framework. It has been developed in partnership with colleagues from all five PCTs and Bexley Care Trust. It explains the rationale of clustering and proposes a governance model designed to streamline processes, support the development of the new commissioning system whilst maintaining grip and accountability through statutory organisations during transition. The paper first outlines guiding principles that were used to develop the proposals and a proposal for joint board meetings and joint board committees. It then explains supporting executive meeting arrangements and stakeholder engagement proposals. The six Local Clinical Commissioning Committees are included in this paper, but are for agreement by individual boards at Agenda Item **BM/010/11**. The paper also includes the proposed Standing Orders and Standing Financial Instructions and financial Scheme of Delegation that will be common across all six boards.

ENCLOSURE 1

KEY ISSUES:
As part of the development a number of issues have been raised about the working arrangements. Whilst these have been addressed where possible in drafting committee terms of reference, It is expected that these will be resolved at the first meetings of the board committees.

INVOLVEMENT:
All six boards have provided input to and reviewed and endorsed the governance framework.

RECOMMENDATIONS:
The board (s) is asked to:-

1. Agree the governance framework
2. Agree the Terms of Reference for the joint board committees
3. Agree the Standing Financial Instructions
4. Agree the Standing Orders
5. Agree the financial scheme of delegation

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Transitional Governance arrangements for South East London PCTs and Bexley Care Trust (v26)

Contents

1. Introduction

1.1 NHS Operating Framework 2011-12

This paper has been informed by the Operating Framework 2011-12 issued on 15th December 2010 and the publication of PCT Cluster Implementation Guidance issued on 31st January 2011 by the Department of Health (Gateway reference 15520). It has also been informed by advice from Capsticks on the statutory requirements for PCT board membership.

Whilst current PCTs /Care Trusts are retained as statutory organisations during the current transitionary period facing the NHS, responding to the agenda and the need to make efficiencies have necessitated a consolidation of management capacity, with single management teams managing a cluster of PCTs. These new clusters are not statutory bodies but are necessary to sustain PCT capability and enable the creation of the new system.

Comparable approaches have been undertaken throughout London with all transitional governance arrangements broadly aligned through an NHS London guided programme of work. South east London's proposals are based on there being a single executive team and a single Accountable Officer with as much business as possible being undertaken by six Borough-based Business Support Units (BSUs). These units will be overseen by local Clinical Commissioning Committees operating as Committees of each PCT/Care Trust Board, the whole overseen by the six PCT/Care Trust Boards operating jointly (the Joint Boards) with some common membership and a single Chair. The composition of local committees is for local determination: the assumption in this paper is that they will be chaired by Clinical GP Commissioner Leads (as PEC Chair) to pave the way for full delegation.

Cluster guidance states that the design principles for governance arrangements should be;

- Effective
- Proportional and cost effective
- Locally determined

And through their operation should;

- Result in clear decision making
- Allow timely consideration
- Be fair and transparent

The exact nature of governance arrangements are for local agreement but guidance includes a range of examples where;

- Individual Boards delegate a range of functions to a cluster Board

- A number of PCTs share identical Board membership forming a cluster Board
- A cluster Board is formed from a single Chair, shared NEDs and individual PCT NEDs ("locality" NEDS)

The following arrangements have drawn on these examples, been informed by arrangements being developed by other clusters in London, and modified and amended following consultation with members of the South East London Boards to reflect the particular circumstances of PCTs and Care Trusts in South East London.

For reference, Appendix 1 summarises the functions of a PCT/Care Trust Board and therefore of the SEL Joint Boards.

2. Guiding principles

2.1 London PCTs will adopt "cluster" arrangements to fulfil their statutory functions

These arrangements will;

- Achieve the management cost savings targets
- Facilitate the transition to GP Consortia led commissioning arrangements
- Comply with the statutory duties of PCTs/ Care Trust

These arrangements need to take account of;

- The developmental nature of devolving responsibilities to GP Pathfinders
- The specific requirements for PCTs/Care Trust who have integrated arrangements in place with local authorities, including Bexley Care Trust whose Establishment Order includes the requirement for Bexley Council to appoint at least one borough-nominated non-executive director with full voting rights.
- The requirement to continue to manage and account for PCT/Care Trust performance at an individual PCT/Care Trust level

South East London PCTs/Care Trust have utilised the recently established principle of non executive directors being able to serve on more than one Board

The complement of NEDs has therefore been altered so that;

- A single chair will serve all PCTs/Care Trust in South East London
- NEDs are appointed with a primary role for a specified PCT/Care Trust to retain local knowledge and accountability, with 6 acting as Vice Chairs of each of the 6 constituent Boards and 1 acting as Chair of all 6 Audit Committees.

2.2 Arrangements should strengthen and not undermine local involvement of clinicians in understanding, leading and being accountable for commissioning decisions that serve the needs of local populations

For clinical commissioners to experience this empowerment:

- Clinical leaders will take key roles in the governance structures proposed
- Arrangements will be put in place to establish Local Clinical Commissioning Committees as formal Committees of each Board that have delegated responsibility for local commissioning budgets and existing arrangements for local delegation to clinical commissioners should continue. These Committees will also assume the responsibilities previously delegated to Professional Executive Committees that include developing local commissioning strategies and plans, ensuring maximum health gain for resources spent and delivery and performance against plans.
- Where cluster arrangements are in place to undertake specific commissioning functions other than those areas outside the scope of clinical commissioning, these functional areas will be managed as shared business service lines, accountable to the Local Clinical Commissioning Committees for their commissioning activities

2.3 Arrangements should retain local accountability

- A single Accountable Officer and Accountable Financial Officer in the central cluster team will manage within the resource limits set for each PCT/Care Trust and account to the Joint Boards separately against these resource limits
- To manage performance effectively there will be devolved delivery structures that support each PCT/Care Trust in meeting its statutory duties
- The cluster recognises that although financial accountability will be through a single Accountable Officer, the commissioning decisions and management actions necessary to influence performance will take place at a local level
- These arrangements will build capacity and understanding in local clinical commissioners in preparation for GP Consortia-led commissioning in PCTs where this is not already in place
- Each local Clinical Commissioning Committee will establish with the Joint Boards the areas that it will be commissioning for and will have formal agreement of the commissioning resource envelope for which it will be accountable. This will allow for continuation of existing levels of delegation to Clinical Commissioners where applicable
- This commissioning envelope will increase as the local commissioners move closer to fulfilling the requirements for full GP Consortia status
- This relationship will be formally agreed in each PCT/Care Trust Board's schemes of delegation with its Clinical Commissioning Committee

The statutory functions of the six current PCT/Care Trust Boards will be fulfilled by the six Boards operating jointly.

The majority of the Joint Boards' business will be transacted as one but should the need arise, for instance to agree an individual PCT/Care Trust's accounts, each Board would meet as an individual PCT/Care Trust Board. Likewise two or more of the individual Boards will be able to meet on an adhoc basis to consider issues that related to particular localities, communities or service providers, e.g. the Boards of Bexley Care Trust, Bromley and Greenwich PCTs might meet to discuss issues relating to South London Healthcare Trust.

2.4 Care Trust arrangements

The joint arrangements take into account individual variations in governance arrangements across south east London. The Establishment Order of Bexley Care Trust requires that at least one of the non-executive directors is nominated by the London Borough of Bexley with full voting rights.

2.5 Subsidiarity

The intentions of these governance arrangements are to ensure that PCTs and Care Trusts can continue to fulfil their statutory duties whilst enabling a smooth transition to the new system of GP led commissioning. During this transitional phase it is essential that local decision making should support ownership, understanding and engagement of local clinicians and that as much business as possible should be delegated to local Clinical Commissioning Committees.

Appendix 2 lists those functions that can be delegated by PCT/Care Trust Boards and work on schemes of delegation will enable local Clinical Commissioning Committees to indicate how much of these functions they wish to have delegated to them.

Appendix 3 lists those functions that cannot be delegated by the Trust Boards. It is anticipated that although local Clinical Commissioning Committees are unable to be delegated these tasks, they will undertake the significant majority of the planning, monitoring and assurance gathering that will enable Joint Boards to undertake these functions.

Appendix 5 sets out draft terms of reference for Committees of the Joint Boards and **Appendix 6** the terms of reference for local Clinical Commissioning Committees.

3. Proposed Joint Board arrangements

3.1 Board membership

Current regulations stipulate that the Board can have up to 7 Non executive members excluding the Chair and that non-executive membership including the Chair should be in the majority.

3.1.1 Membership of Joint Boards

In addition to the Chair and Audit Chair, 13 non-executive directors will be appointed to serve on the six PCT / Care Trust Boards. By appointing two pools of NEDS with one pool serving Lambeth Southwark and Lewisham and the second serving Bexley Bromley and Greenwich each Board NED membership will remain within the total permissible limit of 7, excluding the Chair. This arrangement enables each PCT / Care Trust to retain two non-executive directors and consequently increase continuity, local capacity and support to the Executive Team.

In order to comply with the terms of its Establishment Order one of the non-executive directors for Bexley Care Trust will be a nominee of Bexley Council.

Four executive members will be common to all six Boards. In addition each Chair of local Clinical Commissioning Committees, expected to be the GP Commissioning Lead, and the Managing Director of each Borough Business Support Unit, the Director of Public Health and the PEC Nurse nominee will make up the executive director complement.

Membership is shown in Diagram one.

Diagram One: Proposed Board membership (per Board set out at appendix nine)

	Bexley Care Trust	**Bromley PCT**	**Greenwich TPCT**	**Lambeth PCT**	**Lewisham PCT**	**Southwark PCT**
Non executive members						
8	NED CHAIR					
	NED AUDIT CHAIR					
	NED Vice Chair (Bromley) NED Vice Chair (Greenwich) NED Vice Chair (Bexley) NED (Nominated by London Borough of Bexley for Bexley Board only) * NED NED NED			NED Vice Chair (Lambeth) NED Vice Chair (Lewisham) NED Vice Chair (Southwark) NED NED NED		
Executive members						
7	Chief Executive (1 for 6)(accountable officer)					
	Director of Finance (1 for 6) (accountable finance officer)					
	Director of Development, Director of Operations (1 vote shared)					
	BSU MD	BSU MD	BSU MD*2	BSU MD	BSU MD	BSU MD
	DPH	DPH	DPH	DPH	DPH	DPH
	PEC Nurse	PEC Nurse	PEC Nurse	PEC Nurse	PEC Nurse	PEC Nurse
	Clinical lead*	Clinical lead*	Clinical lead*	Clinical lead*	Clinical lead*	Clinical lead*
[*NOTE – Clinical lead will be local PEC Chair]						
In attendance						
	Other directors as required					

*1 LB Bexley have determined this vote will be shared between 2 Cllrs (0.5 & 0.5 vote) in the event that one attendee does not attend the meeting the sole attendee will assume the full applicable vote

*2 Fulfils required Care Trust Exec Director with LA experience role (Bexley Care Trust Board only)

One NED from each PCT/Care Trust will serve as Vice Chair to the Board and will play a key role in the sub-committee structures of each PCT / Care Trust.

3.1.2 Director of Public Health/Director of Nursing

Current regulations include the Director of Public Health and PEC Nurse Nominee as an executive member of PCT and Care Trust Boards.

Discussion will take place with existing PCTs/Care Trust and DPHs/PEC Nurse Nominees as to how to achieve inclusion of public health and nursing advice and representation of the six PCTs /Care Trust through a single representative at the Joint Board meetings.

When the Board meets to transact the business of a single PCT /Care Trust the DPH role will be filled by the appointed DPH for that PCT. For joint business the cluster DPH will attend unless there is an item that is specific to the borough that requires the local DPH to attend.

Similarly, it is expected that the cluster Director of Nursing will attend board meetings to represent the views of the profession and views of the PEC Nurse nominees.

4. Board Committees

There will be the following Board Committees

- **Local Clinical Commissioning Committee (PEC)**
- **Joint Audit and Risk Committees**
- **Joint Remuneration and Employment Committees**
- **Joint Finance, Performance and QIPP Committees**
- **Joint Quality and Safety Committees**

4.1 Local Clinical Commissioning Committees (LCCC)

The Joint Board will establish a set of Committees, one per Borough, which will operate as a Clinical Commissioning Committee. It will fulfil the statutory duties currently delegated to Professional Executive Committees for developing and recommending commissioning intentions to meet the needs of local residents. Its clinical chair will be an Executive member of each of the Trust Boards. The Committee will be responsible for the day to day commissioning of the Trust and will operate within a scheme of delegation, accountable to the Joint Boards for an agreed commissioning budget. The Nurse representative on the PEC will have a professional link to the Director of Nursing at the Cluster who will attend the Joint Boards meeting.

Membership will be locally determined but the assumption is that it should be chaired by and include strong representation of clinical commissioners that will form GP consortia. The Committee will ensure that there are robust local arrangements for the

involvement of patients and the public and a wide range of clinicians in the work of the Committee. Executive membership will be drawn from the local business support unit.

The Joint Boards will, through the scheme of delegation, ensure that local Clinical Commissioning Committees have significant freedom to determine their membership and terms of reference and will be given responsibility for commissioning for local needs. The NED Vice-Chair, Clinical Commissioning lead and the Borough MD will form the local "three at the centre" that is the unique feature of PCT/Care Trust governance arrangements and who will all, jointly, be responsible for establishing and maintaining constructive relationships with key stakeholders in the local health economy including the local council, clinicians, elected politicians, and local patients and residents and participation and support of development of local Healthwatch arrangements.

Local Clinical Commissioning Committees will operate with at least the level of delegation currently operating within the individual PCTs/Care Trusts and this will be increased as and when the Committee seeks to take on more responsibility in accordance with the pathfinder trajectory.

More information on the business to be delegated to Local Clinical Commissioning Committees is attached with the notes from a Scheme of Delegation workshop at Appendix 5.

The Committee will be responsible for developing and recommending a commissioning plan that meets the health needs of local people to the Joint Boards.

The Local Clinical Commissioning Committees can establish such working groups as it deems necessary for the effective discharge of its duties but will retain its accountability to the PCT/Care Trust Board in the Joint Boards arrangement

It should be noted that the Local Clinical Commissioning Committees cannot 'double delegate' and that whilst they are free to establish groups as required it must be the LCCC that takes any decisions.

4.2 Joint Audit & Risk committees

The Audit & Risk Committees will operate as Joint Audit and Risk Committees of all six PCTs/Care Trust. The single Chair of all six will be appointed from the existing NED Chairs of Audit who wished to be considered.

The Audit and Risk Committees' membership will be one NEDs from each borough, but with a quorum of the chair and one NED from LSL and one from BBG. All Executive Directors will be required to attend the Joint Audit and Risk Committees as requested by the Audit and Risk Committee.

The Committees' work programme will be based upon those set out in the Audit Committee Handbook, overseeing the implementation of a rigorous risk management process. The Committees will also be responsible for seeking assurance that all service changes pass the 4 reconfiguration tests whether at single borough level or cross borough level.

A working group of Audit Committee chairs has developed views on the role of the Committee. Notes from this meeting are attached at **Appendix 6**.

4.3 Joint Remuneration and Employment Committees

A joint Remuneration and Employment Committee will serve all six PCTs/Care Trust.

The Chair and membership will be all of the non-executive directors appointed to serve on the Joint Boards (excluding the Audit Committee Chair) including at least one NED from each PCT / Care Trust Board for a quorum.

4.4 Joint Finance, Performance and QIPP committees

Financial and performance management and progress against delivery of the QIPP plan will be reviewed by a distinct Committee where the LCCCs and Director of Finance and Resources will present their progress against QIPP delivery and discuss financial and performance risks and controls. The Director of Performance will bring performance reports to the Committee and escalate performance issues through this route to the Joint Boards.

4.5 Joint Quality and Safety Committees

The Joint Boards will establish a Committee to oversee the clinical governance framework for the six PCTs/Care Trust. It will provide assurance to the Joint Boards that commissioned services are safe and of high quality and that there are adequate plans in place to respond to issues of poor quality. This Committee will be chaired by a NED who will receive Director support from the Medical Director. The Committee will draw on members nominated by Clinical Commissioning Committees who have clinical governance expertise as well as staff with key governance roles across the cluster and the Business Support Units.

5. Executive Meeting Arrangements

A Cluster Management Board (CMB) has been established by the Cluster Chief Executive Officer. It is not a committee of the board but consists of NHS South East London's Single Management Team. Members are each cluster director and the Managing Director from each Borough Business Support Unit. The Board provides a decision making and assurance forum to progress delivery of cluster objectives, including performance, finance, quality and safety and QIPP initiatives. CMB will support the development of local GP consortia in addition to supporting the work of the Joint Boards and its management of risks both to delivery and during the transition.

The Cluster Management Board will be guided by a Clinical Strategy Group (which has a Stakeholder Reference group advising it). There will also be an Operations group that will manage the delivery of the integrated plan (including contract monitoring and quality) and a Development group that will manage change to the new commissioning system.

Dispute resolution
The PCT Boards of South East London and Bexley Care Trust (SEL) adopted 'Transitional Governance Arrangements' which sets out the principles and approach by which the NHS SEL will operate. Being the SEL Single Management Team, CMB, Chaired by the CEO, will lead on matters of dispute resolution through the Chief Executive with this post having the authority to both impose and broker a solution.

5.1 Executive meetings – strategy and engagement

Two groups will provide advice on strategy and engagement and will provide the mechanism for developing and reviewing service change proposals against the four reconfiguration 'Lansley' tests (GP Support, Strengthened Engagement, Clinical Evidence and Patient Choice).

5.1.1 Clinical Strategy Group

The Clinical Strategy Group would come together to determine, design and recommend service changes across more than one borough. Examples of this will be changes to cancer or vascular services or changes to King's Health Partners.

The forum will take advice from the Stakeholder Reference Group, before reporting to the audit and risk committee, with relation to matters of substantial change, for assurance purposes. The Group's membership will be drawn from leading clinicians based upon advice from LCCCs and relevant cluster directors.

5.1.2 Stakeholder Reference Group

The Stakeholder Reference Group will evolve from the existing BBG Stakeholder Reference Group that has been successful in improving stakeholder engagement following A Picture of Health (APOH) and reviewing the programme against the two reconfiguration tests on patient engagement and Choice.

The group will be independently chaired and report to the Clinical Forum and to the Board through the Chair. Its aim will be to bring together key stakeholders including LINKs, Voluntary Sector representatives, Health Scrutiny Chairs, equality group representatives and the NHS (including a GP representative and the Chair of NHS South East London) to review plans for engagement and to provide an informal setting for stakeholders to understand the changes to the commissioning system and to review communications and engagement plans for delivering the QIPP programme.

Appendix 1 Functions of the Board

The Department of Health model form Standing Orders and Schemes of Delegation retains a number of functions to the Board. Whilst this is a model rather than a required form, the Board would need to be able to explain why it chose to depart from the standard model.

The model form Standing Orders and Schemes of Delegation state that the Board has six key functions for which they are held accountable by the Department of Health on behalf of the Secretary of State

1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy,

2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation,

3. to appoint, appraise and remunerate senior executives,

4. on the recommendation of the Executive Committee (PEC) to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them,

5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary,

6. to ensure that the Executive Committee leads an effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

It notes that it is the Board's duty to:

1. act within statutory financial and other constraints;

2. for PCTs (and PCTs designated as Care Trusts), establish the Executive Committee;

3. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board or PCT Executive Committee and Standing Financial Instructions to reflect these;

4. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of

action and for performance against programmes to be monitored and senior executives held to account;

5. establish performance and quality measures that maintain the effective use of resources and provide value for money;

6. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;

7. establish Audit and Remuneration Committees based on formally agreed terms of reference which set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board."

Appendix 2 Issues which could be delegated to local borough-based subcommittees (Clinical Commissioning Committees)

- delivery of the Borough aspects of the QIPP and integrated delivery plan;
- delivery of the PCTs financial obligations at a borough level;
- ensuring best use of resources and QIPP delivery at a borough level;
- development of and support to GP commissioning development at a borough level;
- to facilitate a process of self-assessment of GP commissioner performance to enable PCT boards to hold them to account for any delegated responsibilities;
- inform the development of the CSP and Integrated Delivery Plan with partners, based on an agreed JSNA;
- making optimal linkages to health and well being boards and GP commissioning operating arrangements;
- development of joint commissioning at a borough level;
- oversight and performance management of operating framework deliverables at a borough level;
- delivering service and quality improvement at a local level;
- ensuring borough based statutory deliverables e.g. safeguarding are achieved;
- assurance mechanisms for ensuring Quality of Primary Care.

Appendix 3 Issues which only the Joint Boards can deal with

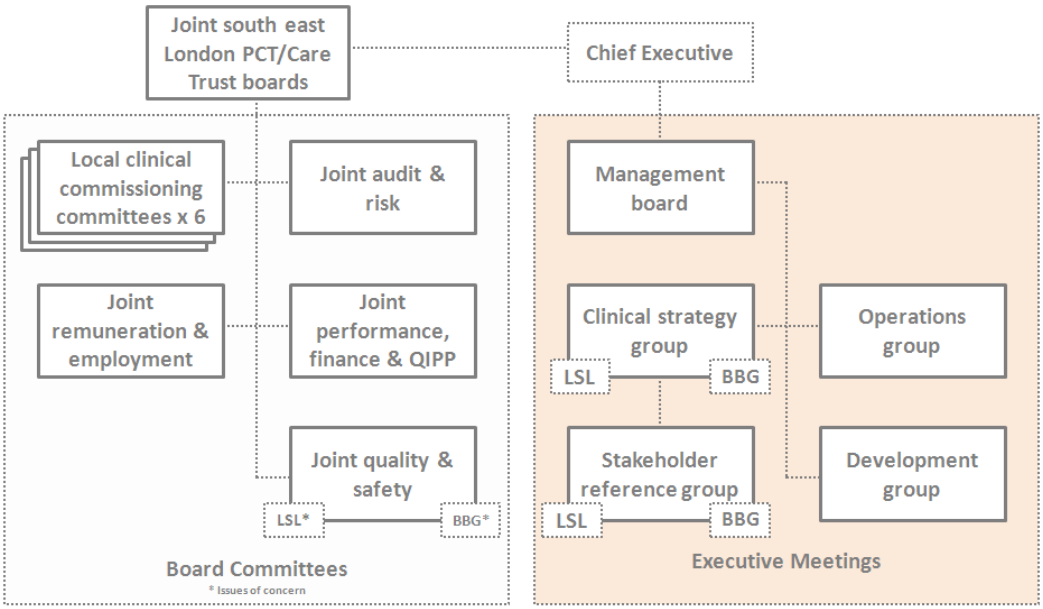
- overseeing the delivery of the single SE London QIPP and Operating Plan;
- decision-making on change programmes that have an impact across the cluster (e.g. potential reconfiguration or SE London wide models of care);
- achieving financial balance across SEL;
- oversight of planning for 2011-14;
- oversight and management of strategic risks;
- whole system performance management;
- market management / FT pipeline;
- tracking the delivery of SEL wide QIPP and change programmes;
- leadership to the organisational development and change implementation in preparation for the new commissioning system;
- adherence and delivery of the statutory PCT responsibilities;
- decisions on further delegation.

Capsticks have also provided a list of twenty four non-delegable statutory functions including responsibilities under various Acts (e.g. Mental Health Act 1983, Local Government and Public Involvement in Health Act 2007, Health and Social Care Act 2008). These are available on request.

Appendix 4

NHS South East London Joint Boards, Committees and Executive meetings

NHS South East London



A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham , Southwark and Bexley Care Trust
www.selondon.nhs.uk

ENCLOSURE 1

DRAFT TERMS OF REFERENCE
NHS SOUTH EAST LONDON JOINT AUDIT COMMITTEES

1. Introduction

The Committee is constituted as a Standing Committee of the Trust Board. This Constitution and Terms of Reference is as agreed by the Audit Committee and Trust Board.

2. Duties

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management that supports the achievement of the NHS South East London Cluster's objectives. Inter alia, the Committee will:

1. consider the effectiveness of the Cluster's arrangements for identifying and managing risk and the work undertaken as part of management's assurance framework;
2. consider the work and reports from all relevant sub-committees and individuals, as appropriate;
3. seek reports and assurances from Cluster and Business Support Unit (BSU) staff on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness;
4. consider all risk and control related disclosure statements (in particular, the Statement on Internal Control and declarations of compliance against Care Quality Commission standards), together with any accompanying Heads of Internal Audit Annual Reports, prior to their endorsement by the Joint Boards;
5. consider fraud and corruption policies and procedures, and their compliance, as set out in Secretary of State's Directions and as required by the Counter Fraud and Security Management Directorate of the Business Services Authority; and
6. review periodically the Cluster's financial performance and the impact of any key financial developments in order to understand how each PCT manages financial risks and any key changes in the financial environment within which they work.

In carrying out this work, the Committee will primarily utilise the work of those responsible within each BSU and the Cluster, their risk and governance committees, Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. The Committee will consider the effectiveness of Management's Assurance Framework and will use this to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provided appropriate independent assurance, to the Committee, Chief Executive and Joint Boards. This will be achieved by:

1. appointing the internal audit service, reviewing their fees and any questions of resignation and dismissal;
2. approving the internal audit strategy and work programme, considering major findings arising from internal audit investigations (and management's response), monitoring management's progress in implementing agreed internal audit recommendations, and to ensure co-ordination between Internal and external Auditors;
3. ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
4. undertaking an annual review of the effectiveness of internal audit.

External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

1. considering the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit;
2. discussing with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy; and
3. reviewing External Audit reports, including value for money reports and annual audit letters, together with management's response.

Financial Reporting

The Committee shall ensure that the Annual Report and Accounts comply with Department of Health guidance and advise the Board and Accountable Officer in signing off the Accounts, including the Statement on Internal Control.

The Committee shall review the Annual Report and Accounts of each PCT, prior to submission to the Joint Boards and Accountable Officer, focussing particularly on:

- the consistency of accounting policies both on a year to year basis and across the organisation and any proposed changes;
- any proposed changes, and compliance with, policies and practices;
- decisions requiring a major element of judgement, including estimates and adjustments;
- the extent to which the financial statements are affected by any unusual transactions;
- the clarity and completeness of disclosures and qualitative aspects of financial reporting;
- significant adjustments resulting from the audit, any unadjusted misstatements, and proposed Letter of Management Representation;
- the assumption that the organisation is a going concern;

- compliance with accounting standards;
- compliance with other legal requirements;
- any losses and special payments;
- the policies and procedures for identifying and assessing risks and the management of those risks by the organisation on a regular basis; and
- Any write off of debt over £10,000 will be presented for review and approval by the committee

3. Accountability

The Committee is responsible and accountable directly to the Board.

4. Committee Membership and Quorum Rules

The Committee shall be appointed by the Board from the Non-Executive Directors of the Cluster and shall consist of not less than three members.

The Chairman of the Joint Boards shall not be appointed to the Committee. The Appointments Commission will appoint the Chairman of the Audit Committee.

5. Required frequency of attendance

All members of the Committee are required to attend all meetings.

The Directors of Finance and Governance, the Internal and External Auditors and other members of the Executive Team will normally attend meetings.

6. Reporting Arrangements.

The minutes of the Audit Committee shall be formally recorded and submitted to the Joint Boards. In addition, a single side update will be circulated by the Chair following every meeting The Chair of the Committee shall draw to the attention of the Joint Boards any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the reporting framework set down by the CQC.

7. Frequency of Meetings

Meetings shall be held at least 4 times per year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. The Committee may wish to meet on an annual basis with External and Internal Audit without any Joint Board's Executive Directors present.

8. Other Matters

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any

employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Joint Boards to obtain legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, it considers this necessary.

The Committee shall be supported administratively by the Joint Boards' Secretariat, whose duties will include:

a. Timely collation of papers for distribution ahead of Committee meetings;
b. Taking the minutes
c. Keeping a record of action points and their implementation; and
d. Supporting the Committee and its members.

9. Review

These terms of reference will be reviewed annually.

DRAFT TERMS OF REFERENCE
SOUTH EAST LONDON
JOINT PERFORMANCE, FINANCE AND QIPP COMMITTEES

1. Introduction

The SEL Performance, Finance and QIPP Committee is a Standing Joint Committee of the five SEL PCTs and Bexley Care Trust (Joint Boards) to provide oversight of performance, financial management and QIPP delivery for the area. This Committee will be chaired by a Non Executive Director and will draw on members nominated by the Board as well as staff with key performance, finance and governance roles across the cluster and the Business Support Units.

2. Duties

a. To consider and assess alignment of delivery with the sector strategy and operating plan and the aggregate position in respect of performance, finance and QIPP delivery making recommendations for improvement and delivery as appropriate

b. To establish and oversee the development of comprehensive performance and financial management frameworks for the South East London cluster which explicitly reflect the agreed deliverables of the integrated plan and which can, where appropriate, be disaggregated to offer a PCT borough specific position.

c. To receive formal assurances against the agreed performance management and financial frameworks

d. To oversee and provide challenge to the pace and delivery of QIPP initiatives in the South East London cluster

e. To advise the Joint Boards on the management of financial risk

f. To support a culture of learning and continuous improvement in healthcare services in South East London

g. The provide a forum whereby any strategic cluster issues relating to the Choice, Competition and Co-operation agenda may be discussed and determined

h. To establish working groups as may be necessary to fulfil the duties of this committee.

3. Roles and Responsibilities

i. Performance

i. To monitor the progress of the Cluster against the performance deliverables set out in the integrated operating plan, to agree an approach to exception based reporting and to provide oversight to a process of scrutiny for any consistently low performing areas

ii. Oversee the development of regular performance reports for presentation to the Joint Boards

iii. To receive assurance that the governance arrangements of the cluster are supporting appropriate information flows and decision making to support the delivery of commissioning performance objectives.

iv. Be assured of appropriate performance management arrangements relating to commissioned services in respect of contract or commissioning outcomes and the development of any relevant recovery plans.

v. Receive assurance of appropriate action and participation in respect of any relevant corporate assessments.

vi. To ensure that any significant performance risks are brought the attention of the Audit and Risk Committee

j. Finance

i. To assure the Joint Boards that there are robust procedures in place for:

- the effective management of finances across all elements of the cluster
- the effective monitoring of activity and financial performance against contracts held by the cluster
- the development and delivery of financial recovery plans when performance is off track

ii. Oversee the development of regular financial performance reports for presentation to the Joint Boards

iii. To provide oversight and ensure rigorous processes are in place to support the development and administration of an annual budget cycle

iv. Oversee the development of any capital schemes and the implementation of an appropriate asset management strategy

v. To ensure that any issues relating to financial probity or emergent financial risks are brought the attention of the Audit and Risk Committee

k. QIPP

i. To receive regular performance and delivery progress reports on each of the agreed SEL QIPP initiatives

ii. To receive regular update reports and provide oversight of the extent to which projected benefits are being achieved and the application of any proposed action or recovery plans.

iii. To keep under regular review the extent to which key enabling initiatives and cluster or other support capability, initiatives or resources are supporting the achievement of key QIPP deliverables.

iv. To oversee the process of review of QIPP for future years.

4. Accountability

The Committee will be accountable to the Joint Boards through the distribution of its minutes and work plan in addition to the production of a report detailing its activities at least annually

The Committee will receive reports from any working groups

5. Committee Membership

6 Non executive directors (3 LSL, 3 BBG), one appointed as Chair, one as Vice Chair
Chair of Joint Boards
Cluster Director of Operations
Cluster Director of Strategy and QIPP
Cluster Director of Finance, Procurement, IT and Estates

In attendance (as required):
Business Support Unit MDs
Other Cluster Directors
Other members of the Cluster Governance Team

This committee will report to the Joint Boards and may also make recommendations to Joint Audit and Risk Committee

6. Required frequency of attendance (by members)

All members of the committee are required to attend all meetings.

7. Reporting Arrangements.

The Committee will share its minutes with the Board and report at least annually on the activities it has undertaken. A single sheet update will be circulated to board members following every meeting.

Monthly Performance and finance Reports will be made available to the Board.

8. Quorum rules

The quorum of the Committee will be five members which must include a NED representative from each PCT / Care Trust pool (LSL / BBG).

A minimum of three NEDs and Two Directors will be in attendance

9. Frequency of Meetings

The Committee will meet a minimum of quarterly.

10. Monitoring adherence to the Terms of Reference

As part of the annual reporting process to the Joint Boards

11. Review

Terms of Reference will be reviewed annually

Key Performance Indicators:
Key performance indicators are in the process of development. It is envisaged that draft Performance Measures and QIPP Metrics will be shared with the Committee no later than its July meeting

DRAFT TERMS OF REFERENCE
SOUTH EAST LONDON
JOINT QUALITY AND SAFETY COMMITTEES

1. Introduction

The Quality and Safety Committee is constituted as a Standing Joint Committee of the five SEL PCTs and Bexley Care Trust (Joint Boards) to oversee the clinical governance framework. This Committee will be chaired by a Non Executive Director and will draw on members nominated by local committees who have clinical governance expertise as well as staff with key governance roles across the cluster and the Business Support Units.

2. Duties

a. To provide assurance to the Joint Boards that commissioned services are safe and high quality and that there are adequate plans in place to respond to issues of poor quality

b. To establish and oversee the clinical governance framework for the South East London cluster to include patient safety, clinical effectiveness and patient experience

c. To advise the Joint Boards on the management of clinical risk

d. To oversee the procedures for identifying, investigating and learning for serious incidents and for safeguarding children and vulnerable adults

e. To support a culture of learning and continuous improvement in healthcare services in South East London

f. To establish sub committees and working groups that are necessary to fulfil the duties of this committee which will include the establishment of two subcommittees reviewing Issues of Concern from Primary Care Contracting

3. Roles and Responsibilities

a. Governance

i. Agree an annual workplan and identify areas for focused thematic review

ii. Present an annual quality report to the Joint Boards

iii. Agree the performance management and monitoring mechanisms for the SLA Quality Schedules developed by South East London contracting teams for commissioned services

iv. Maintain an oversight of the management of clinical risk in south east London and appraise the Audit and Risk Committee of any significant issues

v. Receive regular updates from all service providers on progress towards meeting CQC registration requirements, continuing compliance and the outcomes of special reviews.

vi. To oversee arrangements for the maintenance of independent contractor Performers List and the appropriate and ongoing professional registration of staff in PCT / Care Trust roles where this is a requirement for the post.

vii. To ensure that the PCT / Care Trust fulfils national requirements in respect of the use, transfer and storage of patient identifiable information (Caldicott) and to receive an annual report from Caldicott Guardians

viii. To monitor and review the PCT / Care Trust research governance arrangements.

ix. To assure the Joint Boards that NHS South East London is compliant with duties arising from the Equality Act 2011 through the development of the Equality Delivery System and promotion of equality in the delivery of health services.

b. Emergency Planning and Resilience

i. To assure the Joint Boards that NHS South East London has robust systems and plans in place to respond to emergencies and to maintain the resilience of the organisations in keeping with the PCTs/Care Trust responsibilities as Category 1 responders under the Civil Contingencies Act.

ii. To receive reports on a regular basis from the Emergency Planning and Resilience Steering Group on progress against its work plan to achieve resilience of the organisations in the face of major emergencies, disruptions and significant unplanned events that might impact on service delivery

c. Patient Safety

i. To assure the Joint Boards that there are robust procedures in place:

- for the effective management of clinical incidents within commissioned services and which allow PCT / Care Trust level reporting on incident management

- that promote understanding, learning from serious incidents, mistakes and "near misses" through the use of learning, development and dissemination tools that result in improved patient safety

- for managing infection control within all commissioned services

- for safeguarding children, young people and vulnerable adults within all commissioned services and to promote shared learning and good practice across South East London

- for the safe and effective prescribing and management of medicines

- for the distribution of safety notices and alerts (Central Alerting System) and promotion of compliance

d. Clinical Effectiveness

i. To agree programmes of CQUINS for all major contracts.

ii. To ratify contract managers recommendations in respect of payments for CQUIN achievement.

iii. To receive the annual audit reports of the major providers

iv. To ratify South East London policies relating to Patient Safety, Clinical Effectiveness and Patient experience.

e. Patient Experience

i. To assure the Joint Boards that it is compliant with its Duty to Consult (Section 242/244/245 of the NHS Act 2006)

ii. To monitor and promote compliance with the NHS Constitution

iii. To ensure that mechanisms are in place to seek feedback on patient experience of health services and that promote their involvement in the planning and delivery of health services

iv. To ensure that patient feedback received, including patient surveys, influences the design and review of services

v. To ensure that patient reported outcomes are used to monitor the quality of care

vi. To ensure that feedback gained from patient experience monitoring mechanisms including complaints is used in the commissioning monitoring and review of health care services

4. Accountability

The committee will be accountable to the Joint Boards and will report twice yearly as a minimum. It will set out its plan of work in an annual plan and will produce an annual report.

The committee will receive reports from its subcommittees and from the Local Clinical Commissioning Committees (LCCC) on issues related to local quality and safety.

5. Committee Membership

6 Non executive directors (3 LSL, 3 BBG) one to be appointed as Chair and one as Vice Chair
Chair of Joint Boards
Cluster Medical Director (s)
Cluster Nurse Director
Cluster Director of Public Health
LCCC nominated Clinical Governance lead clinician (x6)
Pharmacy representation tbc
Cluster Deputy Director of Integrated Governance
Cluster AD Communications and Engagement/Head of Engagement

In attendance (as required):
Business Support Unit Governance Manager (x6)
Specialist quality and safety staff eg. Designated doctors and nurses
Other members of the Cluster Governance Team

This committee will report to the Joint Boards and will also make recommendations to local Clinical Commissioning committees to support commissioning for quality.

6. Required frequency of attendance (by members)

All members of the committee are required to attend all meetings.

7. Reporting Arrangements.

A single sheet report will be produced by the Chair following every meeting
Annual Quality and Safety Report to the Joint Boards
Six monthly reports to the Joint Boards

8. Quorum rules

The quorum of the committee will be seven members; one from each PCT / Care Trust and at a minimum two NEDs, 2 Clinicians and one Executive Director.

9. Frequency of Meetings

The committee will meet a minimum of quarterly. Updates against Key Performance Indicators will be included in the monthly performance report circulated to board members.

10. Monitoring adherence to the Terms of Reference

As part of the annual reporting process to the Joint Boards

11. Review

Terms of Reference will be reviewed annually

Key Performance Indicators:

Performance Report against Quality indicators

A selection could include:

Safety:

- SUIs reported in accordance with NHS London guidance – fully investigated and completed within 45-60 working days
- Incidence of MRSA bacteraemia
- Incidence of clostridium difficile
- Rate of patient safety events occurring in trusts that were submitted to the Reporting and Learning System (RLS)

Effectiveness:

- Emergency readmissions to hospital within 28 days of discharge (data relates to 16+ years old only)
- Compliance with NPSA clean your hands campaign Self assessment compliance with infection control standards
- Achievement of the indicators set out in CQUIN

Patient Experience:

- A selection of indicators from the national patient survey

Documentation / Reporting Requirements:

- SLA Quality Schedules – Including CQUIN agreed programme
- SUI policy in place and compliance with NHSL reporting standard regularly audited and reported
- Care Quality Commission Registration – confirmation from providers
- External assurance reviews from providers
- Clinical Audit Programme from providers
- Serious Incidents (SIs) – thematic review – across and by providers
- Infection Control Report
- Complaints – thematic review by provider / independent contractors
- Patient experience surveys by provider
- Patient Experience Tracker report
- Equalities Delivery System Implementation Report
- Implementation of NICE guidance?
- CQUIN Programme – Plan
- CQUIN Programme – Performance Report once agreed
- Clinical Risk Log
- Performers List Report
- Annual report from Caldicott Guardians
- Safeguarding children, young people and vulnerable adults – Assurance of arrangements in place
- Prescribing and management of medicines – potential sub committee report?

- CAS Compliance Report
- Clinical Policies
- Patient Experience as part of commissioning process
- Patient Experience – Publication of duty to consult report

http://www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/20110310ProducingQualityReports.pdf

DRAFT TERMS OF REFERENCE
SOUTH EAST LONDON JOINT REMUNERATION & EMPLOYMENT COMMITTEES

1. Introduction

The Committee is constituted as a Standing Joint Committee of the five SEL PCTs and Bexley Care Trust. These Terms of Reference are agreed by the Remuneration Committee and the Boards.

The Committee is constituted in accordance with the 'Codes of Conduct and Accountability' for NHS Boards' issued by the Secretary of State in April 1994, which require Boards to establish remuneration committees, and the accompanying guidance (EL(94)40) which outlined a role and remit for such committees.

2. Duties

1. To assist the Joint Boards in meeting their responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive, Directors and senior staff, having proper regard to the organisation's circumstances and performance and to the provisions of any national arrangements where appropriate.

2. To oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

3. To consider and approve redundancy payments as required and appropriate in accordance with DoH guidance, value for money principles and audit opinion.

4. To advise the Joint Boards on all general aspects of the remuneration and terms and conditions of senior staff in the Cluster where not covered by Agenda for Change. This will include:
   - All aspects of salary
   - Performance related elements including bonuses
   - Other benefits, including pensions and cars

5. To decide on any changes on rates for remuneration and locum payments to Local Clinical Commissioning Committee (LCCC) members and other clinical leads in their corporate role.

6. To ensure in carrying out items 1-6 that directors, managers and LCCC members of sufficient calibre can be recruited, retained and motivated and that they are fairly rewarded for their contribution to the organisation,

having proper regard to criteria including affordability, value for money, standards of probity and the provisions of national arrangements where appropriate.

7. For consideration of issues relating to consultation proposals, the Committee is responsible for all Cluster staff.

3. Accountability

The Committee is responsible and accountable directly to the Joint Boards.

4. Committee Membership

The membership shall consist of all of the Non-Executive Directors of the Cluster Boards and the Chairman of the Cluster Joint Boards. The Chair of the Joint Boards will act as the Chair of the Remuneration Committee.

Other Persons in Attendance

The Chief Executive will be invited to attend each meeting in an advisory, non-voting capacity. Decisions on the remuneration of these individuals will only be taken in their absence. Other Directors or senior staff may be invited to attend to provide advice or information on particular matters.

The Director of Human Resources will be present to provide advice and information on all aspects of the committee's remit, including the terms of service of the Chief Executive and Director of Finance. No one will be present whilst decisions are made regarding their own terms of service.

5. Reporting Arrangements.

Decisions on the remuneration and terms of service of the Chief Executive, Directors and LCCC members will be made by the committee. A written anonymised annual report will be provided to the Boards.

At meetings of the Joint Boards where specific remuneration and terms of service related issues are to be agreed there will be two parts to the meeting. Attendance at the part of the meeting dealing with remuneration will be restricted to the Chairman of the Joint Boards and the Non-executive Directors. The Joint Boards would use that report as the basis for their decisions but would remain accountable for taking decisions on the remuneration, allowances and terms of service of officer members.

6. Administration and Support

The Head of Corporate Office / Board Secretary will provide administrative services to the Committee and ensure the necessary advice and information is available to

the Committee, including independent external advice where required by the Committee.

7. Minutes of the Committee

Once agreed by the Committee Chair the recommendations of the Committee will be reported to the Trust Board in an anonymised Annual Report.

8. Quorum rules

Three members of the Committee, including the Chair, shall be a quorum. From this membership there must be one NED from LSL and one NED from BBG in attendance.

9. Frequency of Meetings

The Committee will meet sufficiently frequently to fulfil its work plan.

10. Monitoring adherence to the Terms of Reference

The Committee is authorised by the Joint Boards to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Joint Boards to obtain legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

11. Review

These terms of reference will be reviewed annually.

TERMS OF REFERENCE
Bexley Clinical Commissioning Cabinet

1. Constitution and Purpose

The Care Trust Board resolves to establish a Committee of the Board to be known as the Bexley Clinical Commissioning Cabinet (BCCC). The BCCC is an executive committee of the Joint Board for Bexley Care Trust and has executive powers as set out in the Care Trust's Scheme of Delegation.

Its purpose is to further develop Clinical Commissioning while continuing to provide assurance to the Joint Board for Bexley Care Trust on the discharge of its responsibilities within the Borough of Bexley. To provide some context, the Care Trust Board established a Bexley Clinical Cabinet in April 2010 as a sub-committee. Since then, the Bexley Clinical Cabinet has acted as the shadow Bexley GP Consortium with the intention that it becomes the successor organisation to the Bexley Care Trust. It has had delegated responsibility for most day to day operational Bexley Care Trust commissioning services within Bexley. The existing terms of reference of the Bexley Clinical Cabinet have been updated to a) act as a local Clinical Commissioning Committee within the South East London Cluster arrangements and b) fulfil the statutory requirements of the Professional Executive Committee.

2. Roles and Responsibilities

Under the new cluster arrangements, ratification from the Joint Boards is sought to build on its achievements thus far for Clinical Cabinet to become the Bexley Clinical Commissioning Cabinet through a delegation of responsibilities framework to be accountable for:

- agreed delegated responsibilities outlined in section 3 (subject to an increasing trajectory of delegated responsibilities during the transition period to be reviewed every 3 months).
- the delivery of the priorities outlined in the Bexley Pathfinder Prospectus and the borough aspects of the QIPP plan.
- informing the development of the Commissioning Strategy and Integrated Delivery Plan with partners, based on an agreed JSNA.
- making optimal linkages to the Bexley Health and Well Being Board and GP commissioning operating arrangements.
- the development of joint commissioning at a borough level.

- fulfilling the role of the Bexley Care Trust Professional Executive Committee.
- leading communications with partners, stakeholders and the development of a public and patient engagement strategy.
- ensuring that the 'rights and pledges' as set out in the NHS Constitution are delivered.
- the delivery of local financial obligations at a borough level.
- the oversight and performance management of operating framework deliverables within delegated areas at a borough and locality level.
- the development of a performance framework at a borough and locality level to support GP practices.
- the overview of local claims management process by cluster.
- assurance of and the delivering of service and quality improvement at a local level.
- monitoring and assurance with regards to clinical governance, patient safety, clinical effectiveness, quality and patient experience within the borough.
- the oversight of the Bexley BSU and the functions devolved from the Joint Board of Bexley Care Trust.
- preparing Bexley GPs to fully participate in acute commissioning round for 2012/13.

3. Delegations

This section will be regularly reviewed and updated and will specify any delegations as set following adoption of GP consortia / pathfinder delegation authorisation agreement.

The initial delegated responsibility for commissioning and their budgets include;

Immediate effect

- BSU Corporate
- Public Health and health Improvement
- Learning Disabilities
- Community budgets including hospice care and screening
- Continuing care and nursing homes
- Community provider services
- GP prescribing
- Partnership Accounts
- Service Redesign including Kitemark & PbC budgets

Staged delegation

- Acute Commissioning - Full input into contracting round for 2012/13 with a view to picking up full responsibility on April 2012

4. Committee Membership

The membership of the BCCC is drawn up in accordance with the Health Bill's proposals and guidance.

The BCCC shall have no more than 11 voting members.

The members shall comprise:

- 5 elected practising General Medical Practitioners. Namely the GP Chair, one Lead GP appointed from each of the three Bexley localities and a GP elected by the salaried GPs.

- 3 executive members appointed by virtue of their roles within the Business Support Unit (BSU).
  - Joint Managing Director (Medical Director).
  - Joint Managing Director (Director of Operations and Total Health)
  - Chief Financial Officer
- PEC Nurse
- Bexley Vice Chair NED
- A Bexley NED

In addition:

- The Clinical Quality Lead will be co-opted as part of the role.
- The London Borough of Bexley nominated NEDs, will be co-opted, as may other NEDs, in order to provide additional experience and expertise.
- The Chair of the Bexley Patient Council will be invited to the formal monthly meetings as an observer.
- A Bexley LA representative to be invited to the formal monthly meetings as an observer.

The BCCC has the scope to co-opt additional members as necessary to enable it to fulfil its responsibilities.

GP Member Appointment Procedures
The scheme for appointment of GP Members is set out in Annex 1.

The scheme in force will from time to time be reviewed and approved by the Joint Board of Bexley Care Trust.

Roles
The BCCC will take responsibility on behalf of the Joint Board for Bexley Care Trust Board for the transition to the Clinical Commissioning Consortium and Health and Wellbeing arrangements. BCCC members will be expected to take

on lead roles and GP Members will be expected to report to and from their locality.

All members of the BCCC have full responsibility for delivering all the responsibilities and duties thereof. In addition, members have a responsibility to oversee specific aspects of the BCCC activity.

a) General Practitioners

The nominated GPs are accountable and have a responsibility to ensure that resource allocations (commissioning & management) placed within the management of the BCCC are used to maximum benefit for Bexley residents. One of the GP leads will be responsible for ensuing strong links with the Patient Council.

b) Joint Managing Directors

The Joint Managing Directors of Bexley BSU have overall responsibility for ensuring that the BCCC effectively discharges the functions delegated to it by the Joint Board for Bexley Care Trust.

c) Chief Financial Officer

The Chief Financial Officer is responsible for the provision of financial advice to the BCCC and its members, and for the supervision of financial control and accounting systems. He/she shall be responsible along with Joint Managing Directors for ensuring the discharge of obligations under relevant financial directions.

d) Bexley Non-Executive Director Vice Chair

SEL Governance arrangement identifies one NED to act as the Bexley Vice-Chair to the Board and to play a key role in the sub-committee structures of the Care Trust. The Bexley NED Vice Chair, BCCC Chair and Joint Managing Directors form the local "three at the centre" that is the unique feature of a PCO's governance arrangements.

e) PEC Nurse

A Senior Nurse appointed from within the BSU and will link to the Cluster Director of Nursing.

f) Clinical Quality lead

The Clinical Quality lead is co-opted as ex-officio Chair of the Clinical Quality Assurance Group.

g) Patient Council Chair

The Chair of the Patient Council will be invited to attend formal meetings of the BCCC initially in an non-voting capacity. This will put the voice of patients and the local community at the heart of the BCCC's decision making process.

The Chair of the Patient Council will fulfil an internal assurance role, which will act as a check that we are delivering on our obligation to involve patients in service design and are planning our communications effectively and in line with Section 242, NHS Act 2006.

5. Reporting Arrangements and supporting structures

Management Support
Whilst Bexley Care Trust remains established, the BCCC has complete access to the key BSU and Cluster specialist management functions in order to fulfil its responsibilities. (eg Commissioning, Finance, Corporate, Human Resources).

Appointment of sub-committees
The BCCC will establish such subcommittees and working groups as necessary for the effective discharge of its duties. However, it will be the BCCC that will take any decisions. To include:

1) Bexley Business Committee.
2) Operational Management Committee (includes QIPP)
3) Clinical Quality Assurance Group
4) Medicines Management Committee
5) GP Consortium Development Committee
6) Bexley Patient Council

Patient Council

The BCCC will establish a Patient Council, as one of its sub groups. The Patient Council will be made up of representatives from various patient and community bodies and act as the voice of patients and local people. The Patient Council will put the voice of patients and the local community at the heart of the GP shadow consortium's decision making processes. The Chair will have a seat at formal BCCC meetings and other members will be invited to provide the patient voice across the BCCC sub-committees.

The Patient Council will ensure that there is effective communication with a broad range of residents and patient representatives in order to inform GP commissioners' decisions in relation to tests around engagement and patient choice. And moreover to consider proposals that will impact significantly 'on service delivery of the range of health services available' and ensure that patient experience is fully taken into account.

The ongoing transition process across the NHS and the impact of major initiatives such as QIPP (Quality, Innovation, Productivity and Prevention) means that the Patient Council will be able to offer an independent review function. This function does not in any way undermine Bexley Council's duty to scrutinise NHS plans and proposals and is meant entirely to support local

engagement mechanisms. The Patient Council will not engage directly with patients and the public itself but can assess the extent to which such activity has occurred or is likely to occur and provide constructive advice as to how engagement can be further strengthened.

Reporting Procedures

The minutes of meetings of the Committee shall be formally recorded and submitted to the Joint Board of Bexley Care Trust.

The Committee will also provide an annual report to the Joint Board of Bexley Care Trust summarising its activities and the assurances it has provided.

6. Quorum rules

(1) No business shall be transacted at a formal meeting of BCCC unless at least one-third of the whole number of the Chairman and members (including at least one NED, one of the Officer Members and two GP members) are present.

(2) An officer in attendance for an Officer Member but without formal acting up status may not count towards the quorum.

Conflict of Interests

The NHS Code of Accountability requires members to declare interests which are relevant and material to the Board of which they are a member. All existing members should declare such interests. Any members appointed subsequently should do so on appointment.

Interests which are relevant and material are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Research funding/grants that may be received by an individual or their department;

g) Interests in pooled funds that are under separate management.

In addition Any member of the BCCC who comes to know that the Care Trust has entered into or proposes to enter into a contract in which he or any person connected with him (as defined in Standing Order 7.3) has any pecuniary interest, direct or indirect, the member shall declare his/her interest by giving notice in writing of such fact to the Care Trust as soon as practicable.

If Clinical Commissioning Cabinet members have any doubt about the relevance of an interest, this should be discussed with the Vice Chair of the Care Trust or the Chair of the BCCC.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7. Frequency of Meetings

a) Calling meetings

(1) The BCCC will meet formally on a monthly basis with the meeting held in public on an alternate basis.

(2) Ordinary business meetings of the BCCC will be held at regular intervals at such times and places as the BCCC may determine. Any decisions taken at such meetings will need to be ratified at the formal monthly meeting.

(3) The Chairman may call a formal or informal meeting of the BCCC at any time.

b) Notice of Meetings and the Business to be transacted

(1) Before each formal meeting of the BCCC a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear working days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) No business shall be transacted at the formal meeting other than that specified on the agenda, or emergency motions allowed by the chairman.

(3) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman.

c) Agenda and Supporting Papers

The BCCC agenda will be sent to members 6 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.

d) Chairman of meeting

(1) At any meeting of the BCCC the Chairman shall preside.
(2) If the Chairman is absent, the members present shall choose who will preside.

8. Monitoring adherence to the Terms of Reference / Review

These terms of reference shall be reviewed initially after six months, and then annually.

BEXLEY GP Member Appointment Procedures
Annex 1

The GP Members will be appointed by the practising GPs in Bexley using the Bexley Clinical Cabinet eligibility and nomination process following their selection to a Nomination List by an Appointments Panel.

- **Eligibility** – The GP member role will require significant skill and experience. It is a leadership role and not solely a representative role. The Bexley Care Trust Board will create a "GP Member Person Specification". An "Appointments Panel" will then assess whether a GP, who wishes to be nominated, has the qualities set out in the "Person Specification''. The Appointments Panel will then add the candidate to the "Nomination List".

  The "Nomination List" is closed one month before a nomination round commences and reopens immediately after the nomination round has been completed.

- **Nomination** - Each GP Practice will be given one nomination right for the first 5,000 registered patients on their list with a further nomination right for each additional 5,000 registered patients. The list sizes will be assessed using the previous financial quarter return when a nomination process is announced. These nominations can be used to nominate any Bexley GP who has been added to the Nomination List by the Appointments Panel.

- **GP Member Nomination Procedure**

  1 The Bexley Clinical Commissioning Cabinet may initiate a Nomination Round to fill a GP member's position and will appoint a Nomination Officer, who is not a full member of the Bexley CCC

  2 The Nomination Officer will produce the Ballot Paper for each GP member position (as appropriate) and set the final date for its submission to him/her.

  3 Nomination submissions will be via a sealed envelope.

  4 The Nomination Officer will publish the name of the GP candidate for each GP member position with the most nominations but not the number of nominations per candidate.

- **Term of Membership and Removal**

  - Each GP member is appointed to a three year term of office and may put their name forward for re-nomination. With the exception of the first year, no more than 2 GPs should be nominated for GP member positions in any calendar year.
  - A GP Member can be removed from office for failure to comply with the NHS Code of Conduct for NHS Boards as judged by the Bexley Care Trust Board.

- A GP Member may be removed from office on receipt by the BCCC of a petition to this effect signed by 75% of the practices in their locality. (or in the case of BCCC Chair, 75% of practices in Bexley)

Specific Arrangements for GP Member Positions

- **Bexley CCC Chair** is appointed by receiving nominations from all GP Practices within the Bexley Care Trust.

- **Each GP Member is** appointed by nominations from GP practices within their locality with one GP appointed from each of the three Bexley localities.

- **GP Member appointed by salaried GPs –** Bexley Salaried GPs holding a contract of employment with a Bexley GP Practice on the first date of any nomination round may nominate one GP from the nominee list. Each salaried GP has one nomination right.

Terms

1 "Accountable Officer" – A designated person who ensures that the organisation and any subsidiary operates effectively and to a high standard of probity.
2 "Appointments Panel" – A group of people who assess whether a GP has the qualities that meet the "GP Member Person Specification". The panel consists of the Vice Chair, Chief Executive, a representative from the London Borough of Bexley Council and a representative from the LMC.
3 "GP Person Specification" - A document that describes the skills and experience necessary for a GP to be eligible for nomination as a GP Member.
4 "Nomination List" – A list of candidates who have been assessed by the Appointments Panel to meet the "GP Member Person Specification".
5 "Nomination Round" – The process to seek nominations from GP Practices for a new GP Member.
6 "Officer Members" – Joint Managing Directors and Chief Financial Officer.

DRAFT TERMS OF REFERENCE

BROMLEY LOCAL CLINICAL COMMISSIONING COMMITTEE

1. Introduction / Purpose / Constitution

The Joint PCT Board hereby resolves to establish a Committee of the Board to be known as the Local Clinical Commissioning Committee.

Its purpose is to oversee the development of GP clinical commissioning and the progressive devolution of commissioning responsibilities to the GP Consortium, while continuing to provide assurance to the PCT Board on the discharge of its responsibilities within the Borough of Bromley. It will have a key role in facilitating the transformation to the model of commissioning set out in the White Paper "Equity and Excellence: Liberating the NHS". It will also undertake the statutory functions of the PCT's Professional Executive Committee, including clinical governance associated with the development of care pathways.

The development of the Committee will be an evolutionary process reflecting the increasing capacity of local clinicians to manage the commissioning process. This will be reflected in the method of operation of the LCC and the format of its meetings. Initially, LCC meetings will be divided into two Parts:

1. oversight of the operational management of Bromley Borough Support Unit, and the functions devolved to it from the Joint Bromley PCT Board, chaired by the Vice Chair of Bromley PCT
2. oversight of the development work of the GP Consortium Development Group and clinical governance associated with the development of new care pathways, chaired by a GP commissioning lead

In the fullness of time it is anticipated that clinical members will become empowered to make an increasing contribution to Part I of the meeting, culminating in a point where this functional distinction becomes unnecessary, and chairmanship of the whole meeting will be undertaken by the clinical commissioning lead, subject to the review of these terms of reference.

2. Duties/ Roles and Responsibilities

- Inform the development of a borough commissioning strategy based on the joint strategic needs assessment with linkage to the Bromley Health and Well Being Board
- Facilitate a smooth and safe transition to successful commissioning by the GP Consortium

- Ensure the delivery of an effective Borough QIPP programme
- Keep oversight of the Bromley budget and ensure the BSU remains within the allocated budget and achieves required savings targets
- Monitor and provide assurance to the PCT Board on the performance activity of providers
- Monitor and provide assurance to the PCT Board with regard to clinical governance, patient safety, clinical effectiveness, quality and patient experience within the borough
- Lead clinical communications with partners, stakeholders, patients and the public, including the Bromley Health and Well Being Board.
- Establish the GP Consortium Development Group as a sub committee

3. Accountability / Delegations

The Committee is authorised by the Joint PCT Board to investigate any activity within its terms of reference. It is accountable to the Joint PCT Board for the powers delegated to it in the Joint PCT Board's Scheme of Delegation.

It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

4. Committee Membership and Attendance

The Committee members shall be appointed by the Board and will consist of:

- Clinical commissioning lead GPs (6) - of whom one will take the Chair in Part II of the meeting
- Nurse representative (lead practice nurse)
- Other primary care clinicians (?)
- Director of Public Health
- Borough-based Business Support Unit (BSU) Managing Director
- Director of Prescribing and Quality
- BSU Director of Commissioning and Performance
- BSU Director of Pathway Development and Transformation
- PCT Non Executive Chair - to chair Part I of the meeting
- PCT Non Executive Director
- Director of Adult and Community Services, LBB

The BSU Finance Manager and a Healthwatch representative will also normally attend meetings but will not be voting members.

Any other person may also attend all or specific meetings with the agreement of the Chairman of the Committee.

An officer of the BSU shall be assigned to the role of Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

5. Reporting Arrangements and supporting structures

The Committee shall meet in public.

The Committee shall establish such working groups as it considers necessary, consisting of members who may or may not be members of the Committee. The Committee will not delegate to any working group powers delegated to it by the Joint PCT Board.

The minutes of meetings of the Committee shall be formally recorded and submitted to the next Joint PCT Board meeting together with a summary of the main action points.

The Committee will also provide an annual report to the Joint PCT Board summarising its activities and the assurances it has provided.

6. Quorum rules

The Quorum shall be five members including at least one non executive director (who shall take the chair in Part I), at least one GP commissioning lead (who shall take the chair in Part II), and at least one BSU Executive Director.

7. Frequency of Meetings

The Committee shall meet monthly.

8. Monitoring adherence to the Terms of Reference / Review

These terms of reference shall be reviewed initially after six months, and then annually, at which point compliance with the terms will also be reviewed.

DRAFT TERMS OF REFERENCE
Greenwich Clinical Commissioning Committee

1. Constitution & Purpose

Constitution

NHS Greenwich Board resolves to establish a Committee of the Board to be known as the Greenwich Clinical Commissioning Committee (GCCC). The Committee is an executive committee of the Board and has executive powers as set out in the PCT's Scheme of Delegation. The Scheme of Delegation will reflect the stage of development of the local GP commissioning consortium and will be amended from time to time in line with the NHS London GP Consortia Development Programme**.**

Purpose

a. The role of the GCCC is to develop and recommend to the Joint Boards of NHS Greenwich a commissioning plan that meets the health needs of local people.
b. The GCCC will replace and fulfil the statutory duties of the PCT's Professional Executive Committee.
c. The GCCC will ensure that there are robust local arrangements for the involvement of patients and the public and a wide range of clinicians in commissioning decisions affecting local people.

2. Duties/ Roles and Responsibilities

The GCCC will:

Plan

a. take clinical leadership for and approve strategies to achieve improved health outcomes; reduced health inequalities and improve quality and the patient experience
b. lead the design and implementation and recommend to the Board quality, innovation, productivity and prevention (QIPP) schemes for Greenwich

Engagement

c. engage with local clinicians and Allied Health Professionals on joint working
d. work to develop a closer and coordinated working relationship between primary care and secondary care providers to ensure efficiency and high quality clinical services are developed and to ensure value for public money spent
e. develop close and effective working with the Local Authority on joint commissioning and other commissioning bodies to promote health improvements and integrated services
f. develop increased democratic accountability via the Health and Well-being Board and public and patient engagement

g. develop accountability to the National Commissioning Board
h. engage with public health practitioners, including awareness of the potential change in local public health arrangements

Clinical Governance

i. review annual reports of high priority issues such as safeguarding and infection prevention and control.
j. assess and monitor action plans to address issues emerging from reviews or inspections of services commissioned for local people.
k. review and monitor action plans and reports of complaints and incidents arising from all services commissioned for local people.

Service Redesign

l. take clinical leadership for service redesign to achieve improved health outcomes; reduced health inequalities and improve quality and the patient experience
m. monitor service redesign plans
n. lead the development of good quality data and coherent information streams

3. Accountability

a. The GCCC reports to the NHS Greenwich Board.
b. The GCCC Chair will ensure that minutes of all GCCC meetings are available to all NHS Greenwich Boards members on request.
c. The Committee is authorised by the Board to investigate any activity within its terms of reference.
d. The Committee is authorised to seek any information it requires from any employee or provider of services commissioned by NHS Greenwich and employees are directed to co-operate with any request made by the Committee.
e. The Committee is authorised by the Board to obtain outside legal, clinical or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

4. Committee Membership

Membership shall include:

a. The seven elected GP Members of Greenwich Health (the local GP commissioning consortium) one of whom shall be the Chair
b. The Greenwich Business Support Unit (BSU) Managing Director
c. A representative from the London Borough of Greenwich
d. The Greenwich BSU Head of Financial Delivery
e. The Greenwich Director of Public Health and Well-Being
f. A nurse representative
g. 2 Greenwich NEDs (who will share a vote)

In attendance (non-voting members)

1 Greenwich LINK representative
Head of Non Acute Commissioning and Partnerships – Greenwich BSU
Head of Service Redesign & Delivery – Greenwich BSU
Head of Transitional Business Support – Greenwich BSU

Other NHS SEL Cluster managers may be invited to advise on specific agenda items as required or other clinical or other experts to support decision making

Members are required to attend a minimum of 75% of meetings.

The Chair of the NHS Greenwich Board will not be a member of the Committee but can attend meetings as a participating observer.

The GCCC will invite others to be in attendance as required

5. Reporting Arrangements and supporting structures

To support this role the GCCC is authorised to establish any sub-committee or working group as necessary.

The GCCC will be informed by any relevant conclusions of the NHS Greenwich Board Audit Committee and the Cluster Joint Quality and Safety Committee (and the BBG Primary Care Contracting Issues of Concern Committee).

6. Quorum rules

A quorum shall be five members and must include three elected GP Board Members of Greenwich Health.

7. Frequency of Meetings

a. The Committee will meet every month.
b. Cancellation of meetings will only be in exceptional circumstances and must be communicated to Committee members immediately the decision to cancel has been made.
c. Terms of Reference and Membership will be reviewed annually, or as required by changes in organisational requirements.
d. The Committee will meet in public, not less than, 4 times per year

8. Monitoring adherence to the Terms of Reference / Review

The Greenwich Clinical Commissioning Committee is committed to evaluating all programmes, strategic, operating and financial plans delegated to it by the PCT. The GCCC will review its effectiveness on an annual basis. The Terms of Reference and membership will be reviewed as required, and at least on an annual basis.
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Draft Terms of Reference
Lambeth Clinical Commissioning Collaborative Board

1. Introduction / Purpose / Constitution

In South East London the statutory functions of the six current PCT/ Care Trust Boards will be fulfilled by the six boards operating jointly. Within these arrangements each Board will establish borough based Local Clinical Commissioning Committees (LCCCs) as formal sub-committees that have delegated responsibility for local commissioning budgets. In Lambeth this LCCC will be known as the Lambeth Clinical Collaborative Board (LCCCB).

2. Duties/ Roles and Responsibilities

The Lambeth Clinical Commissioning Collaborative Board will operate as a sub-committee of the Lambeth PCT Board and will be a decision making forum. It will take on delegated responsibilities that will change over time as Clinical Commissioning develops in Lambeth and the Lambeth Clinical Commissioning Collaborative Board takes on increasing responsibilities for delivery of Lambeth health commissioning. The Lambeth Clinical Commissioning Collaborative Board on behalf of the Lambeth PCT Board will

- Engage with practices across Lambeth, through the three localities in the development of Clinical Commissioning.
- Engage with a broad range of clinicians in redesigning and implementing new care pathways.
- To provide clinical vision and lead strategic thinking for the commissioning of health services and health improvement in Lambeth
- To provide clinical leadership to commissioning of health services in Lambeth in respect of delegated functions including pathway redesign.
- To monitor and assure clinical quality to the PCT Board, including safeguarding and infection control.
- To drive and monitor delivery and performance, take remedial action as necessary and provide assurance to the PCT Board
- Lead the transition to Clinical Commissioning in Lambeth
- To lead support the transition to new Health and Wellbeing arrangements in Lambeth
- To develop partnership working including with services across Lambeth Localities, London Borough of Lambeth, other PCTs and GP commissioners, King's Health Partners and other secondary care providers, Lambeth LINk, Lambeth Scrutiny and the GSTT Charity.
- To fulfill the role of the Lambeth PCT Professional Executive Committee.

3. Accountability

The Lambeth Clinical Commissioning Collaborative Board members will have delegated responsibility from the Lambeth PCT Board and will have decision making powers. All members will have equal standing and their role will be to consider the key strategic, clinical and managerial issues across the commissioning of these health services in Lambeth delegated to it. The Lambeth Clinical Commissioning Collaborative Board will take responsibility on behalf of the Lambeth PCT Board for the transition to Clinical Commissioning Consortia and Health and Wellbeing arrangements. Locality Board members will be expected to report back to their locality. Lambeth Clinical Commissioning Collaborative Board members will be expected to take on lead roles.

4. Committee Membership

Collaborative Chair
North Locality member
North Locality member
South West Locality member
South West Locality member
South East Locality member
South East Locality member
Lambeth BSU Managing Director
Director of Public Health (joint with LB Lambeth)
Nursing Lead
PCT Non Executive Director
PCT Non Executive Director

If a clinical locality member resigns, a deputy will be co-opted for up to three months to allow time for a new member to be appointed from that locality.

If the Chair resigns, a Chair will be appointed from the existing members for up to three months to allow time for a new Chair to be appointed.

In Attendance
Director of Integrated Commissioning (joint with LB Lambeth)
Director of Care Pathway Commissioning
Director of Corporate Affairs and Human Resources
Chief Financial Officer
Clinical Network lead

Invitees
London Borough of Lambeth Representative
LMC Representative
LINk Representative

5. Reporting Arrangements and supporting structures

The minutes of the each formal LCCCB meeting will be formally recorded and submitted to the next PCT Board meeting for publication in public papers.

Agendas and supporting papers will be circulated five days in advance of meetings. Minutes of the meeting will be circulated to all members within five working days. Minutes will be agreed by the Chair at following formal meeting of the Lambeth Clinical Commissioning Collaborative.

6. Quorum rules

The minimum number of LCCCB members required in order to take decisions is two practice nominated members and two PCT Board members.

7. Frequency of Meetings

The Clinical Board will meet formally on a monthly basis and the Board meeting will be held in public on quarterly basis in June, September, December and March.

8. Monitoring adherence to the Terms of Reference / Review

The LCCCB is committed to evaluating all programmes, strategic, operating and financial plans delegated to it by the PCT. The LCCCB will review it's effectiveness on an annual basis. The Terms of Reference and membership will be reviewed as required, and at least on an annual basis.

DRAFT TERMS OF REFERENCE
Lewisham Clinical Commissioning Committee

1. Introduction

The Government has clearly signaled its intention to move towards GP led Clinical Commissioning arrangements for the NHS in England. Further the NHS Operating Framework outlines the progression to cluster working arrangements during the period until PCTs cease in March 2013.
Transitional arrangements for PCTs must therefore enable the continued delivery of high quality healthcare services to meet the needs of local people, within the resources available and enable a smooth transition for Clinical Consortia to assume full commissioning responsibility in 2013.

Lewisham Clinical Commissioning Committee (LCCC) is a formal sub-committee of the Joint Boards for Lewisham PCT. LCCC will fulfil the statutory duties of the PCT's Professional Executive Committee as such The NHS Code of Accountability requires PCT Board members and Clinical Committee members to declare interests which are relevant and material to the NHS Board of which they are a member. These interests will be recorded on the minutes of the meeting.

1.1 Purpose of the Group

The purpose of the group is to:-

- Work with clinicians and partners to develop and recommend to the Board the vision and strategic direction for the PCT
- Develop and recommend to the Board a commissioning strategy that reflects national policy, which addresses the health inequality issues within Lewisham and which improves the health of the local population
- Oversee the development and delivery of local QIPP Plans that are coherent with and inform the SE London cluster QIPP
- Ensure a strong voice for patients and the public in the planning, delivery and review of clinical services
- Promote the development of Clinical Commissioning as the principal mechanism for planning to meet local health care needs with the full engagement of clinicians.
- Agree and monitor the implementation of strategies that promote the development of high quality, safe, responsive, local services
- Work closely with the London Borough of Lewisham and local providers to ensure that commissioning plans deliver integrated and effective health and social care services for local people
- Advise the Board on the priorities for system and service redesign using appropriate approaches.
- Promote best practice in clinical care.
- Lead clinical communications with partners.
- To ensure that there is a smooth transition to GP led clinical commissioning structures and arrangements

2. Duties and Responsibilities

The duties of the Committee can be categorised as follows:

- Development and recommendation to the Board of a commissioning strategy which secures better care, addresses health inequalities and involves patients and clinicians drawing on joint work with partners through the Health and Wellbeing Board.
- Development of clinical leadership
- Promotion and monitoring of the implementation of clinical commissioning
- Monitoring the implementation of the commissioning strategy
- Ensuring that commissioning plans recommended to the Board reflect the views and have the support of local people including local scrutiny via the Healthier Communities Select Committee
- Responding to patient experience and public feedback of services by agreeing service improvement priorities
- Providing clinical expertise in the development of clinical systems
- Agreeing a Committee annual work plan.
- Completing an annual self assessment of Committee effectiveness
- Preparing an Annual Report for the Committee
- Contributing to the PCT Annual Report.
- The Chair will report monthly to the Board on the progress and work of the committee
- To establish such subcommittees and working as is needed in order to fulfil its duties
- To monitor the quality and safety of local services and to provide reports to and receive recommendations from the Joint Boards' Quality & Safety Committee

The Committee will operate a forward planning system to manage its programme of work.

3. Accountability / Delegations

The Scheme of Delegation will be regularly reviewed and updated with agreement from the Joint Boards to include formal declarations to the Pathfinder GP Consortia.

As a sub-committee of the Joint Boards;

- The LCCC Chair will report monthly to the Joint Boards on the progress and work of the committee.
- The minutes of LCCC meetings will be submitted to the Board.
- The Committee will provide an annual work plan and an annual report to the Joint Boards.

The LCCC will nominate a member to represent the committee on the Quality & Safety Committee to which it will provide reports to and receive recommendations for local action

4. Committee Membership

Professional members should be practicing clinicians in Lewisham and should make up the majority of members.

8 voting clinical members selected on the basis of a set of competencies derived from national guidance and made up as follows:
At least one member must be a GP and one must be a nurse, including Chair of Lewisham Federation
2 Deputy Chairs Lewisham Federation
4 Clinical Executive members Lewisham Federation
Nurse member

5 voting non clinical members made up as follows:
2 Non-executive Directors
Cluster Chief Executive or delegated representative
Director of Public Health
Cluster Director of Finance or delegated representative

Non voting members
Executive Director representing London Borough of Lewisham
A representative nominated by the Local Medical Committee
2 lay representatives from the Lewisham community
A member of the Lewisham LINK executive

In attendance
BSU Clinical Advisor
BSU Senior Service Redesign Programme Lead

Other members of NHS South East London cluster, Lewisham Business Support Unit and Joint Commissioners, may request or be required to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting papers submitted to the Committee.

The committee has scope to co-opt additional members as it sees fit to enable it to fulfill its responsibilities.

Members will be expected to attend all meetings. Where a member does not attend three meetings in one year (without sending an appropriate agreed replacement) the Chair would undertake an enquiry which could lead to a replacement member being appointed.

5. Reporting Arrangements and supporting structures

The Committee will report monthly to the Joint Boards and quarterly to the Quality & Safety Committee through minutes of the meeting and action sheet.

The Committee will produce a work plan and an Annual report of its activity to the Board.

The following working groups will report into the LCCC:

Strategy
Quality and Safety Committee – with reporting lines from Infection Control and Safeguarding Committees
Prescribing and Medicines Management
Patient and Public Involvement

Separate Terms of Reference are being developed for agreement by the LCCC.

6. Quorum rules

Five clinical members including the Chair (a minimum of 2 federation clusters should be represented) and three non-clinical members, one being a Non-Executive Director and one being an Executive Director of the Joint Board.

Declaration of Interests would be managed and reviewed each year with direct conflicts being taken at the start of each LCCC meeting.

7. Frequency of Meetings and Administrative Support

Meetings will be held monthly. These may take the form of formal meetings, seminars or joint LCCC-Board meetings. From September 2011 alternate meetings would be held in public.

The Head of Business Support & Integrated Governance of the BSU will provide administrative support to the LCCC.
The Head of Business Support & Integrated Governance will agree the agenda with the LCCC Chair and take minutes of the meeting, keeping a record of matters arising and issues to be carried forward.
Agendas and supporting papers will be sent to members five working days before the meeting.
Minutes will be drafted for approval by the Chair within five working days of the meeting and then distributed to all attendees within 10 working days.

8. Monitoring adherence to the Terms of Reference / Review

The committee will monitor its adherence to its TOR through an Annual report of its activity to the Board.

Terms of Reference of the LCCC will be reviewed initially in July 2011 as part of the transition to cluster arrangements and then in March 2012

DRAFT TERMS OF REFERENCE
Southwark Clinical Commissioning Committee

1. Introduction / Purpose / Constitution

In South East London the statutory functions of the six current PCT/ Care Trust Boards will be fulfilled by the six boards operating jointly. Within these arrangements each Board will establish borough based Local Clinical Commissioning Committees (LCCCs) as formal sub-committees that have delegated responsibility for local commissioning budgets. In Southwark this LCCC will be known as the Southwark Clinical Commissioning Committee (SCCC).

The SCCC will establish with the Joint Boards (hereafter referred to as the PCT Board, as the NHS Southwark Board remains the legal entity of the transition period) the areas that it will be commissioning for and will have formal agreement of the commissioning resource envelope for which it is responsible. This commissioning envelope will be based upon the areas that GP Commissioners are awarded 'Delegated Responsibility' for in advance of GP Commissioning Consortia becoming statutory bodies in April 2013. As such, this commissioning envelope will increase over time as local GP Commissioners move closer to fulfilling the requirements of full GP Consortia status.

Over the transition period it is essential that local decision making should support ownership, understanding and engagement of local clinicians and that as much business as possible should be delegated to the LCCCs.

Appendix A (below) outlines those areas that can be delegated by PCT/ Care Trust Boards to LCCCs and an agreed scheme of delegation will outline how many of these functions are delegated to the SCCC and within what timeframe.

Appendix B (below) details those areas that cannot be delegated by PCT/ Care Trust Boards[1].

2. Duties/ Roles and Responsibilities

In December 2010 Southwark Health was established as a GP Commissioning Consortium and was awarded First Wave Pathfinder Status within the NHS London development programme. This consortium is currently co-terminus with the current PCT boundaries and comprises all general practice in Southwark. At the same time the PCT Board delegated commissioning responsibility for a limited number of areas to the then Clinical Commissioning Board.

[1] Whilst it is not anticipated that these areas would be delegated, LCCC's would be expected to undertake the significant majority of the planning, monitoring and assurance gathering that will enable PCT Board to undertake these functions.

Southwark Health will seek to achieve 'Delegated Responsibility', under the new NHS London arrangements for this area, for 30% of the current PCT commissioning budget in quarter one of 2011/12 and will seek to agree a trajectory of increasing 'Delegated Responsibility' across the transition period with the PCT Board.

The terms of reference outlined below describe the remit and functions of this PCT Board committee and assumes that 'Delegated Responsibility' will be granted and increased over time.

The SCCC will undertake the following roles:

- To develop and ensure the implementation of local commissioning plans, aligned to the Sector strategy, ensuring value for money services are commissioned that best meet the needs of local people
- Ensure that local commissioning follows a clear policy framework that incorporates national guidance and takes account of local priorities
- Review, assess and make recommendations on commissioning and provider proposals for service delivery in the locality
- Provide guidance on clinical governance requirements to GP practices and other organisations that develop business cases as an alternative provider of services
- Assume the duty to consult local Overview & Scrutiny Committees on proposals for substantial developments or variations in local health service and carry out responsibilities to consult and engage patients as outlined in the Local Government and Public Involvement Act 2007 and other legislation in force.

The Committee is a decision-making body of the PCT Board and will be delegated responsibility for commissioning services within Southwark to ensure that:

- Through strategic leadership, NHS Southwark delivers on its statutory duty to secure the best possible services for the local population within the allocated budget.
- Services commissioned take account of the needs of the local population and aim to improve the health and well-being of local people, reduce health inequalities and provide choice.
- The annual Operating/Business Plan reflects the strategic objectives of the Commissioning Strategy Plan.
- Services commissioned deliver quality and value for money
- Commissioning and joint commissioning are developed, to enable the GP consortium to take on the commissioning responsibilities in accordance with any changes effected through legislation.
- Pathways are redesigned to deliver services closer to home, in line with clinical governance guidelines and delivered by a range of providers.
- Southwark contributes to Cluster Commissioning arrangements.

- There is active engagement with Southwark Local Involvement Network and other patient and user groups.

3. Accountability

The committee will be responsible for the day-to-day commissioning of the Trust and will operate within a scheme of delegation, accountable to the PCT Board for an agreed commissioning budget. Significantly the committee will perform the statutory functions of the PCT's Professional Executive Committee (PEC) and will be responsible for developing and recommending a commissioning plan that meets the health needs of local people to the PCT Board annually.

The remit of the SCCC is as follows:

- To be responsible for developing local commissioning strategies and plans, maximising health gain for the resources spent and delivery and performance against plans
- To oversee and direct the operation of the Southwark borough based Business Support Unit (BSU)
- To be accountable for the delivery of strategic and operational delivery within those areas of 'Delegated Responsibility' to the GP Commissioning Consortium, Southwark Health
- To undertake the significant majority of the planning, monitoring and assurance gathering that will enable PCT Board to undertake those commissioning functions that are not delegated to the SCCC.
- To hold those South East London Sector functional areas, managed by shared business services lines, to account for the delivery commissioning support to the consortium and local BSU commissioners.

4. Committee Membership

Membership of the committee will comprise the Southwark Health's eight mandated GP Commissioning leads, executives of the Southwark BSU, non-executive directors of the PCT Board, the Southwark Director of Public Health and a Southwark LINk representative.

The SCCC will be chaired by the Chair of the Southwark Health GP Commissioning Consortium (and PEC Chair) and the specific membership is outlined below:

Members with voting rights:

- Eight GP Clinical Commissioning leads (including a Chair)
- Two Non-Executive Director of the PCT Board[2]
- One Nurse
- Managing Director, Southwark BSU

[2] Will share a vote

- Director of Finance and Business, Southwark BSU
- Southwark Director of Public Health (and Health & Well Being Board representative)

Non voting members:
- Director of Joint Commissioning and Partnership, Southwark BSU
- Director of Acute and Community Commissioning, Southwark BSU
- Southwark LINk representative (Speaking rights only)
- Southwark Local Medical Committee Chair (Speaking rights only)
- Additional local authority representation may be identified

Other BSU senior managers will be expected to attend meetings in accordance with the annual programme of work and in line with reporting requirements of the defined business cycle. The Committee may co-opt further persons with relevant experience and expertise where it considers this necessary.

The SCCC Chair, the Non Executive Director of the PCT and the Managing Director of the BSU are all members of the PCT Board.

5. Reporting Arrangements and supporting structures

The SCCC will report to the PCT Board. The minutes of Committee meetings and committee decisions shall be formally recorded and submitted to that body. These documents will be made available on the PCT's public website.

The business cycle for the SCCC will be fully aligned with the business cycle of the PCT Boards.

The SCCC will undertake its functions through a series of local sub-committees and groups. The following sub-groups are proposed:

- Integrated Governance Group
- QIPP Delivery Group
- Engagement and Patient Experience Group

The membership of each sub-committee will include a GP Commissioning lead and the relevant members of the Southwark BSU and South East London Cluster functional directorates.

6. Quorum rules

A Quorum shall be one BSU Executive Director, four GP Clinical Commissioning Leads and either one of the NEDs or the Director of Public Health.

Decision making;
The SCCC will seek to make decision by consensus and agreement of its membership. Where decisions can not be made by consensus the SCCC

will take decisions by vote and will approve decisions by majority of those members with voting rights. In the event of a 'tie' the Chair will hold the casting vote.

GP Clinical Commissioning leads have been selected / elected by constituent practices across the borough. The nurse member will also be appointed by the same process. Decision making of the SCCC will take full account of the locality engagement of practices when taking decisions. There maybe those decisions that are considered so important that further consultation with general practices in there localities would be required.

Local approach to managing conflict of interest is set out in appendix 3

7. Frequency of Meetings

The SCCC will meet on a monthly basis. Alternate meetings will be held in public and meetings will provide opportunity for a public 'open session' at the beginning of those meetings where members of the public may submit questions in advance or make representations to the SCCC.

8. Monitoring adherence to the Terms of Reference / Review

These terms of reference shall be reviewed initially after six months, and then annually.

Appendix A

Issues which could be delegated to local borough-based committees (Clinical Commissioning Committees)

- delivery of the Borough aspects of the QIPP and integrated delivery plan;
- delivery of the PCTs financial obligations at a borough level;
- ensuring best use of resources and QIPP delivery at a borough level;
- development of and support to GP commissioning development at a borough level;
- inform the development of the CSP and Integrated Delivery Plan with partners, based on an agreed JSNA;
- making optimal linkages to health and well being boards and GP commissioning operating arrangements;
- development of joint commissioning at a borough level;
- oversight and performance management of operating framework deliverables at a borough level;
- delivering service and quality improvement at a local level;
- ensuring borough based statutory deliverables e.g. safeguarding are achieved;
- assurance mechanisms for ensuring Quality of Primary Care.

Appendix B

Issues which only the Joint Boards can deal with

- overseeing the delivery of the single SE London QIPP and Operating Plan;
- decision-making on change programmes that have an impact across the cluster (e.g. potential reconfiguration or SE London wide models of care);
- achieving financial balance across SEL;
- oversight of planning for 2011-14;
- oversight and management of strategic risks;
- whole system performance management;
- market management / FT pipeline;
- tracking the delivery of SEL wide QIPP and change programmes;
- leadership to the organisational development and change implementation in preparation for the new commissioning system;
- adherence and delivery of the statutory PCT responsibilities; decisions on further delegation.

Appendix 3

SCCC approach to Conflicts of Interest

1.1. A register of interests of members of the SCCC will be systematically maintained and will be made publically available. These details will be published in the PCT Annual Report. Members will also be asked to declare any interests at the start of each SCCC meeting.

1.2. To ensure that no commercial advantage could be gained, a GP lead who declares an interest in an area cannot be involved in it. If after being involved, any bids received from the lead's practice would not be accepted.

1.3. Where the business of the committee requires a decision upon an area where one GP holds a significant conflict of interest, the Chair will ensure that the individual takes no part in the discussion or subsequent decision making.

1.4. Where more than two GP leads holds a significant conflict of interest the committee will require consideration of the proposal / issue to be made by a separate evaluation panel. The evaluation panel would evaluate the proposal for quality and cost-effectiveness and if satisfied it would then make a recommendation to the Clinical Commissioning Committee, excluding the interested GP members, for decision.

1.5. The Evaluation Panel, when called upon, will provide neutrality in the evaluation process and will have the following membership:

- One Non-Executive Director of the PCT Board
- Managing Director, Southwark BSU
- Southwark Director of Public Health (and Health & Well Being Board representative)
- Co-Opted clinical expertise if necessary at discretion of the MD

1.6. In the rare occasion where the Clinical Commissioning Committee is unable to reach a decision under these circumstances the decision may be referred to the PCT Board.

Appendix 7 Board Membership

Bexley Care Trust

Non executive members		
8	NED CHAIR	Caroline Hewitt
	NED AUDIT CHAIR	Steve Corbishley
	NED Vice Chair NED (Nominated by London Borough of Bexley) *[1] NED NED NED NED	Keith Wood Cllr Eileen Pallen Cllr John Davey Paul Cutler Susan Free Jim Gunner Harvey Guntrip
Executive members		
7	Chief Executive (1 for 6)(accountable officer)	Simon Robbins
	Director of Finance (1 for 6) (accountable finance officer)	Marie Farrell
	Director of Development, Director of Operations (1 vote shared)	Covered by Gill Galliano and Jane Schofield
	Bexley BSU Managing Director	Dr Joanna Medhurst / Pamela Creaven*[2]
	Director of Public Health	TBC
	PEC Nurse	TBC
	Clinical lead* [*Clinical lead will be local PEC Chair]	Dr Howard Stoate
In attendance		
	Other directors as required	

*[1] LB Bexley have determined this vote will be shared between 2 Cllrs (0.5 & 0.5 vote) in the event that one attendee does not attend the meeting the sole attendee will assume the full applicable vote

*[2] Fulfils required Care Trust Exec Director with LA experience role

Bromley Primary Care Trust

Non executive members		
8	NED CHAIR	Caroline Hewitt
	NED AUDIT CHAIR	Steve Corbishley
	NED Vice Chair (Bromley) NED NED NED NED NED	Jim Gunner Harvey Guntrip Jeremy Fraser Susan Free Keith Wood Paul Cutler
Executive members		
7	Chief Executive (1 for 6)(accountable officer)	Simon Robbins
	Director of Finance (1 for 6) (accountable finance officer)	Marie Farrell
	Director of Development, Director of Operations (1 vote shared)	Gill Galliano / Jane Schofield
	Bromley Business Support Unit Managing Director	Covered by Angela Bhan
	Director of Public Health	Angela Bhan
	PEC Nurse	TBC
	Clinical lead* [*Clinical lead will be local PEC Chair]	Dr Andrew Parson
In attendance		
	Other directors as required	

Greenwich Teaching Primary Care Trust

Non executive members		
8	NED CHAIR	Caroline Hewitt
	NED AUDIT CHAIR	Steve Corbishley
	NED Vice Chair (shared) NED Vice Chair (shared) NED NED NED NED	Jeremy Fraser (joint VC) Susan Free (joint VC) Jim Gunner Harvey Guntrip Keith Wood Paul Cutler
Executive members		
7	Chief Executive (1 for 6)(accountable officer)	Simon Robbins
	Director of Finance (1 for 6) (accountable finance officer)	Marie Farrell
	Director of Development, Director of Operations (1 vote shared)	Gill Galliano / Jane Schofield
	Greenwich Business Support Unit Managing Director	Annabel Burn
	Director of Public Health	Dr Hilary Guite
	PEC Nurse	TBC
	Clinical lead* [*Clinical lead will be local PEC Chair]	Dr Hany Wabha
In attendance		
	Other directors as required	

Lambeth Primary Care Trust

Non executive members		
8	NED CHAIR	Caroline Hewitt
	NED AUDIT CHAIR	Steve Corbishley
	NED Vice Chair (shared) NED Vice Chair (shared) NED NED NED NED	Sue Gallagher (joint vc) Graham Laylee (joint vc) David Whiting Richard Gibbs Rona Nicholson Robert Park
Executive members		
7	Chief Executive (1 for 6)(accountable officer)	Simon Robbins
	Director of Finance (1 for 6) (accountable finance officer)	Marie Farrell
	Director of Development, Director of Operations (1 vote shared)	Gill Galliano / Jane Schofield
	Lambeth Business Support Unit Managing Director	Andrew Eyres
	Director of Public Health	Dr Ruth Wallis
	PEC Nurse	Vacancy
	Clinical lead* [*Clinical lead will be local PEC Chair]	Dr Adrian McLachlan
In attendance		
	Other directors as required	

Lewisham Primary Care Trust

Non executive members		
8	NED CHAIR	Caroline Hewitt
	NED AUDIT CHAIR	Steve Corbishley
	NED Vice Chair (Lewisham) NED NED NED NED NED	David Whiting Rona Nicholson Sue Gallagher Richard Gibbs Graham Laylee Robert Park
Executive members		
7	Chief Executive (1 for 6)(accountable officer)	Simon Robbins
	Director of Finance (1 for 6) (accountable finance officer)	Marie Farrell
	Director of Development, Director of Operations (1 vote shared)	Gill Galliano / Jane Schofield
	Lewisham BSU MD	Martin Wilkinson
	DPH	Dr Danny Ruta
	PEC Nurse	TBC
	Clinical lead* [*Clinical lead will be local PEC Chair]	Dr Helen Tattersfield
In attendance		
	Other directors as required	

Southwark Primary Care Trust

Non executive members		
8	NED CHAIR	Caroline Hewitt
	NED AUDIT CHAIR	Steve Corbishley
	NED Vice Chair (Southwark) NED NED NED NED NED	Richard Gibbs Robert Park Sue Gallagher David Whiting Graham Laylee Rona Nicholson
Executive members		
7	Chief Executive (1 for 6)(accountable officer)	Simon Robbins
	Director of Finance (1 for 6) (accountable finance officer)	Marie Farrell
	Director of Development, Director of Operations (1 vote shared)	Gill Galliano / Jane Schofield
	Southwark Business Support Unit Managing Director	Andrew Bland
	Director of Public Health	Dr Ann-Marie Connelly
	PEC Nurse	TBC
	Clinical lead* [*Clinical lead will be local PEC Chair]	Dr Amr Zeineldine
In attendance		
	Other directors as required	

Governance arrangements for South East London PCTs and Bexley Care Trust – Standing Orders (v1)

1.1 Statutory Framework

(1) The Primary Care Trusts (PCTs) and Care Trusts of South East London[1] are the statutory bodies which came into existence under their respective Establishment Orders.

(2) The principal place of business for the SEL cluster, its Accountable Officers' and therefore for the Boards of the Primary Care (PCTs) and Care Trusts is 1 Lower Marsh, London SE1 7NT.

(3) Primary Care Trusts (PCTs) and Care Trusts are governed by Acts of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995 and the Health Act 1999 and the Health and Social Care Act 2001.

(4) The PCTs (Membership, Procedure and Administration Arrangements) Regulations 2000 [SI 2000/89], amended by the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment (No.2) (England) Regulations 2002 [SI 2002 No. 557] and the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment (England) Regulations 2003 [SI 2003 No. 1616] ,the Primary Care Trust Professional Executive Committees (Membership) Directions 2003 and the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 [SI 2002/2375] set out in broad terms the functions exercisable by Strategic Health Authorities and PCTs. These Regulations set out the functions which a Strategic Health Authority (SHA) must direct a PCT to perform, and those functions which they must not direct a PCT to perform. Other functions are left to the SHA's discretion. In addition the National Health Service Act 1977 (Schedule 5a, paragraph 12) as inserted by the Health Act 1999 confers a general power directly on PCTs to do certain things ancillary to their main functions, such as the power to acquire land, make contracts and accept gifts.

[1] A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham, Southwark and Bexley Care Trust

(5) Functions are conferred on Care Trusts by directions issued by Strategic Health Authorities. The statutory functions to be conferred on the Care Trust are set out in the Primary Care Trusts (Functions) (England) Regulations 2000 as amended from time to time by subsequent legislation. These Regulations set out the functions which a Strategic Health Authority must direct a Care Trust to perform, and those functions which they must not direct a Care Trust to perform. Other functions are left to the SHA's discretion. In addition the National Health Service Act 1977 (Schedule 5a, paragraph 12) as inserted by the Health Act 1999 confers a general power directly on Care Trusts to do certain things ancillary to their main functions, such as the power to acquire land, make contracts and accept gifts.

(6) As statutory bodies, the PCTs and Care Trust have specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health. The PCT also has statutory powers under Section 28A of the NHS Act 1977 including to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

(7) The Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 No 89, the Primary Care Trusts (Membership Procedure and Administration Arrangements) Amendment (No 2) (England) Regulations 2002 {SI 2002/557} and the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment (England) Regulations 2003 {SI 2003 No 1616) require the Primary Care (PCT) and Care Trusts to adopt Standing Orders for the regulation of its proceedings and business. Such Standing Orders should take account of the National Health Service Reform and Health Care Professions Act 2002. In accordance with the Corporate Governance Framework the PCT must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

(8) The PCTs and Care Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

(1) In addition to the statutory requirements, the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

(2) The Code of Accountability requires that, inter alia, Boards draw up a Schedule of Decisions Reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to the Professional Executive Committee and to senior executives (a scheme of delegation). The code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Codes of Conduct makes various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.3 Delegation of Powers

(1) The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 [SI 2002 / 2375] confer on the PCT powers to delegate and make arrangements for delegation. The PCT Standing Orders set out the detail of these arrangements. Under Standing Order No. 5 relating to the 'Arrangements for the Exercise of Functions', the PCT is given powers to "make arrangements for the exercise, on behalf of the PCT of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order No. 5 or by an officer of the PCT, in each case subject to such restrictions and conditions as the PCT thinks fit or as the Secretary of State may direct".

(2) Delegated Powers are covered in a separate document entitled – 'Schedule of Matters Reserved to the Board and Scheme of Delegation' (See Section 1.8 and Appendix 2 of the Corporate Governance Framework Manual). This document has effect as if incorporated into the Standing Orders and Standing Financial Instructions.

2. The Primary Care Trusts (PCT) and Care Trust Board: Composition of Membership, Tenure and Role of Members

2.1 Composition of the Membership of the PCT and Care Trust Board

In accordance with the Membership, Procedure and Administration arrangements regulations the composition of the Board shall be:

(1) The Chair of the PCT and Care Trust (appointed by the NHS Appointments Commission);
(2) Up to 7 non-officer members (appointed by the NHS Appointments Commission)[2]
(3) Up to 7 officer members (but not exceeding the number of non-officer members) including:

- the Chief Executive;
- the Director of Finance and Information;
- the Director of Public Health
- the Chair of the Professional Executive Committee;
- at least one person, but not more than 3, appointed by the Chair of the PCT following nomination by the Professional Executive Committee;
- Officers of the PCT, other than the Chief Executive and Director of Finance and Information, appointed by the Chair and non-officer members of the PCT.

[2] In respect of Bexley Care Trust these non-officer members there should be:

- At least one local authority member nominated to the Care Trust Board by the Bexley Council. Members of the local authority's Overview & Scrutiny Committee cannot be nominated;
- Other members identified through the Independent Appointments Commission process.

The PCT shall have not more than 14 members (excluding the Chair).

2.2 Appointment of Chair and Members of the PCT and Care Trust

(1) Appointment of the Chair and Members of the PCT / Care Trust- Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chair is appointed by the Secretary of State, as advised by the Independent Appointments Commission. Otherwise the appointment and tenure of office of the Chair and members are set out in the Membership, Procedure and Administration Arrangements Regulations. Disqualification from holding office is defined in The Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment (England) Regulations 2003 (SI 2003 No.1616).

2.3 Terms of Office of the Chair and Members

(1) The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

2.4 Appointment and Powers of Vice-Chair

(1) Subject to Standing Order 2.4 (2) below, the Chair and members of the PCT / Care Trust may appoint one of their number, who is not also an officer member, to be Vice-Chair, for such period, not exceeding the remainder of his/her term as a member of the PCT / Care Trust, as they may specify on appointing him/her.

(2) Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice-Chair in accordance with the provisions of Standing Order 2.4 (1).

(3) Where the Chair of the PCT has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

(2) Where the office of a member of the Board is shared jointly by more than one person:

*(*a) either or both of those persons may attend or take part in meetings of the Board;
(b) if both are present at a meeting they should cast one vote if they agree;
(c) in the case of disagreements no vote should be cast;
(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.6 Officer Members appointed by the Chair of the PCT / Care Trust following nomination by the Professional Executive Committee

Where only one such person is appointed, that person shall be a member of the Professional Executive Committee. Where more than one person is appointed at least two shall be members of that committee.

2.7 Healthwatch

It should be noted that the provisions for a patients' forum, replaced under The Local Government Act 2007 by "LINk" has been replaced again by "Healthwatch". With the establishment of this partnership, SEL will review its arrangements in order to invite a representative from the group to attend Board meetings in public in an observer capacity with the opportunity to comment during Board discussion, under the provisions of Standing Order 4.1.

3.0 Governance and south east London Cluster Implementation

The SEL Cluster Board (a meeting of all PCT and Care Trust Boards in South East London (SEL) and henceforth referred to as the Joint Boards) was formed as a result of the Operating Framework 2011-12 issued on 15th December 2010 and the publication of PCT Cluster Implementation Guidance issued on 31st January 2011 by the Department of Health (Gateway reference 15520). Whilst the current PCTs /Care Trust are retained as statutory organisations the cluster arrangement is a consolidation of management capacity, with a single management team managing the six constituent PCTs/Care Trust.

The statutory functions of the six current PCT/Care Trust Boards will be fulfilled by the six Boards operating jointly (the Joint Boards).

The majority of the Joint Boards' business will be transacted as one but should the need arise, for instance to agree an individual PCT/Care Trust's accounts, each Board can meet as an individual PCT/Care Trust Board. Likewise two or more of the individual Boards will be able to meet on an ad-hoc basis to consider issues related to particular localities, communities or service providers, e.g. the Boards of Bexley Care Trust, Bromley and Greenwich PCTs might meet to discuss issues relating to South London Healthcare Trust.

Whilst not a single entity the Joint Boards and their meeting's will comply with the statutory and fiscal duties as though it were a PCT/Care Trust and as such are required to adopt Standing Orders for the regulation of its proceedings and business. Such Standing Orders take account of the National Health Service Reform and Health Care Professions Act 2002. In accordance with the Corporate Governance Framework the Joint Boards will also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

The Cluster Joint Board will also be bound by such other statutes and legal provisions which govern the conduct of PCT/Care Trusts affairs including taking on the requirements for securing quality through change that will be set shortly by the National Quality Board and for promoting the Equality Delivery System as developed by the National Equality and Diversity Council.

3.1 **The Joint Boards: Composition, Membership and Role of Members**

In addition to the Chair and Audit Chair, 12 non-executive directors will be appointed to serve on the six PCT / Care Trust Boards. By appointing two pools of six NEDS with one pool serving Lambeth Southwark and Lewisham and the second serving Bexley Bromley and Greenwich each Board NED membership will remain within the total permissible limit of 7, excluding the Chair. This arrangement enables each PCT / Care Trust to retain two non-executive directors and consequently increase continuity, local capacity and support to the Executive Team.

In order to comply with the terms of its Establishment Order at least one of the non-executive directors for Bexley Care Trust will be a nominee of Bexley Council. The implication of this is that two NEDs from the LSL pool will require cross-appointing to Bromley and Greenwich as the Local Authority NED cannot be cross appointed to those PCTs.

Five executive members will be common to all six Boards. In addition each Chair of local Clinical Commissioning Committees, expected to be the GP Commissioning Lead, and the Managing Director of each Borough Business Support Unit will make up the executive director complement. Membership is shown in Diagram one (below).

Diagram One: Board membership

	Bexley Care Trust	**Bromley PCT**	**Greenwich TPCT**	**Lambeth PCT**	**Lewisham PCT**	**Southwark PCT**
Non executive members						
8	NED CHAIR					
	NED AUDIT CHAIR					
	NED Vice Chair (Bromley) NED Vice Chair (Greenwich) NED Vice Chair (Bexley) NED (Nominated by London Borough of Bexley for Bexley Board only) [*1] NED NED NED			NED Vice Chair (Lambeth) NED Vice Chair (Lewisham) NED Vice Chair (Southwark) NED NED NED		
	Additional associate NEDs appointed locally as required					
Executive members						
7	Chief Executive (1 for 6)(accountable officer)					
	Director of Finance (1 for 6) (accountable finance officer)					
	Director of Development, Director of Operations (1 vote shared)					
	BSU MD	BSU MD	BSU MD[*2]	BSU MD	BSU MD	BSU MD
	DPH	DPH	DPH	DPH	DPH	DPH
	PEC Nurse	PEC Nurse	PEC Nurse	PEC Nurse	PEC Nurse	PEC Nurse
	Clinical lead*	Clinical lead*	Clinical lead*	Clinical lead*	Clinical lead*	Clinical lead*
[*NOTE – Clinical lead will be local PEC Chair]						
In attendance						
	Other directors as required					

[*1] LB Bexley have determined this vote will be shared between 2 Cllrs (0.5 & 0.5 vote) in the event that one attendee does not attend the meeting the sole attendee will assume the full applicable vote

[*2] Fulfils required Care Trust Exec Director with LA experience role (Bexley Care Trust Board only)

3.2 Role of Members

The Joint Boards will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Cluster and, on occasion, individual PCT/Care Trust in carrying out the statutory and other functions.

(1) **Executive Members**
Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) **Chief Executive**
The Cluster Chief Executive shall be responsible for the overall performance of the executive functions of the Cluster and PCT(s)/Care Trust. He/she is the Accountable Officer for the PCT(s)/Care Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for PCT Chief Executives.

(3) **Director of Finance, Procurement, ICT & Estate**
The Director of Finance, Procurement, ICT & Estate shall be responsible for the provision of financial advice to the Boards and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) **Non-Executive Members**
The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Boards. They may however, exercise collective authority when acting as members of or when chairing a committee of the Board or individual PCT/Care Trust which has delegated powers.

(5) **Chair**

The Chair shall be responsible for the operation of the Boards and chair all Joint Board Meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders. The Chair shall liaise with the NHS Appointments Commission over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Joint Boards in a timely manner with all the necessary information and advice being made available to the Boards to inform the debate and ultimate resolutions.

3.3 Corporate role of the Boards

(1) All business shall be conducted in the name of NHS South East London

(2) All funds received in trust shall be held in the name of the individual PCT/Care Trust as corporate trustee.

(3) The powers of the PCT(s) and Care Trust established under statute shall be exercised by the Boards meeting in public session except as otherwise provided for in Standing Order No. 3.

(4) The Boards shall define and regularly review the functions it exercises on behalf of the Strategic Health Authority, the Secretary of State and the constitute PCTs/Care Trust.

3.4 Schedule of Matters reserved to the Board and Scheme of Delegation

(1) The Boards have resolved that certain powers and decisions may only be exercised by the Boards in formal session. These powers and decisions along with the powers which it has delegated to officers and other bodies are contained in the NHS South East London Scheme of Delegation as set out in Section C below.

3.5 Lead Roles for Board/s Members

The Chair will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

4. Meetings of the Joint Boards or, on occasion, Individual PCT/Care Trust Boards

4.1 Calling meetings

(1) Ordinary meetings of the Boards shall be held at regular intervals at such times and places as the Boards may determine.

(2) The Chair of the Board may call a meeting of the Board/s at any time.

(3) One-third or more members of the Board may requisition a meeting in writing. If the Chair 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.

4.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Boards, or, on occasion, Individual PCT/Care Trust Boards a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least five clear days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 4.6.

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

(5) Before each meeting of the Boards or, on occasion, Individual PCT/Care Trust Boards a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Board or, on occasion, Individual PCT/Care Trust Boards principal offices at least five clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

4.3 **Agenda and Supporting Papers**

The Agenda will be sent to members 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency. The Boards may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders.)

4.4 **Petitions**

Where a petition has been received by a PCT/Primary Care Trust or the Cluster the Chair shall include the petition as an item for the agenda of the next meeting.

3.5 **Notice of Motion**

(1) Subject to the provision of Standing Orders 4.7 'Motions: Procedure at and during a meeting' and 4.8 'Motions to Rescind a Resolution', a member of the Boards wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

4.6 **Emergency Motions**

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 4.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

4.7 **Motions: Procedure at and during a meeting**

i) Who may propose?

A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

ii) Contents of motions

The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

iii) Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

iv) Rights of reply to motions

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

v) Withdrawing a motion

A motion, or an amendment to a motion, may be withdrawn.

vi) Motions once under debate

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order 4.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

4.8 **Motion to Rescind a Resolution**

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Board it shall not be competent for any director/member other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

4.9 **Chair of meeting**

(1) At any meeting of the Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair, if present, shall preside.

(2) If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice-Chairman, if present, shall preside. If the Chair and Vice-Chairman are absent, or are disqualified from participating, such non executive member as the members present shall choose shall preside.

4.10 **Chair's ruling**

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

4.11 **Quorum**

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Officer Member of the Board and one member who is not) is present.

(ii) An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

(iii) If the Chair 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 (see SO No.7) 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.

4.12 **Voting**

(i) Save as provided in Standing Orders 4.13 - Suspension of Standing Orders and 4.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting shall have a second, and casting vote.

(ii) At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair

directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(iii) 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).

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

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

(vi) A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member. A manager attending the PCT 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.

(viii) For the voting rules relating to joint members see Standing Order 2.5.

4.13 **Suspension of Standing Orders**

Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 4.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Board and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Board's minutes. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Board. No formal business may be transacted while Standing Orders are suspended.

The Audit Committee shall review every decision to suspend Standing Orders.

4.14 **Variation and amendment of Standing Orders**

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under Standing Order 4.5;

- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
- that two-thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Board's Non-Officer Members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

4.15 **Record of Attendance**

The names of the Chair and Directors/Members present at the meeting shall be recorded.

4.16 **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 Chair considers discussion appropriate.

Minutes shall be circulated in accordance with members' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

4.17 **Admission of public and the press**

(i) Admission and exclusion on grounds of confidentiality of business to be transacted

The public and representatives of the press may attend all meetings of the PCT, but shall be required to withdraw upon the PCT Board as follows:

- '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 l960

- 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.

(ii) General disturbances

The Chair (or Vice-Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's

business shall 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 public will be required to withdraw upon the Board resolving as follows:

- `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960.

(iii) Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the PCT Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members and Officers or any employee of the PCT in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the PCT, without the express permission of the PCT. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(iv) Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

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

4.18 **Observers at PCT meetings**

The PCT Board 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 PCT Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

5. Appointment of Committees and Sub-Committees

5.1 **Board Committees**

Joint Committees

(i) Joint committees may be appointed by the Board by joining together with one or more other health service bodies consisting of, wholly or partly of the Chair and members of the PCT/Care Trust or other health service bodies, or wholly of persons who are not members of the PCT/Trust or other health service bodies in question.

(ii) Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the PCT/Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the PCT/Care Trust or health bodies in question) or wholly of persons who are not members of the PCT or health bodies in question or the committee of the PCT/Care Trust or health bodies in question.

5.2 **Applicability of Standing Orders and Standing Financial Instructions to Committees**
The Standing Orders and Standing Financial Instructions of the Board, as far as they are applicable, shall as appropriate apply to meetings of the Local Clinical Commissioning Committees (PEC) and any committees established by the Board. In which case the term "Chair" is to be read as a reference to the Chair of the Local Clinical Commissioning Committee (PEC), or other committee as the context permits, and the term "member" is to be read as a reference to a member of the Local Clinical Commissioning Committee (PEC), or other committee also as the context permits. (There is no statutory requirement to hold meetings of committees, including the Local Clinical Commissioning Committee (PEC), established by the Board in public though NHSSEL have agreed that all meetings of the LCCCs will be held in public).

5.3 **Terms of Reference**
Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4 **Delegation of powers by Committees to Sub-Committees**
Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee.

5.5 **Approval of Appointments to Committees**
The Board shall approve the appointments to each of the committees which it has formally constituted except where this has been delegated via the Scheme of delegation. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.6 **Appointments for Statutory functions**
Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

5.7 **Committees established by the PCT Board**

The committees, sub-committees, and joint-committees established by the Board are:

- Local Clinical Commissioning Committees (PEC)
- Joint Audit and Risk Committees
- Joint Remuneration and Employment Committees
- Joint Finance and Performance Committees (QIPP)
- Joint Quality and Safety Committees

Terms of Reference can be obtained from the Board Secretary

5.8 **Trust and Charitable Funds Committees**

Funds held on trust for the NHS can, with a few exceptions, be managed by any NHS body provided the terms of the PCT/Care Trust are adhered to. This includes separate bodies of trustees, created in certain circumstances by legislation or the Secretary of State. Where the PCT/Care Trust has responsibility for managing funds held on trust, either as charitable funds or non charitable funds, the PCT/Care Trust Boards via the scheme of delegation will establish a Trust and Charitable funds Committee to administer those funds in accordance with any statutory or other legal requirements and best practice required by the Charities Commission. In doing so, the PCT/Care Trust Boards will recognise that the establishment of a Trust and Charitable funds Committee does not alter the responsibilities of the PCT/Care Trust Boards, which remain the trustee as a corporate body. The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and Standing Financial Instructions No. 28.

5.9 **Other Committees**

The Board may also establish such other committees as required to discharge the PCT/Care Trust Boards responsibilities

6. Arrangements for the Exercise of Trust Functions by Delegation

6.1 Delegation of Functions to Committees, Officers or other bodies

6.1.1 Subject to such directions as may be given by the Secretary of State, the Joint Board may make arrangements for the exercise, on behalf of the PCT/Care Trust Boards, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order No. 5, or by an officer of the PCT, or by another body as defined in Standing Order 6.1.2 below, in each case subject to such restrictions and conditions as the PCT thinks fit.

6.1.2 Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of PCT/Care Trust Boards to be carried out by third parties. In accordance with The Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 the functions of the PCT/Care Trust Boards may also be carried out in the following ways:

(i) by another PCT;
(ii) jointly with any one or more of the following: Strategic Health Authorities, NHS trusts and other PCTs;
(iii) by a Special Health Authority or by a committee, sub-committee or officer of a SHA;
(iv) by arrangement with the appropriate Strategic Health Authority or PCT, by a joint committee or joint sub-committee of the PCT and one or more other health service bodies;
(v) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more Strategic Health Authorities, SHAs, NHS Trusts or other PCTs.

6.1.3 Where a function is delegated by these Regulations to another PCT or SHA, then that PCT or SHA exercises the function in its own right; the receiving PCT has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub committees or officers, the PCT delegating the function retains full responsibility.

6.2 Emergency Powers and urgent decisions

The powers which the Joint Board has reserved to itself within these Standing Orders (see Standing Order XX) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-officer members. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Joint Board or, on occasion, PCT/Care Trust Board in public session for formal ratification.

6.3 Delegation to Committees

6.3.1 During this transitional phase it is essential that local decision making should support ownership, understanding and engagement of local clinicians and that as much business as possible should be delegated to local Clinical Commissioning Committees. The Joint Board shall agree from time to time to the delegation of executive powers to be exercised by the local Clinical Commissioning Committees, other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State or the Strategic Health Authority. The constitution and terms of

reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Joint Board. The Scheme of Delegation sets out which functions the local clinical commissioning committees will perform. A process by which the scope or scale of the Scheme of Delegation may change over time will be developed including the criteria to be met to secure approval of the proposed changes.

6.3.2 When the Joint Board is not meeting as a PCT/Care Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by a Joint Board in public session.

6.4 Delegation to Officers

6.4.1 Those functions of the PCT's/Care Trust which have not been retained as reserved by the Boards or delegated to the local Clinical Commissioning Committee, other committee or sub-committee or joint-committee shall be exercised on behalf of the PCTs/Care Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the PCTs/Care Trust.

6.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Joint Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Joint Board.

6.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Joint Board of the Director of Finance, Procurement, ICT and Estates to provide information and advise the Joint Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance, Procurement, ICT and Estates shall be accountable to the Chief Executive for operational matters.

6.5 Schedule of Matters Reserved to the PCT and Scheme of Delegation of powers

6.5.1 The arrangements made by the Joint Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers (See Section C) shall have effect as if incorporated in these Standing Orders.

6.6 Duty to report non-compliance with Standing Orders and SFIs

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the relevant local Commissioning Committee and the Joint Board for action or ratification. All members of the Joint Board and local Commissioning Committee and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

7. Overlap with PCTs/Care Trust Policy Statements/Procedures, Regulations and SFIs

7.1 **Policy statements: general principles**

The Joint Board and its supporting committees will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by a PCT or Care Trust. The decisions to approve such policies and procedures will be recorded in an appropriate minute and will be deemed where appropriate to be an integral part of the Joint Board's Standing Orders and Standing Financial Instructions.

7.2 Specific Policy statements

Notwithstanding the application of SO No. 7.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Conflicts of Interest Policy for each PCT/Care Trust staff;
- Code of Conduct for NHS Managers 2002
- ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry;
- The staff Disciplinary and Appeals Procedures adopted by each PCT all of which shall have effect as if incorporated in these Standing Orders
- Whistleblowing Policies
- Counter Fraud procedures

7.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Joint Board in accordance with the relevant Financial Regulations shall have the effect as if incorporated in these Standing Orders.

7.4 Specific guidance

Notwithstanding the application of SO No. 7.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

8. Duties and Obligations of PCT Board Members/Directors and Senior Managers under these Standing Orders.

8.1 Declaration of Interests

8.1.1 **Requirements for Declaring Interests and applicability to Board and Local Clinical Commissioning Committee Members**

i) The NHS Code of Accountability requires PCT/Care Trust Board members and Local Clinical Commissioning Committee members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members

should declare such interests. Any Board members appointed subsequently should do so on appointment. References here to Board members shall mean Joint Board, individual PCT/Care Trust Board members and Local Commissioning Committee members.

8.1.2 **Interests which are relevant and material**

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Research funding/grants that may be received by an individual or their department;

g) Interests in pooled funds that are under separate management (and any relevant company included in this fund that has a potential relationship with a PCT/Care Trust must be declared.)

h) Practice Based Commissioning (see 18.3).

(ii) Any Member of the Joint Board, or individual PCT/Care Trust Board or Local Commissioning Committee who comes to know that a PCT/Care Trust or Local Commissioning Committee has entered into or proposes to enter into a contract in which he or any person connected with him (as defined in Standing Order 8.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member or Local Commissioning Committee member shall declare his/her interest by giving notice in writing of such fact to the Director of Corporate Affairs as soon as practicable.

8.1.3 **Advice on Interests**

If Board or Local Clinical Commissioning Committee members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Board or the Chair of the Local Clinical Commissioning Committee as appropriate, or with the Director of Corporate Affairs.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

8.1.4 **Recording of Interests in Joint Board or PCT/Care Trust Board and Local** Clinical **Commissioning Committee minutes**

At the time Board members' interests are declared, they should be recorded in the Joint Board or PCT/Care Trust Board minutes or in the case of the Local Clinical Commissioning Committee in the Local Clinical Commissioning Committee's minutes. Where interests are declared to the Local Commissioning Committee, these should be formally reported to the Joint Board or PCT/Care Trust Board at the earliest opportunity. Any changes in interests should be declared at the next Joint Board, or PCT/Care Trust Board meeting or Local Clinical Commissioning Committee meeting following the change occurring and recorded in the minutes of that meeting.

8.1.5 **Publication of declared interests in Annual Report**

Board members' and Local Clinical Commissioning Committee Members, Directorships of companies likely or possibly seeking to do business with the NHS should be published in the PCT's/Care Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

8.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Joint Board or PCT/Care Trust Board meeting or a Local Clinical Commissioning Committee meeting, if a conflict of interest is established, the Board or Local Commissioning Committee Member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 8.3)

8.2 Register of Interests

8.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Local Clinical Commissioning Committee members (in this case the record will be held by the MD of the relevant BSU). In particular the Register will include details of all Directorships and other relevant and material interests (as defined in SO 8.1.2) which have been declared by both executive and non-executive PCT/Care Trust Board Members and Local Clinical Commissioning Committee members.

8.2.2. 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.

8.2.3 The register(s) will be available to the public and the Chief Executive (or where applicable the MD of the BSU) will take reasonable steps to bring the existence of the Register(s) to the attention of local residents and to publicise arrangements for viewing it.

8.3 Exclusion of Chair and Members in proceedings on account of pecuniary interest

8.3.1 **Interpretation of 'Pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);
(ii) "contract" shall include any proposed contract

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or
b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

A person shall not be regarded as having a pecuniary interest in any contract if:-

c) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or
d) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or
e) those securities of any company in which he/her (or any person connected with him/her) has a beneficial interest do not exceed £10,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies, the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 8.1.2 (ii).

8.3.2 **Exclusion in proceedings of the Joint Board or PCT/Care Trust Board and Local Clinical Commissioning Committee**

(i) Subject to the following provisions of this Standing Order, if the Chair or a member of the Joint Board, or PCT/Care Trust Board, or Chair or member of the and Local Clinical Commissioning Committee has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Joint Board or PCT/Care Trust Board and Local Commissioning Committee at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
(ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 8.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).

(iii) The Joint Board or PCT/Care Trust Board and Local Clinical Commissioning Committee may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration. The Professional Executive Committee may take the same action in relation to the Professional Executive Committee Chair or Professional Executive Committee Members.

(iv) Any remuneration, compensation or allowance payable to the Chair or a member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(v) This Standing Order applies to a committee (including the Professional Executive Committee) or sub-committee and to a joint committee or sub-committee as it applies to the Joint Board or PCT/Care Trust Board and Local Commissioning Clinical Committees_and applies to a member of any such committee or sub-committee (whether or not he is also a member of the Joint Board or PCT/Care Trust Board and Local Commissioning Committee) as it applies to a Member of the Joint Board or PCT/Care Trust Board and Local Commissioning Committee.

8.3.3 Waiver of Standing Orders made by the Secretary of State of Health

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chair' for the purpose of interpreting this waiver

For the purposes of paragraph 8.3.3. (3) (below), the "relevant Chair" is–

(a) at a meeting of the Joint Board, PCT/Care Trust Board, the Chair of that Joint Board, PCT/Care Trust;

(b) at a meeting of a Local Commissioning Committee–

(i) in a case where the member in question is the Chair of that Committee, the Chair of the a PCT/Care Trust;

(ii) in the case of any other member, the Chair of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of Joint Board or a PCT/Care Trust or a Local Commissioning Committee on account of a pecuniary interest.

It will apply to:

(i) A member of all PCTs/Care Trust, or the Local Clinical Commissioning Committees of the PCTs/Care Trust, who is a healthcare professional, within

the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of–

(a) services under the National Health Service Act 1977; or

(b) services in connection with a pilot scheme under the National Health Service (Primary Care) Act 1997;

for the benefit of persons for whom the PCT/Care Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question;

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the PCT/Care Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant Chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 8.3.3 (2) (b) above, except where that member is the Chief Executive;

(c) in the case of a meeting of the Joint Board or PCT/Care Trust:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded; but

(ii) may not vote on any question with respect to it.

(d) in the case of a meeting of a Local Commissioning Committee:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded; and

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Joint Board or PCT/Care Trust Board as appropriate.

8.4 Standards of Business Conduct

8.4.1 **PCT Policy and National Guidance**

All PCT/Care Trust staff and members of the Joint Boards and Local Clinical Commissioning Committees must comply with the PCT's/Care Trust Standards of Business Conduct and Conflicts of Interest Policy and the national guidance contained in HSG (93) 5 on 'Standards of Business Conduct for NHS staff' (see SO 7.2), the Code of Conduct for NHS Managers 2002 and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry.

8.4.2 **Interest of Officers in Contracts**

i) Any officer or employee of a PCT/Care Trust who comes to know that the PCT/Care Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 8.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Director of Corporate Affairs as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the PCT/Care Trust.

iii) The PCT/Care Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

8.4.3 **Canvassing of and Recommendations by Members in Relation to Appointments**

i) Canvassing of members of the Joint Boards or of any Committee of the Joint Boards directly or indirectly for any appointment under a PCT/Care Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of a PCT/Care Trust or Local Clinical Commissioning Committee shall not solicit for any person any appointment under the PCT/Care Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the PCT/Care Trust.

iii) Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.4.4 **Relatives of Members or Officers**

i) Candidates for any staff appointment under a PCT/Care Trust shall, when making an application, disclose in writing to the PCT/Care Trust whether they are related to any member or the holder of any office under the PCT/Care Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/herself liable to instant dismissal.

ii) The Chair and every member and officer of the PCT/Care Trust shall disclose to the PCT/Care Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other member or holder of any office under a PCT/Care Trust.

iv) Where the relationship to a member of a PCT/Care Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (SO 8) shall apply.

9. Custody of Seals, Sealing of Documents and Signature of Documents

9.1 Custody of Seals

The common seal of each PCT/Care Trust shall be kept by the Director of Corporate Affairs in a secure place.

9.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

9.3 Register of Sealing

The Chief Executive shall keep a register in which he/she, or another manager of the Cluster authorised by him/her, shall enter a record of the sealing of every document.

9.4 Use of Seal – General guide

- All contracts for the purchase/lease of land and/or building
- All contracts for capital works exceeding £100,000
- All lease agreements where the annual lease charge exceeds £10,000 per annum and/or the period of the lease exceeds beyond 31st March 2014.
- Any other lease agreement where the total payable under the lease exceeds £100,000
- Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000

9.5 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the PCT/Care trust, it shall, unless any enactment otherwise requires or authorised, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

10. Miscellaneous (see overlap with SFI No. 21.3)

10.1 **Joint Finance Arrangements**

The relevant PCT/Care Trust Board, or on occasion Joint Board (s) may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The relevant PCT/Care Trust Board, or on occasion Joint Board (s) may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction No. 21.3.

10.2 **Standing Orders to be given to Members and Officers** - It is the duty of the Chief Executive to ensure that existing members and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive via the PCT intranet. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

10.3 Review of Standing Orders - Standing Orders shall be reviewed annually by the Board. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

10.4 Grants to Voluntary Bodies – The Board may provide financial assistance to such voluntary bodies in support of health related functions in accordance with Section 64 of the Health Services and Public Health Act 1968.

Appendix 9 Standing Financial Instructions

11. Introduction

11.1 General

11.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Primary Care Trust (Functions) Directions 2000 as amended by the Primary Care Trust (Functions) (Amendment) Directions 2002 issued by the Secretary of State which require that each Primary Care Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

11.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Joint Boards, individual PCTS/Care Trust and Local Commissioning Committees. They are designed to ensure that the Joint Board, individual PCTS/Care Trust and Local Commissioning Committees financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Joint Boards.

11.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the South East London Cluster and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance, Procurement, ICT and Estates.

11.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance, Procurement, ICT and Estates must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Joint Boards Standing Orders.

11.1.5 The failure to comply with Standing Financial Instructions and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

11.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Joint Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial

Instructions to the Director of Finance, Procurement, ICT and Estates as soon as possible.

11.2 Responsibilities and delegation

11.2.1 **The Joint Boards**
The Joint Boards exercises financial supervision and control by:

(a) Formulating the financial strategy;
(b) Requiring the submission and approval of budgets within approved allocations/overall income;
(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
(d) Defining specific responsibilities placed on members of the Board(s) and Local Commissioning Committees and employees as indicated in the Scheme of Delegation document.

11.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of Matters Reserved to the Board' document as referred to in section 2.10 of the Standing orders and contained within the Joint Boards Scheme of Delegation – Section C. All other powers have been delegated to the Local Commissioning Committees and such other committees as the Joint Boards has established.

11.2.3 The Local Commissioning Committees can not delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the PCT without the express consent of the individual PCT/Care Trust Board.

11.2.4 **The Chief Executive and Director of Finance, Procurement, ICT and Estates**
The Chief Executive and Director of Finance, Procurement, ICT and Estates will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Joint Boards, and as Accountable Officer, to the Secretary of State, for ensuring that the Joint Boards meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees' activities; is responsible to the Chairman and the Joint Boards for ensuring that their financial obligations and targets are met and has overall responsibility for the system of internal control.

11.2.5 It is a duty of the Chief Executive to ensure that Members of the Joint Boards and Local Commissioning Committees, employees and all new appointees are

notified of, and put in a position to understand their responsibilities within these Instructions.

11.2.6 **The Director of Finance, Procurement, ICT and Estates**

The Director of Finance, Procurement, ICT and Estates is responsible for:

a) implementing the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees financial policies and for co-coordinating any corrective action necessary to further these policies;
b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
c) ensuring that sufficient records are maintained to show and explain the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees' transactions, in order to disclose, with reasonable accuracy, the financial position of the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees at any time; and, without prejudice to any other functions of the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees, and employees of the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees.
d) the provision of financial advice to other members of the Board and Local Commissioning Committees and employees; the design, implementation and supervision of systems of internal financial control; and
e) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees may require for the purpose of carrying out its statutory duties.

11.2.7 **Joint Board Members, Local Commissioning Committee Members and Employees**

All members of the Joint Boards and Executive Committee and employees, severally and collectively, are responsible for:

a) The security of the property of the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees;
b) Avoiding loss;
c) Exercising economy and efficiency in the use of resources; and
d) Conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

11.2.8 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees to commit the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

11.2.9 For all members of the Joint Boards and Local Commissioning Committees and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and Local Commissioning Committees and employees discharge their duties must be to the satisfaction of the Director of Finance, Procurement, ICT and Estates.

12. Audit

12.1 Joint Audit Committee

12.1.1 An independent Joint Audit Committee is the central means by which the Joint Boards ensures effective internal control arrangements are in place. In addition, the Joint Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with Standing Orders the Joint Boards shall formally establish a Joint Audit Committee, with defined terms of reference taken from the NHS Audit Committee Handbook (2005) to perform the following tasks:

(a) Ensuring there is an effective internal audit function established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Joint Audit Committee, Chief Executive and Joint Boards;
(b) Reviewing the work and findings of the external auditor(s) appointed by the Audit Commission and considering the implications of and management's responses to their work;
(c) Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and considering the implications for the governance of the organisation;
(d) Ensuring that the systems for financial reporting to the Joint Boards, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Joint Boards;
(e) Reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
(f) Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;
(g) Monitoring compliance with Orders and Standing Financial Instructions by receiving reports of instances where standing orders are waived.
(h) Reviewing schedules of losses and compensations and make recommendations to the Joint Boards;
(i) Reviewing schedules of debtors/creditors balances over 6 months and above £100k;
(j) Review the annual report and financial statements prior to submission to the Joint Boards focusing particularly on;

(i) the wording in the Statement of Internal control and other disclosures relevant to the Terms of Reference of the Committee;
(ii) changes in, and compliance with, accounting policies and practices;
(iii) unadjusted mis-statements in the financial statements;
(iv) major judgmental areas;
(v) significant adjustments resulting from audit.

(k) Reviewing the external auditors report on the financial statements and the annual management letter;

(l) Conducting a review of the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees major accounting policies;

(m) Reviewing any incident of fraud or corruption or possible breach of ethical standards or legal or statutory requirements that could have a significant impact on the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees published financial accounts or reputation;

(n) Reviewing major findings from internal and external audit reports and ensure appropriate action is taken;

(o) Reviewing 'value for money' audits reporting on the effectiveness and efficiency of the selected departments or activities;

(p) Reviewing the mechanisms and levels of authority (e.g. Standing Orders, Standing Financial Instructions, Delegated limits) and make recommendations to the Joint Board;

(q) Reviewing the scope of both internal and external audit including the agreement on the number of audits per year for approval by the Joint Boards;

(r) Investigating any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation;

(s) Review the adequacy of the underlying assurance process that indicates the degree of the achievement of separate objectives, the structures, process and responsibilities for identifying and managing the key risks facing the Joint Boards, individual PCTs/Care Trust and Local Commissioning Committees and the appropriateness of the above disclosure.

(t) Review the adequacy of the policies for ensuring that there is compliance with relevant regularity, legal and code of conduct requirements as set out in relevant guidance.

(u) Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation and carry out an annual review of the effectiveness of internal audit

(v) Responsibility for reviewing the work of other committees within the organisation to obtain relevant assurance for the Joint Audit Committees' own scope of work.

12.1.2 The minutes of the Joint Audit Committee meetings shall be formally recorded by the Director of Corporate Affairs and submitted to the Joint Boards. The Chair of the Committee shall draw to the attention of the Joint Boards any

issues that require disclosure to the full Joint Boards, or individual PCT/Care Trust Board or require executive action. The Committee will report to the Board annually on its work in support of the Statement of Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation ensuring the risk management system is working effectively, the integration of governance arrangements and the appropriateness of the self-assessment against the Standards for Better Health.

12.1.3 Where the Joint Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Joint Audit Committee should raise the matter at a full meeting of the Joint Boards. Exceptionally, the matter may need to be referred to the Department of Health.

12.2 Director of Finance, Procurement, ICT and Estates

12.2.1 The Director of Finance, Procurement, ICT and Estates is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit function meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Joint Audit Committee and the Accountable Officer;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.

(d) ensuring that an annual Internal Audit report is prepared for the consideration of the Joint Audit Committee [and the Joint Boards]. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;

(ii) major internal financial control weaknesses discovered;

(iii) progress on the implementation of Internal Audit recommendations;

(iv) progress against plan over the previous year;

(iv) a strategic audit plan covering the coming two years;

(v) a detailed plan for the coming year.

12.2.2 The Director of Finance, Procurement, ICT and Estates or designated internal or external auditor is entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Joint Boards and Executive Committee or employee of the PCTs/Care Trusts;

(c) the production of any cash, stores or other property of the PCTs/Care Trust under a member of the Joint Boards, Local Commissioning Committee and Executive Committee's or an employee's control; and
(d) explanations concerning any matter under investigation.

12.3 Role of Internal Audit

12.3.1 Internal Audit is an independent and objective appraisal service within an organisation which provides:

(1) an independent and objective opinion to the Accountable Officer, the Joint Boards, and the Joint Audit Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives;
(2) an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

12.3.2 Internal Audit will review, appraise and report upon policies, procedures and operations in place to;

a) establish and monitor the achievement of the organisation's objectives; ;
b) identify, assess and manage the risks to achieving the organisation's objectives;
c) ensure the economical, effective and efficient use of resources;
ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations;
d) safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption;
e) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

12.3.3 The Head of Internal Audit will provide to the Joint Audit Committee;

a) A risk-based plan of internal audit work, agreed with management and approved by the Joint Audit Committee, based upon the management's Assurance Framework that will enable the auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the organisation including systems of internal control;
b) Regular updates on the progress against plan;
c) Reports of management's progress on the implementation of action agreed as a result of internal audit findings;
d) An annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the South East London Clusters organisations risk management, control and governance processes (i.e. the organisation's system of internal control). This opinion is used by the Joint Board and individual PCTs/Care Trust Boards to inform the SIC and by the Strategic Health Authority [from 1st April 2012 the NHS Commissioning Board] as part of its performance management role;
e) A report supporting Trust assurances to the Healthcare Commission on compliance with Standards for Better Health;

f) Additional reports as requested by the Joint Audit Committee.

12.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance, Procurement, ICT and Estates must be notified immediately.

12.3.5 The Head of Internal Audit will normally attend Joint Audit Committee meetings and has a right of access to all Joint Audit Committee members, the Chairman, Chief Executive and Director of Finance, Procurement, ICT and Estates of the PCT.

12.3.6 The Head of Internal Audit reports to the Joint Audit Committee and is managed by the Director of Finance, Procurement, ICT and Estates. The reporting system for Internal Audit shall be agreed between the Director of Finance, Procurement, ICT and Estates, the Joint Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed every year.

12.3.7 The appointment and termination of the Head of Internal Audit and/or the Internal Audit Service must be approved by the Joint Audit Committee.

12.4 External Audit

12.4.1 The External Auditor(s) is appointed by the Audit Commission and paid for by the individual PCTs/Care Trust. The Joint Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor(s), then this should be raised with the External Auditor(s) and referred on to the Audit Commission if the issue cannot be resolved.

12.5 Fraud and Corruption

12.5.1 In line with their responsibilities, the Chief Executive and Director of Finance, Procurement, ICT and Estates shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

12.5.2 The Cluster shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual, and guidance.

12.5.3 The LCFS shall report to the Director of Finance, Procurement, ICT and Estates and shall work with staff in the NHS Counter Fraud Service (NHS CFS) and the Operational Fraud Team (OFT) in accordance with the NHS Counter Fraud and Corruption Manual.

12.5.4 The LCFS will provide a written report, at least annually, on counter fraud work within the each PCT/Care Trust.

12.6 Security Management

126.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

12.6.2 The each PCT/Care Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS Security Management.

12.6.3 The each PCT/Care Trsust shall nominate a Non-Executive Director to oversee the NHS Security Management service who will report to the Board.

12.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

13. Resource and Cash Limits Control

13.1.1 Each PCT/Care Trust is required by statutory provisions not to exceed its Revenue and Capital as well as its total cash limit (Resource Limit). The Chief Executive has overall executive responsibility for each PCT/Care Trust 's activities and is responsible to each PCT/Care Trust for ensuring that it stays within its Resource and Cash Limit.

13.1.2 The definition of use of resources is set out in RAB Directions on use of resources (available on the Departmental Finance Manual web-site).

13.1.3 Any sums received on behalf of the Secretary of State excluding charges arising under Part II of the 1977 NHS Act is treated as sums received by each PCT/Care Trust.

13.1.4 The Director of Finance, Procurement, ICT and Estates will:

(a) provide monthly reports in the form required by the Secretary of State;
(b) ensure money drawn from the Department of Health against the financing requirement arising from the Resource Limit is required for approved expenditure only, and is drawn down only at the time of need, follows best practice as set out in 'Cash Management in the NHS';
(c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable each PCT/Care Trust to fulfill its statutory responsibility not to exceed its Annual Revenue and Capital Resource Limits.
(d) Ensure that total cash limit allocations to each organisation is drawn down in full and all this cash is spent during the year to leave minimal balances in the OPG accounts in line with DoH policies on cash management.

14. Allocations, Operating Plan, Budgets, Budgetary Control and Monitoring

14.1 Allocations

14.1.1 The Director of Finance, Procurement, ICT and Estates will:

(a) periodically review the basis and assumptions used by the the Strategic Health Authority [from 1st April 2012 the NHS Commissioning Board] [from 1st April 2012 the NHS Commissioning Board] for distributing allocations and ensure that these are reasonable and realistic and secure each PCT/Care Trust 's entitlement to funds;

(b) prior to the start of each financial year submit to the Joint Boards and each PCT/Care Trust Board for approval a report showing the total allocations received as well as anticipated and their proposed distribution including any sums to be held in reserve; and

(c) regularly update the Joint Boards on significant changes to the initial allocation and the uses of such funds.

14.2 Preparation and Approval of Operating Plan and Budgets

14.2.1 The Chief Executive will compile and submit to the Joint Boards a Consolidated Operating Plan which takes into account financial targets and forecast limits of available resources. The plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services, resources and Quality Innovation Productivity and Prevention (QIPP) savings required to achieve the plan.

14.2.2 Prior to the start of the financial year the Director of Finance, Procurement, ICT and Estates will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Joint Boards. Such budgets will:

(a) be in accordance with the aims and objectives set out in the plan;
(b) accord with workload and manpower plans;
(c) be produced following discussion with appropriate budget holders;
(d) be prepared within the limits of available funds;
(e) identify potential risks including any associated with the non-delivery of QIPP savings.

14.2.3 The Director of Finance, Procurement, ICT and Estates shall monitor financial performance against budget and plan including QIPP programmes, periodically review them, and report to the Joint Boards.

14.2.4 All budget holders must provide information as required by the Director of Finance, Procurement, ICT and Estates to enable budgets to be compiled.

14.2.5 The Director of Finance, Procurement, ICT and Estates has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

14.3 Budgetary Delegation

14.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.
(g) responsibilities for delivery of QIPP

14.3.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Joint Boards.

14.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

14.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance, Procurement, ICT and Estates.

14.4 Budgetary Control and Reporting

14.4.1 The Director of Finance, Procurement, ICT and Estates will devise and maintain systems of budgetary control. These will include:

(a) consolidated monthly financial reports to the Joint Boards in a form approved by the Joint Boards containing:
(i) income and expenditure to date showing trends and forecast year-end position;
(ii) movements in working capital;
(iii) movements in cash and capital;
(iv) capital project spend and projected outturn against plan;
(v) performance against Better Payment Practice Code and explanations of any material variances from plan;
(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance, Procurement, ICT and Estates's view of whether such actions are sufficient to correct the situation;
(vii) progress of delivery of financial targets in QIPP plans and projects;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
(c) investigation and reporting of variances from financial, QIPP savings targets, workload and manpower budgets;
(d) monitoring of management action to correct variances including QIPP savings targets;
(e) arrangements for the authorisation of budget transfers.

14.4.2 Each Budget Holder or, in the case of QIPP Schemes the Senior Responsible Officer (SRO), is responsible for ensuring that:
(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;
(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorized, subject to the rules of virement;
(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.
(d) QIPP savings targets are met and if achievement is deemed to be unlikely or high risk then bring this to the attention of the Chief Executive including any proposed corrective action

14.4.3 The Chief Executive is overall responsible for identifying and implementing QIPP initiatives in accordance with the requirements of the Operating Plan and a balanced budget.

14.5 Capital Expenditure

14.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 23).

14.6 Monitoring Returns

14.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

15. Annual Accounts and Reports

15.1 The Director of Finance, Procurement, ICT and Estates, on behalf of each PCT/Care Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Joint Boards accounting policies, generally accepted accounting practice and international accounting standards of application;
(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

15.2 The each PCT's/Care Trust annual accounts must be audited by an auditor appointed by the Audit Commission. Each PCT's/Care Trust audited annual accounts must be presented to a public meeting and ma de available to the public.

15.3 Each PCT/Care Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

16. Bank and OPG Accounts

16.1 General

16.1.1 The Director of Finance, Procurement, ICT and Estates is responsible for managing each PCT's/Care Trust banking arrangements and for advising the Joint Boards on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' PCTs should minimize the use of commercial bank accounts and consider using Office of the Paymaster General (OPG) accounts for all banking services.

16.1.2 The Joint Boards shall approve the banking arrangements.

16.2 Bank and OPG Accounts

16.2.1 The Director of Finance, Procurement, ICT and Estates is responsible for:

(a) bank accounts and Office of the Paymaster General (OPG) accounts;
(b) establishing separate bank accounts for each PCT's/Care Trust's non-exchequer funds;
(c) ensuring payments made from bank or OPG accounts do not exceed the amount credited to the account except where arrangements have been made;
(d) reporting to the Joint Boards all arrangements made with each PCT's/Care Trust 's bankers for accounts to be overdrawn;
(e) monitoring compliance with DH guidance on the level of cleared funds.

16.3 Banking Procedures

16.3.1 The Director of Finance, Procurement, ICT and Estates will prepare detailed instructions on the operation of bank and OPG accounts which must include:

(a) the conditions under which each bank and OPG account is to be operated;
(b) those authorised to sign cheques or other orders drawn on the each PCT's/Care Trust's accounts.

16.3.2 The Director of Finance, Procurement, ICT and Estates must advise each PCT's/Care Trust bankers in writing of the conditions under which each account will be operated.

16.4 Tendering and Review

16.4.1 The Director of Finance, Procurement, ICT and Estates will review the banking arrangements of each PCT's/Care Trust to ensure they reflect best practice and represent best value for money and if deemed appropriate taking account of the timeline to the demise of PCTs/Care Trusts seek competitive tenders for the collective PCT's/Care Trust banking business.

16.4.2 This review is not necessary for OPG accounts. The results of the tendering exercise, if undertaken, should be reported to the Joint Boards.

17. Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

16.1 Income Systems

17.1.1 The Director of Finance, Procurement, ICT and Estates is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

17.1.2 The Director of Finance, Procurement, ICT and Estates is also responsible for the prompt banking of all monies received.

17.2 Fees and Charges

17.2.1 The South East Cluster and each PCT/Care Trust shall follow the Department of Health's advice in the "Costing" Manual in setting prices for NHS service agreements.

17.2.2 The Director of Finance, Procurement, ICT and Estates is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

17.2.3 All employees must inform the Director of Finance, Procurement, ICT and Estates promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

17.3 Debt Recovery

17.3.1 The Director of Finance, Procurement, ICT and Estates is responsible for the management and timely recovery of all debts. The Director of Finance, Procurement, ICT and Estates should therefore institute procedures for accurate raising of all invoices which are monitored for their collection within due dates. A summary of debtor position should be reporting monthly and a

detailed aged debt report of all debtors over £100,000 outstanding for more than 6 months should be reported to the Joint Audit Committee.

17.3.2 The Director of Finance, Procurement, ICT and Estates may wish to engage an independent firm of debt collectors to speed up the process of debt collection.

17.3.3 Income not likely to be received should be dealt with in accordance with losses procedures.

17.3.4 The Director of Finance, Procurement, ICT and Estates should implement control procedures for the prevention of overpayments as well as their detection and immediate recovery action.

17.4 Security of Cash, Cheques and other Negotiable Instruments

17.4.1 The Director of Finance, Procurement, ICT and Estates is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Joint Boards.

17.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

17.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance, Procurement, ICT and Estates.

17.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Joint Boards and each PCT/Care Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Joint Boards and each PCT/Care Trust from responsibility for any loss.

18. Tendering and Contracting Procedures

18.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Joint Boards and each PCT/Care Trust shall comply with these Standing Orders and Standing

Financial Instructions (except where Standing Order No. 4.13 Suspension of Standing Orders is applied).

18.2 EU Directives Governing Public Procurement

(a) Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

(b) The Director of Finance, Procurement, ICT and Estates should consider obtaining external procurement advice and support when appropriate

18.3 Reverse e Auctions

The Director of Finance, Procurement, ICT and Estates should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk

18.4 Capital Investment Manual and other Department of Health Guidance

All capital transactions shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions.

18.5 Formal Competitive Tendering

18.5.1 **General Applicability**

The Director of Finance, Procurement, ICT and Estates shall ensure that arrangements are in place and competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

18.5.2 **Health Care Services**

Where the Joint Boards or Local Commissioning Committees elect to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 19 and No. 20.

18.5.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures and quotes **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 or

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements or must be complied with;
(c) regarding disposals as set out in Standing Financial Instructions No. 26;

Formal tendering procedures **may be waived** by the Chief Executive in the following circumstances:

(d) in very exceptional circumstances where formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate record;
(e) where the requirement is covered by an existing contract;
(f) where PASA agreements or Public Sector Framework Agreement are in place and have been approved by the Joint Boards;
(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
(i) where specialist expertise is required and is available from only one source;
(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Director of Finance, Procurement, ICT and Estates will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.
(m) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate record and reported to the Joint Audit Committee at each meeting.

Tendering – *a Summary*

Expenditure (including non-recoverable VAT)

Less than £10,000	1 written quote
£10,000 - £50,000 *	At least 3 written quotes
Greater than £50,000 *	Tendering exercise as follows: - up to £60,000 = 3 competitive tenders - £60,001 - £200,000 = 4 competitive tenders - Greater than £200,000 = 6 competitive tenders

Approval of Quotes/Tenders

Budget Manager	Up to £15,000
Directors	Up to £100,000
Chair/Chief Executive/DoF	Up to £250,000
Board	Above £250,000

* Unless waived by the Chief Executive, where specific conditions are met
n.b. the above amounts do not restrict the ability of approved signatories to approve payments above these thresholds against contracts already approved by the Board e.g. Monthly Acute or Mental Health contractual payments. These are in effect limits to their personal levels of approval without reference to the Board.

18.5.4. **Fair and Adequate Competition**

Where the exceptions set out in SFI Nos. 17.3 and 17.5.3 apply, the Director of Finance, Procurement, ICT and Estates shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

ENCLOSURE 1

18.5.5 **List of Approved Firms**

The Joint Boards and the Executive Committee shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Director of Finance, Procurement, ICT and Estates it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive or Executive Committee (see SFI 18.6.8 List of Approved Firms).

18.5.6 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Department of Health approval.

18.5.7 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate record.

18.6 Contracting/Tendering Procedure

18.6.1 **Invitation to tender**

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

- submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Cluster or individual PCT/Care Trust (or the word "tender" followed by the subject to which it related) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;
- that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions

of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

(v) Every tender must have given, or give a written undertaking, not to engage in collusive tendering or other restrictive practice.

18.6.2 **Receipt and safe custody of tenders**

The Chief Executive or his/her nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

18.6.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(ii) A Director will be required to be one of the two approved persons present for the opening of tenders estimated above £100,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Joint Boards Scheme of Delegation.

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance, Procurement, ICT and Estates or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(v) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department. The Director Corporate Affairs, Director of Human Resources, Director of Strategy and BSU Managing Directors will count as a Director for the purposes of opening tenders.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations dispatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were received and opened;
- the persons present at the opening;
- the price shown on each tender;

- a note where price alterations have been made on the tender and suitably initialled.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his/her own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 18.6.5 below).

18.6.4 **Admissibility**

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance, Procurement, ICT and Estates shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the PCT.

18.6.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his/her nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his/her nominated officer or if the process of evaluation and adjudication has not started

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his/her nominated officer.

(iv) Accepted late tenders will be reported to the Joint Audit Committee.

18.6.6 **Acceptance of formal tenders (See overlap with SFI No. 18.7)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his/her tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by the Joint Boards or individual PCTS/Care Trust, or the highest, if payment is to be received by the Joint Boards or individual PCTS/Care Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;
(b) understanding of client's needs;
(c) feasibility and credibility of proposed approach;
(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Joint Boards and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:
(a) not in excess of the going market rate / price current at the time the contract was awarded;
(b) that best value for money was achieved.

(v) All Tenders should be treated as confidential and should be retained for inspection.

18.6.7 **Tender reports to the Joint Boards**

Reports to the Joint Boards will be made on an exceptional circumstance basis only.

18.6.8 **List(s) of approved firms (see SFI No. 18.5.5)**

(a) **Responsibility for maintaining list(s)**

A manager nominated by the Chief Executive shall on behalf of the Joint Boards, individual PCTs/Care Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Joint Boards, individual PCTs/Care Trust is satisfied. All suppliers must be made aware of the Joint Boards, individual PCTs/Care Trust terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list(s) of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Director of Finance, Procurement, ICT and Estates may make or institute any enquiries he/she deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

18.6.9 **Exceptions to using approved contractors**

If in the opinion of the Chief Executive and the Director of Finance, Procurement, ICT and Estates or Joint Directors of Quality and Professional Development it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

Quotations: Competitive and non-competitive

18.7.1 **General Position on quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not exceed £39,999

18.7.2 **Competitive Quotations**

(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Joint Boards, individual PCTs/Care Trust or Executive Committee.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Joint Boards, individual PCTs/Care Trust, or the highest if payment is to be received by the Joint Boards, individual PCTs/Care Trust, then the choice made and the reasons why should be recorded in a permanent record.

18.7.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the Responsible Officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

18.7.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Joint Boards and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance, Procurement, ICT and Estates.

18.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Designated budget holders/Supplies	up to	£15,000
Directors	up to	£100,000
Chief Executive / DoF	up to	£150,000
PCT Board	over	£150,000

These levels of authorisation may be varied or changed and need to be read in conjunction with the Joint Board's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Joint Boards or Local Commissioning Committee this shall be recorded in their minutes.

18.9 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required, t one of the following alternatives should be adopted:

(a) the Joint Boards, individual PCTs/Care Trust shall use the NHS London Procurement Hub for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) if the NHS London Procurement Hub is not used - where tenders or quotations are not required, because expenditure is below £15,000 the goods and services shall be procured in accordance with procurement procedures approved by the Director of Finance, Procurement, ICT and Estates.

18.10 Private Finance for capital procurement (see overlap with SFI No. 23)

The Joint Boards should normally market-test for PFI (Private Finance Initiative funding) when considering a large capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Joint Boards.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

18.11 Compliance requirements for all contracts

The Joint Board may only enter into contracts on behalf of each PCT/Care Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Standing Orders and Standing Financial Instructions;
(b) EU Directives and other statutory provisions;
(c) Such of the NHS Standard Contract Conditions as are applicable;
(d) 'Standards for Better Health';
(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;
(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited;
(g) In all contracts made by the Joint Board or each individual PCT/Care Trust, the Joint Boards or Local Commissioning Committee shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Joint Board or each individual PCT/Care Trust or Local Commissioning Committee.

18.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

18.13 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Joint Board or each individual PCT/Care Trust or Local Commissioning Committee. Service agreements are not contracts in law and are not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Joint Boards.

18.14 Disposals (See overlap with SFI No. 25)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Joint Board or each individual PCT/Care Trust.;
(c) items to be disposed of with an estimated sale value of less than £1,500 this figure to be reviewed on a periodic basis;
(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

18.15 In-house Services

18.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Joint Boards may also determine from time to time that in-house services should be market tested by competitive tendering.

18.15.2 In all cases where the Joint Boards or Executive Committee determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.
(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.
(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance, Procurement, ICT and Estates representative for services having a likely annual expenditure exceeding £250,000, a non-officer member should be a member of the evaluation team.

18.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

18.15.4 The evaluation team shall make recommendations to the Joint Boards.

18.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Joint Boards.

18.16 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from each PCT/Care Trust trust funds and private resources.

19. NHS Service Agreements for the Provision of Services - see overlap with SFI No. 18.13

19.1 Service Level Agreements (SLAs) (including contracts with Foundation Trusts)

19.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the PCTs/Care Trust and Local Commissioning Committees enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within the Operating Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- NICE Guidance
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

19.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Joint Boards and each Local Commissioning Committee works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Joint Boards and local Commissioning Committee can jointly manage risk with all interested parties. Due consideration in all provider/purchaser arrangements must be observed as the NHS moves toward a 'Patient-led NHS' and GP Commissioning.

19.3 Equity and Excellence: Liberating the NHS

The Department of Health has published its document 'Equity and Excellence: Liberating the NHS' setting out the basis upon which the Government's major reform agenda will be carried forward.

For the commissioning system as a whole, the transition period will run broadly as follows (subject to legislation):

- In 2011/12, PCTs and SHA [from 1st April 2012 the NHS Commissioning Board]s will be statutorily accountable with consortia pathfinders emerging and commissioning support units being developed (Clusters).

- The NHS Commissioning Board will be created in shadow form and will focus on building its own capacity, developing the infrastructure of the new commissioning system, and overseeing planning for 2012/13 at national level
- In 2012/13, PCTs and the NHS Commissioning Board will be statutorily accountable bodies with SHA [from 1st April 2012 the NHS Commissioning Board] abolished on 31 March 2012
- PCTs, through clusters, will be accountable to the NHS Commissioning Board
- In 2013/14 the new system will be fully established with GP consortia and the NHS Commissioning Board statutorily accountable and receiving formal budgets. PCTs will be abolished on 31 March 2013 and commissioning support units will move into social enterprise and joint venture arrangements.

This is a complex transition path with arrangements changing year on year. Alongside these changes to the NHS infrastructure, Local Councils will be developing new Health and Wellbeing Boards to integrate local commissioning across the NHS, social care and public health, in addition the Government will also be developing the new Public Health Service at national and local level

In developing the new arrangements, it is critical that NHS and Local Authority partners work closely together from the outset to improve integration, in anticipation of the new statutory arrangements. The Joint Boards must also ensure that our transition planning does not lose sight of the main thrust of the proposals to create a truly patient-led and customer focused NHS.

Across the transition period, the Joint Boards will be required to continue to reduce the overall running costs of the health system. The Operating Framework sets out more detail on indicative running costs for the new system, including the expectation is that GP consortia will have an allowance for running costs that could be up to a maximum of £25 - £35 per head of population by 2014/15. Undoubtedly, the most significant challenge we face in 2011/12 is to maintain a grip on current performance and QIPP delivery, whilst simultaneously preparing and beginning to put in place the future system.

The changes are being rolled out by the Department of Health and full support and latest guidance may be accessed at http://www.dh.gov.uk

19.4 Reports to Joint Boards on SLAs

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast expenditure against the SLAs. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for across the range of SLAs.

20. Commissioning

20.1 Role of the Joint Board or each individual PCT/Care Trust or Local Commissioning Committee in Commissioning Secondary Services

20.1.1 The Joint Board or each individual PCT/Care Trust or Local Commissioning Committees have responsibilities for commissioning secondary services on behalf of the resident population. This will require the Joint Board or each individual PCT/Care Trust or Local Commissioning Committees to work in partnership with the the Strategic Health Authority [from 1st April 2012 the NHS Commissioning Board] [from 1st April 2012 the NHS Commissioning Board], local NHS Trusts, and FTs, local authority, users, carers and the voluntary sector to develop an Operating Plan.

20.2 Role of the Chief Executive

20.2.1 The Chief Executive as the Accountable Officer has responsibility for ensuring secondary services are commissioned in accordance with the priorities agreed in the Operating Plan. This will involve ensuring SLAs are put in place with the relevant providers, based upon integrated care pathways.

20.2.2 SLAs will be the key means of delivering the objectives of the Operating Plan and therefore they need to have a wider scope. The Chief Executive will need to ensure that all SLAs;

- Meet the standards of service quality expected;
- Fit the requirement of 'Standards for Better Health';
- Fit the requirement of the 'NHS Outcomes Framework';
- Take account of NICE Guidance
- Fit the relevant national service framework (if any);
- Enable the provision of reliable information on cost and volume of services;
- Fit the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based upon cost-effective services;
- that SLAs are based on integrated care pathways.

20.2.3 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast expenditure and activity for each SLA.

20.2.4 Where the Joint Boards or Local Commissioning Committees make arrangements for the provision of services by non-NHS providers it is the Chief Executive, as the Accountable Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided. Before making any agreement with non-NHS providers, the Joint Boards and Local Commissioning Committees should explore fully the scope to make maximum cost-effective use of NHS facilities.

20.3 Role of Director of Finance, Procurement, ICT and Estates

20.3.1 A system of financial monitoring must be maintained by the Director of Finance, Procurement, ICT and Estates to ensure the effective accounting of expenditure under the SLAs. This should provide a suitable audit trail for all payments made under the agreements, but maintains patient confidentiality.

203.2 The Director of Finance, Procurement, ICT and Estates must account for Out of Area Treatments/Non Contract Activity financial adjustments in accordance with national guidelines.

21. Terms of Service, Allowances and Payment of Members of the Joint Boards and Local Commissioning Committees and Employees

21.1 Remuneration and Terms of Service (see overlap with SO No. 5)

21.1.1 In accordance with Standing Orders the Joint Board shall establish a Joint Employment and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report).

21.1.2 The Committee will:

(a) advise the Joint Boards about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Joint Boards and other senior employees including:
  (i) all aspects of salary (including any performance-related elements/bonuses);
  (ii) provisions for other benefits, including pensions and cars;
  (iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Joint Board and Local Commissioning Committees members (and other senior employees) to ensure they are fairly rewarded for their individual contribution - having proper regard to the Joint Boards circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members of the Executive Committee (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

21.1.3 The Committee shall report in writing to the Joint Boards the basis for its recommendations. The Joint Boards shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer Executive Committee members. Minutes of the Joint Board's meetings should record such decisions.

21.1.4 The Joint Boards will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

21.1.5 The Joint Board will pay allowances to the Chairman and non-officer members of the Joint Boards in accordance with instructions issued by the Secretary of State for Health.

21.2 **Funded Establishment**

21.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

21.2.2 The funded establishment of any department or BSU may not be varied without the approval of the responsible Director as long as it remains within the overall annual budget.

21.3 Staff Appointments

21.3.1 No officer or Member of the Local Commissioning Committees, or Member of the Joint Boards or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and
(b) within the limit of their approved budget and funded establishment.

21.3.2 The Joint Boards will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

21.4 Processing Payroll

21.4.1 The Director of Finance, Procurement, ICT and Estates is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates;
(d) agreeing method of payment.

21.4.2 The Director of Finance, Procurement, ICT and Estates will issue instructions regarding:

(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;
(g) methods of payment available to various categories of employee and officers;
(h) procedures for payment by cheque, bank credit, or cash to employees and officers;
(I) procedures for the recall of Cheques and bank credits;
(j) pay advances and their recovery;
(k) maintenance of regular and independent reconciliation of pay control accounts;
(l) separation of duties of preparing records and handling cash
(m) a system to ensure the recovery from those leaving the employment of any PCT/Care Trust of sums of money and property due by them to the PCT/Care Trust.

21.4.3 Appropriately nominated managers and Local Commissioning Committees members have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Director of Finance, Procurement, ICT and Estates's instructions and in the form prescribed by the Director of Finance, Procurement, ICT and Estates;
(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil Executive Committee obligations in circumstances that suggest they have left without notice, the Director of Finance, Procurement, ICT and Estates must be informed immediately.

21.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance, Procurement, ICT and Estates shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

21.5 Contracts of Employment

21.5.1 The Joint Boards shall delegate responsibility to an officer for:
(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Joint Boards and which complies with employment legislation; and
(b) dealing with variations to, or termination of, contracts of employment.

22. Non-Pay Expenditure

22.1 Delegation of Authority

22.1.1 The Joint Boards will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

22.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

22.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

22.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

22.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Joint Boards or each individual PCT/Care Trust or Local Commissioning Committee. In so doing, the advice of the Joint Boards adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance, Procurement, ICT and Estates (and/or the Chief Executive) shall be consulted.

22.2.2 **System of Payment and Payment Verification**

The Director of Finance, Procurement, ICT and Estates shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

22.2.3 **The Director of Finance, Procurement, ICT and Estates will:**

(a) advise the Joint Boards regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Joint Boards Executive Committee members/employees and BSU based staff (including specimens of their signatures) authorised to certify invoices.
(ii) Certification that:
- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance, Procurement, ICT and Estates of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

22.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).
(b) The appropriate officer member of the Executive Committee must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Joint Board or each individual PCT/Care Trust or Local Commissioning Committee if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
(c) The Director of Finance, Procurement, ICT and Estates will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

22.2.5 **Official orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance, Procurement, ICT and Estates;

(c) state the Joint Boards or each individual PCT/Care Trust or Local Commissioning Committees terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

22.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance, Procurement, ICT and Estates and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance, Procurement, ICT and Estates in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff"; the Code of Conduct for NHS Managers 2002); and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance, Procurement, ICT and Estates on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
(i) goods are not taken on trial or loan in circumstances that could commit the PCT to a future uncompetitive purchase;
(j) changes to the list of members/employees and officers authorised to certify invoices are notified to the Director of Finance, Procurement, ICT and Estates;
(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance, Procurement, ICT and Estates;
(l) petty cash records are maintained in a form as determined by the Director of Finance, Procurement, ICT and Estates.

22.2.7 The Chief Executive and Director of Finance, Procurement, ICT and Estates shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Concode and Estatecode. The technical audit of these contracts shall be the responsibility of the relevant Director.

22.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

22.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 1977 **shall** comply with procedures laid down by the Director of Finance, Procurement, ICT and Estates which shall be in accordance with that Acts. (See overlap with Standing Order No. 9.1)

23. Financial Framework

23.3.1 The Director of Finance, Procurement, ICT and Estates should ensure that members of the Joint Board or each individual PCT/Care Trust or Local Commissioning Committee and the Executive Committee are aware of the Financial Framework. This document contains directions which the Joint Board or each individual PCT/Care Trust or Local Commissioning Committee must follow. It also contains directions to Strategic Health Authorities regarding resource and capital allocation and funding to PCTs/Care Trust. The Director of Finance, Procurement, ICT and Estates should also ensure that the direction and guidance in the framework is followed by the Joint Board or each individual PCT/Care Trust or Local Commissioning Committees.

24. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

24.1 Capital Investment

24.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

24.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the (*Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance, Procurement, ICT and Estates has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate personnel and external agencies in the process.

24.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Estatecode.

The Director of Finance, Procurement, ICT and Estates shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

24.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.5);

(c) approval to accept a successful tender (see overlap with SFI No. 17.5).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Estatecode guidance and the PCT's Standing Orders.

24.1.5 The Director of Finance, Procurement, ICT and Estates shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

24.2 Private Finance (see overlap with SFI No. 18.10)

24.2.1 The Joint Board or each individual PCT/Care Trust or Local Commissioning Committee should normally test for PFI when considering capital procurement. When the Joint Board or each individual PCT/Care Trust or Local Commissioning Committee proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Director of Finance, Procurement, ICT and Estates shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.
(c) The proposal must be specifically agreed by the Joint Boards.

24.3 Asset Registers

24.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance, Procurement, ICT and Estates concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

24.3.2 Each PCT/Care Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the *Capital Accounting Manual* as issued by the Department of Health.

24.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;
(c) lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be

validated by reference to authorisation documents and invoices (where appropriate).

24.3.5 The Director of Finance, Procurement, ICT and Estates shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the *Capital Accounting Manual* issued by the Department of Health.

24.3.7 The value of each asset shall be depreciated using methods and rates as specified in the *Capital Accounting Manual* issued by the Department of Health.

24.3.8 The Director of Finance, Procurement, ICT and Estates of the PCT shall calculate and pay capital charges as specified in the *Capital Accounting Manual* issued by the Department of Health.

24.4 Security of Assets

24.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

24.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance, Procurement, ICT and Estates. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;
(b) identification of additions and disposals;
(c) identification of all repairs and maintenance expenses;
(d) physical security of assets;
(e) periodic verification of the existence of, condition of, and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset;
(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

24.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance, Procurement, ICT and Estates.

24.4.4 Whilst each employee and officer has a responsibility for the security of property of the PCT/Care Trust, it is the responsibility of Joint Boards and Executive Committee members and senior employees in BSUs in all disciplines to apply appropriate routine security practices in relation to NHS property as may be determined by the Joint Boards. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5 Any damage to a PCT's/Care Trust premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Joint Boards and Executive Committee members and employees in accordance with the procedure for reporting losses.

24.4.6 Where practical, assets should be marked as PCT/Care Trust property.

24.5 NHS LIFT

24.5 A Primary Care Trust planning involvement with LIFT projects should access guidance from the joint DH and Partnerships UK website at www.partnershipsforhealth.co.uk.

25. Stores and Receipt of Goods

25.1 General position

25.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;
(b) subjected to annual stock take;
(c) valued at the lower of cost and net realisable value.

25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1 Subject to the responsibility of the Director of Finance, Procurement, ICT and Estates for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance, Procurement, ICT and Estates. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

25.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

25.2.3 The Director of Finance, Procurement, ICT and Estates shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores and losses.

25.2.4 Stocktaking arrangements shall be agreed with the Director of Finance, Procurement, ICT and Estates and there shall be a physical check covering all items in store at least once a year.

25.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance, Procurement, ICT and Estates.

25.2.6 The designated Manager shall be responsible for a system approved by the Director of Finance, Procurement, ICT and Estates for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance, Procurement, ICT and Estates any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

25.3 **Goods supplied by NHS Logistics**

25.3.1 For goods supplied via the NHS Logistics central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance, Procurement, ICT and Estates who shall satisfy himself that the goods have been received before accepting the recharge.

26. Disposals And Condemnations, Losses And Special Payments

26.1 Disposals and Condemnations

26.1.1 **Procedures**

The Director of Finance, Procurement, ICT and Estates must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a PCT/Care Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance, Procurement, ICT and Estates of the estimated market value of the item, taking account of professional advice where appropriate.

26.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance, Procurement, ICT and Estates;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance, Procurement, ICT and Estates which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance, Procurement, ICT and Estates.

26.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the

Director of Finance, Procurement, ICT and Estates who will take the appropriate action.

26.2 Losses and Special Payments

26.2.1 **Procedures**

The Director of Finance, Procurement, ICT and Estates must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

26.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Chief Executive and the Director of Finance, Procurement, ICT and Estates or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance, Procurement, ICT and Estates and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance, Procurement, ICT and Estates must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance, Procurement, ICT and Estates must inform the relevant LCFS and Operational Fraud Team (OFT) in accordance with Secretary of State for Health's Directions.

26.2.3 **Suspected fraud**

The Director of Finance, Procurement, ICT and Estates must notify the NHS CFS and the External Auditor of all frauds.

26.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance, Procurement, ICT and Estates must immediately notify:

(a) the Joint Boards, and
(b) the External Auditor.

26.2.5 Within limits delegated to it by the Department of Health, the Joint Boards shall approve the writing-off of losses.

26.2.6 The Director of Finance, Procurement, ICT and Estates shall be authorised to take any necessary steps to safeguard the PCT's interests in bankruptcies and company liquidations.

26.2.7 For any loss, the Director of Finance, Procurement, ICT and Estates should consider whether any insurance claim can be made.

26.2.8 The Director of Finance, Procurement, ICT and Estates shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

26.2.10 All losses and special payments must be reported to the Joint Audit Committee at every meeting.

27. Information Technology

26.1 Responsibilities and duties of the Director of Finance, Procurement, ICT and Estates

27.1.1 The Director of Finance, Procurement, ICT and Estates, who is responsible for the accuracy and security of the computerised financial data of the Joint Board or each individual PCT/Care Trust or Local Commissioning Committees, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Joint Board or each individual PCT/Care Trust or Local Commissioning Committees data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2 The Director of Finance, Procurement, ICT and Estates shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

27.1.3 The Director of Corporate Affairs shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Joint Board or each individual PCT/Care Trust or Local Commissioning Committees that we make publicly available.

27.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

27.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of PCTs/Care Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance, Procurement, ICT and Estates:

(a) details of the outline design of the system;
(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

27.3 Contracts for computer services with other health bodies or outside agencies

The Director of Finance, Procurement, ICT and Estates shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance, Procurement, ICT and Estates shall periodically seek assurances that adequate controls are in operation.

27.4 Requirements for computer systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance, Procurement, ICT and Estates shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Director of Finance, Procurement, ICT and Estates staff have access to such data;
(d) such computer audit reviews as are considered necessary are being carried out.

28. Patients' Property

28.1 The Joint Boards and each individual PCT/Care Trust or Local Commissioning Committee no longer have responsibility for the direct provision of services to patients and as such it is unlikely to have a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. If this position changes then the Director of Finance,

Procurement, ICT and Estates will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

29. Funds held on Trust

29.1 Corporate Trustee

(1) Standing Order No. 2.9 outlines the PCT/Care Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SO 4.9.4 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the PCT/Care Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Director of Finance, Procurement, ICT and Estates shall ensure that each trust fund which the PCT/Care Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the PCT/Care Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Schedule of Matters Reserved to the Joint Boards and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All PCT Boards and Local Commissioning Committee members and BSU officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No. 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

30. Acceptance of Gifts By Staff and Link To Standards of Business Conduct (See Overlap With So No. 6 And SFI No. 21.2.6 (D))

The Director of Finance, Procurement, ICT and Estates shall ensure that all staff are made aware of the Joint Boards policy on acceptance of gifts and other

benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff'; the Code of Conduct for NHS Managers 2002; and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 7).

31. Payments to Independent Contractors

31.1 Role of the Joint Boards

The Joint Boards will approve additions to, and deletions from, approved lists of contractors, taking into account the health needs of the local population, and the access to existing services. All applications and resignations received shall be dealt with equitably, within any time limits laid down in the contractors NHS terms and conditions of service.

31.2 Duties of the Chief Executive

The Chief Executive shall:

(a) ensure that lists of all contractors, for which the Joint Boards and Local Commissioning Committees are responsible, are maintained in an up to date condition;

(b) ensure that systems are in place to deal with applications, resignations, inspection of premises, etc, within the appropriate contractor's terms and conditions of service.

31.3 Duties of the Director of Finance, Procurement, ICT and Estates

The Director of Finance, Procurement, ICT and Estates shall:

(a) ensure that contractors who are included on an approved list(s) receives payments;

(b) maintain a system of payments such that all valid contractors' claims are paid promptly and correctly, and are supported by the appropriate documentation and signatures;

(c) ensure that regular independent verification of claims is undertaken, to confirm that:

  (i) rules have been correctly and consistently applied;

  (ii) overpayments are detected (or preferably prevented) and recovery initiated;

  (iii) suspicions of possible fraud are identified and subsequently dealt with in line with the Secretary of State for Health's Directions on the management of fraud and corruption.

(d) ensure that arrangements are in place to identify contractors receiving exceptionally high, low or no payments, and highlight these for further investigation; and

(e) ensure that a prompt response is made to any query raised by either the Prescription Pricing Division or the Dental Practice Division of the NHS Business Services Authority, regarding claims from contractors submitted directly to them.

32. Retention of Records

32.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with NHS Code of Practice - Records Management 2006.

32.2 The records held in archives shall be capable of retrieval by authorised persons.

32.3 Records held in accordance with NHS Code of Practice - Records Management 2006, shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

33. Risk Management and Insurance

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Joint Boards has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Joint Boards.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;
b) engendering among all levels of staff a positive attitude towards the control of risk;
c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
d) contingency plans to offset the impact of adverse events and non delivery of QIPP savings plans;
e) audit including; internal audit, clinical audit, health and safety review;
f) a clear indication of which risks shall be insured;
g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts as required by current Department of Health guidance.

33.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Joint Boards shall decide if the Joint Boards will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Joint Boards decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3 Insurance arrangements with commercial insurers

33.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when PCTs/Care Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) for **insuring motor vehicles** owned by the PCT/Care Trust including insuring third party liability arising from their use;

(2) where the PCT/Care Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into;

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the PCT/Care Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Litigation Authority. In any case of doubt concerning a PCT's powers to enter into commercial insurance arrangements the Director of Finance, Procurement, ICT and Estates should consult the DoH.

33.4 Arrangements to be followed by the Joint Boards in agreeing Insurance cover

(1) Where the Joint Boards decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance, Procurement, ICT and Estates shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance, Procurement, ICT and Estates shall ensure that documented procedures cover these arrangements.

(2) Where the Joint Boards decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance, Procurement, ICT and Estates shall ensure that the Joint Boards is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance, Procurement, ICT and Estates will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Appendix 10 – Financial Scheme of Delegation

Section C - Scheme of Reservation and Delegation

Ref	the Joint Boards	Decisions Reserved to the Joint Boards
NA	THE JOINT BOARDS	**General Enabling Provision** the Joint Boards may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE JOINT BOARDS	**Regulations and Control** • Approve Standing Orders (SOs), a schedule of matters reserved to the Joint Boards and Standing Financial Instructions for the regulation of its proceedings and business. • Suspension of Standing Orders • Vary or amend the Standing Orders. • Approve a scheme of delegation of powers from the Joint Boards to the Local Clinical Commissioning Committees and other committees**.** • Require and receive the declaration of Joint Boards members' interests which may conflict with those of the Joint Boards and, taking account of any waiver which the Secretary of State for Health may have made in any case, determining the extent to which that member may remain involved with the matter under consideration. • Require and receive the declaration of officers' interests that may conflict with those of the Joint Boards. • Approve arrangements for dealing with complaints. • Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Joint Boards and to agree modifications thereto. • Receive reports from committees including those that the Joint Boards is required by the Secretary of State or other regulation to establish and to action appropriately. • Confirm the recommendations of the Joint Boards committees where the committees do not have executive powers. • Approve arrangements relating to the discharge of the Joint Boards or PCT/Care Trust responsibilities as a corporate trustee for funds held on trust. • Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Joint Boards. • Authorise use of the seal. • Discipline members of the Joint Boards or Local Clinical Commissioning Committees or employees who are in breach of statutory requirements or SOs. • Comply with Information Governance Standards

Ref	the Joint Boards	Decisions Reserved To the Joint Boards
NA	THE JOINT BOARDS	**Appointments/ Dismissal** • Appoint the Vice Chair of the Joint Boards. • Appoint and dismiss other committees (and individual members) that are directly accountable to the Joint Boards. • Appoint, appraise, discipline and dismiss officer members (subject to SO 3.2). • Confirm appointment of members of any committee of the Joint Boards as representatives on outside bodies. • Appoint appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). • Approve proposals of the Joint Remuneration Committee regarding directors and senior employees and those of the CE for staff not covered by the Joint Remuneration Committee.
NA	THE JOINT BOARDS	**Strategy, Operating plan and Budgets** • Define the strategic aims and objectives of the Joint Boards. • Approve plans in respect of the application of available financial resources to support the agreed Operating Plan/Commissioning Strategy Plan. • Approve proposals for ensuring quality and developing clinical governance in services provided by the Joint Boards and Local Clinical Commissioning Committees or its constituent practices, having regard to any guidance issued by the Secretary of State. • Approve (with any necessary appropriate modification) the annual commissioning strategy or plan. • Approve annually (with any necessary appropriate modification) the Joint Boards and Local Clinical Commissioning Committees Operating Plans/ Commissioning Strategy Plans • Approve (with any necessary appropriate modification) the Joint Boards and Local Clinical Commissioning Committees Operating Plans. • Approve the Joint Boards and Local Clinical Commissioning Committees policies and procedures for the management of risk. • Approve budgets. • Approve annually Joint Boards and Local Clinical Commissioning Committees proposed organisational development proposals. • Approve contracts with the individual PCT/Care Trusts to provide PMS or PDS, or have contracts with PMS providers to provide services to some or all of each PCT/Care Trust population. • Ratify proposals for primary care development, including the draft PCIP, proposed GMS Local Development Scheme, proposed practice incentive schemes and proposed new or changes in existing GMS infrastructure reimbursement payments to GP practices. • Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

Ref	the Joint Boards	Decisions Reserved to the Joint Boards
		• Approve PFI proposals. • Approve the opening of bank accounts. • Approve Local Clinical Commissioning Committees proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £100,000 over a 2 year period or the period of the contract if longer. • Approve Local Clinical Commissioning Committees' proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance, Procurement, ICT and Estates (for losses and special payments) previously approved by the Joint Boards. • Approve individual compensation payments. • Approve proposals for action on litigation against or on behalf of the individual PCT/Care Trusts. • Approve Local Clinical Commissioning Committees' proposals for PCT/Care Trust or practice incentive schemes, having regard to guidance by the Secretary of State.
	the Joint Boards/ Joint Employment and Remuneration Committee	**Policy Determination** • Approve management policies including human resource policies incorporating the arrangements for the appointment, removal and remuneration of staff.
	The Joint Audit Committee	**Audit** • Approve the appointment (and where necessary dismissal) of External Auditors and advise the Audit Commission on the appointment (and where necessary change/removal) of External Auditors including arrangements for the separate audit of funds held on trust, and take appropriate action. • Receive the annual management letter received from the External Auditor and agreement of Local Clinical Commissioning Committees' proposed action, taking account of the advice, where appropriate. • Receive an annual report from the Internal Auditor and agree action on recommendations .
NA	EACH PCT/CARE TRUST BOARD	**Annual Reports and Accounts** • Receipt and approval of the individual PCT/Care Trust Annual Report and Annual Accounts. • Receipt and approval of the Annual Report and Accounts for funds held on trust.
NA	THE JOINT BOARDS	**Monitoring**

Ref	the Joint Boards	Decisions Reserved to the Joint Boards
		Receipt of such reports as the Joint Boards sees fit from the Local Clinical Commissioning Committees in respect of its exercise of powers delegated.

Ref	Local Clinical Commissioning Committees	Decisions Reserved To the Local Clinical Commissioning Committees
	Local Clinical Commissioning Committees	**Regulation and Control**. • Require and receive the declaration of any Local Clinical Commissioning Committees member's interests which may conflict with those of each PCT/Care Trust and taking account of any waiver which the SofS may have made in any case, and after consultation with the Chief Executive, determining the extent to which that member may participate in the consideration of a matter in which he/she has an interest. • Advise on quality and clinical governance, having regard to any guidance by the Secretary of State, and including preparation of proposals to develop and monitor clinical standards in each PCT/Care Trust and its constituent practices. • Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 6.6. Such failures to be reported to the Joint Boards in formal session.
	Local Clinical Commissioning Committees	**Strategy, Plans and Budgets** • Advise the Joint Boards on the strategic aims and objectives of each PCT/Care Trust. • Advise the Joint Boards on the development and delivery of QIPP plans

Ref	Committee	Decisions/Duties Delegated to other committees
Corporate Governance Manual section 1.4 SFI 11.1.1	JOINT AUDIT COMMITTEE	The Committee will: • Advise the Joint Boards on internal and external audit services; • Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; • Monitor compliance with Standing Orders and Standing Financial Instructions; • Review schedules of losses and compensations and making recommendations to the Joint Boards;
Corporate Governance Manual section 1.5 SFI 20.1.2	JOINT REMUNERATION AND TERMS OF SERVICE COMMITTEE	The Committee will: • advise the Joint Boards about appropriate remuneration and terms of service for the Chief Executive, other executive directors and other senior employees including: o all aspects of salary (including any performance-related elements/bonuses); o provisions for other benefits, including pensions and cars; o arrangements for termination of employment and other contractual terms; • make recommendations to the Joint Boards on any proposed remuneration for individual Local Clinical Commissioning Committees Members for specific work in addition to their corporate PCT/Care Trust role, so as to ensure that the individual is fairly rewarded for their individual contribution to each PCT/Care Trust while having proper regard to each PCT/Care Trust circumstances and performance, and to the requirements of fair and open tendering or recruitment policies; • make recommendations to the Joint Boards on the remuneration and terms of service of senior employees to ensure they are fairly rewarded for their individual contribution to each PCT/Care Trust - having proper regard to each PCT/Care Trust circumstances and performance and to the provisions of any national arrangements for such staff; • proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff; • report in writing to the Joint Boards the basis for its recommendations.
HSC 1999/065 HSC 1998/70 HSC 1999/123	Joint Quality and Safety Committee	The purpose of the Joint Quality and Safety Committee is to ensure excellence of care in directly provided, independent contractor and commissioned services throughout the Cluster. The Committee will provide strategic direction to support the development of robust quality & safety structures within the Cluster and the development of the governance and

Ref	Committee	Decisions/Duties Delegated to other committees
		risk management strategies.
	Joint Finance and Performance Committees (QIPP)	The Committee will: • advise the Joint Boards on all aspects of financial and performance issues including development and delivery of QIPP schemes, including: ○ receiving and reviewing regular reports on current performance against targets; ○ receiving reports and reviewing the adequacy of any planned corrective action instigated when targets are not being met; ○ on the adequacy of the risk assessment and assurance systems [note not to duplicate the role of the Joint Audit Committees] based on the experience of the reporting framework; ○ that it has gained sufficient assurance as to the financial sustainability of all operational plans including the development and delivery of QIPP savings.
-	Other Committees	In discharging its Commissioning function, the Joint Boards may delegate responsibilities to other committees to act on behalf of each PCT/Care Trust .
-	London Specialised Commissioning Group	With representation from South East London, to contribute to the London Specialised Commissioning arrangements and make recommendations to Lambeth PCT/Care Trust with respect to nationally designated specialised services.

Ref	Delegated to	Delegation from the Accountable Officer Memorandum
10	CHIEF EXECUTIVE (CE)	• Accountable through NHS Accountable Officer Memorandum to Parliament for stewardship of each PCT/Care Trust resources.
12	CE AND DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES (DOF)	• Ensure the accounts of each PCT/Care Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of each PCT/Care Trust/Care Trust income and expenditure and its state of affairs. • Sign the accounts on behalf of the Joint Boards.
13	CE	• Sign a statement in the accounts outlining responsibilities as the Accountable Officer. • Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
15 & 16	CE	• Ensure effective management systems that safeguard public funds and assist each PCT/Care Trust to implement requirements of governance including ensuring managers:

Ref	Delegated to	Delegation from the Accountable Officer Memorandum
		○ have a clear view of their objectives and the means to assess achievements in relation to those objectives; ○ be assigned well defined responsibilities for making best use of resources; ○ have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
15	CHAIR	• Implement requirements of corporate governance
18	CE	• Achieve value for money from the resources available to each PCT/Care Trust and avoid waste and extravagance in the organisation's activities. • Follow through the implementation of any recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and the National Audit Office (NAO). • Use to best effect the funds available for commissioning healthcare, developing services and promoting health to meet the needs of the local population.
20	DoF	• Operational responsibility for effective and sound financial management and information.
20	CE	• Primary duty to see that DoF discharges this function.
21	CE	• Ensuring that expenditure by each PCT/Care Trust complies with Parliamentary requirements
22	CE	• The Codes of Conduct and Accountability incorporated in the Corporate Governance Framework issued to NHS Boards by the Secretary of State are fundamental in exercising their responsibilities for regularity and probity. As a Board member they have explicitly subscribed to the Codes and should promote their observance by all staff.
23	CE and DoF	• Chief Executive, supported by Director of Finance, Procurement, ICT and Estates , to ensure appropriate advice is given to the Joint Boards and Local Clinical Commissioning Committees on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
24	CE	• If CE considers the Joint Boards, Chair or Local Clinical Commissioning Committees is doing something that might infringe probity or regularity; he/she should set this out in writing to the Chair and the Joint Boards. If the matter is unresolved, he/she should ask the Joint Audit Committee to inquire and if necessary the SHA [from 1st April 2012 NHS Commissioning Board] and Department of Health.
26	CE	• If the Joint Boards or Local Clinical Commissioning Committees is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Joint Boards and Local Clinical Commissioning Committees. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the Strategic Health Authority [from

Ref	Delegated to	Delegation from the Accountable Officer Memorandum
		1st April 2012 NHS Commissioning Board and the DH. In such cases, and in those described in reference 24, the CE should as a member of the Joint Boards vote against the course of action rather than merely abstain from voting.

ENCLOSURE 1

Ref	Delegated To	Delegation from The Codes Of Conduct And Accountability
1.3.1.7	JOINT BOARDS	• Approve procedure for declaration of hospitality and sponsorship
1.3.1.8	JOINT BOARDS	• Ensure proper and widely publicised procedures for voicing complaints, concerns about maladministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS AND LOCAL CLINICAL COMMISSIONING COMMITTEES MEMBERS	• Subscribe to Code of Conduct
1.3.2.4	JOINT BOARDS	• Board members share corporate responsibility for all decisions of the Joint Boards.
1.3.2.4	CHAIR AND NON-OFFICER MEMBERS	• Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
1.3.2.4	JOINT BOARDS	• the Joint Boards has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. on the recommendation of the Local Clinical Commissioning Committees, to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure that the Local Clinical Commissioning Committees leads an effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

Ref	Delegated To	Delegation from The Codes Of Conduct And Accountability
1.3.24	JOINT BOARDS	It is the Joint Boards' duty to: • act within statutory financial and other constraints; • for each PCT/Care Trusts, establish the Local Clinical Commissioning Committees; • be clear what decisions and information are appropriate to the Joint Boards and draw up Standing Orders, a Schedule of Decisions Reserved to the Joint Boards or Local Clinical Commissioning Committees and Standing Financial Instructions to reflect these; • ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; • establish performance and quality measures that maintain the effective use of resources and provide value for money; • specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Joint Boards can fully undertake its responsibilities; • establish Joint Audit and Joint Remuneration Committees on the basis of formally agreed terms of reference which set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Joint Boards.
1.3.2.5	CHAIR	It is the Chair's role to: • provide leadership to the Joint Boards; • enable all Board members to make a full contribution to the Joint Boards' affairs and ensure that the Joint Boards acts as a team; • ensure that key and appropriate issues are discussed by the Joint Boards in a timely manner; • ensure the Joint Boards has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; • lead non-executive Board members through a formally-appointed Joint Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other executive Board members; • appoint non-executive Board members to an Joint Audit Committee of the main Board; • advise the Secretary of State through the regional member of the Policy Board on the performance of non-executive Board members.

Ref	Delegated To	Delegation from The Codes Of Conduct And Accountability
1.3.2.5	CHIEF EXECUTIVE	• The Chief Executive is accountable to the Chair and non-executive members of the Joint Boards for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. • The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Joint Boards. • The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	NON OFFICER MEMBERS	• Non-officer Board members are appointed by or on behalf of the Secretary of State to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR, BOARD AND LOCAL CLINICAL COMMISSIONING COMMITTEE MEMBERS	• Declaration of conflict of interests.
1.3.2.9	JOINT BOARDS	• NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

Ref	Delegated To	Delegation From Model Standing Orders
1.1	CHAIR	• Final authority in interpretation of Standing Orders.
2.4	JOINT BOARDS	• Appointment of Vice-Chair.
3.1	CHAIR	• Calling meetings.
3.9	CHAIR	• Chair all Board meetings and associated responsibilities.
3.10	CHAIR	• Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	• Having a second or casting vote.
3.13	JOINT BOARDS	• Suspension of Standing Orders.
3.13	JOINT AUDIT COMMITTEE	• Joint Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Joint Boards).
3.14	JOINT BOARDS	• Variation or amendment of Standing Orders
4.2	CHAIR	• Appoint one of the members of the Local Clinical Commissioning Committees (not including the CE or Director of Finance, Procurement, ICT and Estates) as Chair of the Executive Committee, and another member as vice-chair following nomination by that Committee.
4.7	JOINT BOARDS	The Joint Boards shall approve the appointments to each of the committees which it has formally constituted – however, the Local Clinical Commissioning Committees will have significant freedom to determine their membership and terms of reference and will be given responsibility for commissioning for local needs. The NED Vice-Chair, Clinical Commissioning lead and the Borough MD would form the local "three at the centre" that is the unique feature of PCT/Care Trust governance arrangements.
5.2	CHAIR & CHIEF EXECUTIVE	• The powers which the Joint Boards has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two non-officer members
5.3	JOINT BOARDS	• Formal delegation of powers to Local Clinical Commissioning Committees, other committees, sub-committees or joint committees and approval of their constitution and terms of reference. (The Chief Executive may approve Constitution and terms of reference of sub-committees.)
5.4	CHIEF EXECUTIVE	• The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals, which shall be considered and approved by the Joint Boards, subject to any amendment agreed during the discussion.
5.6	ALL	• Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	ALL BOARD AND	• Declare relevant and material interests.

ENCLOSURE 1

Ref	Delegated To	Delegation From Model Standing Orders
	LOCAL CLINICAL COMMISSIONING COMMITTEES MEMBERS	
7.2	CHIEF EXECUTIVE	• Maintain Register(s) of Interests.
7.1	CHAIR OF A MEETING	• Making a declaration on a declared interest.
7.4	ALL STAFF	• Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff" and the code of conduct for NHS Managers 2002.
7.4	ALL	• Disclose of relationship between self and candidate for staff appointment. (CE to report the disclosure to the Joint Boards/Local Clinical Commissioning Committees).
8.1/8.3	CHIEF EXECUTIVE	• Keep seal(s) in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	• Approve and sign all documents which will be necessary in legal proceedings.

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
11.1.3	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Approval of all financial procedures.
11.1.4	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Advice on interpretation or application of SFIs.
11.1.6	ALL MEMBERS OF THE JOINT BOARDS AND EMPLOYEES	• Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance, Procurement, ICT and Estates as soon as possible.
11.2.4	CHIEF EXECUTIVE	• Responsible as the Accountable Officer to ensure financial targets and obligations, including QIPP target savings, are met and have overall responsibility for the System of Internal Control.
11.2.4	CHIEF EXECUTIVE & DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
11.2.5	CHIEF EXECUTIVE	• To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
11.2.6	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Responsible for: a) implementing the Joint Boards, individual PCTs/Care Trust and Local Clinical Commissioning Committees financial policies and for co-coordinating any corrective action necessary to further these policies; b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; c) ensuring that sufficient records are maintained to show and explain the Joint Boards, individual PCTs/Care Trust and Local Clinical Commissioning Committees' transactions, in order to disclose, with reasonable accuracy, the financial position of the Joint Boards, individual PCTs/Care Trust and Local Clinical Commissioning Committees at any time; and, without prejudice to any other functions of the Joint Boards, individual PCTs/Care Trust and Local Clinical Commissioning Committees, and employees of the Joint Boards, individual PCTs/Care Trust and Local Clinical Commissioning Committees. d) the provision of financial advice to other members of the Board and Local Clinical Commissioning

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
		Committees and employees; the design, implementation and supervision of systems of internal financial control; and e) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Joint Boards, individual PCTs/Care Trust and Local Clinical Commissioning Committees may require for the purpose of carrying out its statutory duties.
11.2.7	ALL MEMBERS OF THE JOINT BOARDS AND EMPLOYEES	• Responsible for security of each PCT/Care Trust property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures.
11.2.8	CHIEF EXECUTIVE	• Ensure that any contractor or employee of a contractor who is empowered by each PCT/Care Trust to commit each PCT/Care Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
12.1.1	JOINT AUDIT COMMITTEE	• Provide independent and objective view on internal control and probity.
12.13	CHAIR	• Raise the matter at the Joint Boards meeting where the Chair of the Joint Audit Committee considers there is evidence of ultra vires transactions or improper acts.
12.1.3 & 12.2.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Joint Audit Committee in the selection process when/if an internal audit service provider is changed.) • Ensure the annual audit report is prepared for consideration by the Joint Audit Committee.
12.2.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
12.3	HEAD OF INTERNAL AUDIT	• Review, appraise and report in accordance with NHS Internal Audit Standards and best practice.
12.4	JOINT AUDIT COMMITTEE	• Ensure cost-effective External Audit.
12.5	CHIEF EXECUTIVE & DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
12.6	CHIEF EXECUTIVE	• Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	• Has overall responsibility for each PCT/Care Trust activities and ensuring each PCT/Care Trust stays within its

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
		resource limit.
13.1.4	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Will provide monthly reports to the SofS, ensure draw down is for approved expenditure and timely and follows best practice in Cash Management.
13.1.4	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Ensure monitoring systems are in place to enable each PCT/Care Trust not to exceed its limits.
14.1.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Periodically review assumptions, submit a report to each PCT/Care Trust annually showing total allocations received and their proposed distribution.
14.1.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Regularly update each PCT/Care Trust and the Joint Boards on significant changes to the initial allocation and the uses of such funds.
14.2.1	CHIEF EXECUTIVE	• Compile and submit to the Joint Boards an operating plan which takes into account financial targets and forecast limits of available resources. The plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources and Quality Innovation Productivity and Prevention (QIPP) savings required to achieve the plan.
14.2.2 & 14.2.3	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Submit budgets to the Joint Boards for approval. • Monitor performance against budget and plan including QIPP programmes; submit to the Joint Boards financial estimates and forecasts.
14.2.5	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Ensure adequate training is delivered on an ongoing basis to budget holders.
14.3.1	CHIEF EXECUTIVE	• Delegate budget to budget holders.
14.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	• Must not exceed the budgetary total or virement limits set by the Joint Boards.
14.4.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Devise and maintain systems of budgetary control.

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
14.4.2	BUDGET HOLDERS or, in the case of QIPP Schemes the Senior Responsible Officer (SRO)	Ensure that: • no overspend or reduction of income that cannot be met from virement is incurred without prior consent of the Joint Boards; • approved budget is not used for any other than specified purpose subject to rules of virement; • no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment; • QIPP savings targets are met and if achievement is deemed to be unlikely or high risk then bring this to the attention of the Chief Executive including any proposed corrective action.
14.4.3	CHIEF EXECUTIVE	• for identifying and implementing QIPP initiatives in accordance with the requirements of the Operating Plan and a balanced budget.
14.6.1	CHIEF EXECUTIVE	• Submit monitoring returns.
15.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Preparation of annual accounts and reports.
16.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. • (Board approves arrangements.)
16.4	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• a) review the banking arrangements of each PCT/Care Trust at regular intervals to ensure they reflect best practice and represent best value for money. b) if deemed appropriate seek competitive tenders.
17.	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
17.2.3	ALL EMPLOYEES	• Duty to inform DoF of money due from transactions which they initiate/deal with.
18.	CHIEF EXECUTIVE	• Tendering and contracting procedure.
18.5.3	CHIEF EXECUTIVE	• Waive formal tendering procedures.
18.5.3	CHIEF EXECUTIVE	• Report waivers of tendering procedures to the Joint Audit Committee.
18.5.5	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Where a supplier is chosen that is not on the approved list(s) the reason shall be recorded in writing to the Chief Executive.

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
18.6.2	CHIEF EXECUTIVE	• Responsible for the receipt, endorsement and safe custody of tenders received.
18.6.3	CHIEF EXECUTIVE	• Shall maintain a register to show each set of competitive tender invitations dispatched.
18.6.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Where one tender is received will assess for value for money and fair price.
18.6.5	CHIEF EXECUTIVE	• Responsible for treatment of 'late' tenders
18.6.6	CHIEF EXECUTIVE	• No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Joint Boards and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
18.6.8	CHIEF EXECUTIVE	• Will appoint a manager to maintain a list(s) of approved firms.
18.6.8	CHIEF EXECUTIVE	• Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
18.7.2	CHIEF EXECUTIVE	• The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
18.7.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Joint Boards and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
18.10	CHIEF EXECUTIVE	• The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
18.10	Joint Boards	• All PFI proposals must be agreed by the Joint Boards.
18.11	CHIEF EXECUTIVE	• The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of each PCT/Care Trust.
18.12	CHIEF EXECUTIVE	• The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
18.13	CHIEF EXECUTIVE	• The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Joint Boards.
18.15	CHIEF EXECUTIVE	• The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.

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SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
18.15.5	CHIEF EXECUTIVE	• The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of each PCT/Care Trust.
19.1.1	CHIEF EXECUTIVE	• Must ensure each PCT/Care Trust enters into suitable Service Level Agreements (SLAs) with service providers for the provision of NHS services.
19.4	CHIEF EXECUTIVE	• As the Accountable Officer, ensure that regular reports are provided to the Joint Boards detailing actual and forecast expenditure against the SLA.
20.2.1	CHIEF EXECUTIVE	• As the Accountable Officer, ensure secondary services are commissioned in line with the operating plan and reach the required standards.
20.2.3	CHIEF EXECUTIVE	• As the Accountable Officer, ensure regular reports are provided to the Joint Boards detailing actual and forecast expenditure for each SLA.
20.2.4	CHIEF EXECUTIVE	• As the Accountable Officer, ensure that all agreements for provision of services with non-NHS providers achieve quality and are cost effective.
20.3.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Will maintain a system of control to ensure effective accounting of expenditure against SLAs.
20.3.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Must account for non contractual activity in accordance with national guidelines.
21.1.1	JOINT BOARDS	• Establish a Joint Remuneration & Terms of Service Committee.
21.1.2	JOINT REMUNERATION COMMITTEE	• Advise the Joint Boards on and make recommendations on the remuneration and terms of service of the CE, other officer members and senior employees to ensure they are fairly rewarded having proper regard to each PCT/Care Trust circumstances and any national agreements. • Monitor and evaluate the performance of individual senior employees. • Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
21.1.3	JOINT REMUNERATION COMMITTEE	• Report in writing to the Joint Boards its advice and its bases about remuneration and terms of service of directors and senior employees.
21.1.4	BOARD	• Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Joint Remuneration Committee.

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
21.2.2	CHIEF EXECUTIVE	• Approval of variation to funded establishment of any department.
21.3	CHIEF EXECUTIVE	• Approval of appointment of staff, including agency staff, appointments and re-grading within approved budget and funded establishment.
21.4.1 and 21.4.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 11.4.2).
21.4.3	NOMINATED MANAGERS	• Submit time records in line with timetable; • Complete time records and other notifications in required form; • Submitting termination forms in prescribed form and on time.
21.4.4	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
21.5	DIRECTOR OF HUMAN RESOURCES	• Ensure that all employees are issued with a Contract of Employment in a form approved by the Joint Boards and which complies with employment legislation; • Deal with variations to, or termination of, contracts of employment.
22.1	JOINT BOARDS	• the Joint Boards will approve the level of non-pay expenditure on an annual basis.
22.1	CHIEF EXECUTIVE	• Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
22.1.3	CHIEF EXECUTIVE	• Set out procedures on the seeking of professional advice regarding the supply of goods and services.
22.2.1	REQUISITIONER*	• In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Joint Boards or each individual PCT/Care Trust or Local Clinical Commissioning Committee. In so doing, the advice of each PCT/Care Trust adviser on supply shall be sought.
22.2.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Shall be responsible for the prompt payment of accounts and claims.

ENCLOSURE 1

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
22.2.3	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	a) Advise the Joint Boards regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
22.2.4	APPROPRIATE DIRECTOR	• Make a written case to support the need for a pre-payment.
22.2.4	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Approve proposed pre-payment arrangements.
22.2.4	BUDGET HOLDER	• Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
22.2.5	CHIEF EXECUTIVE	• Authorise who may use and be issued with official orders.
22.2.6	MANAGERS AND OFFICERS	• Ensure that they comply fully with the guidance and limits specified by the Director of Finance, Procurement, ICT and Estates .
22.2.7	CHIEF EXECUTIVE DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
22.3	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
23	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Ensure that Board and Local Clinical Commissioning Committees members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	• Capital investment programme:

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
		a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans; b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Certify professionally the costs and revenue consequences set out in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	• Issue procedures for management of contracts involving stage payments.
24.1.3	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.4	CHIEF EXECUTIVE	• Shall issue to the manager responsible for any scheme specific authority to commit expenditure, proceed to tender and accept a successful tender.
24.1.4	CHIEF EXECUTIVE	• Shall issue a scheme of delegation for capital investment management in accordance with Estatecode and Standing Orders.
24.1.5	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	Board	• Proposal to use PFI must be specifically agreed by the Joint Boards.
24.3.1	CHIEF EXECUTIVE	• Maintenance of asset registers (on advice from DoF).
24.3.5	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	DIRECTOR OF FINANCE,	• Calculate and pay capital charges in accordance with Department of Health requirements.

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
	PROCUREMENT, ICT AND ESTATES	
24.4.1	CHIEF EXECUTIVE	• Overall responsibility for fixed assets.
24.4.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Approval of fixed asset control procedures.
24.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	• Responsibility for security of PCT/Care Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with PCT/Care Trust procedure.
25.2	CHIEF EXECUTIVE	• Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
24.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Responsible for systems of control over stores and receipt of goods.
25.2	DESIGNATED PHARMACEUTICAL OFFICER	• Responsible for controls of pharmaceutical stocks.
25.2	DESIGNATED FACILITIES OFFICER	• Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	• Security arrangements and custody of keys.
25.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Set out procedures and systems to regulate the stores.
25.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Agree stocktaking arrangements.
25.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Approve alternative arrangements where a complete system of stores control is not justified.
25.2	DIRECTOR OF FINANCE,	• Approve system for review of slow moving and obsolete items and for condemnation, disposal and

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
	PROCUREMENT, ICT AND ESTATES	replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	• Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	• Identify persons authorised to requisition and accept goods from NHS Supplies stores.
26.1.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Prepare procedures for recording and accounting for losses, special payments.
26.2.2	ALL STAFF	• Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
26.2.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Where a criminal offence is suspected DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS and NHS CFS Operational Fraud Team in line with SofS directions.
26.2.2	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Notify LCFS and External Audit of all frauds.
26.2.3	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	BOARD	• Approve write off of losses (within limits delegated by DH).
26.2.6	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Consider whether any insurance claim can be made.
26.2.7	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Maintain losses and special payments register.
27.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND	• Responsible for accuracy and security of computerised financial data.

ENCLOSURE 1

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
	ESTATES	
27.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurance of adequacy must be obtained from them prior to implementation.
27.1.3	DIRECTOR OF CORPORATE AFFAIRS	• Shall publish and maintain a Freedom of Information Scheme.
27.2.1	RELEVANT OFFICERS	• Send proposals for general computer systems to DoF.
27.3	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. • Seek periodic assurances from the provider that adequate controls are in operation.
27.4	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Where computer systems have in impact on corporate financial systems satisfy himself/herself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; d) Such computer audit reviews are being carried out as are considered necessary.
28.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Responsible will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property.
28.3	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.
29.1	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Shall ensure that each trust fund which each PCT/Care Trust is responsible for managing is managed appropriately.

SFI Ref	Delegated To	Delegation From the Model Standing Financial Instructions
30	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Ensure all staff are made aware of each PCT/Care Trust policy on the acceptance of gifts and other benefits in kind by staff.
31.2	CHIEF EXECUTIVE	• Ensure lists of all contractors are maintained up to date and systems are in place to deal with applications, resignations, inspection of premises etc. within contractors' terms of service.
31.3	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Ensure only contractors included on each PCT/Care Trust lists receive payments; maintain a system of control to ensure prompt and accurate payments and validation of same.
32	CHIEF EXECUTIVE	• Retention of document procedures in accordance with Department of Health guidance.
33.1	CHIEF EXECUTIVE	• Risk management programme.
33.1	BOARD	• Approve and monitor risk management programme.
33.2	CHIEF EXECUTIVE	• Decide whether each PCT/Care Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	DIRECTOR OF FINANCE, PROCUREMENT, ICT AND ESTATES	• Where the Joint Boards decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance, Procurement, ICT and Estates shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance, Procurement, ICT and Estates shall ensure that documented procedures cover these arrangements. • Where the Joint Boards decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Director of Finance, Procurement, ICT and Estates shall ensure that the Joint Boards is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance, Procurement, ICT and Estates will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

* Nominated officers and the areas for which they are responsible should be incorporated into each PCT/Care Trust of Delegation document.

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 2 **PRINCIPLES OF PUBLIC LIFE**
DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development
AUTHOR: Oliver Lake, Director of Corporate Affairs
TO BE CONSIDERED BY: All
SUMMARY: The Nolan Principles on standards in public life are seven principles of conduct that should underpin the work of public authorities. They are: ▪ Selflessness ▪ Integrity ▪ Objectivity ▪ Accountability ▪ Openness ▪ Honesty ▪ Leadership
RECOMMENDATIONS: The board (s) is asked to:- **1.** Affirm acceptance of the Nolan Principles on Standards for Public Life

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South East London

The Seven Principles of Public Life (or the Nolan Principles)

Lord Nolan began the First Report of his Committee on Standards in Public Life by setting out what he called "The Seven Principles of Public Life", often described as "the Nolan Principles".

The Seven Principles of Public Life are:-

- **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** - Holders of public office should promote and support these principles by leadership and example.

ENCLOSURE 2

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 3 **NHS SOUTH EAST LONDON BOARDS' CONTRACT**
AUTHOR: Caroline Hewitt, Chair
TO BE CONSIDERED BY: All
SUMMARY: The NHS South East London Boards' Contract sets out a way of working for board members. The contract was discussed at the board away time on May 5th and has been reviewed subsequently.
RECOMMENDATIONS: The board (s) is asked to:- **1.** Affirm acceptance of the NHS South East London Boards' Contract **2.** Confirm collective responsibility for adherence to the contract and implied way of working.
AUTHOR CONTACT: Name: Caroline Hewitt E-Mail: caroline.hewitt@lambethpct.nhs.uk Telephone: 0203 049 5183

NHS South East London Boards' Contract

South East London

The way we do business is important to us:

- **We spend our time on what we say we care about and remain focused on our key objectives**
- **We base our decisions on the best available evidence, exercising our best judgement where necessary**
- **We take responsibility for speaking up but are respectful of opposing views; everyone should get 'airtime', but no one should dominate it**
- **We work well together, do not undermine each other; debate and challenge is welcome but once a decision is made we take full collective responsibility**
- **We honour our agreements and implement what we have said we will do**
- **When problems arise we 'lead' and find answers; we don't resort to blame**
- **We deal with difficulties face to face; we don't 'gossip' to others**
- **We respect the distinctions in role between the operational management and board governance**
- **We recognise effort and contribution and offer praise and thanks**
- **We seek to exemplify public sector values of openness, probity and accountability at all times**

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 4

ENCLOSURE 4

CONFIRMATION OF LEAD OFFICER ROLES

DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development

AUTHOR: Ben Vinter, Integrated Governance Manager

TO BE CONSIDERED BY: All

SUMMARY:
A number of statutory requirements exist that require PCTs / Care Trusts to have certain named post holders and/or executive appointments.

Changes to corporate governance arrangements have been enacted by each of the PCT / Care Trust Boards through Chairs Action from 1/4/11 arising from the establishment of Cluster Executive Arrangements. This report sets out the arrangements and positions held in each of the PCTs / Care Trusts.

A list of PCT statutory duties and responsibilities is attached for information (Appendix A). The Chief Executive, through the Management Board will ensure that these duties are managed.

KEY ISSUES:
NHS South East London is a partnership of PCTs and Care Trusts within a geographical area, operating upon the basis of shared executive arrangements.

A number of executive posts holders must be designated to each Board's membership with an additional requirement for further executive director designations as follows;

1. Accountable Officer
2. Accountable Finance Officer
3. Safeguarding lead Director
4. Director of Infection Prevention and Control
5. Caldicott Guardian

6. Senior Information Responsible Officer
7. Nominated GP Revalidation lead Officer

INVOLVEMENT:
COMMITTEE INVOLVEMENT
- Each of the PCT Boards have been engaged in the development and adoption of the transition governance arrangements

IMPACT ASSEESMENT
- Changes are required to fulfill statutory commitments

RECOMMENDATIONS:
The board (s) is asked to:-
- Note the updated designations previously taken forward by Boards through Chair's action

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Lead Officers to be noted at the meeting of the Joint Boards meeting on 19th May 2011

Bexley Care Trust

1. Accountable Officer – Simon Robbins
2. Accountable Finance Officer – Marie Farrell
3. Safeguarding lead Director – Dr Joanne Medhurst/Pamela Creaven
4. Director of Infection Prevention and Control – Dr Joanne Medhurst
5. Caldicott Guardian – Dr Joanne Medhurst / Pamela Creaven
6. Senior Information Responsible Officer – Dr Joanne Medhurst/Pamela Creaven
7. Executive Directors
    a. Simon Robbins – Chief Executive Officer
    b. Marie Farrell – Director of Finance, ICT and Estates
    c. Dr Joanne Medhurst/Pamela Creaven – Managing Director, Bexley BSU
    d. Director of Public Health – Vacancy
    e. PEC Chair – Dr Howard Stoate
    f. PEC Nurse – Vacancy
    g. Director of Operations and Development (1 vote on the board – covered by Jane Schofield (operations) and Gill Galliano (Development)
8. Nominated GP Validation lead Officer – Dr Jane Fryer

Bromley Primary Care Trust

1. Accountable Officer – Simon Robbins
2. Accountable Finance Officer – Marie Farrell
3. Safeguarding lead Director – Dr Angela Bhan
4. Director of Infection Prevention and Control – Dr Angela Bhan
5. Caldicott Guardian – Dr Nada Lemic
6. Senior Information Responsible Officer – Dr Nada Lemic
7. Executive Directors
    a. Simon Robbins – Chief Executive Officer
    b. Marie Farrell – Director of Finance, ICT and Estates
    c. Dr Angela Bhan – Managing Director, Bromley BSU
    d. Dr Nada Lemic – Director of Public Health
    e. PEC Chair – Dr Andrew Parson
    f. PEC Nurse – Vacancy
    g. Director of Operations and Development (1 vote on the board – covered by Jane Schofield (operations) and Gill Galliano (Development)
8. Nominated GP Validation lead Officer – Dr Jane Fryer

Greenwich Teaching Primary Care Trust

1. Accountable Officer – Simon Robbins
2. Accountable Finance Officer – Marie Farrell

3. Safeguarding lead Director – Annabel Burn
4. Director of Infection Prevention and Control – Dr Hilary Guite
5. Caldicott Guardian – Annabel Burn
6. Senior Information Responsible Officer – Annabel Burn
7. Executive Directors
    a. Simon Robbins – Chief Executive Officer
    b. Marie Farrell – Director of Finance, ICT and Estates
    c. Annabel Burn – Managing Director, Greenwich BSU
    d. Dr Hilary Guite – Director of Public Health
    e. PEC Chair – Dr Hanny Wahba
    f. PEC Nurse – Vacancy
    g. Director of Operations and Development (1 vote on the board – covered by Jane Schofield (operations) and Gill Galliano (Development)
8. Nominated GP Validation lead Officer – Dr Jane Fryer

Lambeth Primary Care Trust

1. Accountable Officer – Simon Robbins
2. Accountable Finance Officer – Marie Farrell
3. Safeguarding lead Director – Children: Dr Ruth Wallis, Adults: Helen Charlesworth-May
4. Director of Infection Prevention and Control – Dr Ruth Wallis
5. Caldicott Guardian – Dr Ruth Wallis
6. Senior Information Responsible Officer – Andrew Eyres
7. Executive Directors
    a. Simon Robbins – Chief Executive Officer
    b. Marie Farrell – Director of Finance, ICT and Estates
    c. Andrew Eyres – Managing Director, Lambeth BSU
    d. Dr Ruth Wallis – Director of Public Health
    e. PEC Chair – Dr Adrian McLachlan
    f. PEC Nurse – Vacancy
    g. Director of Operations and Development (1 vote on the board – covered by Jane Schofield (operations) and Gill Galliano (Development)
8. Nominated GP Validation lead Officer – Dr Jane Fryer

Lewisham Primary Care Trust

1. Accountable Officer – Simon Robbins
2. Accountable Finance Officer – Marie Farrell
3. Safeguarding lead Director – Dr Danny Ruta
4. Director of Infection Prevention and Control – Dr Danny Ruta
5. Caldicott Guardian – Dr Danny Ruta
6. Senior Information Responsible Officer – Marie Farrell
7. Executive Directors

a. Simon Robbins – Chief Executive Officer
b. Marie Farrell – Director of Finance, ICT and Estates
c. Martin Wilkinson – Managing Director, Lewisham BSU
d. Dr Danny Ruta – Director of Public Health
e. PEC Chair – Dr Helen Tattersfield
f. PEC Nurse – Vacancy
g. Director of Operations and Development (1 vote on the board – covered by Jane Schofield (operations) and Gill Galliano (Development)

8. Nominated GP Validation lead Officer – Dr Jane Fryer

Southwark Primary Care Trust

1. Accountable Officer – Simon Robbins
2. Accountable Finance Officer – Marie Farrell
3. Safeguarding lead Director – Andrew Bland
4. Director of Infection Prevention and Control – Dr Ann-Marie Connolly
5. Caldicott Guardian – Dr Ann-Marie Connolly
6. Senior Information Responsible Officer – Andrew Bland
7. Executive Directors
    a. Simon Robbins – Chief Executive Officer
    b. Marie Farrell – Director of Finance, ICT and Estates
    c. Andrew Bland – Managing Director, Southwark BSU
    d. Dr Ann-Marie Connolly – Director of Public Health (Joint with LB Southwark)
    e. PEC Chair – Dr Amr Zeineldine
    f. PEC Nurse – Vacancy
    g. Director of Operations and Development (1 vote on the board – covered by Jane Schofield (operations) and Gill Galliano (Development)
8. Nominated GP Validation lead Officer – Dr Jane Fryer

PCT Functions (derived from NHS Confederation List)

PCT Functions
Overall duties
Duty to have regard to the NHS Constitution section 2(1) of the Health Act 2009.
It is in the exercise of these functions that PCTs are responsible for the provision of hospital, community health and certain public health services to their local population and the basis for their commissioning role. The functions under sections 2 to 4 and Schedule 1 to the NHS Act 2006 ("the Act") are stated as duties or powers to provide; but the duties is to provide services "to such extent as [the PCT] considers necessary to meet all reasonable requirements".
Waiting Times - There are duties imposed on PCTs under the Primary Care Trusts and Strategic Health Authorities (Waiting Times) Directions 2010 to make arrangements to meet 18 week operational standards and subject to exceptions, where that target will not be met to offer an alternative provider.
Duty to act compatibly with the rights under the European Convention on Human Rights (section 6 of the Human Rights Act 1998).
Duties not to discriminate in the provision of services or otherwise in the exercise of the PCT's functions: - sections 19B and 20 of the Race Relations Act 1976 (race) - sections 46 and 52 of the Equality Act 2006 (religion) - sections 21A and 29 of the Sex Discrimination Act 1975 (sex) - sections 19 and 21B of the Disability Discrimination Act 1995 (disability) - regulations 4 and 8 of the Equality Act (Sexual Orientation) Regulations 2007 (sexual orientation).
Duties to have due regard to the need to eliminate unlawful discrimination and promote equality of opportunity: - race (section 71 of the Race Relations Act 1976) - sex (section 76A of the Sex Discrimination Act 1975) - disability (section 49A of the Disability Discrimination Act 1995).
Duties to publish race, sex and disability equality schemes (Race Relations Act (Statutory Duties) Order 2001, Sex Discrimination Act 1975 (Public Authorities) (Statutory Duties) Order 2006 and Disability Discrimination Public Authorities) (Statutory Duties) Regulations 2005).
In addition, the Secretary of State has delegated to PCTs his power under section 12 of the Act to arrange for other persons or bodies to provide services. This enables PCTs to enter commissioning arrangements for secondary care and community services with NHS trusts, FTs and independent providers.
Strategic Leadership and planning
Key role description: Responsibility for ensuring that services for their population are commissioned in a way which delivers improved health, better clinical outcomes, excellent patient experience and productivity, and reduces health inequalities.
Statutory duties of PCTs: PCTs must determine local health needs and determine what services are to be provided to meet those, having regard to the resources available to them.
Quality and Standards- Duty to make arrangements to secure continuous improvement in the quality of care by or for the PCT, having regard to standards published by the Secretary of State ("the duty of quality") section 23 of the Act.
Duty to make arrangements with a view to securing that it receives appropriate advice from persons with professional expertise relating to health (section 23 of the NHS Act 2006)
Functions: Locally leading the NHS – setting priorities, system management, managing and being accountable for the reputation of the NHS locally.
Develop Strategic commissioning plans which should reflect individual strategies and NSFs including for Carers, Dementia, Cancer services, CHD, Mental Health, Diabetes, Renal Services, Long Term conditions,

Young People, Maternity Services, and the National Cancer Plan, and Valuing People. The commissioning plan should also describe how the PCT will meet operating framework targets such as eliminating mixed sex wards and separating PCT provision from commissioning.
Ensure strong commissioning through Practice Based Commissioning.
Develop QIPP plans with detailed milestones demonstrating the PCT will meet SHA requirements of quality improvement, and productivity.
Undertake strategic planning and service redesign at a health economy level to include undertaking demand modelling, forecasting and capacity planning.
Develop disinvestment as well as investment plans based on agreed criteria including quality, local needs, cost evidence of effectiveness.
Facilitate links with clinicians (acute, primary care and mental health) to redesign services across whole patient pathways, including specialised services.
Work in partnership with Local Authorities (LAs) to undertake regular needs assessments. Using the identified current health needs, and identifying future trends, ensure that all commissioned services meet the needs of the population, especially those whose needs are the greatest.
Taking account of available resources, provide or secure healthcare services, ensuring high quality care, improvement in health outcomes, and value for money across all settings and for all patients.
Working with Local Authorities, determine local health improvement targets e.g. in relation to stop smoking, obesity, teenage pregnancy and health promotion, substance misuse, and exercise. Lead and also coordinate health improvement activities to address these.
Develop collaborative commissioning arrangements through Specialised Commissioning Groups, (SCGs), with; other PCTs, and other commissioners such as prison services, schools etc.
Ensure an “appropriate” degree of stability across the LHE.
Horizon scanning – in relation to policy development across all sectors
Local delivery of national public health policies
Deliver on 2010 Carbon Reduction Strategy.
Local implementation of national operating framework/vital signs
Joint strategic needs assessment
Key role description: Ensuring continuous and meaningful engagement with the public and patients to shape services and improve health. Work collaboratively with a range of partners to commission services which will improve health, and reduce health inequalities.
Duty to co-operate with other NHS bodies (section 72 of the 2006 Act)
Duty to co-operate with local authorities (section 82 of the 2006 Act)
SofS may issue guidance to NHS bodies and LAs in respect of prescribed arrangements; and has powers to direct LAs and NHS bodies (not FTs) to enter partnership arrangements where a body is failing to exercise its functions adequately (section 78)
Duties under the Local Government and Public Involvement in Health Act 2007 (local area agreements and joint strategic needs assessments) – duty to co-operate with local authority in determining local improvement targets, additional targets, or changes to or removal of existing targets, in local area agreements (sections 106(3) and 111(5)); - duty to have regard to local improvement targets in their local area agreement (section 108); and - duty to prepare joint strategic needs assessments for health & social care, with local authorities and other PCTs (section 116).

Duty to consider requests from local authorities for assistance in the planning of services for carers etc (section 3 of the Carers (Equal Opportunities) Act 2004).
Various Secretary of State functions relating to local authorities are delegated to PCTs by direction.
Duty to make arrangements with a view to securing that health service users are involved in the planning of the provision of services for which the PCT is responsible, the development and consideration of proposals for changes in the way those services are provided, and decisions to be made by that body affecting the operation of those services (section 242 of the 2006 Act).
Duty to consult local authority overview and scrutiny committee(s) on proposals for substantial developments or variations in the local health service (regulations made under section 244 of the 2006 Act1).
Child Poverty Act 2010 - s20 (PCT partnership duty in respect of child poverty).
Duty to act under guidance issued by the Secretary of State pursuant to section 2 of the Autism Act 2009, under section 3 of that Act (applies to a local authority or an NHS body).
NHS Act 2006 Section 24A (inserted under section 234 (2) of the Local Government and Public Involvement in Health Act 2007 c.27); PCT must prepare and publish a report on consultations carried out before making commissioning decisions and on the influence that the results of the consultation have on its commissioning decisions.
Civil Contingencies Act 2004 – duty to assess, plan and advise in relation to emergencies and the risk of emergencies.
Power to enter partnership arrangements (pooled budgets etc) with local authorities (regulations under section 75).
Power to delegate functions to another PCT (by agreement) and to exercise functions jointly with other PCTs, SHAs, SpHAs and NHS trusts bodies (regulations under section 19 of the Acts
Director of Public Health local authority proper officers (National Assistance Act 1947)
Undertake formal consultation before making significant commissioning decisions
Consult formally and informally with Overview and Scrutiny Committees (OSCs) on proposals for service development or variation.
Working with a range of partners, e.g. social care, education and the voluntary sector, develop and deliver the Local Area Agreement.
Actively participate in the Local Strategic Partnership, working with a range of partners, (education, commerce, LAs , police etc) to consider the wider determinants of health and the impact the PCT can make in improving health ad reducing health inequalities.
Ensure there are effective systems in place for effective adult protection – including policies, procedures and relationships with key partners. This has particular relevance to e.g victims of domestic violence, users of mental health services, and clients with a Learning Disability.
Working with LAs, jointly commission (plan, agree, monitor and evaluate) services e.g. through joint commissioning arrangements, section 75 agreements and shared posts.
Ensure effective winter planning.
Undertake emergency planning duties including assessment, planning and advising in relation to emergencies or risks of emergencies. Respond to emergencies – e.g. swine flu – procuring equipment, changing working arrangements, communications
Effectively participate in local resilience forums.
Working with partners to develop and implement strategies to reduce crime and disorder, and reduce misuse

of , alcohol and other substances.
Participate in Children's Trusts to ensure the health and wellbeing of children including undertaking responsibilities for Safeguarding (membership of the Local Safeguarding Board, ensuring roles of Designated Dr and Nurse are fulfilled)
Provide effective support for carers.
Effectively involve patients, the public, their carers, and other stakeholders in the planning and delivery of services.
Undertake Equality impact assessments.
Engage with Local Involvement Networks (LINks) *(presumption of expansion to Healthwatch)*
Respond effectively to patients through the PCT patient advisory and liaison service (PALS)
Act as a natural point of contact for local MPs and other community leaders – dealing with all written correspondence and ensuring regular and effective relationship management.
Protect the reputation of the NHS
Manage internal and external communication strategies – including effective media handling.
Proactively influence the behaviours of patients and the public eg using social marketing to support stop smoking campaigns.
Providing or securing services
Key role description: Ensure there is a full range of providers which provide choice, and which secure the desired outcomes, quality and value for money
Statutory duties of PCTs: Duty to provide or secure the provision of primary medical services in its area (section 83 of the Act); the duty is to provide or secure.
Duty to provide or secure the provision of primary dental services in its area (section 99 of the Act).
Duty to provide or secure the provision of certain ophthalmic services, including sight-testing, in its area (section 115 of the Act).
Duty to make arrangements for the provision of pharmaceutical services in their area – i.e. the provision of drugs, medicines and certain appliances prescribed by GPs or dentists, and such additional pharmaceutical services as directed by Secretary of State (sections 126 and 127 and 129 of the Act).
Duty to administer the arrangements for primary care services (i.e. the services referred to above), and perform such other management and other functions as may be prescribed (section 22 of the Act).
PCT duty under Directions to make arrangements to ensure vaccination is offered in accordance with JCVI recommendations.
Affects who has to decide if it is safe to discharge patient and notify LA of likely need for community care services. If health service hospital, done by the hospital. If independent, done by the contracting NHS body. (Community Care (Delayed Discharges etc.) Act 2003 (c.5))
Statutory powers of PCTs: Power to make pilot schemes for the provision of local pharmaceutical services (section 134 of the Act).
PCTs have a power to provide services under primary medical services & primary dental services agreements (section 21(1) of the 2006 Act).

Power to make payments to local authorities and voluntary organisations towards expenditure on community services (sections 256 and 257.
Power to give grants to voluntary organisations (section 64 of the Health Services and Public Health Act 1968 – Secretary of State functions delegated to PCTs by direction – see Annex A).
Functions: PCTs currently contract Home Oxygen services. Current contracts expiring around 2012/13 but Capital & Revenues Investment branch are in the process of procuring 5-year contracts starting in 2011 with lead PCT as a party. This function requires significant contract management capability and need to recover costs from other commissioners.
Negotiate contracts with full range of providers (acute, primary, community, mental health, third sector independent sector etc) to include: - Financial envelope - Capacity plans - Incentives e.g. CQIN - Clinical and quality outcomes (N.B. Contracts with foundation trusts are legally binding)
Ensure application of mandatory NICE guidance across providers.
Determination for treatment abroad.
Develop "section 75 "arrangements to manage jointly commissioned services – most commonly in mental health, learning disability and children's services. Such arrangements have clear governance and specific accountability arrangements for LAs and NHS organisations.
Ensure pathway coordination across commissioners and providers for "high end" secondary care services. This is usually managed through the networks for stroke, CHD, cancer etc.
Develop a procurement strategy and ensure compliance with PRCC. This includes development of service specifications, tendering, Board sign off of award of contract, and managing the transition between providers
Manage the local provider market to ensure there is an appropriate range and choice of providers.
Manage vaccination and screening programmes (implemented through primary care providers) – notifying call and recall to practices, maintaining databases for breast and cervical screening
Managing individual funding requests – e.g. to meet complex health care needs, working with education, social services, prison services etc when appropriate.
Assessing/appraising evidence to underpin commissioning
Issuing commissioning intentions
Monitoring and evaluation
Key role description: Ensure contract compliance and continuous improvement in quality, health outcomes, and value for money.
Statutory duties of PCTs : Duty to maintain and publish Performers Lists (NHS Act 2006 and subsequent regulations): - S91 Primary Medical services - S106 Primary Dental services - S123 Primary Optical services - S129 Pharmaceutical services (inc. appliance contractor)
Functions: Continuously monitor performance of contracts (and grants) with all providers (NHS, L A, independent or thirdsector. Specifically, regularly review: - Financial performance - Activity levels - Quality standards and outcomes including patient experience - Clinical standards.
Provide pre intervention support to providers where there is a concern over performance.
"Relationship management" with range of providers (informal and formal).

Comment on and agree quality accounts
Undertake surveys, analyse and use the data to improve services e.g patient choice surveys.
Working with clinicians, patients and others, continually review effectiveness and improve pathways.
Continually review PCTs performance and outcomes against similar populations.
Measure and understand the efficiency and effectiveness of PCT spend in all commissioned services, benchmarking against identified best practice.
Undertake payment and invoice reconciliation.
Financial audit (internal and external)
Accountability and Assurance
Key role description: Accountable for ensuring and demonstrating high quality services, and ensuring the most effective and efficient use of resources.
Statutory duties of PCTs: Duty to publish an annual document setting out information in relation to the quality of the services they provide or commission (other than in relation to primary care services and community health services) section 8 of the Health Act 2009.
A PCT has various financial duties under the NHS Act 2006 including: - to secure that its expenditure in any financial year does not exceed its allotment from Secretary of State for that year (section 229) - to secure that its use of resources in any financial year do not exceed the amount specified by the Secretary of State (section 230) - to keep proper accounts and related records (Schedule 15, paragraph 2) - to prepare annual accounts and send copy of accounts to SHA and Secretary of State (Schedule 15, paragraphs 3 and 4).
Duties to prepare an annual report, send it to SHA & Secretary of State and to publicise the report and annual accounts (NHS Act 2006, Schedule 3, paragraphs 20 and 21).
Power to provide hospital services for private patients or provide other services, or carry out other activities, for the purpose of making additional income available ("income generation") (section 21(5)).
Power to raise money (by appeals, competitions etc) (section 222 of the 2006 Act).
Data Protection Act 1998 – - duty to process personal data in accordance with the Act - duty to grant individuals access to personal data relating to them (sections 7 to 15 of the Act) - duties to register with Information Commissioner (sections 17 to 21).
Freedom of Information Act 2000 – - duty to comply with requests for information in accordance with the Act (sections 1 to 16); - duty adopt and maintain a publication scheme and publish information in accordance with that scheme (section 19).
Duties in relation to the supervision and management of controlled drugs (regulations under sections 17 and 18).
Duty to provide periodical reports on matters relating to HIV and AIDS (section 1 of the Aids (Control) Act 1987.
PCTs currently hold some contracts for Wave 1, Phase 2 ISTCs and now successors to Wave 1 contracts.
For some contracts for Wave 1, Phase 2 ISTCs, PCTs have provided indemnities to the ISTC contractor to cover their clinical negligence. Effectively, if a claim is made, the indemnity means it is made against the PCT rather than the ISTC and the PCT is covered through the clinical negligence scheme for trusts (CNST).
Mental Capacity Act 2005; A PCT has a duty to act as a Supervisory Body in relation to Deprivation of Liberty Safeguards.

Duty to appoint Responsible Officer (RO Regulations 2010 under Health and Social Care Act 2008) – duties of responsible officers in PCTs relate to all doctors on Performers List and some locum doctors.
Duty to make a pharmaceutical needs assessments for its area (section 128A of the Act)
FT Board membership – NHS Act 2006, Schedule 7, Para 9(3); "at least one member of the board must be appointed by a Primary Care Trust for which the corporation provides goods and services" [**DN – unsure if this is a duty to FTs or for PCTs. Awaiting Legal Comments and Policy Steer from FT team**.]
Apply Equality Act 2010 (from 1 October 2010)
Statutory powers of PCTs: Power to enter agreements for the provision of overseas development
Education and Skills Act 2008 - s16 (PCT power to supply information to local education authorities)
Functions: Function/role of Local Security Management Specialists working in PCTs
Publish an annual public health report.
Management of communicable diseases – including providing reports matters relating to HIV and AIDs.
Manage decision-making process for use of high cost drugs and new interventions
Medicines management – provision of prescribing advice to all primary care contractors, supervising and managing controlled drugs. - Communicating and managing drugs and medical devices alerts. - Provide prescribing advice to care homes. - Manage prescribing incentive schemes for practices. - Accountable officer across the system (including independent sector) - Maintaining drugs – eg. cold chain vaccines
Manage all elements of Data Protection.
Assurance and risk management – review all risks and issues eg internal risks, SUIs, provider risks, risks associated with partners such as Safeguarding Boards.
Ensure effective information governance.
Comply with all requests under FOI –and publish information in accordance with the publication scheme.
Manage requests for access to medical records.
Manage all complaints (including complaints made directly to PCT).
Respond appropriately to all SUIs, independent enquiries and incidents, child death reviews.
Undertake serious case reviews
Prepare and publish annual report and annual accounts.
Manage litigation issues and Clinical Negligence Scheme for Trusts (CNST).
Manage charitable funds.
Ensure links with CQC and meet requirements and requests.
Provide management account support to commissioners, PbC clusters etc.
Ensure effective financial governance including adhering to Standing Orders, Standing Financial Instructions etc.
Financial services – cash management.
Meet Infection control responsibilities.(inc. Auditing and monitoring implementation of recovery plans)
NHS Library services.
Ensure effective business continuity planning and testing.

Clinical governance responsibilities
Communications planning/local voice of NHS
Research governance
Workforce
Key role description: Ensuring the organisation develops the capacity and capability to commission outcomes that deliver high quality care and give value for money.
Statutory duties of PCTs: Duty not to discriminate in relation to staff and recruitment: - section 4 of the Race Relations Act 1976 (race) - section 6 of the Sex Discrimination Act 1975 (sex) - section 4 of the Disability Discrimination Act 1995 (disability) - regulation 6 of the Equality Act (Sexual Orientation) Regulations 2003 (sexual orientation) - regulation 7 of the Employment Equality (Age) Regulations 2006 (age)
Health & safety - duty to ensure, so far as reasonable practicable, the health, safety and welfare of employees at work (section 2 of the Health and Safety at Work etc Act 1974) - duty to ensure, so far as reasonable practicable, that persons who may be affected by the PCT's undertaking are not exposed to risks to their health and safety (section 3 of the 1974 Act) - duty to ensure that PCT premises are safe for visitors etc (section 4 of the 1974 Act) - function of making arrangements for a medical practitioner to provide medical records of persons under 18 to employment medical advisers (section 60 of the 1974 Act) Health Act 2006 – - duties to prevent smoking and to display no-smoking signs in PCT premises (sections 6 and 8) Statutory powers of PCTs:
Schedule 3 to the NHS Act 2006 confers various miscellaneous powers including– - employ staff (paragraph 7); - pay remuneration and allowances to chairman and other board members of the PCT (paragraph 11); - do anything which appears to the PCT to be necessary or expedient for the purposes of or in connection with its functions, including acquiring and disposing of property, entering contracts and accepting gifts of property (paragraph 15); - enter externally financed development agreements (PFI etc) (paragraph 17); - conduct, commission or assist the conduct of research (paragraph 18); - make staff available for training purposes (paragraph 19); - to purchase land compulsorily where approved by Secretary of State (paragraph 22).
Functions: Commissioning of education programmes – clinical and non clinical.
Providing training and development opportunities for all staff.
Ensuring effective clinical leadership.
Ensure organisational development which in turn ensures development of people, capacity and capability of the organisation to meet the QIPP challenges.
Development of Board and PEC.
Workforce planning
Payroll
Develop recruitment and retention strategies for staff
Ensure workforce policies are developed to demonstrate the PCT is a good employer, and reflects best practice in relation to equality and diversity (including occupational health, personal development, protecting and improving staff wellbeing).
Undertake formal trade union processes in relation to recognition and consultation.

Undertake annual staff surveys
Meet all statutory health and safety duties
Develop and implement a single diversity scheme.
Undertake CRB checks
Estates and IT
Key role description: Ensure the PCTs estate & I.T are effective and enable the delivery of high quality and cost effective care.
Statutory duties of PCTs: Duties in relation to Estates: - Reimbursing GPs for the costs of operating their premises (unless, of course, major changes are made to the arrangements for funding primary care); - Planning and funding of NHS-owned primary and community facilities; - Contracting through frameworks, in particular LIFT and Procure 21 for the delivery of facilities.
Statutory powers of PCTs: Power to provide premises for the use of persons providing primary care services (section 21(3) of the Act).
Power to form, or participate in the formation of, companies for the purposes of improving primary care facilities or services (in LIFT areas) (section 223 of the 2006 Act – Secretary of State power delegated to PCTs by directions – see Annex A)
Licensing Act 2003 - s16 (PCT power to apply for premises license).
Functions: Ownership and maintenance of PCT asset.
Support local implementation of national transformational projects such as Connecting for Health ensuring that there is an integrated approach to service development and informatics planning.
Ensure primary care premises are developed and maintained in such a way as to support provision of high quality primary care.
Assure quality of premises, issuing improvement notices or closure orders where problems are identified
Strategic planning of wider estates policy
Enter into externally financed development agreements such as PFI and LIFT.
Holding contracts with LIFT/PFI and paying rent
Management of all IT.
Providing IT support to GPs and other primary care contractors.
Ownership of IT equipment in practices.
Knowledge management including data systems
Service specific responsibilities Most PCT functions apply to all services, services settings and care groups. There are some specific services issues and duties listed below.
Statutory duties of PCTs: *After-care services for mental health patients* - Duty on PCTs and local authorities to provide after-care services for patients after detention under the Mental Health Act (section 117 of the Mental Health Act 1983).
Direct Payments - There is provision in sections 12A to 13 of the 2006 Act for the Secretary of State to make direct payments to patients in lieu of providing healthcare. Section 12A(4) provides for PCTs to make direct payments to secure after-care services under section 117 of the Mental Health Act 1983, if regulations so provide

Mental Health Act 1983, s23/s24 – power to discharge NHS patients from detention (etc) in independent hospitals. Associated power to authorise certain persons to visit and interview such patients.
Mental Health Act 1983, s39 – duty to provide court on request with information about availability etc of hospital places
Mental Health Act 1983, s130A – duty to make arrangements for independent mental health advocates (IMHAs) to be available to qualifying patients. (Power conferred on SofS, but is delegated to PCTs via the Functions Regulations).
Mental Health Act 1983, s140 – duty to notify local social services authorities of availability of suitable hospital places for emergency admissions and for under 18s.
NHS Act 2006, s236. Duty to make payments to doctors for medical examinations in connection with Part 2 of the Mental Health Act.
Mental Capacity Act 2005; A PCT has a duty (by virtue of regulations) under ss 37 & 38 MCA to consult an IMCA
Coroners and Justice Act 2009 - ss19 & 20 (PCT duty to appoint medical examiners)
Statutory powers of PCTs: Mental Health Act 1983, s122 – power to make pocket money payments to certain psychiatric in-patients. (Power conferred on SofS, but is delegated – by implication – via the Functions Regulations).
Functions: Provide courts with information about availability of hospital places.
Ensure independent mental health advocates are available to patients where appropriate.
Working with Local Authorities, provide aftercare for patients who have been detained under the mental health
Children and Young People
Statutory duties of PCTs: Duty to co-operate with local authorities and other to improve well-being of children (section 10 of the Children Act 2004);
Duty to make arrangements to ensure that PCT functions are discharged having regard to the need to safeguard and promote the welfare of children (section 11 of the Children Act 2004);
Duty to work with local authority in connection with the authority's arrangements for improving well-being etc of young children (section 4 of the Childcare Act 2006).
Statutory powers of PCTs: Learning and Skills Act 2000 - s120 (PCT power to supply information about young people to SofS etc)
Functions: Commissioning services for looked after children.
Managing transition :between adult and older peoples services, and between children's and adult services. Specifically patients and users face issues in transition in Mental health, learning disability and services provided for children with complex health care needs.
Commissioning for vulnerable groups : ensure services are commissioned specifically, for seldom heard and vulnerable groups such as travellers, asylum seekers.

Offender health
Statutory duties of PCTs: Duty to co-operate with the prison service with a view to improving the way in which functions are exercised in relation to the health of prisoners (section 249 of the NHS Act 2006)
Duty to formulate and implement, with local authorities etc, strategies for the reduction of crime and disorder, and for combatting the misuse of drugs, alcohol and other substances (section 6 of the Crime and Disorder Act 1998);
Duty to co-operate with local authorities in relation to youth justice services, youth offending teams etc (sections 38 and 39 of the Crime and Disorder Act 1998);
Duty to co-operate with police, probation and prison services in relation to arrangements for assessing risks of violent or sexual offenders (section 325 of the Criminal Justice Act 2003).
Functions: Work with prison services to improve the health of prisoners.
Working with police, probation and prison services to asses risks of violent or sexual offenders
Cooperate with youth justice services and youth offending teams to ensure effective health care services are available.
Appoint medical examiners.
Continuing health care
Statutory duties of PCTs: There is a single set of eligibility criteria for NHS CHC used across England. The criteria are set out in Directions and are supported by guidance in the revised National Framework for NHS Continuing Healthcare introduced in 2007 and revised in 2009.
Functions: Undertake assessment processes and review panels jointly with Local Authorities using the nationally agreed criteria.
Maternity
Statutory duties of PCTs: Duty to establish Maternity Services Liaison Committees (MSLCs) comprising both users and providers of maternity services
Functions: Establishment of maternity services liaison committees
Primary Care
Patient registration • Process additions, deletions and amendments to patient database • Issue of medical cards, transfer of information to organ and blood donor registers • Undertake practice list reconciliations • Management of data quality • Manage links transactions for patient registrations • Transfer of medical records • Adoptions, gender reassignments and witness protection • Research and information requests • Administration of violent patient scheme • Management of closed practice lists • Assignment of patients to practice lists • Removal of patients from practice lists • Resolution of GP links queries • Management of GP services for homeless people
Screening (Cervical and Breast and pilot chlamydia) • Notification of cervical screening call and recall to GP practices • Preparation, printing and issue of call and recall letters to women • Issue of results letters to women • Updating of Exeter database with screening results • Management of electronic links between laboratories and PCT • Achievement of 14 day turnaround • Communication with GP practices and national screening programme

- Training of nurses and practice staff regarding call and recall
- Attendance at local and regional training events
- Preparation, printing and issue of breast screening batches
- Maintaining accuracy of databases for breast and cervical screening
- Provision of information on screening uptake

FHS Finance

- Payment of:
  - -GMS global sum and correction factor
  - -PMS contract sums
  - -QOF payment
  - -Local and National Enhanced Services
  - -Premises – rent, rates, trade refuse, improvement grants
  - -GP retainer and flexible career scheme
  - -Locum costs
- Payment of contract variations
- Deduction of:
  - Superannuation
  - LMC levy
  - Health Centre charges

Provision of financial information

- Notification to practitioners of payments made
- Provision of quarterly information on weighted
- Provision of creditor and debtor information
- Recording of all payment information to be entered into each PCO's financial ledger
- system using Exeter system interface

Pay contractor

- Business rates
- Commitment payments
- Electronic prescriptions scheme
- Clawback

Ophthalmic care contracts

- Sight test vouchers
- Domiciliary visits
- Repairs and replacements
- Retinal screening
- CET grants
- Cataract choice scheme
- Counter fraud checks

Pharmaceutical contracts

- Management of contracts for GP clinical waste and sharps
- Management of contracts for waste medicines
- Returned medicines
  - Local payments, eg high cost prescriptions, out of hours
  - Pre registration trainees
  - Essential Small Pharmacy Scheme
  - PCO local schemes
  - Levy to representative committees
- Enhanced services on pilot basis

Contract management for all primary care contracts
Support to primary care providers

- QOF 5% fraud check
- Ophthalmic counter fraud checks
- Contractor list management
- Applications for inclusion in
  - Medical Performers List
  - Dental Performers List
  - Ophthalmic Performers List
  - Pharmacy control of entry
- Applications for new pharmacies (exempt and non exempt)
- Applications to re-locate pharmacies
- Changes in hours or services
- Administration of GP rent and rates scheme
- Data quality checks on Performers Lists
- Annual Professional Body checks

• Locum catch up exercise • Provision of contractor information • Provision of CRB services to PCOs and Contractors
Regulatory Support • Provision of advice regarding Performers List Regulations in relation to: –Suspension –Review of suspension –Conditional inclusion –Contingent removal • Support to PCO panels regarding decisions around control of entry • Support regarding appeals against any of the above decisions
immunisation activities) • Provision of information to Contractors and SHA • Update of NHS Choices • Provision of mapping services to support pharmacy applications • Website • Intranet • Introduction of PCIS
Performance & Contracting (FHSA) • Provision of courier services to transport NHS stationery and medical records • Management of NEAS contract for courier services • Performance management and KPIs • Health and Safety • Complaints – including direct to PCT complaints • Practice premises quality assurance
Doctor appraisal toolkit
Quality accounts toolkit
QOF
Annual public meeting
Engagement with, timely submission to and compliance with regulatory agencies such as CQC, HSE NPSA, Audit Commission etc
Liaison with NHSLA; Including; • NHSLA assessment • Liability to third parties (LTPS) • Property Expenses Scheme (PES) • RPST
Safeguarding duties and provisions
Appoint Caldicott Guardian,
Appoint Director of Infection Prevention and Control
Ensure appropriate Use of Resources
Publish Statement of Internal Control
Counter Fraud Service Management
Appoint Senior Information Risk Officer (SIRO)
Serious Incident Reporting
Complaints KO41 returns
QMAS to support the QOF
Comply with NHS information standards
Comply with Public register of data controllers
Complete Professional registration
Ensure Health and safety/health and wellbeing in the work place
Comply with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
Comply with Control of substances hazardous to health (COSHH)

Comply with Biosafety legislation
Comply with Food Safety legislation
Complete Toolkits;
Information Governance Toolkit
Cancer commissioning toolkit
Sustainability toolkit
NHS constitution toolkit
NCAS toolkit

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 5

INDICATIVE CORPORATE RISK REGISTER

DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development

AUTHOR: Sarah Gardner (Deputy Director Integrated Governance) & Ben Vinter (Integrated Governance Manager)

TO BE CONSIDERED BY: All

SUMMARY:
NHS SEL as an organisation came into being in April 2011 as a partnership of the South East London PCTs and Bexley Care Trust.

This report provides the Board with an indicative summary of risks for NHS SEL and common risks as identified across the 6 Business Support Units.

Its contents relate to 3 Corporate Objectives as have been agreed (Improve health, quality and maintain safety of local NHS services, Sustain an effective grip on finance, performance and QIPP, Proactively manage the transition to the new commissioning system). From the time of establishment, the organisation's focus has been on recruitment, establishing management structures and setting objectives. Each directorate and BSU will now have the opportunity to implement local approaches to risk management.

NHS SEL has already agreed a single approach for management of risks (to be overseen by the Cluster Management Board) and is in the process of developing a framework for its application, common escalation and subsequent aggregation for presentation of a single cluster view to the Joint Boards.

KEY ISSUES:
This indicative risk register for NHS South East London aims to identify formative risks either carried forward from PCT operation, emerging risk in or across the cluster and any specific high risk areas held by BSUs. A cluster wide approach to risk management has now been agreed and will be embedded over the following two months with a view to reporting to the July meeting of the Joint Boards (details below)

The most significant areas of risk identified at this time are as follows;

- Reputational risks associated with organisational change
- Impact of organisational change on staff morale, capacity and delivery
- Emergency Planning & Planning for the Olympic
- Delivery of QIPP and operating plan
- BSU and GP development
- Retaining a grip on finances
- Maintaining performance
- Commissioning high quality and safe services
- Breach of Data Protection Act

Future meetings of the Boards will be able to review an aggregate position of assurance and risk management derived from embedded local approaches based upon common presentation, scrutiny and scoring of risks, controls and assurance.

Risks and assurance will be managed at a local level, tracked and reported through identified risk leads (within each directorate and / or BSU), discussed at an operational forum prior to presentation of risks to the CMB. CMB will take decisions and make recommendations on the presentation of issues, as appropriate to the Boards or their committees.

BSU approaches to risk management will be overseen by the each MD with the local approach to risk management overseen by the relevant LCCC – such discussions may reflect, where appropriate, the implications of cluster held risks. Risks and assurance issues arising from cluster directorates will be owned by those directors. .

Appendices
a) Indicative NHSL SEL risk register and Heat Map

INVOLVEMENT:
An operational risk forum will be established based upon representation from each Board level director for presentation and aggregation of risks for corporate presentation, first to the CMB and then to the Joint Audit Committee before consideration by the Joint Boards.

Going forward it is envisaged that each LCCCs will review the approach to local risk management. The work of such committees will be supported by local governance teams.
RECOMMENDATIONS: The board (s) is asked to:- **1.** NOTE the contents of this report **2.** ADVISE on preferences and / or expectations with respect to the developing approach for reporting risks to the July meeting of the Joint Boards and thereafter
DIRECTORS CONTACT: Name: Gill Galliano E-Mail: g.galliano@nhs.net Telephone: 020 7206 3332
AUTHOR CONTACT: Name: Ben Vinter E-Mail: ben.vinter@nhs.net Telephone: 0203 049 4421

ENCLOSURE 5

Risk Register	SEL
Directorate	Corporate
Accountable Officer	Simon Robbins
Last Review Date	09/05/11

Corporate Objectives

1. Improve health, quality and maintain safety of local NHS services
2. Sustain an effective grip on finance, performance and QIPP
3. Proactively manage the transition to the new commissioning syst

Risk Identification								Risk Description and Assessment					
Source Ref	Directorate	Corporate Objective	Work Stream	Date Raised	Risk Category	Risk Owner	Risk Description (There is a risk that…caused by……leading to……..)	Inherent Risk	EXISTING CONTROLS ie. actions implemented where this is evidenced/documented note evidence of risk being controlled	Residual Likelihood	Residual Impact	Current Residual Risk	Control Gap What still needs to be put in place
DD1	**Development**	Improve health, quality and maintain safety of local NHS services	Communications	01/05/11	Change	Oliver Lake	There is a risk of failure to protect the reputation of NHS South East London caused by the organisational change set out in the NHS Health Reforms leading to the abolition of PCTs in 2013.	**16**	Reputation management included in the Director of Corporate Affairs Objectives and will be included within the Communications and Engagement work plan. Effective systems are being established to manage media, effective engagement and stakeholder communications.	Possible	Major	**12**	Detailed work plan for C&E to be developed with actions identified to minimise reputational risk. Directorate objective setting across the organisation to be completed so that all areas are clear on their role in delivering NHS South East London's Corporate Objectives. Effective delivery of these objectives will reduce the risk of reputational damage.
PC1	**Primary Care**	Improve health, quality and maintain safety of local NHS services	Primary Care	03/05/11	Clinical	David Sturgeon	Manage issues of concern regarding Independent Contractors - The establishment of the Cluster Primary Care Director has establsiheed from existing records, currently live 77 Issues of Concern cases that need management action. 22 are considered to have a RED rating	**25**	Recruitment of an Issues of Concern Team. Creation of an Issues of Concern Register Report to Boards on Issues of Concern 19/5/11 Development workstream of Primary Care Decision Panel established	Likely	Major	**16**	Establishment of Primary Care Decision Panel & Issues of Concern Group
DD2	**Strategy & QIPP and All BSUs**	Improve health, quality and maintain safety of local NHS services.	QIPP	14/04/11	Clinical	Tony Read & BSU MDs	There is a risk that the QIPP initiatives do not focus adequately on maintaining / improving quality and safety. Arising as a specific BSU risk of failure to maintain sufficient focus on quality and day to day delivery of Business as Usual caused by capacity and capability to idenify failure before it happens, unclear accountabilities leading to loss of grip on finance, performance and quality / safety.	**16**	Establish PMO function including reporting on performance including quality and safety in addition to savings against initiative critical milestones and KPIs. Ensure reporting of quality and safety is included in governance arrangememts. BSU SMT review LCC Supporting committee agreed Existing quarterly quality reporting for PCT. BSU attend acute hospitals contract performance meetings SUIs / Governance, Cluster Performance Information and Governance team. Quality Alerts PALS / Complaints LINKS Database and feedback reports Quarterly Performance stocktake with Cluster - Terms of Reference in place	Possible	Major	**12**	Quality and sefety reporting. Functioning Joint Quality and Safety Committee. Qaulity review structures of LCCCs established

ENCLOSURE 5

Risk Identification								Risk Description and Assessment				
Source Ref	Directorate	Corporate Objective	Work Stream	Date Raised	Risk Category	Risk Owner	Risk Description (There is a risk that…caused by.....leading to.....)	Inherent Risk	EXISTING CONTROLS ie. actions implemented where this is evidenced/documented note evidence of risk being controlled	Residual Likelihood	Residual Impact	Current Residual Risk	Control Gap What still needs to be put in place
PH 1	Public Health and all BSUs	Improve health, quality and maintain safety of local NHS services.	Public Health	01/05/11	Operations	DPH and all BSU MDs	Achieving health protection outcomes (immunisations & screening) in context of demographics, GP incentivisation, across cluster and in partnership with providers	16	Use of effective social marketing methods Media and Comms Action Plan Revised Immunisation Plan, Direct Letters to parents re booster General Comms Prevention/early intervention programs (e.g. smoking; health screening) via commissioned services in primary care/agencies. Action plan for screening & immunisations in place NHS London & PCT modelling. Public Health Action Plan. Root Cause Analyses promoting targeted action plan. Use of success feedback from leading practices. JSNA. LAA. Quality and Safety and Performance & QIPP Ctte reporting & monitoring	Unlikely	Moderate	8	Variable expertise and resources to undertake effective social marketing. Staff retention and capacity in light of organisational changes
PH 2	Public Health and all BSUs	Improve health, quality and maintain safety of local NHS services.	Public Health	01/05/11	Operations	DPH and all BSU MDs	Emergency Planning. Hazard: Level 2 or 3 (Mass casualty) incident; Risk of: services overwhelmed and services break down. Business Continuity during the Olympics	20	SEL DPH forum established Emergency Prepardness Report to May 19th Board Participation in NHSL Olympic Planning Groups Greeenwich handover arrangements in place	Possible	Catastrophic	15	Cluster wide support arrangements Testing emergency preparedness arrangements Capacity issues arising from transition Olympics Delivery (contingency) Group
G 1	Greenwich BSU	Improve health, quality and maintain safety of local NHS services.	Commissioning	01/05/11	Clinical	Annable Burn	Prison Health: Commissioning Prison Health services at Belmarsh which are not safe or lacking in quality ; Risk of: Deaths in custody and other Serious Untoward Incidents related to the Prison Health Service; controlled drugs incidents, significant resource issues for investigation purposes; reputational risks, risks to development of new prison. Legal advice confirms that despite not being the employer, liability for negligence would accrue to the PCT	12	Lessons have been identified during Death in Custody Reviews. NHS Greewich tendered and identified a preferred provider for prison estate. Interim solution for Isis. Implementation of recommendations from the Prison and Probation Service Ombudsman are being monitored (updated (7/7) Increased officer capacity. CQC registration solution in place for providers	Unlikely	Major	8	Align skills to make best use of commissioing capacity within cluster
F1	Finance	Sustain an effective grip on finance, performance and QIPP	Finance	01/05/11	Financial	DoF and Bsu MDs	Risk of non delivery of effective use of resources and delivery of statutory financial duties (i.e. to remain within the revenue resource limit, capital resource limit and cash limit.); - Lack of robust timely activity information from Providers - Challenging and diverse agenda ie NHS Operating Framework, CIPs, PMO establishment, Organisational Chance, Acute providers performance and resiliance	16	- Regular monitoring to identify early warning signs. - Focus on forecasting and risk management via best/ worst / most likely case predictive modelling. - ongoing budget review of pressures / slippage with schemes to manage variance agreed with directors - Cluster finance team being recruited to	Unlikely	Major	12	Increasingly diverse , extensive and challenging agenda in terms of separation, procurement, costing and project support is a significant ongoing risk.

Risk Identification								Risk Description and Assessment				
Source Ref	Directorate	Corporate Objective	Work Stream	Date Raised	Risk Category	Risk Owner	Risk Description (There is a risk that…caused by……leading to……..)	Inherent Risk	EXISTING CONTROLS ie. actions implemented where this is evidenced/documented note evidence of risk being controlled	Residual Likelihood	Residual Impact	Current Residual Risk	Control Gap What still needs to be put in place
F2	Finance	Sustain an effective grip on finance, performance and QIPP	Finance	02/05/11	Financial	DoF and Bsu MDs	Insufficiently robust financial strategy to deliver PCT / Care Trust strategic initiatives - Lack of robust timely activity information from Providers - Challenging and diverse agenda ie NHS Operating Framework, CIPs, PMO establishment, CPU and LD separation, acute providers stretching capacity of finance resources. Lack of capacity and procurement expertise across organisation results in lack of compliance with Standing Orders/ SFIs	16	- financial control embedded and subject to external scrutiny. - Development of performance indicators and benchmark performance internally and in contractual relationships. - Investment in infrastructure e.g. patient referral centre to secure delivery -Robust business cases required for developments with sensitivity modelling around growth in demand PMO established with more rigorous approach to milestone setting and monitoring. Ownership at Board level with all Directorates actively engaged - Monthly review of contract performance; Implementation of contract requirements for monthly activity reconciliation. - Review of partnerhship with primary care IT financial arrangements	Unlikely	Major	12	Economic Factors and Policy changes outside PCT control
BSU 1	ALL BSUs	Sustain an effective grip on finance, performance and QIPP	QIPP	18/04/11	Financial	BSU MDs	Financial pressures in partner organisatioins lead to cost shift or demand shift	12	Close partnership working including through QIPP programme boards with trusts and local authority. New joint commissioning arrangements in place with local authority. Regular meetings between Boroughs and senior health team.	Possible	Moderate	9	Implementation of agreed care pathways. Development and implementation of new pathways in agreed priority areas. Further work with local authority to understand proposals for savings in children's servics.
BSU 2	All BSUs	Sustain an effective grip on finance, performance and QIPP	QIPP	03/05/11	Financial	All BSU MDs	There is a risk that failure to deliver sufficient local QIPP Initiatives in a timely manner caused by a lack of GP ownership and engagement, lack of stakeholder management including appropriate patient and public / provider involvement, insufficient tracking of delivery plans and associated KPI's, lack of pipeline schemes and alignment of enablers leading to breach of financial control total and non delivery of local QIPP Plan.	20	Pathfinder application Federation and Cluster structure GP Interaction BSU Structure including Facilitators Clinical Commissioning Committee with QIPP on the agenda since September 2010 Implementation plans in place Borough engagement in QIPP spring 2011 QIPP in Contracts PMO structures Highlight / Exception Reporting Framework with LCCC (shared with Cluster) Development of QIPP Plan Bs (April) Cluster QIPP Structure and meetings Invest to save initiatives RAG Financial adjusted, QIPP being monitored PPE Steering Groups Service and System Redesign focus LCCC leadership and focus, BSU QIPP committees, Developing clinical OD plans. Monthly Director of Development GP Delegation and Development task group established. GP Delegation report to May 11 Board	Likely	Major	16	Previous management approach to gaps in assurance process developed by PCT / Care Trust no longer applicable due to introduction of transition arrangements. Risks still to be clearly identified Alignment with Contracting teams Defining GP Executive Team Formalised PMO Structure LCCC supporting committees Engagement Plans Strengthen Implementation Plan KPI to be agreed There is a risk on the availability of real time data/ Information so that GP consortia can monitor plan implementations Lack of/slow change in clinical behaviour

ENCLOSURE 5

Risk Identification								Risk Description and Assessment					
Source Ref	Directorate	Corporate Objective	Work Stream	Date Raised	Risk Category	Risk Owner	Risk Description (There is a risk that…caused by……leading to……..)	Inherent Risk	EXISTING CONTROLS ie. actions implemented where this is evidenced/documented note evidence of risk being controlled	Residual Likelihood	Residual Impact	Current Residual Risk	Control Gap What still needs to be put in place
DD3	Strategy & QIPP	Sustain an effective grip on finance, performance and QIPP	QIPP	14/04/11	Financial	Director of Finance	There is a risk that the National tariffs will increase at a rate higher than planned for resulting in lower level of technical efficiency saving reducing the level of resource available for other investments	20	Review programme of planned investments and instigate changes to the programme in areas of lower priority/lower return on investment	Likely	Major	16	Developing Plan B's Establishment of LCCCs with QIPP focus Established Joint QIPP Committeee
DD4	Strategy & QIPP	Sustain an effective grip on finance, performance and QIPP	QIPP	14/04/11	Financial	Director of Finance, Director of Operations/ BSU MDs	There is a risk of failing to deliver the operating plans and associated loss of financial delivery. GP ownership of pathway redesign and demand management is required, to allow for invest to save intiaitves.	20	LCCC leadership and focus, BSU QIPP committees, Developing clinical OD plans. Monthly Director of Development GP Delegation and Development task group established. Delegation report to May 11 Board. Performance Framework in development.	Likely	Major	16	To be established; Operational Board with responsibility for delivery. Clear and high profile performance framework which securely identifies where accountability lies for delivery and which is regular monitored with corrective action taken as appropriate. Regular programme of 'stock takes' at local level chaired by Director of Operations and with Director of Finance and Director of Performance becoming local 'recovery boards' if required. ICT will be scoping capacity and poteintial shortfall to deliver NPFIT programmes
OD1	Operations	Sustain an effective grip on finance, performance and QIPP	Performance	04/04/11	Operations	Sean Morgan	There is a risk of failing to deliver one or more key (headline) performance measures in 2011/12	12	New performance framework for 2011/12 includes focus on delivery of Operating Framework priorities. The Performance team will monitor performance in-year and ensure accurate information is collated and reported to borough Stocktake meetings and to the Cluster Management Board, individual Clinical Commissioning Committees, QIPP, Finance & Performance Committee and to the Board as appropriate for action to be agreed as required	Possible	Moderate	9	
OD2	Operations	Sustain an effective grip on finance, performance and QIPP	Acute Contracting	04/04/11	Financial	Susanna Masters / Sarah Cottingham	There is a risk of acute contract overperformance, of a value greater than contingency budgets	16	Rigorous contract monitoring. Challenging invoiced activity in accordance with Contract terms. Early discussions with GP commissioners about the causes of any overperformance and agreement on mitigating action. A review of FSTFT SLA with ICT	Possible	Major	12	Activity thresholds in contracts, risk share agreements, referral protocols.
PC3	Primary Care	Sustain an effective grip on finance, performance and QIPP	QIPP	11/05/11	Operations	David Sturgeon Geenwich BSU MD	Following PMS review in NHS Greenwich, one practice has requested a Judical Review in regard to the iimplementation of the 2010 Directions providing the Commissioner the right to terminate his PMSwithout reason by serving six months notice.	20	Process of engagement with practices and LMC during the period Oct 09 to Jun 10 to determine the outcome of the review. 39 of 41 practices have agreed the new PMS contract arrangements. Capsticks to act on behalf of NHS Greenwich in regard to this matter. DH listed as interested party. Joined with NHS Havering who have similar issue but have engaged separate counsel to present NHS Greenwich case. Witness statements and documenation submitted to Court.	Likely	Major	16	Briefing of Counsel. JR planed for 8/9 June

Risk Identification								Risk Description and Assessment					
Source Ref	Directorate	Corporate Objective	Work Stream	Date Raised	Risk Category	Risk Owner	Risk Description (There is a risk that…caused by……leading to……..)	Inherent Risk	EXISTING CONTROLS ie. actions implemented where this is evidenced/documented note evidence of risk being controlled	Residual Likelihood	Residual Impact	Current Residual Risk	Control Gap What still needs to be put in place
IG1	Finance	Sustain an effective grip on finance, performance and QIPP	ICT	12/05/11	Legal & Compliance	Leroy Adamson-Parks	There is a risk that the Cluster is accessing and processing PID from PCTs in breach of the Data Protection Act, leading to potential fines from the Information Commissioner, reputational damage and civil action by any patients affected	25	An IG Framework is being developed, including an overarching information sharing agreement between the cluster and the 6 PCTs, to set out how this will work and meet legal, Information Commissioner and other requirements. A draft of this has been sent to BSU MDs, with southwark and Greenwich agreed, the remainder outstanding	Almost Certain	Catastr ophic	25	Agree IG Framework Outstanding BSUs: Lambeth, Lewisham, Bromley and Bexley
DD 5	Development	Proactively manage the transition to the new commissioning system	Governance	05/05/11	Governance	Gill Galliano	There is a risk that all Pathfinders will not be ready to take on delegated responsibilites in order for there to be a full year of shadow running prior to April 2013.	16	LCCC leadership and focus, Developing clinical OD plans. Monthly Director of Development GP Delegation and Development task group established. Delegation report to May 11 Board Pathfinder development plans in development	Possible	Major	12	Joint Boards ownership Clarity of expectations NHSL approval role and assurance requirement Retained BSU focus on QIPP delivery in tandem with organisational development
DD 6	Development	Proactively manage the transition to the new commmissioning system	Transition	03.05.11	People	Gill Galliano / BSU MDs / Director of HR	There is a risk that uncertainty for staff over their future jobs caused by speed and severity of national transition to new commissioning arrangements leading to poor staff morale and affecting NHSSEL objective delivery.	16	Regular Staff Briefings - weekly and monthly Local briefings via all staff / teams BSU agreed structures, JD, existing appraisal and PDP Policy OD Posts and Strategy Flexible Working Policy Regular staff 1:1's	Possible	Major	12	Establish Personal Objectives for BSU Staff Accommodation certainty and ways of working OD Plan for pathfinder development and Commissioning Support Services
DD 7	Development	Proactively manage the transition to the new commmissioning system	Development	10/05/11	Strategic	Gill Galliano	There is a risk that development objectives will not be achieved caused by the lack of momentum created by the listening excercise (pause) leading to a failure to deliver key targets in year and prepare for the introduction of a new commissioning system	16	Objectives for development team take account of changing landscape, Regular review of objectives and plans in line with changing policy environment Strong communications links with NHS London and DH to ensure continual alignment of plans	Possible	Major	12	Clarity on revisions to health bill from DH
DD 8	Development	Proactively manage the transition to the new commmissioning system	Development	10/05/11	Strategic	Gill Galliano	There is a risk that development of Comissioning Support services will prevent staff from the delivery and reform agenda, caused by distraction of key staff and leading to a failure to deliver financial, quality and performance objectives and reform the commissioning system.	16	Participate actively in shaping Commissioning Suport approach through NHS London thinktank Effective and timely communications through Management Brief and briefing system to inform staff of process Effective relationship with staffside keeping them informed of potential impact on staff	Possible	Major	12	Detailed plan for transition to commissioning support organisation Staff roadshows planned and delivered Staff Conference arranged
PC4	Primary Care	Proactively manage the transition to the new commmissioning system	Transition	03/05/11	Change	David Sturgeon	Merging of six primary care operations into one directorate with reduced workfore while undertaking preparations for onward transfer to National Commissioning Board in 12/13	20	Recruitment to Cluster Primary Care Directorate Participate in NHSL and DH dialogue	Likely	Major	16	Staff workshops dates to be agreed Cluster protocols and polices to be developed. Directorate objectives to be established Directorate workplan to be developed Government pause

ENCLOSURE 5

Risk Identification								Risk Description and Assessment					
Source Ref	Directorate	Corporate Objective	Work Stream	Date Raised	Risk Category	Risk Owner	Risk Description (There is a risk that…caused by……leading to……..)	Inherent Risk	EXISTING CONTROLS ie. actions implemented where this is evidenced/documented note evidence of risk being controlled	Residual Likelihood	Residual Impact	Current Residual Risk	Control Gap What still needs to be put in place
BSU 3	All BSUs	Proactively manage the transition to the new commissioning system.	Transition	19/04/11	Operations	BSU MDs / Director of Development	The a risk of lack of clarity between the organisational and functional responsibilities of the Cluster, BSU and GP Commissioners and constituent practices	16	LCCC leadership and focus, BSU QIPP committees, Developing clinical OD plans. Monthly Director of Development GP Delegation and Development task group established. Delegation report to May 11 Board. Performance Framework in development.	Possible	major	12	Clear identification of roles and responsibilities

South East London NHS Cluster Board Assurance Framework 2011/12 - Heat Map of Existing Residual Risks

Risk Matrix	Impact				
Likely-hood	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1	1	2	3	4	5
Unlikely 2	2	4	6	8 (D, F)	10
Possible 3	3	6	9 (I, M)	12 (A, C, P, N, H, S, U, R, G, Q)	15 (E)
Likely 4	4	8	12	16 (K, O, T, J, L, B)	20
Almost Certain 5	5	10	15	20	25 (V)

	Risk Description	
A	DD1	Reputation
B	PC1	Primary Care Issues of Concern
C	DD2	QIPP Delivery
D	PH1	Health protection Outcomes
E	PH2	Emergency Planning
F	G1	Prison Health
G	F1	Use of Resources - finance
H	F2	Robust Financial Strategy
I	BSU1	Partner Provider Finance Pressure
J	BSU2	QIPP Delivery - Change in GP Practice/engagement
K	DD3	Tariff Risk on QIPP
L	DD4	Delivery of Operating Plan - finance
M	OD1	Failure to deliver Performance measures
N	OD2	Provider Over performance
O	PC3	PMS Review
P	DD5	Delegation
Q	DD6	Organisational Change
R	DD7	White paper Pause
S	DD8	Commissioning Support Services
T	PC4	Primary Care move to National Commissioning Board
U	BSU3	Clarity of roles and responsibilities across Cluster and BSUs
V	IG1	Breach of the Data Protection Act

Printed on 12/05/2011

ENCLOSURE 5

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 6

NHS SOUTH EAST LONDON BUSINESS PLAN AND CORPORATE OBJECTIVES

DIRECTOR RESPONSIBLE: Gill Galliano, Covering role of Director of Development

AUTHOR: Kathryn MacDermott, AD Strategy and QIPP

TO BE CONSIDERED BY: All

SUMMARY:
The aim of this Business Plan is to set out the objectives for NHS South East London and the key inputs / outputs of each Directorate team to ensure a greater understanding of precisely what specialist inputs are needed, by whom and by when.

The three corporate objectives are;

- **Delivery**
  - Sustain an effective grip on Finance, Performance and delivery of the QIPP programme
  - Delivery of national Operating Framework priorities
- **Reform**
  - Proactively manage the transition to the new commissioning system
- **Legacy**
  - Improve health, quality and maintain safety of local services

The plan has been designed primarily as a high level work plan to enable the Cluster Management Board to track implementation and assure the Joint Board on progress. This will be developed into simple format for future monitoring by the joint boards.

Contained within the plan is a workplan that covers a set of key actions that are common to all BSUs. This is followed by a set of work plans that list any borough specific priorities. These will be compiled into individual plans for each of the BSU to combine with their plans for GP delegation.

The Director of Development and the Development Board have overall responsibility for this plan and tracking its implementation. It is proposed that the business plan be reviewed and updated on a quarterly basis. Staff briefings have started on the content and each directorate will be required to have team plans and staff personal development plans in place by the end of June.

KEY ISSUES:
This business plan covers a two year transition period of 2011/12 to 2012/13. The role of the NHS SEL cluster will evolve over time to meet the needs of the new commissioning system and will cease to exist, as currently described, at the end of the transition period (expected to be March 2013).

It is envisaged that elements of the corporate structures will transfer to new bodies during the course of this transitional period [e.g. primary care contracting will move to National Commissioning Board]. Ways of working will need to change during the transition period to ensure that all functions can continue to provide professional input at key points of the commissioning cycle.

The Finance, Performance, Information and Contracting teams will need to co-ordinate their business planning to ensure the right inputs and collaboration can be achieved at the right time. Teams will need to work flexibly according to the task, priorities or transition requirements.

The aim of the business plan is to clearly set out the key actions required by SEL Cluster with associated KPIs to allow the Board a method of assurance.

INVOLVEMENT:
Staff to be involved in developing team objectives and individual Personal Development Plans (PDPs).

RECOMMENDATIONS:
The board (s) is asked to:-

1. Agree that the NHS SEL Cluster vision be completed with the GP Commissioning Consortia by the July Board meeting, coordinated by the BSU MDs
2. Agree three core corporate objectives under the headings of Delivery, Reform and Legacy
3. Agree the priorities listed under each core objective (**see page 8 of the business plan)**
4. Note the work plans/objectives for each of the cluster directorates
5. Agree the KPIs for ‘measuring success’

6. Note that this is work in progress and the plan will continue to be developed **7.** Note that the business plan will need to be reviewed and updated on a quarterly basis
DIRECTORS CONTACT: Name: Gill Galliano E-Mail: g.galliano@nhs.net Telephone: 020 7206 3209
AUTHOR CONTACT: Name: Kathryn MacDermott E-Mail: kmacdermott@nhs.net Telephone: 020 3049 4047 Contact details 07901 918509

South East London

SEL Business Plan

2011/12 and 2012/13
Version 5

Please give comments to Kathryn.macdermott@southwarkpct.nhs.uk

South East London

Version Number: 5
Created: 21st April 2011
Printed:

Review

Reviewed by	Role	Organisation	Date
Tony Read	Director Strategy & QIPP	SEL	26th April 2011
Gill Galliano	Director Development	SEL	26th April 2011
Sections sent to all lead Directors		SEL	26th April 2011
SEL Management Board.		SEL	30th April 2011
SEL Board		SEL	5th May 2011
Sections sent to lead Directors		SEL	5th May 2011
M Farrell	Director Finances	SEL	6th May 2011
G Galliano, T Read	Director Development Director Strategy & QIPP	SEL	6th May
T Read	Director Strategy & QIPP	SEL	9th May
Sent to J Walker for joint board mailing		SEL	11th May

Approval

Approved by	Organisation	Date

Document History

Version	Summary of Changes	Document Status	Date published
V1	First draft	Draft	26th April 2011
V1	Emailed to all lead directors	Draft	26th April 2011
V2	Updated with sections from Donna Kinnair, Ann-Marie Connolly. Comments from G Galliano and S Robbins. Circulated to Management Board.	Draft	28th April 2011
V2a	Updated section on delegation and HR leads	Draft	5th May 2011

V3	Sections emailed to lead directors for updating,	Draft	5th May 2011
V3	emailed whole plan to MF as requested	Draft	6th May 2011
V3a	Updated with workplans received. Emailed to G Galliano, T Read.	Draft	6th May 2011
V4	Incorporating changes from G Galliano, Southwark, Bromley, Bexley BSUs, A Selby, and U Dalton.	Draft	9th May
V4a	Incorporates changes from Lam BSU	Draft	10th may
V4b	Incorporates changes from Operations, communications, Greenwich BSU, D Sturgeon, M Farrell, Lam BSU.	Draft	11th May
V4b	Circulated to J walker for joint board mailing.	Draft	11th May
V5	Amendments to priorities from S Robbins included. Updates from J Fryer, M Farrell and T Read. Resent to OL and JW for board.	Draft	12th May

South East London

Contents

Executive summary

To be included last.

Section one: About us and our role

SEL NHS Cluster fulfills the function of the 6 PCTs/ Care Trust's in SEL London. It is made up of a single shared corporate management team and six borough based Business Support Units (BSUs). There is a single accountable officer post (a chief executive officer), and a single executive team made up of a director of finance, a director of operations, a director of development, director of operations, director of performance, director of Public Health and medical and nurse directors plus the 6 Managing Directors of the Business Support Units.

The executive team supports the majority of corporate functions, undertake primary care contracting, core acute contracting including contract negotiation and the performance management of contracts (final service specification to be agreed with borough consortia). The BSUs are aligned to the six GP consortia developing in SE London with a view to providing a platform for the evolution of the Consortia over time. These units are function with the GP Boards as the local Clinical Commissioning Committees operating as Committees of each PCT/Care Trust Board, and the whole overseen by the six PCT/Care Trust Boards operating jointly (the Joint Boards) with common membership and a single Chair.

The structure and the size of the BSUs have been determined locally. The size of the BSU varies according to the budget available, determined by population size and whether support services are being procured from the NHS South East London corporate team, or provided under local arrangements. There have been discussions with GP commissioning leads about their expectations of borough level structures.

The Business Support Unit structures have been developed at local level by existing PCT teams working with GP Commissioners (and some with explicit input from Local Authorities). Across all six the purpose of the BSU in each borough is to:

- **Support** - the transition to GP-led commissioning and implementation of the GP consortia pathfinder programme

- **Plan** – health needs assessment, prioritisation based on population needs, current service delivery, modelling options for the future and identifying changes opportunities to improve current service design.
- **Engagement** – GP Consortia, Local Authority and other partners, the public and patients and drawing on support from the NHS South East London communications team comply with engagement responsibilities
- **Service redesign –** propose local QIPP elements based on local position and work with acute contracting team to design acute services and QIPP plan.
- **Delivery** – drive implementation of change programme and track impact for cost and quality including on acute contracts.

Each BSU has a Managing Director with clear delegated responsibility and accountability. The Managing Director is part of the Senior Management Team of NHS South East London cluster and has an important role in ensuring delivery of both the borough and sector-wide agenda successfully. Each BSU team will work with the other Directorates in NHS South East London to identify opportunities for working collectively to achieve the best outcome from the resources available.

The role of the cluster organisation will evolve over time to meet the needs of the new commissioning system and will cease to exist, as currently described, at the end of the transition period (expected to be March 2013). It is envisaged that elements of the corporate structures will transfer to new bodies during the course of this transitional period [e.g. primary care contracting will move to National Commissioning Board]. Ways of working will need to change during the transition period to ensure that all functions can continue to provide professional input at key points of the commissioning cycle. The Finance, Performance, Information and Contracting teams will need to co-ordinate their business planning to ensure the right inputs and collaboration can be achieved at the right time. Teams will need to work flexibly according to the task, priorities or transition requirements.

The aim of this Business Plan is to set out the key inputs / outputs of each Directorate team to ensure a greater understanding of precisely what specialist inputs are needed, by whom and by when.

South East London

Vision, Values and Strategic Objectives

Vision for SEL

To be completed with the GP Commissioning Consortia by the July Board meeting

Objectives

- Delivery
  - Sustain an effective grip on Finance, Performance and delivery of the QIPP programme
  - Delivery of national Operating Framework priorities'
- Reform
  - Proactively manage the transition to the new commissioning system
- Legacy
  - Improve health, quality and maintain safety of local services

The values underpinning our approach

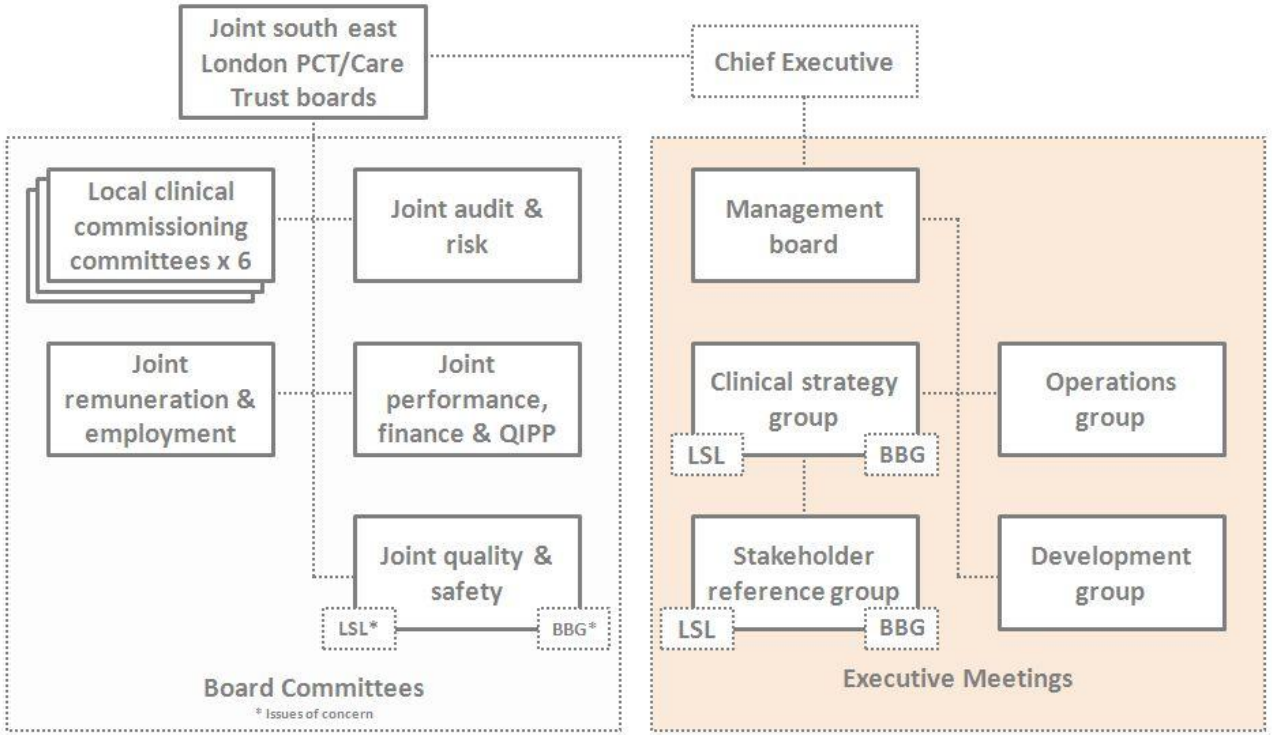
- High Quality Patient focused Care
- Working in Partnership
- Respect & Dignity
- Value for Money
- Support & development for Staff
- Quality
- Customer Service
- Empowerment

Delivery Priorities	Reform priorities	Legacy priorities
Maintaining financial security, quality and performance across South East London • Manage providers and implement the change programme as set out in QIPP and the Integrated Plan • Manage providers to assure quality, performance and financial control building sustainable capacity across the system • Achieve 2011/12 Financial targets • Delivery of national Operating Framework priorities • Maintain and improve service performance and patient safety • Increase information to the public so they can make informed decisions • Improve Quality and access to primary care • Meet Statutory obligations and core business	**Support the development of GP Commissioning Consortia** • Full delegation of commissioning functions • Develop Commissioning Support services **Implement the new cluster structure** **Implement Public Health changes** **Transfer of Primary care contracting to the National Commissioning Board** **Retaining capability and capacity and leadership talent** • Support staff to align to new arrangements	**Ensure GP Consortia are equipped to deliver** Embed HfL decisions – Stroke, Trauma, Cancer etc Improvement of whole system relationships Finalising the implementation of A Picture of Health (APOH) – Safe, efficient services & improved patient experience – QMS Campus Development Delivery of FT pipeline – challenging starting point and impact of QIPP Maintain and continue to improve public health outcomes within SEL

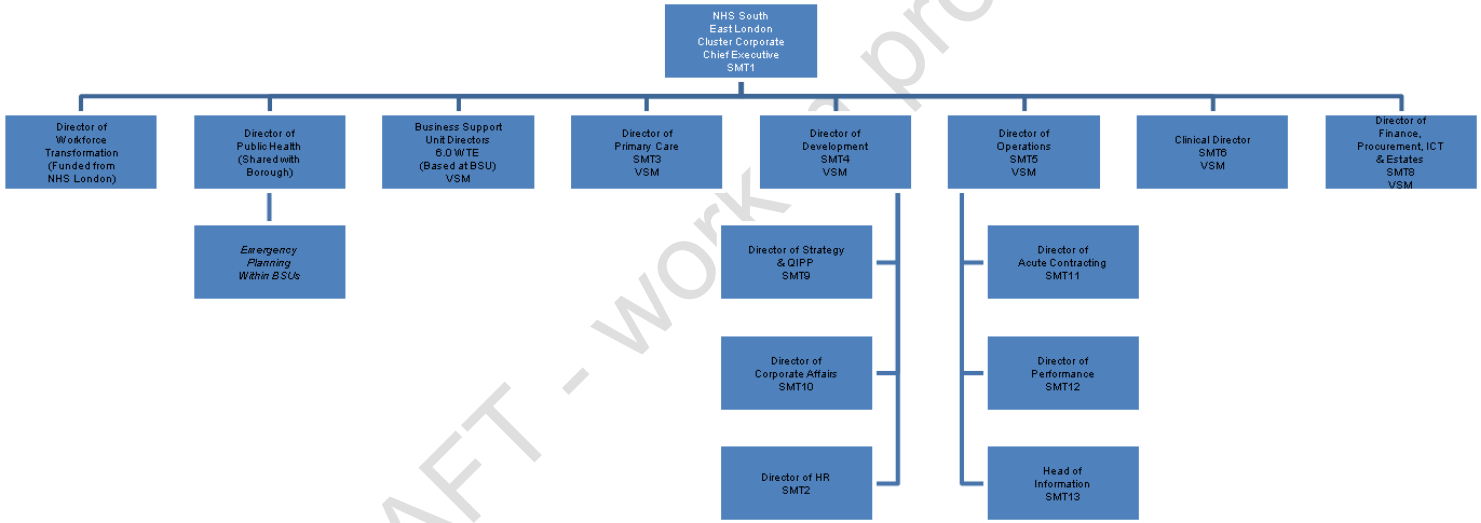
Section Two: Our Structure

NHS South East London Joint Boards, Committees and Executive meetings

NHS
South East London



A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham , Southwark and Bexley Care Trust
www.selondon.nhs.uk



This gives us thirteen directorates:

- Six Business Support Units
- Operations including acute contracting, performance and information
- Primary Care
- Development including Strategy and QIPP, Corporate Affairs, and HR
- Public Health
- Clinical covering medical and nursing
- Finance, procurement, ICT and estates
- Workforce transformation (funded separately by NHS London)

Section four sets out the priorities and business plan for each directorate.

Section Three: The Policy Context

Since May 2010 the Coalition government has published significant White papers that spell out radical reforms to the NHS. *"Liberating the NHS: Equity and Excellence"* and four supporting consultation papers published in July 2010 set out plans that build upon the existing market based approach to health care with commissioning responsibilities moving to new GP commissioning arrangements and a new NHS National Commissioning Board. Strategic health authorities and primary care trusts will be abolished by April 2013 whilst on the supply side there will be a mix of private and 3rd sector organizations providing health care and no longer NHS trusts.

Patient and public involvement in decision making is to be strengthened through consumerist and citizenship models aimed at creating individual choice for patients and greater local democracy. This White paper forms the basis of the draft Health and Social Care bill currently passing through parliament. The government has recently announced a 'pause' in the process to listen more widely to the views of stakeholders.

There have been a number of public health white papers that set out plans for the creation of a national public health service (Public Health England), the realignment of local public health arrangements with local authorities, check 3rd.

These constitute arguably the largest reform of the NHS in the history of the NHS which means that we are now in a transitional period to manage the wind down of the existing NHS commissioning whilst we develop capacity and capabilities of new GP commissioning arrangements.

Section Four: Priorities and Directorate plans

The SEL priorities are divided into three groups: delivery, reform and legacy. Each of the Directorates contributes to one or more of the SEL priorities. The table below illustrates the lead directorate and contributing directorates. No priority can be delivered without the contribution of at least two directorates, many involve all.

Also listed are suggestions for the KPIs to be used to measure success.

Priorities	Lead Directorate	Contributing Directorates	KPI
Delivery priorities			
Maintaining financial security, quality and performance across South East London Manage provider and implement the change programme as set out in QIPP and the Integrated Plan	Operations (acute) BSUs (non-acute includes medicines management)) Primary care (primary care) Public health (staying healthy)	Development including Strategy and QIPP (for development of QIPP) and Corporate Affairs Clinical Finance Workforce Transformation	KPIs from QIPP PMO including finance / savings targets
Manage providers to assure quality, performance and financial control building sustainable capacity across	Operations including acute contracting, performance and information for acute contracts	Public Health Primary Care Clinical Finance	KPIs in performance dashboard / framework developed by performance team to

Priorities	Lead Directorate	Contributing Directorates	KPI
the system	BSUs for non-acute contracts and safeguarding adults and children		include Operating Framework Headline and Supporting Measures, including: A&E, HCAIs, RTT waits, cancer waiting times, bowel screening age extension, cervical screening test results, NHS Health and C. Difficile and existing public health indicators.
Achieve 2011/12 Financial targets	Finance	Business Support Units Primary Care Development particularly Strategy and QIPP Operations including acute contracting, performance and information Clinical covering medical and nursing	Achieve surplus Achieve statutory duty balanced budget Achieve QIPP savings targets Achieve other savings targets
Delivery of national Operating Framework priorities	Performance	Operations BSUs Finance	Operating Framework Headline and Supporting Measures

Priorities	Lead Directorate	Contributing Directorates	KPI
Maintain and improve service performance and patient safety	Operations	Development Clinical BSUs (including Medicines Management) Public Health	Service performance on the Operating Framework Headline and Supporting Measures and existing Public Health indicators. Patient safety KPIs by development team
Increase information to the public	Development particularly Corporate Affairs	Strategy and QIPP BSUs Primary Care Public Health Operations (Information and Knowledge Management)	Patient information provided via web
Improve Quality and access to primary care	Primary Care	Workforce transformation Public Health Business Support Units Development Operations particularly performance and information Clinical	QoF indicators Improve national patient survey scores Improved GP survey scores
Meet Statutory obligations and core business	Operations including acute contracting, performance and information	Public Health Business Support Units Primary Care	All Stat Obs met

Priorities	Lead Directorate	Contributing Directorates	KPI
		Development particularly Corporate Affairs Clinical Finance	
Reform priorities			
Support the development of GP Commissioning Consortia Delegation of commissioning functions	Development	Finance BSUs Operations Public Health	Delegated by April 2013
Implement the new cluster structure	Development	Workforce transformation Business Support Units Operations particularly performance and information Clinical Finance	By March 2012
Implement Public Health changes	Public Health	HR Business Support Units Development Clinical Finance	
Transfer of Primary care contracting to the National	Primary Care	Finance Development	By March 2013

Priorities	Lead Directorate	Contributing Directorates	KPI
Commissioning Board			
Retaining capability and capacity and leadership talent	HR	Workforce transformation Public Health Business Support Units Primary Care Development particularly HR	
Legacy priorities			
Ensure GP Consortia are equipped to deliver	Development	Finance BSUs	Six pathfinders by June
Embed HfL decisions	Strategy and QIPP	Operations Clinical BSUs Public Health	
Improvement of whole systems relationships	Development	BSUs Operations Clinical Primary Care Public health Finance Workforce Transformation	
Finalising implementation of A Picture of Health (APOH) – safe, efficient services and improved patient experience –	Strategy and QIPP	Operations BSUs Clinical Finance	Full APOH vision to be delivered. QMS campus fully

Priorities	Lead Directorate	Contributing Directorates	KPI
QMS Campus development			operational
Delivery of FT pipeline	Operations	Clinical Strategy and QIPP Finance	LHNT and SLHT FTs by 2014
Maintain and continue to improve public health outcomes within SEL	Public Health	Commissioning Strategy and QIPP Finance	Life expectancy improvements Disability free life expectancy

Directorate work plans

Business Support Units

Listed below are seven work plans. The first lists the core priorities that are common across the six BSUs followed by six shorter work plans that set out any priorities that are specific to the individual BSUs:

Priorities and actions common to all six Business Support Units:

Priority	Actions	Timescale
QIPP	• Develop commissioning intentions for 2012-13 to inform the acute contracting round	*Sept 2011 – Jan 2012*
	• Develop Strategic Commissioning plan for 2012/13 outlining emerging GP Consortium priorities in line with Delegation for that period	*March 2012*
	• Implementation of local QIPP initiatives to support delivery of the Integrated Plan (March 2012)	*March 2012*
	• Establish and implement contingency plans to address identified performance variance in-year and ensure the achievement of required borough outturn in 2011/12 (Ongoing)	*Ongoing*
	• Monitoring of QIPP delivery	*Ongoing*

Priority	Actions	Timescale
Commissioning	• Set up joint commissioning arrangements for services, joint posts and section 75	
	• Assure quality of services and improve outcome and performance through contract management of non-acute contracts with appropriate clinical input	
	• Manage local surge planning, working with local partners such as for winter with appropriate links to business continuity and local emergency planning arrangements	*Ongoing*
	• Work with cluster team to ensure robust arrangements to maintain and improve service performance and patient safety for acute services	*Ongoing*
	• Work with cluster team to ensure robust arrangements to maintain and improve service performance and patient safety for primary care services	*Ongoing*

	• Ensure robust plans for the development and monitoring specific programmes (including prevention and population approaches):
	  • Planned Care
	  • Primary care
	  • Unscheduled and urgent care
		Ongoing

Medicine's Management	• Improve quality of prescribing across the health economy to improve clinical effectiveness, cost effectiveness and safety	*Ongoing*
Financial management	• Contribute to achievement of 2011/12 Financial targets and ensuring underlying financial balance and ensuring financial controls	*Ongoing*
Consortium development/ GP engagement – preparation for delegation	• Develop strategy for consortium development and draw down resources to implement • Arrangements to receive full delegation by April 2012	*April 2012*
	• Implement consortium development strategy, with increasing integration between BSU and consortium	*Ongoing*

Priority	Actions	Timescale
	• Reduce local variation in the quality of and access to local primary care services through working with clinical commissioners on their peer review structures/methods	*Ongoing*
	• Support education and training commissioning to meet QIPP and pathway redesign. Lead on commissioning skills for GPs, other primary care staff and BSU staff	*Ongoing*
	• Embed new GP Executives in shared work with BSU; support ongoing development and portfolios	*June 2011*
Mental health	• Improve the management of people with mental health problems, including expansion of IAPT programme • Reduce out of borough placements by improving local facilities for those with long term needs • Review local mental health strategy	*October 2011*
	• Begin work looking at Mental health budgets to identify potential QIPP for 2012/13	*June 2011*
Learning disability	• **E**nsure completion of transfer of these services to local authority • Ensure robust future joint commissioning arrangements	*November 2011*
Health and Well Being / Safeguarding children and adults	• Ensure joint arrangements to address the health and well being of children including safeguarding arrangements and adults through local Health and Wellbeing Board and Joint Strategies based on local JSNA. Ensure local safeguarding arrangements for both children and adults	*Ongoing*
Patient and public engagement	• Involve patients and public and their careers and other stakeholders in the planning and delivery of services	*Ongoing*
	• Engage with Local Involvement Networks (LINks)	*Ongoing*
	• Ensure that local people have access to PALs and complaints services and that their concerns and queries are responded to appropriately and that the services develop in the light of user experience	*Ongoing*

Priority	Actions	Timescale
Communications	• Internal and external communications - health promote through social marketing	
Governance and Quality	• Ensure effective local governance systems, structures and processes that maintains safe, high quality care • Implement a quality plan that best enables transformational change aligned to Cluster OD plans • Ensure compliance with national standards and emerging requirements of NHS regulators. Ensure focus on the core components of Quality, namely Patient Safety, Effectiveness of Care and Patient Experience	
Public Health	Explore options to transfer Public Health functions to local authorities under S75.	
	Maintain and improve focus on the need analysis and evidence base that underpins the local health strategy through a robust and inclusive JSNA process.	

Additional Bexley specific priorities

Priority	Actions	*Timescale*
Commissioning	• Review current section 75 arrangements and develop new joint commissioning arrangements in line with the agreed statement of intent between BCT and LBB.	
	• Acute children's service configuration to be audited and potentially reconfigured. • Work with LBB to align the social care budgets with health under the Total Health project as agreed through the project's statement of intent.	
GP Engagement	• Support GP pathfinders through a development programme. • Enable effective communications using multi media. • Maintain and recruit to supportive GP backfill schemes. • Using QIPP outreach teams support practices op participate and deliver QIPP schemes. • Fund and maintain key informatics enablers e.g. MEDE • Maintain this year's incentive scheme- i.e. local Kitemark scheme and by end of year design the subsequent scheme.	
Patient and public engagement	• Set up a patient council • Membership scheme will continue to be rolled out • To extend the seldom heard engagement programme.	
Communications	• Support GPCC through its high profile initial development	

Priority	Actions	*Timescale*
	• Maintain wider GP engagement to maintain federated principles • Develop multi channel communication strategies and tools that face the public and other stakeholders	

Additional Bromley specific priorities

Priority	Actions	*Timescale*
Commissioning	• Jointly with LBB, agree, monitor and evaluate plans for • reablement monies • NHS funding for social care	*Ongoing*
Public Health	• Finalise and implement section 75, with SLA back for BSU for commissioning support, IFRs, safeguarding and governance	*July 2011*
	• Working in partnership with primary care directorate and other key stakeholders to achieve improvements in the following programmes according to national and London wider targets (including implementation of new programmes) where required: • immunization and vaccination • sexual health, including Chlamydia screening • screening, cancer and non cancer • communicable disease control, including infection control • emergency planning, incl preparation for Olympics • flu pandemic	*ongoing*

Priority	Actions	*Timescale*
	• flu vaccination • production of JSNA • participation/leadership in care pathway work, with particular focus on prevention of LTCs • key PH programme such as vascular checks and healthy child programme • Leadership for maternity services • Audit and evaluation, and leadership for research function	
Children and Young People	• Explore further opportunities for joint commissioning arrangements • Jointly with LBB and other key partners, review how to maximize use of remaining children and family centres and possibly develop a Early Years Strategy	*November 2011*
Partnership working	• Further develop Health and Well-Being Board and support development of HealthWatch. • Develop Bromley's Health and Well-Being Strategy	*Ongoing* *November 2011*

Additional Greenwich specific priorities

Priority	Actions	*Timescale*
Prison health	• Continue to improve quality of outcomes for prisoners in HMP Belmarsh and the Youth Offending Institution Isis (opened August 2010) • Procure health services for the new prison Belmarsh West aligned to opening in 2012	*Ongoing* *January 2012*
Out of hospital services	• Gain full approvals for Eltham Community Hospital securing capital investment so that developers can be procured • Develop business case for Heart of East Greenwich in partnership with London Borough of Greenwich and start approval process	*January 2012* *March 2012*

Children	• Secure a designated doctor for safeguarding children
	  • Short term
	  • Substantively
	• Improve health services to Looked After Children through improved routine medicals
		July 2011
		December 2012
		October 2011

Olympics	• Ensure that local people benefit from the health improvement opportunities	*Ongoing through*

Priority	Actions	*Timescale*
	available through being an Olympic Borough • Continue to develop plans to assure safety and continuation of services to local residents through the Olympics games (including the Paralympics)	*the year*
Partnership working	• Refresh the Health and Wellbeing Board linking together current partnership arrangements and Greenwich Health Board (Greenwich GP Consortium) • Develop plans to support the implementation of the Greenwich Health and Well-Being Strategy ensuring the Integrated Plan reflects these priorities and those of the refreshed JSNA • Progress partnership working with the DAAT to deliver a comprehensive range of addiction services.	*August 2011* *October 2011*

Additional Public Health Directorate Priorities (Greenwich)

Aim: To improve and protect the health of the population of Greenwich and reduce health inequalities within the borough and between Greenwich and the country as a whole.

Priority	Actions	Timescale
Strategic leadership for public health	• To make an effective contribution to the emerging Health and Well-being Board, ensuring the board is provided with robust evidence of health needs to inform shared prioritisation. • To lead the implementation of key public health elements of the Joint Health and Well-being Strategy (e.g. chairing the Greenwich men's Health Forum, leading the Greenwich Healthy Workplace programme etc). • To produce an Annual Public Health Report focused on the health and well-being needs of Children and Young People. • To lead the NHS contribution to the production of the 2011/12 Joint Strategic Needs Assessment, including the development of a new on-line JSNA tool for public access. • To continue to deliver improvements in life expectancy and disability free life expectancy	*Ongoing* *Ongoing* *July 2011* *Dec 2011* *Ongoing*
QIPP	• To lead on the implementation of 'Staying Healthy' QIPP initiatives for Greenwich, with a focus on the NHS Health Check + programme, and interventions to tackle smoking, diet, obesity, physical activity and sexual health. • To ensure that primary care audits occur of effective management of LTCs (CVD; resp; diabetes;) using technological solutions to gain efficiencies in conducting the audits • To work jointly with the primary care directorate and GP pathfinders to deliver	*2012*

Priority	Actions	Timescale
	the QIPP programme on improvements in flu vaccine uptake	
Health Improvement	• To progress the development programme for the in-house Greenwich Healthy Living Service (GHLiS) to ensure that it is fully established as a discrete 'business-ready' service • To progress the further implementation of health improvement commissioning plans as set out in the NHSG CSP, the joint Health and Well-being Strategy and using partnership arrangements such as S256 to secure partnership commitments. • To deliver on stretch target for stop smoking with QIPP budget	*March 2012*
Health Service Quality	• To negotiate and deliver specialist public health advice and support to GP, BSU and cluster commissioning colleagues and processes to support wider QIPP and ongoing commissioning work streams, including IFRs. • Further develop and implement the Integrated Practice Improvement Tool (IPIT) to support GP practices to effectively improvement performance against key public health and clinical priority areas.	*During 2011-12* *Dec 2011*
Health Protection	• To ensure that efficient ongoing processes are in place to protect the public against communicable diseases through: providing senior staff for the public health on-call rota; implementing plans to address specific current health protection challenges (TB, HIV, improving childhood immunisations, winter flu vaccinations, with primary care); providing surge capacity to the Health Protection Agency as required (e.g. in the event of major outbreaks such as	*Ongoing*

Priority	Actions	Timescale
	pandemic flu).	
Planning for change	• To develop a detailed costed business plan for the work of the directorate aligned to the Public Health Running Costs identified in DH Guidance, and the functions and outcomes set-out in the government White Paper on Public Health. • To review the current organizational capacity within the directorate to ensure that staff posts are appropriately aligned to the future public health priorities, and recruit to vacancies and / or make adjustments to structures accordingly. • To establish internal forward planning processes and continue to progress discussions with Greenwich Council to ensure that plans to transfer public health functions to the local authority are as advantageous to public health as possible. • To ensure that discussions continue proactively at cluster level (with commissioners and other borough PH teams), and at borough level (with the BSU and GP Commissioners) to ensure that public health input is threaded appropriately into core NHS business as the changes take place.	*June 2011* *July 2011* *May 2011* *Ongoing*
Olympics	• To lead the Greenwich contribution to the Olympic Health and Well-being SRF work stream to secure health benefits for the Greenwich population in the run-up to and the legacy of the Olympics and Paralympics.	*Ongoing*
Professional affairs	• To provide a secure training platform for Public Health Specialist trainees and GP trainees on placement in Public Health, hosting an ongoing cohort of trainees supplied through the Deanery and GP Training programme.	*Ongoing*

Priority	Actions	Timescale
	• To ensure that PDP plans are in place across the directorate, and secure specific training and professional development support for senior staff working towards accreditation with the UK Public Health Register.	*July 2011*

Additional Lambeth specific priorities

Priority	Actions	Timescale
Operational Delivery	To deliver our four priority health programmes with robust operational risk and financial management and effective high quality care as follows:	*March 2012*
Mental Health	The mental health programme is a continuation of the work that has been carried out over the past year to re-design key mental health services, including serious mental illness, forensic services, and payment by results. The review of talking therapies is also to be taken forward, setting this in the context of care pathways for people experiencing anxiety and depression. In addition we have a new workstream in	

Priority	Actions	Timescale
	respect of dementia. **Transforming primary and community mental health services (serious mental illness)** The 2011/12 work programme will build on the co-production work initiated by the Lambeth Living Well Collaborative in 2010 and scale up the initial new service offer targeting people with SMI from July 2011 underpinned by a business case, to be agreed by June 2011. It is expected that people receiving services will spend less time in secondary care, that more people (1,000 over 4 years) will be supported by primary care and the voluntary sector, through peer support and with a greater focus on self care and management.	*July 2011*
Forensic	This workstream will continue in conjunction with the criminal justice system/forensic service redesign project, which will seek to agree plans with SLaM to significantly reduce MSU provision by up to 50% through focus on improved case management, recovery and early intervention and change in the way section and court / hospital orders are deployed.	*July 2011*
Payment by Results	Preparation for payment by results in mental health will continue along with roll out of self directed support and the personal health budget pilot.	*March 2012*
Talking Therapies/Counseling services	Consideration of current service delivery is underway for both service areas; contracts for IAPT and primary care counseling are due to expire during 2011/12. Proposals to re-commission and tender services will be brought forward during 2011 with the aim of new service arrangements in place from April 2012 based on the agreed care pathways for people experiencing anxiety and depression.	*September 2011*
Dementia	The programme will prioritise the delivery of the dementia strategy. This will include the mobilisation of services from Clifton House, the evaluation of the first stage of the memory service, extension of assistive technology solutions for people with dementia, a review of institutional care including continuing care for people with	*June 2011*

Priority	Actions	Timescale
	dementia, the provision of domiciliary care for people with dementia, improving the quality of health care experiences for people with dementia, working with primary care regarding recognising dementia and appropriately referring, and reviewing the carer's strategy to ensure it is meeting the needs of carers of people with dementia.	
Unplanned care	Lambeth continues to have a high number of non-elective admissions compared to London and England and a high level of dependency on hospital based care. Local audits show that between 40-60% of people attending A&E could have their care provided safely and appropriately in primary and community settings. The major service challenge includes the need to improve access, quality and capacity of primary care services to manage care more effectively including out of hours, to identify areas that need require whole system pathway redesign The Unplanned Care Programme will operate across two main workstreams: • Frail Elderly, (including admission avoidance and intermediate care) • Urgent Care, (including Urgent Care Centres and Out of Hours). The Programme will be further supported through the King's Health Partners Integrated Care Project. The aim of the Unplanned Care Programme to is to design and implement improved unplanned care services across the two boroughs that support the shift to improved health outcomes through greater planned and co-ordinated care, and reflected in lower A&E attendances and subsequent emergency admissions, fewer readmissions, enhanced quality of care and the delivery of national standards. This is a key area of QIPP delivery in enhanced quality and improved productivity of care.	*November 2011* *March 2012* *August 2011*
Planned care	To develop our outpatient strategy, to deliver improvements in life expectancy and reduces morbidity associated with long term conditions (including HIV), secures the quality and productivity in the management of elective condition and identifies the most appropriate settings for treatment i.e. local v hospital based. In doing so, facilitate patient-centred care, with a shift in service provision along the care	*June 2011*

Priority	Actions	Timescale
	pathway, for identified priorities, from treatment to prevention. Development and implementation of Lambeth wide referral management processes and further embedding Choose and Book through electronic booking. Commissioning of new services and the transfer of services to new Akerman Road Neighborhood Resource Centre in Myatts Field and the successful stage 2 business cases (July 2011) development and Financial Close (2011) for the Norwood Hall scheme.	*July 2011*
Staying Healthy	To improve health outcomes for Lambeth residents through the commissioning of systematic health promotion and prevention services that have the effect of improving mortality rates, reducing morbidity, reducing the prevalence/incidence of key risk factors and reducing health inequalities. The 2011/12 programme covers the following areas; Stop Smoking, Teenage Pregnancy, NHS Checks, Childhood/Adult Obesity and Physical activity, Alcohol Prevention and Lambeth Early Intervention and Prevention Service.	*March 2012*
Organisational Development	To manage the transition of commissioning responsibility to GP Consortia and the establishment of new Health and Wellbeing arrangements. Our OD objectives cover: • Clinical commissioning and Consortia development • Embedding public and patient engagement • Equalities and our equality delivery system	*March 2012*

Priority	Actions	Timescale
	• Development of Lambeth Health and Well-being Board A structured approach to be undertaken to identify the development needs of the Lambeth Clinical Commissioning with the intention that full commissioning responsibility transfers to the GP Consortia in 2012/13 and new Health and Wellbeing arrangements are fully in place from April 2013. The development plan will cover empowering patient and the public, vision and strategy, finance, leadership, clinical/corporate governance, planning, agreeing, monitoring, skills and capacity, process and IM&T. As an early implementer Health and Well-being site, deliver on agreed shared priorities, including the development of our JSNA and engagement with the LINK/HealthWatch.	
Quality and Assurance	To ensure systems and processes are in place to support individual, team and corporate accountability for delivering patient centred, safe, high quality care. To work with partners and stakeholders to ensure on-going confidence in the local NHS. The organisation is responsible for delivering on key performance and quality standards and financial objectives. A structured approach will ensure that there are robust governance structures and processes in place for managing delegated responsibilities. This will include: • Safe care for children and adults through the delivery of robust safeguarding systems and processes. • Appropriate infection contract arrangements in place. • Complaints and FOI requests are responded to appropriately and learning is acted upon.	*Ongoing*

Priority	Actions	Timescale
	• Information and research governance • Financial stewardship and controls	

Additional Lewisham specific priorities

Priority	Actions	Timescale
QIPP	• Opening of UCC on LHCT site	*August 2011*
Commissioning / Systems management	• Refresh and maintain local Section 75 to encompass Adult Client Groups, Mental Health, Children & Young People and Public Health • Work with Cluster to integrate Community and Acute contracts for LHCT	*Dec 2011* *Sept 2011*

Additional Southwark specific priorities

Priority	Actions	Timescale
Communications	Establish and deploy systems for effective internal and external communications	*Ongoing*
Partnership working	• Work with partners to establish the Southwark Health and Wellbeing Board	*October 2011*

Priority	Actions	Timescale
	linking together with current local partnerships, GP Commissioners and the PCT Board	*March 2012*
	• Develop plans to support the implementation of the Southwark Health and Well-being strategy ensuring the Integrated Plan reflects these priorities and those of the refreshed JSNA	*March 2012*
	• Work with Kings Health Partners and GP Commissioners to progress the development of the Integrated Care Pilot in it's initial priority areas (Frail Elderly services, Urgent Care and Long Term Conditions)	*Ongoing*
	• Work with the Local Authority and emerging health bodies to manage the transition of public health functions to their new organisations	*Ongoing*
	• Develop effective working relationships with the Third and Voluntary sector within new and emerging systems for local commissioning (including as part of the Health and Well-being Board)	

Operations including acute contracting, performance and information

Overall lead Director: Jane Schofield, Director of Operations

Priority: Maintain and improve outcomes and performance, QIPP and winter planning

The work of the Operations Directorate includes:

- The development of a comprehensive performance framework for the new organisation which securely identifies the core annual deliverables, the accountability for delivery within the new structure and timeframe for delivery.
- The tracking of key targets and outcomes linked to operating plan deliverables ensuring that corrective action is taken where necessary
- Key QIPP milestones including the delivery of activity reductions through demand management and redesign ensuring that corrective action is taken where necessary
- Tracking of SI's, complaints and other patient safety issues ensuring that appropriate action is taken where necessary
- Ensuring appropriate plans are in place to handle predictable pressure points throughout the year [e.g. winter planning]
- Financial delivery in line with operating plan ensuring corrective action where necessary

Aim: Maintain and improve outcomes and performance

Lead Director: Sean Morgan, Director of Performance		
Priority	**Action**	**Timescale**
Performance framework	• Develop and implement a performance framework for Headline and Supporting Measures and existing Public Health indicators, assurance on Integrated Plans and delivery of QIPP	*May 2011*
Performance monitoring	• Regular 'stock take' meetings of IP and QIPP delivery with BSUs and GP leads	*Quarterly, from May 2011*
	• Reporting on contract performance (activity and quality) and performance on Operating Framework headline and supporting measures and existing public health indicators, including production of monthly dashboards and benchmarking and analysis, and formal performance reports to the Board, Finance, Performance and QIPP Committee and the Cluster Management Board	*Ongoing*
QIPP PMO	• Establish PMO function	*April 2011*
	• Establish QIPP Performance framework, including a monthly reporting cycle	*May 2011*
Acute contracts	• Establish and implement performance framework for acute contracts	*April 2011*
	• Monthly contract monitoring (performance) meetings with each acute provider	*Monthly*
Ensure appropriate plans are in place to handle pressure points	• Assurance of health community and organisational capacity plans, including escalation arrangements for dealing with unusual pressure in	*Winter plans to be in place by no later than*

throughout the year, including winter planning	activity, for the whole year and in particular the winter period.	*October*
Coordination of the annual planning round for 2012/13	• Develop a planning timetable. Agree a process for production of annual Operating Plans covering the responsibilities of the 6 PCTs/Care Trust. Ensure that the Operating Plan(s) delivers the financial and service performance outcomes set out in the Integrated Plan.	*Process to commence in June. Operating Plans to be finalized by March 2012*
Develop a performance framework for 2012/13 taking account of the NHS and Public Health Outcomes Frameworks	• Build on the 2011/12 Performance Framework to incorporate the new NHS Outcomes Framework and the Public Health Outcomes Framework	*By March 2012*

Aim: Provision of hospital services - through commissioning. Section 2-4 schedule 1 of NHS Act			
Lead Director: Sarah Cottingham / Susanna Masters, Directors Acute Contracting			
Priority	**Action**	**Target**	**Timescale**
Acute contracts	• Monitoring and Management of the acute contracts through monthly reporting and meetings across the key domains finance and activity, and ensuring corrective action where necessary	*Financial delivery of acute contracts*	*Ongoing*
Quality	• Improve the contracting arrangements to ensure continuous improvement - quality of care - Section 23	*Commission high quality*	*Ongoing*

	of the Act – by focusing on Serious Incidents, complaints, patient experience, infection control and mortality rates - and ensuring that appropriate action is taken where necessary	*services*	
2011/12 QIPPs and contracts	• Develop and negotiate acute QIPP for SEL London 2011/12	*Implement SE London QIPP*	*March 2012*
IFRs	• Managing individual funding requests on behalf of the sector.	*Ensure effective implementation of sector IFR policy.*	*Ongoing*

Primary Care

Priority: Improve Quality and access to primary care

Lead Director: David Sturgeon, Director of Primary Care

Aim: Improve the quality of primary care, and reduce variations in primary care across SEL. Consolidate and improve the quality of existing primary and community care, consolidating unscheduled care access points and shifting patient care from hospital based settings to primary and community care.			
Lead Director: David Sturgeon			
Priority	**Action**	**Target**	**Timescale**
Quality of primary care	• Adopt, implement and deliver the 'Pan-London Approach to Improving Quality in General Practice'.	QA of data to be completed by Practices by July 2001 with publication of information to Public/patients	*September 2011*
	• Focus on key outcome measures for general practice (an essential component of DH transition assurance).	Review existing benchmarking/balanced Scorecards. Develop Cluster Model and commence engagement with Practices/LMC	*June 2011* *September 2011*

		Implement Revised Model across Cluster	*December 2011*
Reduce variation	• Linked to the PMS review below to reward practices for outcomes that respond to local need, whilst ensuring equity of funding. • Payment to be associated with the achievement of key performance indicators and will require a higher level of productivity and internal efficiency with general practices.	Implement Existing PMS reviews in Bromley & Lewisham Financials £1.829m	*June 2011*
Single point of access to unscheduled care	• Complete DOS locally • Clinical engagement of care pathways	Minimum Data Set	*June 2011*
Primary Care Contracts	• Each PCT develop a detailed QIPP plan for primary care. • Each PCT complete or continue reviewing and rebasing their existing PMS contracts locally ensuring an equitable and fair distribution of funding to general practice. • Undertaken through negotiation with Local Medical Committees (LMC). • Review and re-commission existing enhanced services commissioned • Implement Post-payment verification of enhanced services • Assess and take action to ensure standardized approaches to exception reporting within the	Develop Primary Care Strategy Plan for Cluster Commence reviews in Lambeth & Southwark Financials £4.457m Develop “Fair Price” Model and commence Engagement with Practices & LMC Implement Revised Model	*September 2011* *June 2011* *September 2011* *December 2011*

	Quality and Outcomes Framework for General Practice • Review of any discretionary funding	Implement Cluster Policy across all PCTS	*June 2011*
	• Undertake, where appropriate and agreed with the LMC, list size reviews	Implement Cluster Policy across all PCTS Financials £0.5m	*June 2011*
	• Review the quality of access to general practices locally, recognising the impact of this area on the quality of the patient experience, the effectiveness of LTC management and spend	Review 10/11 Patient Survey Results and agree action plans with Practices. Implement Patient Participation DES	
	• Improve access by reviewing appointment utilization, matching supply and demand and exploring alternatives (e.g. telephone)		*2nd Qtr11/12*
	Revaluation and use of buildings	Undertake 6 Facet Surveys of Primary Care Premises & action remedial/breach notices as appropriate Financial £1.2m	
	• Further enhancement of Performance Management Frameworks for General Practice and General Dentistry	Revue existing PCT frameworks and develop Cluster approach Engagement with LDC	*2nd Qtr 11/12*
	• Review of UDA prices and delivery		*1st qtr 11/12*

	• Review of check-up frequency and revisits • Reduce failures to attend • Review of emergency dental access systems • Review of sector community dental services	Implement new arrangements Financials £0.4m ??? BSU???	 *June 2011* *September 2011*
	• Transfer of primary care to National Commissioning Board (NCB)	Establish Working Sub Group of Development Group Scope Transition Arrangements Implement Plans	*June 2011* *March 2012*

Development including Strategy and QIPP, Corporate Affairs, and HR

Overall Lead Director: Gill Galliano, Director of Development

Priority: Increase information to the public

Lead Director: Oliver Lake, Director Corporate Affairs

Aim: Internal and external communications, patient and public engagement, equal opportunities			
Lead Director: Oliver Lake, Director Corporate Affairs			
Priority	**Actions**	**Target**	**Timescale**
Health Campaigns	Ensure that communication campaigns support key health improvement priorities. Focus on quality not quantity of campaigns	Identify those from QIPP where shared approach could be undertaken	*Ongoing*
Engagement on service change	Ensure early, meaningful and legal stakeholder/public engagement on key areas of service change to improve quality – e.g. Cancer, cardiovascular and King's Health partners		*Ongoing*
QIPP	Deliver a cluster wide communications and engagement strategy to support the delivery of QIPP – focusing on areas where common approaches will deliver better results.	A cluster wide C&E strategy with clear plans for co-ordinated work on areas of communality	
Reputation	Ensure that the reputation of the local NHS is maintained through the transition.	Systems and processes in place to protect and enhance reputation of NHS South East London	*Ongoing*
Clinical Commissioners	Ensure that clinical commissioners are aware of communications and engagement requirements to enable them to be effective commissioners in the future.	Clear workplan established which sets out C&E activity to support development of	*Workplan by June 2011*

		GP Consortium.	
Stakeholder management	Ensure all stakeholders are kept appraised, involved and able to influence the new commissioning system, especially in terms of public accountability.		
Commissioning Support	Develop future Commissioning Support Services options for communications and engagement		
Business as usual	Ensure that there is ongoing delivery of business as usual during the transition for all communication and engagement areas.		*Ongoing*
Public information	Web based public information		
	Transfer of informatics functions to Clusters??	Ongoing	
	Online project on primary care info and outcomes		*live Autumn 2011*
NHS Constitution, Equal Opportunities & Human Rights Act -	Undertake equality impact assessment		
Public engagement	Duty to involve users in planning and changes to services section 242 of 2006 Act & Section 24a NHS ACT 2006. Formal consultation prior to significant commissioning decisions		
	Involve patients and public and their careers and other stakeholders in the planning and delivery of service		
	Engage with Local Involvement Networks (LINks)		
Internal and external communications	health promote through social marketing		

Lead Director: Oliver Lake, Director Corporate Affairs

Lead Director: Oliver Lake, Director Corporate Affairs		
Priority	**Actions**	***Timescale***
Governance	SEL NHS cluster transition governance framework set up.	*April 2011*
	All Cluster governance arrangements in place	*June 2011*

Priority: Commissioning Development

Lead Director: Gill Galliano, Director Development

Aim: Support the development of GP Commissioning Consortia, support the transition of commissioning to NCB and CSUs
Lead Director: Gill Galliano, Director of Development

Priority	Actions	*Timescales*
GP Commissioning Consortia	Complete Pathfinder coverage across SE London.	*June 2011*
	Authorisation process of comprehensive system of consortia begins, with all practices as members, acting under delegated arrangements with PCTs.	*June 2011*
	Consortia notified of 2013/14 allocations.	*March 2012*
	Complete shadow delegation of commissioning responsibilities to all Consortia	*June 2012*
Commissioning Support Units	Work with London clusters to consider options for CSUs	*July 2011*
	Work with SEL GP Consortia to test options	*August – November 2011*
	Undertake transition assurance process	*Dec 2011*
	Development plan in place for CSUs	*Sept – Dec 2011*
CSU Accreditation	Complete Stock take analysis / diagnostics	*May 2011*
	Test options with GP Consortia	*May – August 2011*
	Develop road map and development plan	*August 2011*
	Assurance process completed	*December 2011*
	Decision on future of SEL NHS Cluster.	*June 2012*
	Go live of new system.	*April 2013*

Priority: Strategy and QIPP

Lead Director: Tony Read, Director Strategy and QIPP

Aim: Development of QIPP, Integrated Plans, Transition plans. Working with GP consortia to ensure plans are embedded.
Lead Director: Tony Read, Director Strategy and QIPP

Priority	Actions	Timescale
Strategy and QIPP	Development of strategic plans	
	QIPP Plans & Service redesign (Investment & disinvestment plans)	*December 2010*
	Refresh of Cluster QIPP for 2011	*September 2011*
	Support the BSU development of borough based QIPP plans	*April 2011*
	Development of Plan B options	
	Development of QIPP network	*May 2011*
Integrated Plan	Development of 2011/12 IP	*March 2011*
	Refresh of IP for 2011/12	

	Development of 2012/13 IP	*March 2012*
Reform and Transition Plan	Development of 2011/12 R&T Plan	*February 2011*
	Refresh R&T plan for 2012/13	*December 2011*
A Picture of Health	Finalising the implementation of APoH QMS campus development (business case)	*October 2011*
SEL Business Plan	Development of SEL Business Plan 2011/12 to 2012/13	*May 2011*
	Agreement of BSU corporate objectives / priorities	*May 2011*
	Directorate work plans in place	*May 2011*
	Individual work plans in place	*June 2011*
Clinical engagement	Development of Clinical Strategy Group	*May 2011*
	QIPP Implementations plans refreshed	*September 2011*
Single Point of Access	Development of project plan	*May 2011*
	Clinical engagement on care pathways	*July 2011*
	DOS database completed	*May 2011*
Shared services	Decide options for shared services	*September 2011*
	FHSA review of and implementation	*March 2012*

Human Resources

Priority: Manage the workforce transition from the current NHS system to the new system

Lead Director: Una Dalton, Director HR

By the end of June 2011, SEL Cluster will have completed the mapping of staff to GP consortia and pathfinders, and will have an emerging view on the destinations for other functions and staff (dependent on clarification on policy around end destinations). The HR implementation plans to transition functions to GP consortia and other destinations will be informed by DH HR Framework decisions on pooling and timelines, decisions around the application of TUPE, and lessons learnt from our experiences in London of implementing the clusters. These implementation plans will cover transition business continuity and ongoing stakeholder management with GP pathfinders and local authorities.

Aim: To provide strategic leadership on all HR issues and ensure supporting plans and processes are established to manage the transition of the employed workforce into new arrangements.
Lead Director: Una Dalton, Director HR

Priority	Actions	Timescale

Priority	Actions	Timescale

Human Resources	• To provide a high quality HR service to Cluster/BSUs including:
	  • Recruitment and Selection, completing the recruitment process to fill all vacancies
	  • Employee Relations
	  • The management of terms and conditions of service
	  • Provision of workforce information (NHS London/internal)
	  • Staff support
		End March 2012

Training and Development	• Using the content of personal development plans (PDPs) for all employed staff, develop a training programme to address mandatory training requirements and individual/team development needs. • Commission training as appropriate. • Establish and co-ordinate a training panel to consider all requests for development funding.	*End June 2011*
Policy Development	• Review and revise an organisational change policy building on established local arrangements.	*End September 2011*
Working in Partnership with Staff	• Develop local arrangements for the development of partnership working with staff side representatives including the establishment of a Cluster partnership forum.	*End June 2011*
BSU local workforce priorities	• Working with BSUs, develop local HR priorities as agreed.	*End March 2012*

Organisational Change	• Support ongoing organisational change including the local implementation of national and London HR policy to include:
	  • Implementation of RETs
	  • The assignment of staff to consortia
	  • The transfer of staff to the National Commissioning Board, Health and Wellbeing Boards and Consortia
		End March 2013

Workforce transformation

Priority: Strategic lead on workforce transition

This work is funded separately by NHS London.

The Director of Workforce Transformation has a remit to support the transition of the workforce from the current NHS system to the new system including the development of a provider skills network for south east London. The Directorate will also lead the OD support required for emerging organisations such as GP consortia and commissioning support units.

Other key responsibilities will include monitoring Trusts organisational health through a workforce Dashboard, developing a workforce plan/strategy which highlights the level of risk, together with education and training priorities. Support will be given to delivering the workforce elements of the QIPP plan and links with the South London HIEC will be strengthened through individual initiatives to develop the future workforce.

Aim: To ensure a robust workforce for the future and support the local workforce in the current transition.
Lead Director: Ana Selby, Director Workforce Transformation

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Priority	Action	Timescale

Priority	Action	Timescale
Workforce strategy/plan and components aligned to QIPP plan	• Develop agreed outputs highlighting the level of risk together with education and training priorities	*End of Sept.*
Workforce Assurance	• Monitor organisational/workforce health of local NHS organisations	*3 monthly*
Support workforce elements of QIPP plan	• Enable nurses in for example the acute sector to 'make the move' into primary care by commissioning a training & development programme. • Commission key training for practice nurses and other staff groups to improve quality. • Facilitate delivery of workforce QIPP in provider organisations.	*March 2012*
Leadership Development & Talent Management	• Identify specific groups of staff for Leadership development such as senior managers and practice nurses. • Support to local NHS organisations who undertake the Talent process	*Ongoing* *Feb 2012*
Deliver and facilitate OD, Transition support and workforce development plans	• To give OD support to organisations such as GP consortia and commissioning support units or to particular workforce issues highlighted in the QIPP plan by designing OD solutions that fit with reform or delivery agenda. • Facilitate and use local relationships to develop provider skills network	*ongoing*

Priority	Action	Timescale
Set up Networks	• Set up future networks in south east London rather than London wide e.g. HR network, partnership forum, practice nurses.	*End of Oct*

Public Health

Priority: Implementing Public Health changes

Lead Director: Ann-Marie Connolly, Director Public Health

During 2011/12 the London Health Transition Board will provide oversight of the new relationship between local government and GP consortia and the sharing of public health functions between Public Health England (PHE), the Mayor of London and local government. Building on a strong history of joint working the board will ensure priorities; actions and resources are aligned to secure the effective transition of services for Londoners.

Aim: Develop Health and Well Being Boards, ensure transfer of the Public Health functions to Local Authorities and other receiving bodies such as Public Health England

Lead Director: Ann-Marie Connolly			
Area	**Process**	**Target**	**Timescale**
Health and Well Being Boards	Local processes to be coordinated Governance, TORs, responsibilities and budgets (shadow) for shadow Boards to be agreed, partnership arrangements with LAs to be agreed Develop in association with GP Pathfinders and BSUs	Shadow Boards to be developed Full Boards to be in place with devolved accountabilities	*October 2011* *April – July 2013*
Implementation of Public Health White Paper guidance	Coordinate and Develop transitional arrangements including agreements with local authorities for provisional transfer of staff under local agreements (e.g. S75 agreements) Liaise with London wide transition planning to ensure that local arrangement align with London wide picture and organization arrangements Plan for transition of functions – possibly in shadow form to Public Health England and NHS Commissioning Board where appropriate Ensure on-going accountabilities for Public health are clarified throughout the transition process		*October 2011* *Ongoing* *Possibly as early as November 2011 but unclear June 2011*
implementation of QIPP Staying	Processes for monitoring QIPP are in place	In accordance	*Process in place*

Healthy	Regular review of Staying Healthy QIPP milestones and targets	with milestones	*by June 2011*
Strategy	Health promotion/prevention strategies		
	Develop joint local improvement targets - section 106 (3) and 111 (5) of local Gov & Public Involvement in Health Act 2007.		
	Develop joint health needs assessments - - Section 106 (3) and 111 (5) of local Gov & Public Involvement in Health Act 2007		
Support to commissioning	Coordinate Public Health support to commissioning as appropriate		*Ongoing*

Clinical

Medical – lead Jane Fryer, Medical Director
Nursing – lead Donna Kinnair, Director of Nursing

Aim:			
Lead Director: Jane Fryer, Medical Director			
Priority	**Actions**	**Target**	**Timescale**
Clinical Strategy	Establish the Clinical Strategy group Agree and oversee delivery of QIPP plans Delivery and quality of QIPP plans working with BSUs Improve quality of primary care through the Primary Care Quality group Establish framework of robust management of poor primary care performance	Clinical Strategy developed with BSUs	*May 2011* *Ongoing* *Ongoing* *Ongoing* *End May 2011*
Patient safety assurance of quality of all providers	Establish Quality and Governance group Establish Quality groups with all main providers (part of contract monitoring) including a separate Primary Care Quality group	Improvement in primary care performance	*End May 2011* *End May 2011*
Appraisal and validation (GPs) and development of responsible officer	Cluster wide appraisal and revalidation framework in development Involved in 11/12 RST deanery pilot		*Ongoing* *Sept – Dec 11*

role			

Lead Director: Donna Kinnair, Director of Nursing

Priority	Actions	Timescale
Establish nursing advice to boards	Work with boroughs ensure fair process in place for electing nursing and AHP's advisory role onto CC boards Establish nursing network	*June 2011*
Quality and patient safety issues	Support contracting team / BSU's with clinical advice on quality and safety issues. Clinical advice into commissioning /QIPP plans. Establish designated nurse forum	*June 2011*
Clinical leadership nursing and AHP's	Establish Cluster nursing forum with DON's from acute providers for workforce issues. LSL infant mortality/maternity network BBG maternity network	

Finance, procurement, ICT and estates

Priority: Achieve 2011/12 Financial targets

Aim: Deliver 2011/12 Statutory Financial Duties and Develop Financial Strategy to deliver sustainable financial legacy			
Lead Director: Marie Farrell, Director Finance			
Priority	**Actions**	**Target**	**Timescale**
Finance Structure	Ensure robust structure is in place with staff in post	Complete recruitment or identify interim alternatives	*By July 2011*
Statutory Financial Duties and Targets	Establish effective systems of financial control and governance	Have adopted SFIs and scheme of delegation	*End June 2011*
	Ensure effective financial management and reporting systems in place with training and expert support/ advice to BSUs and stakeholders	Achievement of statutory financial duties	*by 31 March 2012*
Planning	Align planning cycles and develop integrated financial planning approach	PMO fully established in Financial Planning and Delivery Unit	*By end June 2011*
	Translate operating plan into reconciled and robust budgets	Agreed cluster and BSU budgets in place reflecting delivery requirements of	*By end June 2011*

		Operating framework	
Financial Management	Financial Reporting	Establish standardised cluster reporting structures	*By end May 2011*
	Financial Ledger and Associated systems	Ensure systems are in place to produce Month 2 financial monitoring	*By end May 2011*
	Migration to standardised integrated ledger systems	Standardised ledger in place across cluster with common reporting structures	*By 1 January 2012*
	Claims Management and Contract Monitoring Systems	Ensure robust systems are in place to provide financial challenges/ validation where appropriate and to reflect accurate acute positions in cluster reports	*By end May 2011*
	Provide expert financial advice and support to stakeholders	Establishment of financial briefing/training sessions	*throughout 2011/12*
	Support and advice in Delivery of QIPP	PMO in FP&DU established with clear links to BSU	*by end June 2011*
VFM and CIP	Review productivity opportunities across all budgets via benchmarking	Ensure cluster structures are cost effective and maximise productivity opportunities	*Continuous process*
		Robust CIP programme in place to deliver required cost reductions and deliver improvements to the underlying financial position	*Continuous process to identify further cost reduction opportunities*

		Delivery of national requirements in terms of efficiencies and cost reductions	*By 31 March 2012*
		Procurement advice in place to underpin delivery of QIPP	*By end June 2011*

ICT

Aim:			
Lead Director: Marie Farrell, Director Finance			
Priority	**Actions**	**Target**	**Timescale**
ICT Structure	Ensure robust structure is in place with staff in post	Complete recruitment or identify alternatives for resourcing	*By June 2011*
Information Governance	Review IG arrangements across the cluster, including IG frameworks, policies, assurance processes and roles	Develop an assurance framework to facilitate compliance with the Data Protection Act and other legal requirements, including NHS Connecting for Health's Information Governance Toolkit	*By end September 2011*
NPfIT	Review deployment plans for the 6 Boroughs for 2011/12, including bids for the capital programme	Identify and scope an NPfIT deployment plan for Primary Care in South East London, in support of NHS South East London Cluster's strategic vision	*By end June 2011*
Capital programme	Review deployment plans for the 6 Boroughs for 2010/11, 2011/12 and	Identify and scope an ICT capital programme plan for Primary Care in	*By end June 2011*

	2012/13, including identifying funding allocations in business cases	South East London, in support of NHS South East London Cluster's strategic vision	
Contracts	Review contracts, identify ICT standards in place, develop and agree a plan to standardise where possible, including GPSoC contracts and other support arrangements	Review and develop a programme of ICT standardisation across South East London	*By end September 2011*
Strategy	Review contracts, identify ICT standards in place, develop and agree a plan to standardise where possible, including GPSoC contracts and other support arrangements	Define an ICT Strategy for NHS South East London Cluster, including: a) a network strategy, and b) a primary care ICT strategy	*By end September 2011*

Estates

Aim:			
Lead Director: Marie Farrell, Director Finance			
Priority	**Actions**	**Target**	**Timescale**
Estates Structure	Ensure robust structure is in place with staff in post	Complete recruitment or identify alternatives for resourcing	*By June 2011*
Develop cluster Estates Strategy	Agree HQ sites for cluster and BSUs	Business Case to be approved by cluster (June 2011) and NHS London (July 2011)	*By July 2011*

	Engage with business units and cluster teams regarding estates required	Identify resourcing and project plan for completion of estates strategy	*By June 2011*
	Identify and progress new build, refurbishment and disposal projects underway	Identify current plans and further options for estates rationalisation and delivery of projects required to meet commissioning strategies	*By July 2011*
		Complete Estates Strategy	*By October 2011*
Compliance with Statutory Health and Safety Requirements etc	Assess baseline information on compliance versus requirements	Identify resourcing and project plan for completion of PCT Estate compliance programme	*By June 2011*
	Review compliance of all PCT estate to ensure compliant		*By July 2011*
	Estates, Primary Care and Business Units to agree process to ensure GP estate compliant (including CQC)	Identify resourcing and project plan for completion of GP Estate compliance programme	*By July 2011*
		Ensure GP Estate is compliant re H&S and CQC	*By March 2012*
Complete Transforming	Negotiate and agree leases to community service	Leases to be completed	*By July 2011*

Community Services (TCS) Estates Workstream	providers	with community providers	
Capital Investment Plan (CIP)	Engage with business units and cluster teams regarding estates required	Agree 2011/12 Capital Investment Plan	*By July 2011*
		Complete 2011/12 Capital Investment Plan	*By March 2012*
Contracts	Review all existing contracts	Rationalise and ensure efficient and effective use of consultancy support	*By June 2011*
		Agree plan for rationalise and ensure efficient and effective use of building management contracts (maintenance etc)	*By July 2011*

Section five: Measuring success

Priorities	KPI
Delivery priorities	
Manage providers and implement the change programme as set out in QIPP and the Integrated Plan	KPIs from QIPP PMO including finance / savings targets
Manage providers to assure quality, performance and financial control building sustainable capacity across the system	KPIs in performance dashboard / framework to include Headline and Supporting Measures (e.g. A&E new clinical indicators, HCAIs, RTT waits, VTE risk assessments, cancer waiting times, bowel screening age extension, cervical screening test results, NHS Health Checks) and existing Public Health indicators.
Achieve 2011/12 Financial targets	Achieve surplus Achieve statutory duty balanced budget Achieve QIPP savings targets Achieve other savings targets
Delivery of national Operating Framework priorities	Operating Framework Headline and Supporting Measures
Maintain and improve service performance and patient safety	Service performance dashboards to include al Headline and Supporting measures e.g., immunisations, RTT, MRSA, A&E. Patient safety KPIs by development team
Increase information to the public	Patient information provided via web

Improve Quality and access to primary care	QoF indicators Improve national patient survey scores Improved GP survey scores
Meet Statutory obligations and core business	All Statutory Obligations met

Priorities	KPI
Reform priorities	
Delegation of commissioning functions	Delegated by April 2013
Implement the new cluster structure	Transition process successfully managed and on target (majority of cluster management team in place)
Development of commissioning support services	Options agreed with GP Consortia
Implementing Public Health changes	By April 2013
Transfer primary care contracting to National Commissioning Board	By April 2013
Support staff to align to new arrangements	By April 2014
Legacy priorities	

Support development of pathfinders	Six pathfinders by June 2011 Governance to be resolved and improvement of whole system relationships
QMS Campus – to offer a range of innovative primary, community and hospital services for local people	QMS campus fully operational
Delivery of FT pipeline	LHNT and SLHT FTs by 2014
Maintain and continue to improve public health outcomes within SEL	Public health indicators

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11th May 2011

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 7 **2011/12 INTEGRATED PLAN**
DIRECTOR RESPONSIBLE: Gill Galliano, Covering role of Director of Development
AUTHOR: Tony Read, Director Strategy and QIPP & Kathryn MacDermott, AD Strategy and QIPP
TO BE CONSIDERED BY: All
SUMMARY: The attached summary provides the Board with an overview of the financial position for the six SEL PCTs and Care Trust, illustrates the key drivers in the financial case for change, shows each PCT spend by QIPP category, and the potential QIPP savings – both new initiatives and existing. The impact of QIPP is shown by impact on expenditure and by provider. For each of the QIPP initiatives a vision and the key headline commissioning intentions are set out. Followed by a risk assessment and key next steps.
KEY ISSUES: The risk assessed QIPP position would leave a potential gap of c£17.9m which will be bridged by a mixture of local and Cluster schemes. The cluster intention is to move to reduce operating costs to £55 per head which will address £15-18m of this gap. The planned investment to accelerate QUIPP schemes should deliver significant additional benefit – the business cases are currently being assessed, BSUs are also continuing to develop alternative plans which are subject to stocktake review commencing beginning of May. Main schemes assessed as high risk: • Lewisham – outpatient referral reductions £1.3m

- Bromley – referral management centre £1.7m
- Bexley – unidentified QIPP £2.9m

INVOLVEMENT: Not applicable

RECOMMENDATIONS:
The board (s) is asked to:-

1. Note that the six SEL PCTs have submitted Operating Plans for 2011/12 which are in line with Operating Framework guidelines and NHS London financial planning guidance.
2. Note the planning assumptions used and process
3. Note the impact of QIPP
4. Note the results of the cluster challenge process
5. Agree the steps being taken at cluster and local level to close the QIPP gap

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South East London

NHS South East London

2011/12 Integrated Plan

Joint Boards 19th May 2011

A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham, Southwark and Bexley Care Trust

ENCLOSURE 7

Contents

South East London

- Financial Plan
- QIPP
- Impact
- Commissioning intentions
- Risk assessment

Financial Plan 2011-15 Summary

South East London

The six SEL PCTs have submitted Operating Plans for 2011/12 which are in line with Operating Framework guidelines and NHS London financial planning guidance.

The Operating Plans are fully integrated in the medium term financial plan for the Cluster developed for the Commissioning Strategy Plan. This delivers the following surpluses after QIPP over the plan period:

Cumulative Surplus/(Deficit)	2010/11 OT	2011/12 Plan	2012/13 Plan	2013/14 Plan	2014/15 Plan
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Bexley	506	1,759*	3,640	3,735	3,834
Lewisham	5,285	5,269	5,390	5,530	5,676
Lambeth	6,266	6,546	6,695	6,870	7,052
Bromley	6,889	5,000	5,113	5,247	5,387
Greenwich	5,326	4,549	4,652	4,774	4,901
Southwark	1,291	5,500	5,625	5,772	5,925
Total	**25,507**	**28,623**	**31,115**	**31,929**	**32,775**

*Agreed reduction in 1% surplus to fund £1.8m deficit repayment

Cluster CSP and Operating Plan process

South East London

- The SEL CSP model consolidates the 6 PCTs 5 year financial plans and includes the following assumptions:
- 2009/10 finance and activity outturn used as the baseline adjusted for 2010/11 forecast outturn (as at m11)
- Local growth and tariff assumptions – see Appendix 1
- 1.5% Net tariff deflation for acute and non acute provider contracts
- Management cost savings accelerated to 2011/12
- Required contingencies (0.5% of RRL) and non recurrent reserves (2% of RRL) for each PCT each year
- All PCTs achieve at least 1% surplus each year
- Pay inflation assumptions per NHS London guidance (0% in 2011/12 and beyond with some local assumptions on increments)
- The CSP has been reconciled to the March Operating Plan submission.
- The submissions have also been quality assured by the Cluster through a financial planning stocktake which has checked the consistency and completeness of planning assumptions for all PCTs, in line with the Operating Framework guidance.
- Updated notification of Revenue Resource Limits including adjusted for social care funding, learning disabilities and cancer drugs
- Operating Framework investments including health visitors, re-enablement funding and share of £150m, GP development fund, (£4 per head of population) dementia and IAPT.
- The plans reflect the PCTs views of the latest position on contract negotiation for 2011/12 with providers.

CSP Case for Change gap
28 March 2011

South East London

Before the impact of planned QIPP schemes is taken into account, the SEL PCTs baseline financial position worsens from 2010/11 to 2014/15 due to significant forecast growth in demand for acute and non acute services as well as the requirement to retain 2% non recurrent reserves.

Cumulative Surplus/(Deficit)	2010/11	2011/12	2012/13	2013/14	2014/15
	£000s	£000s	£000s	£000s	£000s
Bexley	(2,128)	(12,097)	(22,246)	(32,490)	(42,885)
Lewisham	1,495	(11,476)	(35,072)	(62,932)	(94,020)
Lambeth	2,199	(9,404)	(26,707)	(49,050)	(75,724)
Bromley	3,115	(3,667)	(14,050)	(25,651)	(38,533)
Greenwich	(2,943)	(20,941)	(47,743)	(84,106)	(122,479)
Southwark	(16,078)	(33,693)	(57,991)	(81,694)	(107,008)
Total	**(14,340)**	**(91,279)**	**(203,809)**	**(335,923)**	**(480,648)**

PCT Annual Revenue and Surplus/(Deficit) before QIPP

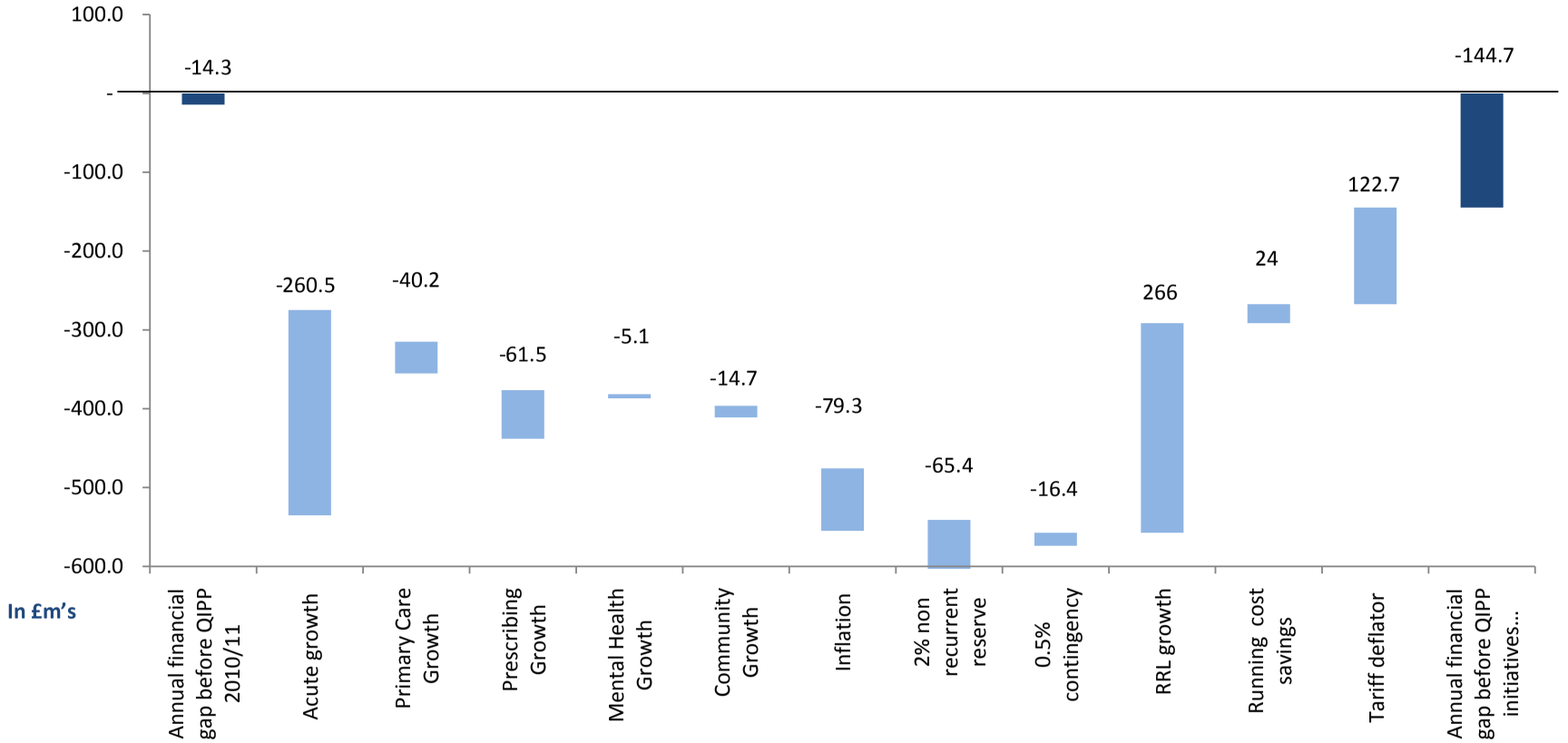
NHS South East London

Whilst the revenue resource limit is forecast to grow each year in the period by between 2 and 2.6%, this is not sufficient to offset increasing annual expenditure driven by planning assumptions (see appendix 1).

Revenue	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000
Bexley	342,533	342,605	349,538	356,927	364,818
Lewisham	533,209	540,048	544,599	556,286	569,701
Lambeth	648,436	655,639	661,170	670,156	682,067
Bromley	505,252	511,838	520,872	532,831	545,228
Greenwich	475,755	483,660	493,290	502,731	517,807
Southwark	536,934	546,078	550,439	565,946	582,196
Total	**3,042,119**	**3,079,868**	**3,119,907**	**3,184,877**	**3,261,817**
Annual Surplus/(deficit)	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Bexley	(2,128)	(9,969)	(10,149)	(10,244)	(10,395)
Lewisham	1,495	(12,972)	(23,596)	(27,860)	(31,088)
Lambeth	2,199	(11,603)	(17,303)	(22,343)	(26,674)
Bromley	3,115	(6,782)	(10,382)	(11,601)	(12,882)
Greenwich	(2,943)	(17,997)	(26,802)	(36,363)	(38,373)
Southwark	(16,078)	(17,615)	(24,298)	(23,703)	(25,313)
Total	**(14,340)**	**(76,938)**	**(112,531)**	**(132,114)**	**(144,725)**

Key drivers of the annual financial gap at 2014/15 (before QIPP)

South East London



ENCLOSURE 7

PCT Spend by category

NHS
South East London

Before QIPP:

Commissioning area	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000
Acute Services	1,552,986	1,612,201	1,656,564	1,705,453	1,756,233
Mental Health	224,884	228,789	232,693	237,418	239,592
Community services	437,437	391,703	391,948	394,008	396,096
Primary care	179,165	238,330	241,557	244,048	250,888
Operating Costs	661,987	685,783	709,676	736,064	763,733
Total	**3,056,459**	**3,156,807**	**3,232,438**	**3,316,992**	**3,406,542**

After QIPP:

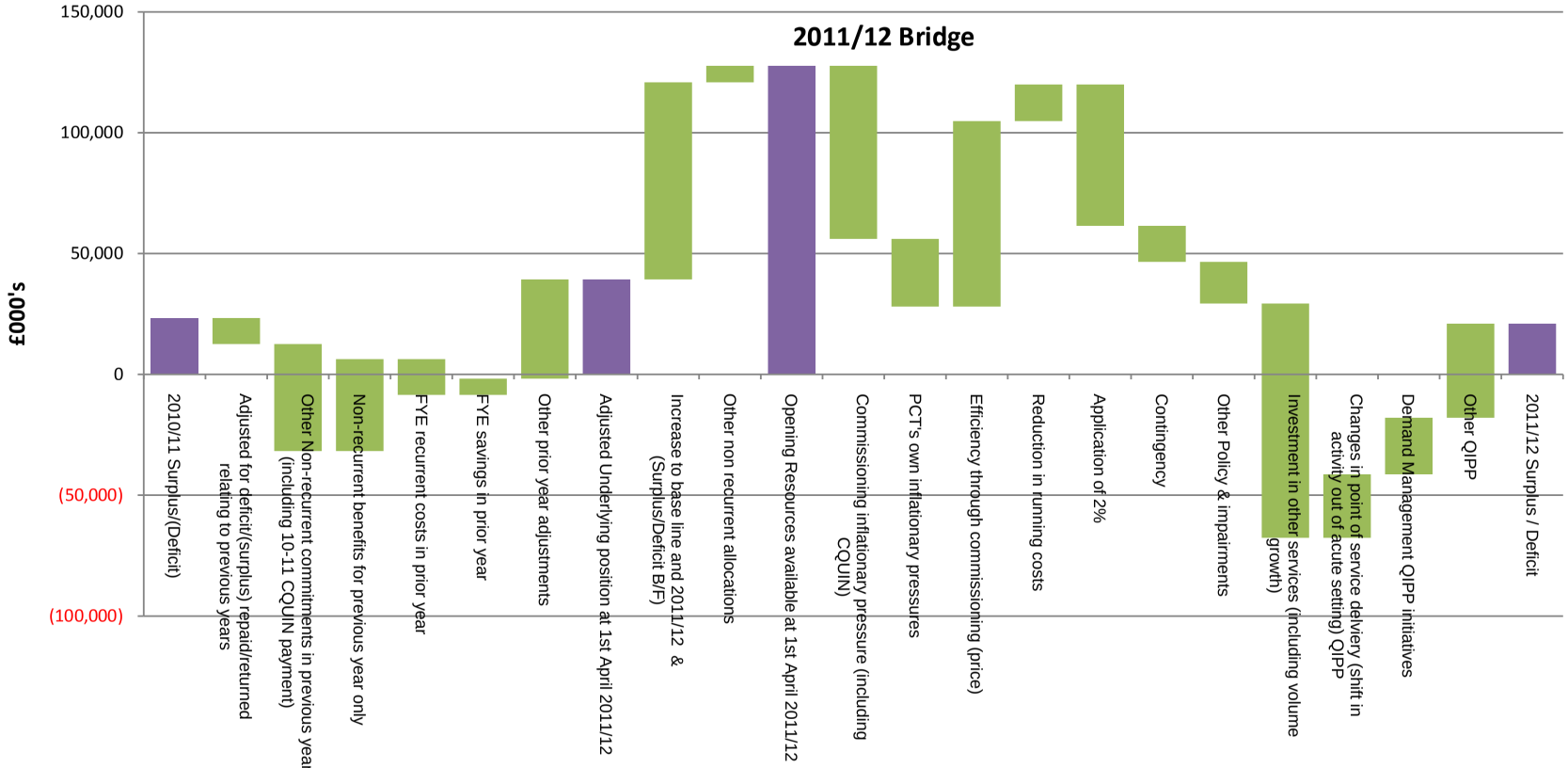
Commissioning area	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000
Acute Services	1,533,422	1,544,029	1,562,617	1,602,907	1,647,018
Mental Health	224,657	225,674	228,371	232,225	233,785
Community services	433,637	381,286	377,693	375,677	375,285
Primary care	174,346	232,072	237,190	239,212	243,570
Operating Costs	652,105	666,384	682,921	702,927	729,384
Total	**3,018,166**	**3,049,445**	**3,088,792**	**3,152,948**	**3,229,042**

Operating costs include the impact of the 2% NRR and contingencies

Underlying Financial Position 2010/11 to 2011/12

South East London

Before 2011/12 operating plan requirements are reflected, the SEL Cluster financial position is a surplus of £39 million. The operating plan cost pressures, 2% non recurrent reserve and growth in commissioning are offset in part by inflation but require significant QIPP savings to achieve the 1% surplus requirement.



ENCLOSURE 7

QIPP Plans 2010-15: Summary of new schemes by theme

NHS
South East London

New Savings Initiatives	2010/11	2011/12	2012/13	2013/14	2014/15
	£000s	£000s	£000s	£000s	£000s
Long term conditions	228	2,590	671	320	315
Urgent care	5,432	16,912	4,165	2,680	1,451
End of life care	0	298	511	551	300
Planned care	14,132	31,696	21,606	6,187	5,218
Mental Health	3,800	6,856	4,306	4,637	2,080
Maternity and newborn	0	813	0	0	0
Medicines use, clinical procurement, prescribing	1,320	4,938	1,165	1,309	1,338
Back office	119	1,244	2,649	375	375
Staying Healthy	(737)	(572)	412	504	681
Community support services	3,132	2,744	(3,290)	1,476	107
Estates	1,568	451	0	0	0
Primary care	9,299	8,220	7,390	5,404	230
Incremental in year QIPP	**38,293**	**76,191**	**39,585**	**23,442**	**12,095**

QIPP Plans 2010-15: Total Savings

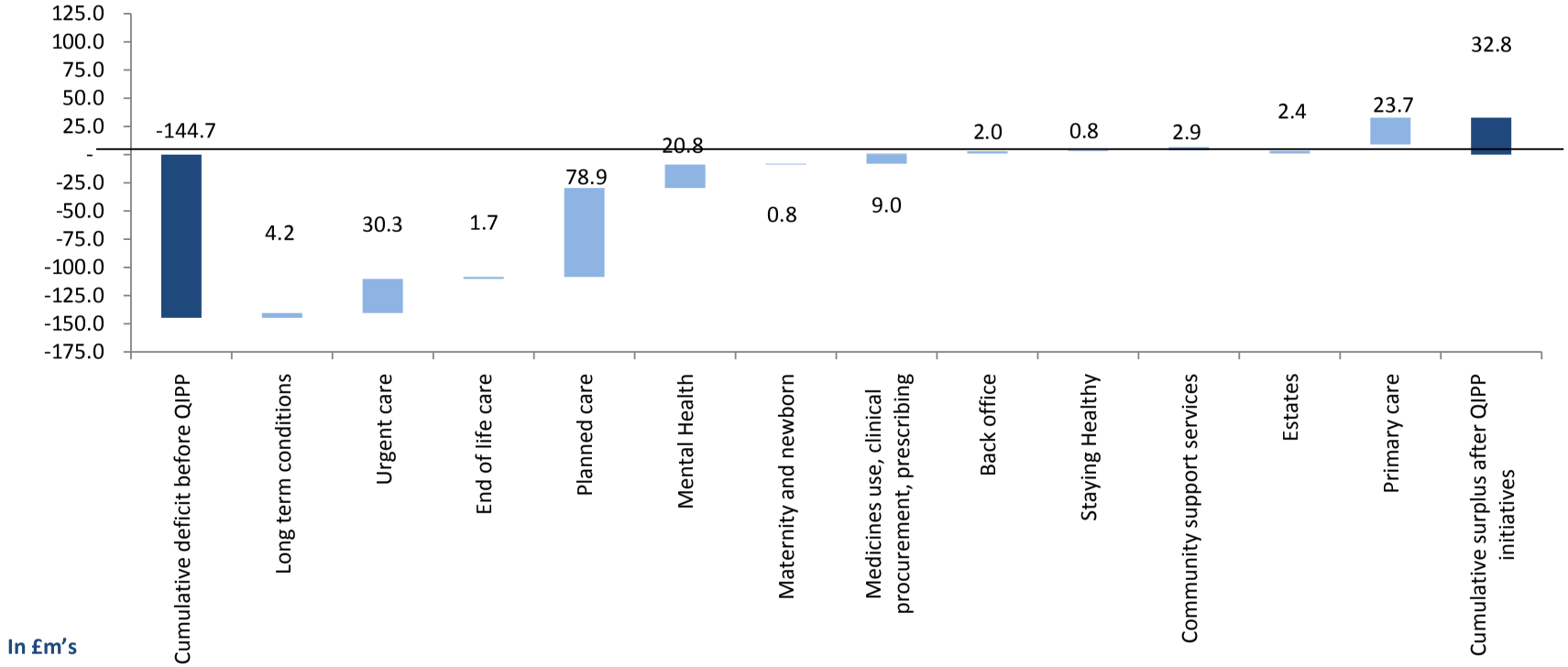
South East London

Total Savings per year	2010/11	2011/12	2012/13	2013/14	2014/15
	£000s	£000s	£000s	£000s	£000s
Long term conditions	228	2,817	3,512	3,832	4,147
Urgent care	5,432	22,344	26,510	28,830	30,280
End of life care	0	298	809	1,361	1,661
Planned care	14,132	45,828	67,438	73,716	78,935
Mental Health	3,800	10,417	14,255	18,331	20,811
Maternity and newborn	0	813	813	813	813
Medicines use, clinical procurement, prescribing	1,320	6,259	7,013	7,669	9,007
Back office	1,568	2,019	2,019	2,019	2,019
Staying Healthy	(737)	(817)	(405)	99	780
Community support services	3,132	2,876	(1,664)	812	2,919
Estates	119	1,363	4,012	2,004	2,380
Primary care	9,299	13,144	19,334	24,557	23,749
TOTAL QIPP Savings	**38,293**	**107,362**	**143,645**	**164,042**	**177,500**

Impact of QIPP initiatives on annual gap at 2014/15 (graph)

South East London

By 2014/15 the annual financial gap to be mitigated is £144.7m. The graph below shows how the £177.5m total QIPP schemes achieve the required 1% surplus.



QIPP provider analysis summary of cumulative impact

NHS South East London

QIPP by provider	2010/11	2011/12	2012/13	2013/14	2014/15	Total
	£000	£000	£000	£000	£000	£000
Acute Metrics (KPIs etc)	11,041	25,536	31,268	35,089	38,911	**141,845**
Acute other (including POLCE)	10,022	51,510	75,606	85,576	92,302	**315,016**
Primary and community	11,862	11,979	19,171	23,757	22,897	**89,666**
Mental Health	2,800	8,899	13,205	17,281	19,761	**61,946**
Other	2,568	9,437	4,397	2,340	3,629	**22,371**
Total Savings	**38,293**	**107,362**	**143,646**	**164,043**	**177,500**	**630,844**

Provider analysis – acute expenditure budgets 2010/11 to 2011/12

NHS
South East London

Spend by provider	SLHT	Lewisham	GSTT	Kings	Total SEL
	£000	£000	£000	£000	£000
2010/11 outturn	348,187	140,617	354,418	293,234	1,136,456
2011/12 proposals	328,261	141,764	357,166	302,006	1,129,197
Change	**-19,926**	**1,147**	**2,748**	**8,772**	**(7,259)**

QIPP provider analysis annual impact

South East London

QIPP by provider	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000
Kings	7,907	10,003	8,105	4,567	4,059
GSTT	10,635	5,266	7,420	4,192	3,802
UHL	-3,607	5,393	6,807	2,017	2,106
SLHT	7,562	19,254	6,457	1,588	0
Other Acute	0	1,233	1,291	378	367
SLAM	2,800	3,979	3,626	3,496	3,324
Oxleas	0	1,420	680	580	580
Community	1,004	543	1,699	2,319	0
Primary care	9,424	267	-908	-294	-2,553
Other	2,568	8,212	1,107	1,554	1,772
Total	**38,293**	**55,570***	**36,283**	**20,397**	**13,457**

* This does not agree to QIPP totals earlier in the presentation as the use of £16.6m 2% NRR is netted off above

SEL Strategic commissioning intentions – QIPP

South East London

- Reforming urgent care
- Reforming Planned Care
- Reforming primary care
- Specialist services – cancer, cardiac and stroke
- Reforming maternity services
- Mental health
- Staying healthy
- End of life services

Urgent Care

NHS
South East London

Our model for urgent care has primary care-led Urgent Care Centres (UCCs) at the front door of all A&Es, with Urgent Care services also located in the community, where required. Our urgent care model spans multiple settings of care from local GP-led out of hospital services to consolidated, consultant-led trauma and multi-specialist services, with a focus on admission avoidance, integrated care in the community and rapid discharge.

Key Work Programmes:

- Urgent care centres
- Integrating GP extended hours, out-of hours and A&E urgent care services
- Intermediate care
- Single point of access

Planned Care

South East London

Our model for planned care will deliver care closer to home for minor procedures, diagnostic, regular attendees and outpatients whilst concentrating complex care in specialist units.

Key Work Programmes:

- Referral management
- Pathway redesign
- Medicines management
- PoLCE
- Choice of named Consultant led team

Primary Care

NHS
South East London

We plan to improve the quality of primary care, and reduce variations in primary care across SEL. We will consolidate and improve the quality of existing primary and community care, consolidating unscheduled care access points and shifting patient care from hospital based settings to primary and community care.

Key Work Programmes:

- Supporting GP Consortia
- Primary Care Contracts
- Quality and access
- Investment and development
- Quality and long term conditions
- Pan London approach to improving quality in primary care
- Quality and performance management

Cancer and Cardiac vascular services

NHS
South East London

We are will be implementing the London-wide pathways on specialist services including tertiary paediatrics, cancer and cardiac/cardio-vascular. Our models of care are based on London-wide reviews of services

Pathways for:

- Stroke
- Cardiac/cardio-vascular
- Cancer
- Tertiary paediatrics

Mental Health

NHS
South East London

Within mental health, a more detailed strategy needs to be developed in partnership with providers, and this will be completed during 2011.

Key Work Programmes

- Primary care and psychological therapies
- Secondary care
- Shift in the model of care
- Role of 3rd sector in care pathways
- Role of primary care in care pathways

Maternity

South East London

Further work is being completed on the maternity pathway but our model will develop parallel services for midwifery led and obstetric led care, with patient choice at the heart of the model.

Key Work Programmes

- Quality and access
- Reduce C sections
- Choice of location
- Improve key health outcomes

Staying Healthy

NHS
South East London

This strategy focuses on 3 sets of interventions: i) interventions that the Public Health White Paper and consultation papers signal will be led by Public Health England and potentially led at a cluster level in the future ii) interventions where there is either new investment within the QIPP or a business case has been made by one or more PCTs/CTs; and iii) interventions where each PCTs/CTs public health priorities overlap and meet the shared health challenges.

Key Work Programmes

- Communicable disease (TB)
- Immunisations
- Smoking cessation
- Health Checks / Vascular Prevention
- Obesity
- Sexual health

End of Life

NHS
South East London

Our end of life care model is patient-centred and is based on the “gold standard” care pathway with the end-of-life hospital care focussed on enabling people to choose where they die.

Key work programmes:

- Implementing the national end of life care pathway.
- Implementation of the Gold Standard Framework in all primary care providers and nursing homes in SELS
- Implement Liverpool Care Pathway (LCP) in acute settings

QIPP Risk Assessment Summary - update

NHS South East London

High Risk Financial saving< 25% achievable	Medium Risk Financial saving< 75% achievable	Low Risk Financial saving >90% achievable

BSU	2011/12 Saving per Operating Plan	Scheme Risk assessment			2011/12 Risk Assessed Savings
	£000	Green	Amber	Red	£000
Lambeth	13,626	4,837	8,138	651	11,613
Lewisham	14,893	4,870	6,751	3,272	10,898
Southwark	13,914	6,768	6,076	1,069	11,814
Bromley	8,995	5,532	1,470	1,991	7,232
Bexley	10,203	2,802	4,130	3,370	6,505
Greenwich	14,840	3,112	9,720	2,008	10,470
Total	**76,470**	**27,921**	**36,285**	**12,360**	**58,533**
Percentage of Overall Scheme		**37%**	**47%**	**16%**	
Previously Reported		**30%**	**53%**	**17%**	

The risk assessed QIPP position would leave a potential gap of c£17.9m which will be bridged by a mixture of local and Cluster schemes. The cluster intention is to move to reduce operating costs to £55 per head which will address £15-18m of this gap. The planned investment to accelerate QUIPP schemes should deliver significant additional benefit – the business cases are currently being assessed, BSUs are also continuing to develop alternative plans which are subject to stocktake review commencing beginning of May.

Main schemes assessed as high risk:

- Lewisham – outpatient referral reductions £1.3m
- Bromley – referral management centre £1.7m
- Bexley – unidentified QIPP £2.9m

QIPP Closing the Gap

South East London

The results of the Cluster challenge process was as follows:

- Very mixed in terms of planning processes and
- A lack of mature implementation plans in some cases
- There was a need to inject capacity at BSU level
- A need to engage more with providers
- A need to clarify responsibilities for delivery of QIPP schemes at BSU and Cluster level.

The following steps are being taken to close the QIPP gap:

Locally:

- Revisit Green rated schemes to see if stretch targets could be achieved
- Revisit Amber and Red Schemes to establish reason behind the rating and use local 2% to assist in delivery
- Review 2012/13 schemes to identify potential for bringing forward into 2011/12
- Review LES schemes
- Significant work with GP Commissioners re decommissioning and demand management delivery to secure “buy-in”
- Develop further plan B schemes by end of May 2011.

Cluster:

- Develop acceleration of estate and running costs rationalisation to deliver an average Commissioner running cost of £55 per head which will produce a c£15m reduction in 2011/12
- Ensure Cluster projects have capacity to deliver and consider means of early delivery
- Develop further Plan B schemes by end of May 2011

SUMMARY AGENDA

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

SUMMARY AGENDA
Thursday 19th May 2011

BM/001/11	3.00	**Welcome & Introductions**		Caroline Hewitt
BM/002/11	3.05	**Apologies for Absence**		Caroline Hewitt
BM/003/11		**Declaration of Interests**		All
BM/004/11	3.10	**Matters Arising not on the agenda**		Caroline Hewitt
BM/005/11	3.15	**Governance**	ENC 1-5	Simon Robbins
BM/006/11	3.30	**NHS SEL Business Plan & Corporate Objectives**	ENC 6	Tony Read
BM/007/11	3.40	**Integrated Plan**	ENC 7	Gill Galliano
BM/008/11	3.55	**Emergency Planning & Business Continuity Policy**	ENC 8	Dr Ann-Marie Connelly
BM/009/11	4.05	**Minutes of previous PCT Board meetings**	ENC 9	PCT MDs
BM/010/11	4.15	**Pathfinder Development & Delegation**	ENC 10	Gill Galliano
BM/011/11	4.35	**Local Clinical Commissioning Committees**	(See ENC 1)	LCCC Chairs
BM/012/11	4.45	**Performance & Quality**	ENC 11	Jane Schofield
BM/013/11	4.55	**Finance Report**	ENC 12	Marie Farrell
BM/014/11	5.05	**Quality Report**	ENC 13	Dr Jane Fryer
BM/015/11	5.15	**London Review of Cancer Services**	ENC 14	Andrew Eyres
BM/016/11	5.25	**Pharmaceutical Applications Panel**	ENC 15	David Sturgeon
BM/017/11	5.30	**BEXLEY CARE TRUST** To discuss progress on the QMS Campus Outline Proposal	ENC 16	Dr Joanne Medhurst/ Pamela Creaven
BM/018/11	5.45	**BEXLEY CARE TRUST** Business Case and transfer of £2.4 million to the Local Authority for Social Care	ENC 17	Dr Joanne Medhurst/ Pamela Creaven
BM/019/11	5.45	**LAMBETH PRIMARY CARE TRUST** Lambeth PCT & Southwark PCT Community Services Integration at GSTT	ENC 18	Andrew Eyres
BM/020/11	5.45	**BROMLEY PRIMARY CARE TRUST** Local Pharmaceutical Service Continuation of Designation	ENC 19	Dr Angela Bhan
BM/021/11		**Chair's Report**	ENC 20	Caroline Hewitt
BM/022/11		**Chief Executive's Report**	ENC 21	Simon Robbins
BM/023/11		**Director of Public Health Briefing**	ENC 22	Dr Ann-Marie Connolly
BM/024/11	5.50	**Any Other Business**		
BM/025/11	5.50	**Questions from the Public**		Caroline Hewitt
BM/026/11		**Date of Next Meeting**		
BM/027/11		**Close**		