Transforming Community Services: the establishment of NHS BIRMINGHAM EAST AND NORTH Community Health Services as a Direct Provider Organisation within NHS Birmingham East and North

1. Introduction

In January 2009, the PCT Board considered the future role the Operations Directorate plays in the community health services market and agreed that in light of the significant benefits realised from having a close relationship with our own community service, and the need to consider, from a commissioning perspective the future nature and shape of community service provision, we should at this stage, be circumspect in future structural arrangements and positioning of provider services.

This approach is endorsed by National Policy: *Transforming Community Services – Enabling New Patterns of Provision* (DH Jan 2009), which clearly articulates the benefits of taking a considered and coordinated approach to the future positioning of services within our community provider portfolio. The guidance makes clear that improving community services is a whole-systems challenge and not one solely for PCT provider services arms. It points out that, from a commissioning standpoint, it is up to the PCT, with the assistance of Practice-based Commissioners and other co-commissioners (such as Local Authorities), to determine the context within which the local community health services supply side (re)organises itself.

Transforming Community Services – Enabling New Patterns of Provision (DH Jan 2009), also indentifies the potential options for future organisational form of PCT Provider services which range from remaining under the umbrella of the PCT as a Direct Provider Organisation (DPO) to options which see PCT Provider Services either integrating with other existing NHS Organisations or standing alone as an enterprise independent from the PCT[1]. Where PCTs choose for their Provider to become a Direct Provider Organisation, they are required, to consider and keep under regular review, at least annually, the viability of directly provided services and attendant financial and/or service risks. Therefore DPO as an organisational form will necessitate the PCT going through a rigorous annual process in order for its commissioning business to demonstrate contestability.

[1] Form options include CFT, Social Enterprise or a commercial enterprise

1.1 What is a Direct Provider Organisation (DPO)?

- A Direct Provider Organisation (DPO) sees the Community Health Services of NHS Birmingham East and North becoming a discreet business unit within the PCT.
- The PCT is required to demonstrate that it is treating the DPO no more or less favourably than any other provider with which it contracts for the provision of services.
- The PCT Board, in essence, will govern 2 businesses, the Commissioning Business and the Provider Business. Clear lines of separation will exist between the two businesses and as such governance arrangements, currently in place across the PCT, will need to be reviewed.
- The PCT Board is required to achieve a state where they can operate their commissioning and provider business separately based on the same business and financial rules as applied to all other providers. As a minimum providers will need to prepare to work in a commercial environment.

2. Shaping our Future: Programme of Change to secure business readiness

To support the provider business of the PCT to take its place in the Market, the PCT board sponsored a significant programme of change. **Phase One** of the Programme commenced in October 2007 with a robust review of the 33 service lines within the provider portfolio. This review resulted in a small number of service lines being decommissioned and all remaining services lines having a clear development path which supports them to increase their competitive position.

Phase Two of the programme commenced in December 2008 and focuses on the internal separation of the commissioner and provider business functions of the PCT which, in line with the rules of collaboration and competition (Operating Framework 2008/09), aims to achieve greater transparency between the purchaser and provider relationship. In essence, Phase Two sees the PCT putting in place the associated governance and infrastructure required to run two discreet businesses governed by one PCT Board.

Since commencing **Phase Two** of the programme, DH Guidance *Transforming Community Services – Enabling New Patterns of Provision* has been released. The guidance adds clarity to the expected future positioning of PCT Provider services and the definition of business

capabilities required of community provider organisations of the future. The guidance introduces the term '*business ready*'. There is requirement that Provider Services are significantly *business ready* by April 2009 and fully *business ready* by October 2009 and that a robust options appraisal should be conducted (and led by the PCT commissioner) to inform decisions regarding the configuration and positioning of all services within the provider business. SHAs are to assure that the options appraisal follows due process. Once decisions regarding the future configuration and form of services within the provider portfolio have been made, further criteria are to be achieved which enable the Provider (or services within the portfolio) to achieve the business capabilities required of the chosen organisation form(s).

This paper concerns itself with **Phase Two** of the Programme (internal separation of business processes) dealing with two main components: the governance arrangements to be put in place between the PCT Board and the DPO, and the progress the DPO is making in achieving business ready criteria.

Before turning to the two main components, it is important that some **naming conventions** are addressed and agreed, as documentation relating to the governance of the provider business of the PCT will need reflect the names used to define the provider business.

- The provider business of the PCT is currently known interchangeably as the Provider arm and the Operations Directorate. In line with its current positioning as a business within the PCT it is proposed that the Provider Operations Directorate be known as Community Health Services within NHS Birmingham East and North ie NHS Birmingham East and North, Community Health Services. This naming convention is similar to that of other PCTs who have chosen to retain their Provider Service as a DPO

- A shadow Community Health Services Committee was established in 2007 and is known as the Provider Arm Committee. It is proposed that the name of this committee should be changed to Community Health Services Committee

For the purposes of consistency, the proposed names shall be used throughout this document and within the attached governance documentation. Such names can be changed if the PCT Board chose not to accept the naming proposals.

Action: The PCT Board are asked to consider and approve the above naming conventions

2.1 NHS BEN Community Health Services Governance arrangements

In January 2009, the PCT board agreed that the provider business of the PCT should review and establish it governance arrangements which ensure that it is able to act as a discreet business within the PCT. The review of governance arrangements would see the existing Community Health Services Committee membership and terms of reference being amended to reflect its role as governing the community health services business. The Board agreed the scope and level of freedom to be delegated to the Community Health Services Committee and the resultant development required to assure the PCT Board that robust governance mechanisms are put in place which allow the Community Health Services Committee to effectively govern the Community Health Service business and for the PCT Board to discharge its accountabilities as accountable officers of the Community Health Services business. These developments are now complete and are presented to the Board for consideration and approval. Following this approval, the agreed governance arrangements will be implemented. A record of the freedoms afforded to the Community Health Services alongside the resulting actions and progress against those actions are presented in detail in **Annex 1** of this document. A summary of the key actions are located in **Table 1**

Table 1: Summary of Key Actions

To develop a memorandum of understanding between the PCT Board and Community Health Services Committee
To put in place an accountability agreement between the CEO and Director of Community Health Services
To develop an insert to the PCT scheme of delegation which reflects the change of position and level of delegated powers to the Community Health Services Committee
To revise the terms of reference and membership of the Community Health Services Committee
To put in place a development plan for the Community Health Services Committee which enables the committee to discharge its responsibilities
To ensure SLAs are in place for clinical services
To develop and agree SLA's for corporate services
To develop the sub-group structure of the Community Health Services Committee
To agree the format and timing of the Provider completing the statement on internal control which will inform the statement on internal control completed by the PCT Board
To put in place an assurance and escalation framework both between the PCT Board and Community Health Services Committee and the Community Health Services Committee and its services
To develop a financial protocol which clarifies how deficits and financial surplus will be managed

2.2 Progress against the above action plan

A. The following governance documentation has been developed in line with 'business readiness' requirements and reflect the delegated freedoms agreed between the PCT Board and Community Health Services Committee in January 2009. The documentation has been developed in conjunction with Partnerships UK and their legal advisors, Capsticks. The memorandum of understanding is the overarching agreement between the PCT Board and sets out the function of each of the subsequent documents.

Action: The PCT Board are asked to consider and approve the adoption of the following governance documents:

i. The memorandum of understanding (Annex 2a)

ii. Terms of Reference for a Community Health Services Committee (Annex 2b)

iii. The Scheme of Reservation and Delegation (Annex 2c)

iv. Governance Subcommittee Structure (Annex 2d)

B. Membership of the Community Health Services Committee has been discussed with the CEO, Chair and NEDs of the PCT. Two PCT Board non-executive members are to be members of the Community Health Services Committee, one of which shall chair the Community Health Services Committee and focus solely on Community Health Services business. To secure the relevant balance of skills and independent scrutiny, the Community Health Services Committee will also secure the skills of an independent lay member(s), one of whom will bring commercial skills. A role description for the lay member will be developed as a first order task and consideration will be given regarding the tenure of the lay member position. Executive membership will comprise the Director of Community Health Services, The Director of Finance, Director of HR and the Director of Nursing and Clinical Development or her deputy. Chinese wall principles will be operated by those members of the Community Health Services Committee who are both members of the Provider and Commissioner businesses. The membership has been expanded to include the HR Director since the draft TOR was presented to the January PCT Board for consideration in January. This decision has been informed by examining the transformation journey ahead of us which involves a high degree of change management and workforce development. The

introduction of the HR Director on the Community Health Services Committee will provide the balance of skills and competence needed to lead and govern the CHS business. The introduction of an addition executive position on the committee impacts on the balance of independent membership, in that the Community Health Services Committee will comprise 4 executives and 3 independent members, of which 2 are NED's. As a result of discussions with the Board Chairman When the PCT Board recruits to its NED vacancy a third NED will participate as a committee member. Whilst good practice suggests that independent members should outweigh executive members by one member, pragmatism and economics leads us to treat the Community Health Services Committee as all other committees within the PCT in relation to the number of NEDs allocating time to the CHS Community Health Services Committee. The impact of the arrangements on the Community Health Services Committees ability to effectively govern the CHS Business will be kept under ongoing review.

Once the membership and supporting governance documentation has been agreed with the PCT Board, a development programme will be designed (in conjunction with Vista and PUK) to ensure the Community Health Services Committee is able to effectively govern the CHS business in line with its delegated responsibilities and accountabilities. It is intended that the internal audit programme for CHS will include a review of the effectiveness of the Community Health Services Committee six months into operation.

Action: The PCT Board are asked to approve the Community Health Services Committee Membership

C. To secure effective governance arrangements, the Community Health Services Committee will need to develop sub groups which focus on specific aspects of the CHS business. It is felt that the PCT Audit and remuneration Committee should consider both the business of the PCT Commissioner and CHS, operating its agenda in two distinct parts. CHS business considered by the audit committee will not be presented directly to the PCT Board unless it is from a commissioning standpoint and is in line with the way the committee reports the performance of other providers. The Integrated Governance and Performance Committee will consider matters relating to the CHS only where they have a commissioning focus or where a full organisation impact is evident. The proposed Community Health Services Committee sub-group structure is based on agreements with the PCT Board that such groups should be formed only where they are add value and where it was not appropriate to utilise an existing subcommittee or sub group. This was to avoid duplication, contain costs and make best use of the time of the skilled people involved. **Annex 2d** presents a map of

the relationship between the PCT Board and its sub-committees and the relationship between the Community Health Services Committee and its proposed sub-groups. The terms of reference of all relevant PCT sub-committees will be reviewed to reflect the changes proposed in this paper. Any resultant development needs will be addressed to ensure that sub-committees are able to operate within the rules of collaboration and competition.

Action: The PCT Board are asked to approve the sub-committee structure, proposals to review the Terms of reference of existing subcommittees and reporting arrangement

D. The Community Health Services Committee will utilise the PCT committee reporting format to report its activities to the PCT Board. The risk profile of CHS is being reviewed to reflect its development as a business ready organisation. The Community Health Services Committee will adopt the PCT assurance process. The risk profile of CHS will be presented to the PCT Board in line with this process.

Action: The PCT Board are asked to approve the proposed Community Health Services Committee reporting arrangements to the PCT Board

E. A statement on internal control (SIC) will be developed by CHS and agreed with the Community Health Services Committee one month prior to the PCT SIC being developed. The Community Health Services Committee will adopt the agreed PCT format for the SIC. The CHS SIC will be integrated into the PCT SIC

F. Clinical service contracts have been developed and agreed in partnership with the Commissioners of CHS. The Department of Health Community Contract has been utilised and forms a legal contractual platform for provision and performance management of community health services. The contract is for 3 years with year one allowing development of clarity on currency and pricing, which enables a move to an activity based costing model basis year 2 onwards.

The contract includes a rigorous reporting and review cycle which is as comprehensive as the contract with HEFT as an acute provider. Performance will be monitored against key performance and quality indicators. During the initial few months of the contract, Commissioner and Provider along with Corporate Support teams will develop metrics and reporting mechanisms.

A multilateral approach has been taken for the Community Contract as we provide some services cross city and others for PCTs on our borders. NHS Birmingham East and North commissions are the lead commissioner for the contract. The appropriateness of Bi Lateral contracts in the future will be considered as the community commissioning plan takes expression.

G. An overarching service level agreement has been put in place between Community Health Services and BEN Corporate Services. Individual corporate services schedules are included in the SLA which will allow monitoring and review of the services provided. The cost of the SLA for corporate services has been calculated and such costs will be used to inform the indirect costs of services within the provider portfolio. There is currently a discrepancy between the CHS allocated budget for corporate services and the calculated value of the SLA. In the main, this is felt to be attributed to the immaturity of the methodology used to estimate the volume of activity undertaken by corporate services on behalf of CHS. Work is underway to understand such costs and the method by which we will allocate these to individual service lines. It is also intended that the current overarching SLA should be reviewed six months into operation. The review process will be developed in the coming months in conjunction with the Directors of corporate services and agreed with the PCT Board prior to the review commencing

H. A financial protocol dealing with matters of CHS financial surplus and deficits has been developed and is presented in **Annex 3.** The protocol is based on the principles that CHS will have in place a robust financial strategy and management systems which will see CHS working towards a planned surplus secured through efficiency savings and taking a zero tolerance approach to a deficit position.

3. Achieving Business readiness

Business readiness comprises two separate but interdependent components:

- The internal 'technical' separation of critical business, financial and governance functions of the PCT as commissioner and the PCT as provider of services aimed at ensuring that CHS is treated no less or more favourably that other providers, and,

- The development of business processes and infrastructure which enable CHS to take its place in a contestable market of community health care provision.

In February 2009, DH released guidance to SHAs: *Internal Separation to Support Business Readiness in PCT Provision.* The guidance focuses primarily on the critical business, financial and governance issues facing PCTs and PCT

in-house Provider Services as they seek to internally separate their functions in the following areas:

- Relationship between PCT Board and Community Health Services Committee
- Integrated Governance & Board Assurance
- Business Operations and Financial Strategy
- IM&T systems
- Budgets, income & expenditure, balance sheets, cash flow
- Workforce
- Relationships with provider partners and commissioners of services

The Shaping our Future Programme is designed to ensure that NHS Birmingham East and North and more specifically, NHS Birmingham East and North CHS achieves the business readiness criteria by October 2009.

SHAs are mandated to develop the local criteria and assurance mechanisms by which they will assess PCTs, and in particular, PCT in-house Provider Services success in being fully business ready by October 2009.

There is a risk that the achievement of business readiness criteria is seen as a checklist exercise verses taking the opportunity to prepare individual services and the Community Health Services Provider as whole, to develop effective business processes which allow our CHS to take its place in the developing market. We need to ensure that progression through this process also enhances the quality of services and addresses inequalities. If we are to mitigate these risks, our approach to achieving business readiness must be transformational is nature and be guided by the following principles:

- The change programme will not distract from providing safe, efficient and high quality services to patients served by the CHS Staff

- That NHS Birmingham East and North CHS will be treated no more or less favourably than any similar provider

- Staff engagement (across all directorates of the PCT) is of upmost importance

- Duplication or increases in resource required to secure greater transparency between Commissioner and Provider functions of the PCT will only be approved where there is a clear business reason

- The Community Health Services Committee will be delegated increased levels of autonomy to make decisions on behalf of the PCT board as it develops increased competence in executive decision making

3.1 Progress against business readiness criteria

The business readiness criteria are based on those used by Monitor and are challenging to achieve. West Midlands SHA issued the first draft of their business readiness criteria in February 2009 in conjunction with their development partner, Grant Thornton, and is in the process of establishing a base line position of PCT in house provider services across West Midlands. NHS West Midlands has not, as yet, described how they will define the requirement to be 'significantly business ready' by April 2009.

The base line assessment of NHS Birmingham East and North Community Health Services took place in early March 2009 and early indications show CHS to be in the lower third of PCT provider services in respect of achieving the NHS West Midlands business readiness standards. However, NHS Birmingham East and North have chosen to take a well thought through approach to achieving the business readiness standards which will take expression following full consideration of the proposed governance and assurance mechanisms to be put in place which aim to assure the PCT Board that CHS committee is able to govern the operations business on behalf of the PCT Board.

The shaping our future programme plan guides the development needed to ensure CHS are business ready by the national target of October 2009. However, we feel that the most significant area of risk at this time is the achievement of the financial separation criteria which in essence sees the separation of financial management of the two businesses. This requires, amongst other things, the adoption of separate financial processes and procedures which are not without their challenges. These challenges and the suggested way forward are presented below.

3.2 Financial Separation

Financial separation enables both the CHS and Commissioning businesses of the PCT to firstly understand and manage their costs and liabilities but more fundamentally that, in the event of a competitive challenge both parties could demonstrate that the CHS is not in receipt of any advantage/disadvantage as a result of their relationship with the PCT.

The financial separation criteria are extensive, very detailed, challenging and costly to achieve. A detailed finance project plan is in place as a component part of the *Shaping our Future* programme plan. The SHA assessment of CHS progress against the financial elements of business readiness criteria reflects our approach to development, which is to fully consider the challenges and issues which such activities present, assess the options available to us against

Our agreed development principles (identified in **Section 3** of this paper), and take the most beneficial action once full consideration has been give to such options.

The business readiness criteria require the CHS and Commissioning Business of the PCT to present separate business accounts to an auditable level. This should include balance sheets, opening and closing cash and cash flow, clear control of income and expenditure and treatment of creditors and debtors, prepayments and accruals, assets and liabilities, cost of capital, and security of systems etc. The PCT needs to demonstrate the full cost of delivering each service in a standalone way and / or what it would cost to transfer the service if that decision were made.

To date we have established discreet cost centres associated with the CHS business to enable income and expenditure to be clearly distinguishable. The cost centres include the income streams (at individual commissioner level) and direct costs associated with the provision of services attributed to each service line. At present, indirect costs are held notionally at CHS Organisational level verses being attributed to individual service lines. Indirect costs for corporate support of community health services are currently not reflected in those indirect costs: However, the corporate services SLA will rectify that situation from 2009/10 when we will see these costs reflected within the CHS budget. The project plan takes account of the need to calculate the true cost of service provision which takes account of both direct and indirect costs. This work is scheduled to take place in the first half of the new financial year.

The Birmingham Primary Care Shared Service Agency finance team have advised the PCT on options to achieve ledger split, taking into account their experience with setting up SBPCT for autonomous running and a tender response for setting up a new ledger for a care trust. We are conscious that for NHS Birmingham East and North the options appraisal for the future configuration and form of services within the CHS portfolio could lead to different homes for different service lines, and as such, further derivatives of financial separation at service line level. We therefore need to be robust, yet prudent in our approach to developing the financial apparatus needed to

achieve the financial separation business readiness criteria. The following options are being considered:

- **Option 1 -** Continuing with the level of financial split (use of account codes) currently in place recognising the progress made in understanding our true detailed costs and the additional work planned in this area. Create reporting which will demonstrate the separate financial position. Make no additional technical split of the ledgers. The view from the SHA was this our current level of technical separation of ledgers would not deliver business ready status. The Director of Resources will be exploring this with them further.

- **Option 2** - Utilise existing ledger and implement analysis by grouping codes and cost centres and operate manual analysis. This maintains the current PCT level of balance sheet and control accounts for the legal entity. This is the fastest option to achieve if further technical separation is chosen and the least costly but does have a high level of analysis outside of the ledger. It would deliver:
  - An organisational view so that each business can be distinguished and reported upon using activity analysis as entities within the PCT.
  - Cost centres which are distinguishable between Provider and Commissioner/Corporate Services
  - A set of control accounts and a balance sheet for Provider and Commissioner/Corporate Services
  - Operate one bank account attached to the ledger for payments and deposits – operate two bank accounts externally and transfer between each to reflect true cash movement
  - Analysis of the payment runs / income by cost centre- operate 2 sets of control codes below the originating therefore audit trail is always accessible
  - Journal and transfer funds to bank account 2 to distinguish cash flow
  - Enhance ESR to set up appropriate reports, and also do specific journal and cash transfers.

Estimated cost of implementation based on estimates from the Shared Services Agency	**£21K**
Estimated ongoing cost 2 band 5 WTE	**£55K**

- **Option 3** Operate the NHS Birmingham East and North Ledger and make system changes to create two subsidiary companies each with

nominal ledger under the parent company NHS Birmingham East and North. Create a mirrored chart of accounts, a hierarchy and all sub ledgers for each subsidiary company. This will allow accounts to be created for each subsidiary company. Intervention is needed to then "sum them back up" to the PCT level.

Estimated cost of implementation based on estimates from the Shared Services Agency	**£90K**
Estimated ongoing costs in Shared Services Agency for operating system as 2 organisations and have accountants in the PCT finance teams capable of pulling the 2 ledgers back together to report for the PCT legal entity. Estimated pay cost increase	**£150K plus systems costs**

- **Option 4** Set up and Run two completely separate ledgers. NHS BEN ledger closes no longer live, therefore one of new organisations accept liabilities.

Estimated cost of implementation based on estimates from the Shared Services Agency	**£175K**
Estimated ongoing licence costs, maintenance and running 2 separate ledgers, and have accountants to pull the 2 ledgers back together to report for the PCT legal entity and finance teams to manage each ledger and the PCT overall position.	This could **double the current cost of the finance department**.

Advantages and disadvantages of each option

	Option 1	Option 2	Option 3	Option 4
Advantages	-No additional cost -No System changes	-Low cost -Low labour costs ongoing -No ongoing additional systems costs	-Completes much of the work needed to fully split ledgers -More automation of accounting -Separate ledgers beneath the nominal ledger -Creation of separate accounts enabled with less manual intervention -Reporting can be driven by the company code rather than cost centre codes	-Completes the work needed to fully split ledgers if the NHSBEN CHS remains as one entity -Real autonomy -Accounts generated from own ledger -Implementation and ongoing costs in place and reflected in correct company accounts
Disadvantages	-Not fully established if Business Readiness will be achieved in the view of the SHA and what consequences that will create. -Provides an analysed rather than an actual separation . -Open to challenge by other providers as being given an advantage by sharing ledgers, cash, and not taking the cost of managing finances.	-Manual intervention -Analysis outside the ledger of all aspects of work -All paperwork still NHS BEN not separately identifiable -Intervention to journal between the control accounts and to transfer cash between bank accounts	-Medium cost -Server space increases -Set up activity large -All paperwork still NHS BEN not separately identifiable -Maintenance and running business analysis change size medium -Duplication of work	-Highest cost -Server space greater -Longest time to achieve -2 sets of support costs from system provider -Provider function totally split off when not clear on final outcome

For all options:

- further work will be needed dependant on the outcome for services.
- new cost is associated with the options, and in each case it is unlikely to be the final position that is delivered.
- allows us to progress on establishing real understanding of costs from a pathway perspective.

3.2.1 Recommendation

Balancing the options available against the knowledge that the proposed method of achieving financial separation is an interim solution, it is felt prudent to choose the path which can deliver the minimum requirement for business readiness in the most timely and cost effective manner. As such, we recommend that the exploration of option one with the SHA is completed prior to a decision being taken. The Director of Resources should weigh the additional information from discussions with SHA and make a recommendation on the way forwards for agreement before the end of April. As this element is required before the next Board sits that the recommendation is taken to the CEO and Board Chair for a decision. Detailed plans are then developed to pursue the agreed option. The implementation plan will deliver the financial element of the business readiness criteria by the 1st October 2009. The actual cost of implementation will be calculated and presented to NHS Birmingham East and North Executive team for approval and to the PCT Board for information, alongside the implementation plan.

Action: The PCT board is requested:

- **to note the progress and challenges presented by achieving the financial element of the business readiness criteria**
- **Endorse delegating the decision from the Board to the Board Chair and the CEO on how to move forward on Financial Separation. This will be informed by the further information, analysis and recommendations provided by the Director of Resources and needs to be completed before the end of April**

4. Summary and next steps

This paper has presented the governance arrangements to be put in place which will enable CHS to operate as a discreet business within NHS Birmingham East and North and will allow the PCT to demonstrate that we are complying with the rules of collaboration and competition. Overall CHS is making steady progress toward achieving business readiness with many of the development associated with Phase 2 of the programme coming into fruition during April 2009.

Phase 2 of the Programme has focussed on establishing the infrastructure required to operate CHS as a DPO within NHS Birmingham East and North. The next stage of the programme **(Phase 3)** will focus on the development of the NHS BEN Community Health Services (in the first instance) as a contestable business whilst preparing services within the CHS business for market and in doing achieve business readiness criteria by October 2009. The

Programme plan for **Phase 3** is in development and will include, amongst other things:

- Securing a market position
  - Scanning the market and understanding our competitive position
  - Relationship management and partnering
- Development of the Performance management framework
  - Performance reporting at DPO and service level
  - Performance systems and data quality
- Infrastructure development
  - Separation and ownership of assets (systems and estates)
  - The development of the IM&T infrastructure requirements which will also include consideration of access to data and systems
  - Development of CHS Intranet site
  - Process for NHSLA accreditation
  - SfBHC accreditation
- Finance
  - Management of potential risk or ligation claims
  - Management of NHSLA costs
  - Management of Education and training contracts and associated funding
- Governance
  - PPI systems and practices
  - Population CHS assurance framework
  - Clinical Governance
  - Policy review process
  - Internal audit plans
  - Procedure for the recruitment of Community Health Services Committee members
  - Shared services agreements
- Corporate services review
- Options appraisal of the future configuration and form of provider services

The PCT Board are asked to:

1. consider and agree the proposed naming conventions identified in Section 2 of this paper
2. consider and approve the adoption of the governance documents located in Annex 2
3. approve the Community Health Services Committee Membership
4. approve the sub-committee and sub-group structure, proposals to review the terms of reference of existing sub-committees and reporting arrangements
5. approve the proposed Community Health Services Committee reporting arrangements to the PCT Board
6. to note the progress and challenges presented by achieving the financial element of the business readiness criteria and endorse delegating the decision from the Board to the Board Chair and the CEO on how to move forward on Financial Separation.

Annex 1: Degrees of freedom to be afforded to BEN Community Health Services

A ITEM 2.3

Domain	Actions	Progress	Status
Community Health Services Committee Role and Function			
The CHS Committee will concentrate on governing and assuring provider operations on behalf of the PCT board. In doing so its focus will be on strategy/development of the provider business, operations, risk and performance.	To be reflected in the Scheme of delegation between the PCT Board and Community Health Services Committee and TOR of Community Health Services Committee	Scheme of delegation and terms of reference developed	Complete
The Community Health Services Committee to be formally recognised as a sub-committee of the PCT Board	To be reflected in the Scheme of delegation between the PCT Board and Community Health Services Committee and TOR of Community Health Services Committee	Scheme of delegation and terms of reference developed	Complete
The TOR, Scheme of Delegation and membership of the Community Health Services Committee will reflect its role in governing the operations of Community Health Services	To be reflected in the Scheme of delegation between the PCT Board and Community Health Services Committee and TOR of Community Health Services Committee	Scheme of delegation and terms of reference developed	Complete
A memorandum of understanding will be developed and agreed between the PCT and the Community Health Services Committee	Memorandum of understanding to be put in place	Memorandum of understanding developed	Complete
Community Health Services Committee Membership and Development			
The Community Health Services Committee will be chaired by a NED	To be reflected in the TOR of the Community Health Services Committee	ToR developed The Community Health Services Committee will be chaired by a NED who will focus solely on CHS Business but will remain a member of the PCT Board This updates from January to create greater focus by the NED CHSC Chair on the Provider Function	Complete
The number of NED's and/or independent members should where practical and prudent, outweigh number of Executives by 1 member	To be reflected in the TOR of the Community Health Services Committee	ToR developed The CHS Committee will comprise 3 NEDs and at least 1 lay member. Consideration will be given to the appointment of a second lay member. (this represents a change to the January statement which identified that where possible the number of NEDs should, where practical, outweigh the number of execs by 1) a parity of 4 will be in place initially	Complete

Executive members will be agreed between Provider Director and CEO	To be agreed between CEO and Provider Director	Membership agreed and articulated within TOR	Complete
A CHS Committee development programme will be put in place in line with PCT Board development programme	Meeting to be secured with PUK and Vista to out in place a development programme	Meeting secured. To be progressed after PCT Board approval of key governance documentation	In progress
Assurance to be provided to PCT Board			
A Statement on internal control will be presented to PCT board a quarter in advance to PCT SIC being developed	Timescales and format of SIC to be confirmed.	Template for format to follow PCT format. Provider Director to discuss timing and process for development and submission with PCT Governance lead	In progress
A formal sub-committee report to PCT board will be put in place in line with PCT sub-committee reporting framework	Reporting framework to form part of the assurance framework	Framework to follow PCT format. First report presented to PCT Board in March	Complete
The PCT board may ask for additional reports on a case by case basis in response to identified issues.	To be reflected in the scheme of delegation	Scheme of delegation developed Freedoms will reflect Such reports should be based on the principle that the PCT Board wants to avoid surprises	Complete
An escalation system will be put in place to ensure PCT board is appraised on significant financial, operational and/or clinical risks in a timely manner in line with PCT risk management procedures	To be reflected in the scheme of delegation and assurance framework	Scheme of Delegation developed. Assurance Framework in development	In progress
Clinical Service performance with be managed via SLAs with Commissioners	Clinical Services SLAs to be put in place	SLA's for all Community Health Services in Place and agreed with Commissioners	Complete
Protocols for external and internal communications to be agreed.	Develop protocol of standards within communications strategy •	Communication Strategy developed in draft will be completed within Phase 3	In progress

AGENDA ITEM 2.3

Community Health Services Committee Sub-Committees/groups			
To prevent confusion, any group which is not a formally recognised sub-committee of the PCT Board will be known as a sub-group of the CHS Committee	To be reflected in Governance Documentation and naming conventions	Naming conventions addressed in PCT Board paper April 2009	Complete
The Community Health Services Committee can develop sub-groups of the Committee but only after notifying PCT Board of its intentions to do so	To be reflected in Scheme of Delegation and TOR for Community Health Services Committee	Scheme of delegation and terms of reference developed	Complete
The sub-group structure should not duplicate existing PCT Sub-Committees but should work with them to ensure that provider business is reported to the CHS Committee directly verses to the PCT Board by such sub-committees	To be reflected in proposed governance structures	Governance Structures developed	Complete
Decision making within sub-groups of the Community Health Services Committee can only be delegated to Community Health Services Committee Executive Officers or Senior officer's names by executive officer of the Community Health Services Committee. Where such delegation occurs, named Executive Officers of the Community Health Services Committee shall be appointed to act as the senior responsible owner for the sub-group.	To be reflected in the TOR of subgroups, scheme of delegation between the Community Health Services Committee and its sub-groups	TOR for subgroups to be developed once PCT Board have approved the governance structures	to commence in Phase 3
Treatment of Financial surplus and deficit			
Surplus			
CHS is to generate an agreed financial surplus each year. Unplanned surplus should be avoided through effective financial managements	Financial protocol dealing with the management of surplus and deficits to be developed and referenced within the Scheme of delegation between the PCT Board and Community Health Services Committee	Financial protocol developed This supersedes the Freedoms described in January around surpluses and better reflects the approach which would be taken to other providers	Complete
A mid range surplus will be agreed which will enable CHS to reinvest the mid range surplus in discussion with commissioners			
The top end surplus will be returned to commissioners at agreed time periods within year			
Deficits			
A deficit tolerance level for CHS will be set	Reflected in scheme of delegation and financial protocol	Financial protocol developed It should be noted that this freedom has been changed to state that there is a zero tolerance to deficits., however, where CHS are at risk of falling into deficit, they should comply with the protocol relating to the	Complete
Potential or actual breaches will be escalated to PCT Board in line with escalation procedure. A Recovery plan will accompany the reporting of a potential financial deficit	Financial protocol dealing with the management of surplus and deficits to be developed and referenced within the		

The PCT Board has the right to intervene if recovery plan milestones as not achieved	Scheme of delegation between the PCT Board and Community Health Services Committee	management of deficits and surplus	

Operational decisions: Corporate Services			
Detailed SLA's to be put in place between CHS and the existing PCT Corporate services which are to be reviewed in 6 months from inception	To be reflected in Scheme of Delegation between the PCT Board and Community Health Services Committee	SLAs developed and agreed with corporate support services	Complete
SLA's will secure a named relationship manager from each corporate support service function	to be included in the corporate services SLA discussion and agreements	SLAs developed and agreed with corporate support services	Complete
The review of SLAs will determine which corporate services should be transferred to CHS and/or which require separate arrangements to be put in place	Review process to be developed and agreed with the PCT Executive team	Project plan for the review of corporate services to be developed and agreed with the executive team	to commence in Phase 3
Community Health Services should not (in the short term) seek out support services from alternative providers if this results in destabilisation of existing PCT support functions	To be reflected in memorandum of understanding between PCT and Community Health Services	Memorandum of understanding developed	Complete
Operational Decisions: Service Portfolio			
The Director of BEN DPO should seek the authority of the CEO if it wishes to respond to tenders for additional services or increased volume of existing services. Decisions to respond to tenders will be supported by a robust business case	To be reflected in the accountability agreement between the CEO and Provider Director	Accountability agreement developed The Director of CHS should seek the authority of the CHS Committee and NHS BEN CEO if it wishes to respond to tenders for additional services or increased volume of existing services. Decisions to respond to tenders will be supported by a robust business case This changes from January to recognise the path via the CHS Committee	Complete
The Director of BEN DPO will seek authority of the CEO if Community Health Services wishes to cease the provision of existing services within the portfolio	To be reflected in the accountability agreement between the CEO and Provider Director	Accountability agreement developed The Director of CHS should seek the authority of the CHS Committee and NHS BEN CEO if it wishes to cease the provision of existing services within the portfolio (as above)	Complete

ANNEX 2 a

NHS BIRMINGHAM EAST AND NORTH

MEMORANDUM OF UNDERSTANDING BETWEEN BIRMINGHAM EAST AND NORTH PCT AND THE PCT'S COMMUNITY HEALTH SERVICES COMMITTEE ON THE PROPOSED GOVERNANCE ARRANGEMENTS TO BE PUT INTO PLACE TO CREATE A FORMAL INTERNAL SEPARATION OF THE PCT'S PROVIDER BUSINESS

A. INTRODUCTION

1. NHS Birmingham East and North ("the PCT") has established a Community Health Services Committee ("the Community Health Services Committee") in accordance with the following documents:

   a. The PCT's Board Report on its Provider Service Development Strategy [(2008)]; and

   b. The Department of Health's Operating Frameworks for 2008/09 and 2009/10; and

   c. The Department of Health's paper on the "Principles and Rules for Cooperation and Competition; and

   d. The Primary Care Trust's Standing Orders and Standing Financial Instructions; and

   e. Department of Health Guidance "Transforming Community Services".

2. It is clear that the PCT needs to create as much autonomy as it can for its provider business to enable it to be put on a much fairer and more equal footing with other third party providers in the market-place. This meets the objectives of the Department of Health which is trying to create a dynamic market place in which the PCTs have a clear focus on commissioning but ensure that they encourage providers who deliver a high quality and value for money service.

3. This Memorandum of Understanding sets out the background to the proposed separation, how the separation will be achieved including the documents needed and a brief explanation of those documents and also how the PCT and its Community Health Services Committee will work together

B. BACKGROUND

1. The PCT has been working on the issue of separation now for some time and has been supported by Partnerships UK ("PUK") on this work. One of the areas that has particularly concerned PUK and the PCTs in the PUK programme is governance. Governance is key in any organisation but it is even more important in circumstances where an internal separation of a business is being undertaken, where delegation of functions takes place and which

involves decision-making outside of the PCT's Board. It is the intention that the proposed internal separation involves very clear delegation of responsibility. The Board of the PCT needs to firstly understand the nature of this delegation and, secondly, that, as the Board will remain ultimately accountable for the actions of the provider business, there are enough checks and balances built into this delegation to enable the Board to continue to fulfil its own obligations as a PCT Board.

2. The PCT will be more comfortable with the concept of significant delegation to its Community Health Services Committee if the governance arrangements are robust. For example, if the members of the Community Health Services Committee are of a high calibre, including having independent "non-executive" members who are able to challenge the provider business in a strong but supportive way, then the PCT Board will be more comfortable with significant delegation.

3. The PCT has considered a more detailed Discussion Paper on various governance issues relating to the issue of separation including dealing with key concepts, such as how delegation works, the use of committees to establish separate provider businesses and duties and obligations of PCTs. This Memorandum of Understanding explains how the PCT in particular is continuing to create the separation it needs to meet the Department of Health's time table requirements and the documentation it will need to put into place to achieve this and other related issues.

C. KEY DOCUMENTS TO EFFECT THE SEPARATION

1. Description of the Proposed Separation Arrangements

The following arrangements will enable Community Health Services to achieve the necessary internal separation for the PCT;

a. The establishment of a committee comprising, both "executive" and "independent members" to manage the provider business Community Health Services Committee. The establishment of the Community Health Services Committee is evidenced by the TERMS OF REFERENCE as set out in Annex 2b

b. The PCT will delegate to the Community Health Services Committee (and this Community Health Services Committee will be empowered to then delegate further to individual Committee members) certain functions and powers in relation to the management and operation of the provider business. This delegation will be evidenced by the SCHEME OF RESERVATION AND DELEGATION set out in Annex 2c.

c. The PCT will enter into a COMMUNITY SERVICES CONTRACT with the Community Health Services Committee in the form of the Department of Health's standard Community Services template which sets out the services to be provided and the budget

to be made available to do this. Issues such as quality and performance management requirements will also be dealt with. Further, the CORPORATE SERVICES SLA will set out what other support, such as HR, informatics and financial support both the PCT and the Community Health Services Committee, it will provide to the other to enable it to function.

d. The Community Health Services Committee acknowledges that it needs good governance mechanisms in place to enable it to stay in control of its business, just like the PCT itself. The basis of a good governance infrastructure will be the Terms of Reference, the Scheme of Delegation and a set of STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS ("SOs"). The Community Health Services Committee shall make use of the PCT's current SOs as a base for its own SOs, but a separate set of SOs shall be specifically created in due course for the Community Health Services Committee.

e. In the same way that the NHS Accounting Officer issues a Memorandum of Accountability to PCT Chief Executives in relation to a Chief Executive's particular responsibilities for financial, probity and regulatory matters, it is appropriate for a similar COMMUNITY HEALTH SERVICES ACCOUNTABILITY MEMORANDUM to be entered into between the PCT Chief Executive and the Director of Community Health Services.

2. **Brief Comments on each of the Documents**

a. **Terms of Reference**

i. **Functions and Membership**

The Terms of Reference set out the remit and functions of the Community Health Services Committee. Further the Terms of Reference also set out details about the membership of the Community Health Services Committee. This can be considered both in terms of competencies needed and/or posts, such as the Provider Director, the person responsible for financial matters, clinical expertise etc, and in terms of actual individuals who will fulfil these roles. The Terms of Reference can set down how decisions will be made, how the Community Health Services Committee will report to the Board of the PCT, frequency of meetings, quorum, etc.

ii. **Non Executives**

The Terms of Reference reflect the Department of Health Guidance that Community Health Services Committees should look to ensure, where prudent, that non-executive officers exceed the number of executive officers. The parties acknowledge that this is currently hard to achieve but note that the Appointments Commission is working with the Department of Health to develop further guidance on this issue. Further, the Appointments Commission has confirmed that they are

providing advice and recruitment support to PCTs to help them with this issue including conducting campaigns to fully establish the PCT Boards where these have low numbers to recruit and independent members for the Community Health Services Committee. The benefit of recruits being found for the Community Health Services Committee by the Appointments Commission is that they can be seen as independent and made as a result of a transparent and vigorous process.

iii. **Conflicts**

Due to the fact that for a period of time the Community Health Services Committee will have members who are also on the PCT Board, it is possible that conflicts of interest may arise. In view of this, it is important that the Community Health Services Committee takes account of the potential for conflicts of interest to arise.

b. **Scheme of Reservation and Delegations**

i. The Scheme of Reservation and Delegation ("Scheme") sets out what functions are reserved to the PCT Board and what is delegated to the Community Health Services Committee. Currently PCT Schemes delegate certain issues to certain officers, such as the Chief Executive, and to certain Committees, such as the PEC or the Audit Committee. The key in relation to the Community Health Services Committee is determining and documenting what is delegated to it and then from the Community Health Services Committee (acting as a whole) to individual members of that Committee. Delegation is such an important issue that it needs thinking about carefully. Delegation involves the transfer of responsibilities and has an impact on potential liabilities and consequences both for the PCT and for individuals.

ii. Different approaches can be taken with Schemes but the PCT needs to consider its current Scheme and determine how best to amend it to ensure it reflects the reality of what is to take place and that it is practical and easy to follow and understand.

c. **Service Level Agreements**

PCTs are well-versed in putting in place SLAs with other NHS organisations and they will wish, in the first instance, to document their arrangements with the Community Health Services Committee in a similar fashion. The aim is to have an agreement in place with the Community Health Services Committee which would be similar to the arrangements it would have in place with any third party provider and therefore the SLAs need to be as robust as possible and in relation to the provision of community services based on the Department of Health Community Services template. At the same time, the SLAs must be practical and reflect what is actually able to be put in place at any given time and

clearly the terms of such an agreement could develop over time as "contractual" mechanisms are developed.

d. **Standing Orders**

The PCT's normal SOs are drafted in a way to apply to Committees as well as the PCT Board and therefore, it is possible, in the first instance, to use these SOs as being directly applicable to the Community Health Services Committee. However, it is appropriate and sensible to begin the process of tailoring and creating a bespoke set of SOs so that they reflect the Community Health Services Committee's business, even if they are based on the PCTs SOs. These can be documented as a subset of the overall PCT Standing orders

e. **Community Health Services Accountability Memorandum**

This document has been designed so that it operates in a back-to-back fashion with the document that applies between the NHS Accounting officer and the PCT Chief Executive, so that the Director of the Community Health Services is clear about his/her duties. Further, this document could be used to pull together any other governance strands that may need to be mentioned in connection with the arrangements apply.

D. REVIEWS

The workings of this Memorandum of Understanding shall be reviewed at regular meetings between the authorised officers of the Parties and such other persons as the authorised officers shall agree and the Parties agree to consider at such reviews the issues referred to in Appendix 6.

E. STAFF

1. To the extent needed and agreed in accordance with the Scheme of Reservation and Delegation, as subject to the reporting requirements agreed with the PCT the Community Health Services Committee may recruit and employ or engage such staff as may be consistent with the provisions of this Memorandum of Understanding for the administration of the business of the Community Health Services.

F. AUTHORISED OFFICER

1. The Parties may each appoint a person to be their authorised officer for the purposes of this Memorandum of Understanding. Such person and any replacements shall be notified to the other Parties.

G. CONFIDENTIALITY

1. Each of the Parties shall not, and each party shall ensure that their staff do not, disclose to any person other than a person authorised by the relevant party or Parties, any information of a confidential nature received, or acquired by them, in connection with this Memorandum of Understanding, including without prejudice to the generality of the foregoing:

   a. financial or other confidential information about or relating to the other party;

   b. the identity of any patient; or

   c. the medical condition of or the treatment received by any patient.

2. The Parties agree to comply with any NHS guidance on patient confidentiality.

3. Nothing in this Memorandum of Understanding shall prevent them from complying with their duties under the Freedom of Information Act 2000.

H. DATA PROTECTION

1. The Parties shall at all times work co-operatively together in relation to the use of personal data and the requirements of the Data Protection Act 1998 including ensuring that appropriate technical and organisational security measures are taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

I. DISSOLUTION

1. In the event of a dissolution of the Community Health Services Committee for any reason:

   a. The Parties shall co-operate to secure an efficient transfer of the arrangements to new arrangements with minimum disruption

2. The Parties shall work together and use all reasonable endeavours to resolve and deal with any other implications of the dissolution including dealing with the transfer and keeping of records.

J. DISPUTE RESOLUTION

1. In the event of a dispute arising out of this Memorandum of Understanding the Authorised Officers of the Parties shall use all reasonable endeavours to resolve any such dispute.

2. If the Authorised Officers of the Parties are unable to resolve any dispute within twenty working days of the dispute arising, the matter shall immediately be referred jointly by the Parties to the Chairman of each of the Parties.

3. If the persons referred to in 2 above are unable to resolve any dispute, then any party may seek the assistance of a mutually agreed mediator or if the Parties agree attempt to settle it by mediation in accordance with the Centre for Dispute Resolution ("CEDR") Model Mediation Procedure.

K. NOTICES

1. Any notice or other document to be served on any party under the provisions of or in connection with this Memorandum of Understanding shall be sufficiently served if it is hand delivered to the authorised officer of the other Party.

L. AUDIT

1. Each Party shall provide the others with such audit and other information as they each may reasonably required, to answer all reasonable enquiries raised by other persons in relation to the workings of this Memorandum of Understanding.

M. INTELLECTUAL PROPERTY

1. The Parties agree that if any intellectual property is likely to be developed in connection with or related to this Memorandum of Understanding they will agree beforehand in writing how such intellectual property might be used

N. PLAN OF ACTION FOR PERIOD BETWEEN NOW AND 1st OCTOBER 2009

1. The proposed plan of action between now and 1st October 2009 is for the PCT and the Community Health Services Committee to continue to develop the Provider business and achieve business readiness requirements. This includes agreeing a "road map" for achieving the requirements of "Transforming Community Services" including agreeing with the SHA the future of Community Health Services. The PCT understands that the "direction of travel" of the Department of Health is to have significant levels of delegation and autonomy for PCT provider businesses and that needs to be achieved sooner rather than later. However, the PCT does need to ensure that significant delegation is accompanied by good governance arrangements, which will provide the necessary comfort to the PCT Board that the Community Health Services Committee will stay in control of its business.

Each party or its duly authorised representatives have signed this Memorandum of Understanding on the date set out below.

SIGNED by)
for and on behalf of NHS Birmingham East and North Board)
[ ]Primary Care Trust)

SIGNED by)
for and on behalf of the Community Health Services Committee at)
[ ]Primary Care Trust)

ANNEX 2b

NHS Birmingham East and North

Terms of Reference for a Community Health Services Committee

1. Introduction

NHS Birmingham East and North ("the PCT") has established a Community Health Services Committee ("the Community Health Services Committee") in accordance with the following documents:

(a) The PCT's Board Report on its Provider Service Development Strategy [(2008)]; and

(b) The Department of Health's Operating Frameworks for 2008/09 and 2009/10; and

(c) The Department of Health's paper on the "Principles and Rules for Cooperation and Competition; and

(d) The Primary Care Trust's Standing Orders and Standing Financial Instructions; and

(e) Department of Health Guidance "Transforming Community Services"

2. Remit and Functions of the Community Health Services Committee

The remit and functions of the Community Health Services Committee shall be as follows:

(a) To be responsible for on behalf of the PCT and in accordance with delegated authority from the PCT pursuant to these Terms of Reference and the PCT's Scheme of Reservation and Delegation, for governing all operational Community Health Services of the PCT;

(b) The above mentioned services shall include planning, organising and delivering Community Health Services in accordance with service level agreements agreed or to be agreed with the PCT and other commissioners with whom contracts/SLAs have been agreed and which services shall be provided and based on the same business and financial rules as the PCT applies to all other providers;

(c) To know its business, and understand the intention of its commissioners, to carry out consultations with stakeholders and to provide a detailed business plan;

(d) To consider with the PCT future appropriate organisational forms for Community Health Services including those referred to in "Transforming Community Services";

(e) The Community Health Services Committee shall carry out its activities in relation to Community Health Services in accordance with the same duties and obligations which the PCT is required to carry them out pursuant to any legislation or other requirements including the duty to act efficiently, effectively and economically;

(f) Attached to these Terms of Reference is an extract from the PCT's Scheme of Reservation and Delegation which sets out in more detail the functions which have been delegated to the Community Health Services Committee.

3. Membership and Decision Making

(a) The Committee will be appointed by the PCT Board except where otherwise stated or agreed and will comprise:

(i) The Director of Community Health Services

(ii) The Director of Finance - responsible for the financial matters of Community Health Services

(iii) The Director of Nursing and Clinical Development (or her Deputy who would not have voting rights but could advise) - A person responsible for clinical governance and overall clinical professional leadership.

(iv) The HR Director – responsible for issues of staffing and transition

(v) The Committee will look to secure independent scrutiny through the appointment of three non-executive officers and at least one independent lay member to add a balance of skills to the executive team.

(vi) The committee will be chaired by a non-executive officer. The Committee will work towards having, as soon as practicable, no overlap between members of the PCT Board and members of the Community Health Services Committee and in the meantime members of the Community Health Services Committee who are also on the PCT Board shall have particular regard to the issue of conflicts of interest and they shall step out during discussions that represent a conflict of interest in accordance with the PCT's Standing orders.

(b) The Community Health Services Committee shall at all times have regard to determining and re-assessing the number of non-executive officers required and the skills and levels of experience they and the Chair of the Community Health Services Committee need to ensure a well balanced Community Health Services Committee.

(c) The Community Health Services Committee shall maintain a list of officer affiliations and financial interests in accordance with the PCT’s Standing Orders.

(d) The Community Health Services Committee will operate in accordance with PCT’s Standing Orders and Standing Financial Instructions as amended by the Community Health Services Committee in agreement with the PCT Board and in accordance with Scheme of Reservation and Delegation that the Community Health Services Committee may put into place in relation to its own activities.

(e) Subject as set out in the Standing Orders, Standing Financial Instructions referred to in (b) above, decisions on recommendations will be reached by consensus where possible. Where there is not unanimous agreement, a simple majority will be sufficient and a vote shall be taken and the result recorded. The Non-Executive Chair of the Community Health Services Committee will have the deciding vote if applicable. Staff and others in attendance who are not members of the Community Health Services Committee shall not have voting rights.

(f) The Community Health Services Committee is a committee of the PCT Board and any payment to members will be in accordance with Department of Health guidance or instructions where applicable or otherwise in accordance with the PCT’s powers.

4. Relationship with the Boards

(a) The Community Health Services Committee will not be required to present its minutes to the Board. It is acknowledged that the Board is ultimately accountable for the actions of the Community Health Services Committee and that therefore the Community Health Services Committee and the Board will agree appropriate reporting and other mechanisms to ensure that the Board is able to manage the PCT's business and stay in control of the organisation including agreeing flows and timings of information between them. Any such mechanisms shall be incorporated into any relevant Service Level Agreements between the PCT and the Committee and/or the PCT's Scheme of Reservation and Delegation. Any Community Health Services Committee reports should be submitted to the PCT Board in advance of any dates which the PCT itself needs to comply with and where the PCT needs to take account of Community Health Services Committee reports. So for example, Community Health Services Committee Statement on Internal Control may be required in the quarter period before the quarter in which the PCT Statement on internal control is due.

(b) The Community Health Services Committee shall:

(i) provide any information which it has to the PCT Board and which the PCT Board considers is necessary for it to receive and to comply with any requirement of the Secretary of State or the PCT's Strategic Health Authority;

(ii) comply with any requirements of the PCT Board which the PCT Board reasonably believes are in the best interests of the PCT having regard to its functions and duties;

(iii) comply with PCT policies and procedures where this is appropriate and the Community Health Services Committee does not have similar policies or procedures in place;

(iv) wherever possible, undertake business, internal reporting and external reporting in the manner of an autonomous organisation;

(v) keep in place an audit process for its business by ensuring that agenda items on the main PCT audit committee are kept separate;

(vi) comply with such work guidance as may be issued by the Department of Health in relation to the operation of the Community Health Services Committee including guidance issued by the Appointments Commission;

(vii) have the ability to set up and delegate to sub-groups of the Community Health Services Committee [subject to it notifying the PCT Board] and provided that the Community Health Services Committee has regard to sub committees already operational so as not to create unnecessary duplication;

(viii) only delegate individual decision making responsibilities to executive officers and not non-executives;

(ix) sign a statement on internal control in relation to its Provider Business in accordance with the Department of Health's guidance and any required assessment of the Community Health Services Committee's assurance framework in relation to providing reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the Community Health Services Committee. In this respect the Community Health Services Committee shall follow and comply with the Department of Health's annual requirements in relation to Statements of Internal Control as well as its March 2003 Guidance "Building the Assurance Framework: A Practical Guide for Boards" and the Department of Health's "Integrated Governance Handbook February 2006" on the subject; Any new guidance publish must be taken into account which supersedes any of the detailed documents.

(x) report to the PCT Board on a regular basis as agreed in relation to its development and operation generally including in relation to its assurance framework and the Community Health Services Committee shall respond to such other assurances as the PCT may reasonably require;

(xi) report on its management of and its performance under the Community Health Services Committee's SLA with the PCT in relation to the provision of services to the PCT.

(c) Strategy, Plans and Budgets:

(i) The Community Health Services Committee shall use all reasonable endeavours to generate an agreed level of surplus and to agree with the PCT a mechanism to enable in-year surpluses (in excess of an agreed threshold) to be reinvested by the Community Health Services Committee subject to meeting service commitments defined within SLA's with the Commissioners. The management of surplus and deficits are governed in the NHS BEN and NHSBEN CHS surplus and deficits protocol which will be reviewed, as a minimum, on an annual basis.

(ii) It is agreed that:

(a) as part of the Provider SIC assurance arrangements referred to above, tolerance limits would be set which, if breached, would trigger an early warning signal to the PCT Board from the Community Health Services Committee. Amongst other things, early warning signals would cover any serious risk of clinical, corporate or financial failure, including a serious risk of breaching the control total set for the provider by the PCT.

(b) The PCT Board would first provide provider management with an opportunity to rectify the situation by submitting a recovery plan, and demonstrating progress against it.

(c) In the event any milestones in the recovery plan are missed, the PCT Board shall reserve the right to intervene directly by *inter alia*:

- Removing or replacing the chair/non-executive members of the Community Health Services Committee;
- Removing or replacing the executive members of the Community Health Services Committee;
- Requiring an independent audit of provider operations; and/or
- Dissolving the Community Health Services Committee.

(d) Operational Decisions

(i) It is acknowledged that the Community Health Services Committee currently does not have the resources it requires to run all its operations effectively, particularly in the areas of finance and information. It was agreed that as a starting mechanism, relatively detailed Service Level Agreements would be drafted with the PCT's corporate support services, enabling named individuals to be identified to work with Community Health Services in key corporate support functions.

(ii) It was also agreed that this arrangement should be reviewed within 6 months to determine if some functions should be transferred over to the provider entirely (i.e. reporting into the Director of Community Health Services), or separate arrangements set up within the Provider.

(iii) The Provider would not (in the short term) have the ability to source corporate support from other providers if this resulted in destabilisation of the PCT's corporate support functions.

(iv) It is agreed that in the short term, no decision can be taken on giving the Community Health Services Committee authority to tender for new services outside of the host PCT, or to cease to provide services under existing contracts. All such decisions would need to be discussed with the Community Health Services Committee and Chief Executive of the PCT on a case by case basis, although they did not all necessarily need to go to the PCT Board (this would need to follow the PCT's own Scheme of Delegation).

(v) The Provider would not (in the short term) lease or purchase any buildings for the purpose of delivering clinical services or operating the business without the express permission of the PCT Board

5. Frequency and Venue of Meetings

The Community Health Services Committee will meet monthly. However, there may be occasions when it is necessary to have urgent meetings and where this is necessary the members use all reasonable endeavours to do so. These meetings will not be held in public. The Community Health Services Committee shall split its time appropriately between strategic, operational, performance and risk issues.

6. Quorum

The Quorum shall be one third of the members of the Community Health Services Committee and which shall include at least two independent members (one of which is a non-executive member) and the Provider Director or the senior finance officer[2].

7. Papers

The deadline for notification of agenda items and submission and despatch of papers shall be in accordance with the Standing Orders referred to in these Terms of Reference.

8. Dissolution of the Community Health Services Committee

The PCT Board acknowledges the strategic and operational importance of the Community Health Services Committee and agrees for the purposes of certainty that it will not dissolve the Community Health Services Committee without good cause acting reasonably after consultation with the Community Health Services Committee members and upon the giving of not less than [3] months notice to the Director of the Community Health Services.

9. Review of Terms of Reference

These Terms of Reference shall be reviewed, at a minimum, annually and may only be varied by the PCT Board acting reasonably and after consultation with the Community Health Services Committee.

Updated March 2009.

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[2] *For comparison purposes paragraph 6 of Schedule 2 to the Membership Regulations states that no business shall be transacted at a PCT Board meeting unless:*

- *the number present is not less than one third of the whole membership of the Trust (including the Chairman); and*
- *those present include at least one non-officer member but with Care Trusts, two non-officer members and one officer member.*

Where there are circumstances within organisations which might give rise to the possibility of conflicts more often than normal, for example perhaps where there is a non-executive who is both on the Board and the Community Health Services Committee, then it is always useful to bear this in mind when setting quorums. The Community Health Services Committee will not want to have the issue of conflicts making it difficult to have quorate meetings.

Annex 2c

NHS BIRMINGHAM EAST AND NORTH

Section to be added to the PCT's current Scheme of Reservation and Delegation and relating to the delegation of functions to the Community Health Services Committee

DECISIONS DELEGATED BY THE BOARD TO, AND RESERVED BY, THE COMMUNITY HEALTH SERVICES COMMITTEE

REF	COMMUNITY HEALTH SERVICES COMMITTEE	DECISIONS DELEGATED BY THE BOARD TO, AND RESERVED BY, THE COMMUNITY HEALTH SERVICES COMMITTEE
THE COMMUNITY HEALTH SERVICES COMMITTEE		*Regulation and Control* 1. Following agreement with PCT Board, approve a scheme of delegation of powers from the Community Health Services Committee to sub-committees, Community Health Services Committee members and PCT employees. Including considering the creation and use of governance and audit sub-committee/sub-groups, such as, for example, a CHS Operations sub-group 2. Require and receive the declaration of any Community Health Services Committee member's interests which may conflict with those of the Community Health Services Committee and taking account of any waiver which the SofS may have made in any case and after consultation with the Community Health Services Committee Director and Chair where appropriate, determining the extent to which that member may participate in the consideration of a matter in which he/she has an interest. 3. Advise on and be responsible for governing and taking forward the PCT's community health services business as set out in this Scheme of Reservation and Delegation and otherwise as agreed with the PCT Board including ensuring robust quality and governance arrangements are in place having regard to any guidance by the Secretary of State, and including preparation of proposals to develop and monitor clinical standards. 4. Advise on and ensure robust governance arrangements are in place within Community Health Services through the development and maintenance of an assurance framework to enable the Community Health Services Director to sign a Statement on internal control relating to Provider Services. 5. Ratify or otherwise instances of failure to comply with Standing Orders in accordance with [SO 5.6]. Such failures to be reported to the PCT Board in formal session in line with the Provider Services escalation procedure.

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<td>THE COMMUNITY HEALTH SERVICES COMMITTEE</td>
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Strategy, Plans and Budgets
1. Consider and approve Community Health Services Strategy and Plans and Budgets, on an annual basis, in relation to Community Health Services issues for approval by the PCT Board including:
(i) managing such budgets when they are set and dealing with any issues relating to deficits or surpluses which may arise in accordance with the Provider Services Surplus and deficits management protocol
(ii) maintaining and considering segmented management accounts for provider services and reporting any significant variances from the budget to the PCT Board (in line with agreed escalation procedures). The PCT Board and the Community Health Services Committee shall agree what is a “significant variance”.
2. Advise the PCT Board on the strategic aims and objectives of the PCT in relation to Community Health Services issues.
3. Prepare and review annually draft plans in respect of the application of available financial resources to support the business processes the PCT is required to undertake including:
(i) working with local partners and conducting the Joint Strategic Needs Assessment and developing the Local Area Agreements;
(ii) developing a strategic plan that describes the context for the next three to five years.
(iii) developing an operational plan that:
describes local targets
defines success
details milestones
details proposed LAA content on health outcomes.
4. Determine arrangements in respect of provider services for agreeing the above mentioned business processes and advising the PCT Board, as required, in relation to Community Health Services on the above mentioned business processes.
5. Having regard to the PCT’s commissioning intentions, discuss, negotiate and agree any relevant service agreements between the PCT and provider services in relation to the (1) provision of services arranged by the Community Health Services Committee to the PCT (2) the provision of services arranged by the Community Health Services Committee to any third party commissioners, and (3) the provision of support services by the PCT to the provider services.
6. Develop and operationalise the PCT’s policies and procedures for the management of risk in relation to Community Health Services
7. Negotiate the amount of the annual capital investment budget that is to be allocated
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	to Community Health Services and, from there, to determine how that capital investment will be applied within Community Health Services, completing as appropriate, outline and final business cases for approval by the Community Health Services Committee (up to a capital value of £100,000 and, for investments in excess of £100,000+ further approval by the PCT Board. 8. If approved by the PCT Board, to work with the PCT Board in relation to the transfer of Community Health Services to an appropriate organisation or putting in place other arrangements relating to the future of Community Health Services.

THE COMMUNITY HEALTH SERVICES COMMITTEE	**Direct Operational Decisions** 1. To advise on and be responsible for governing and taking forward the PCT's Community Health Services business as set out in this Scheme of Reservation and Delegation and otherwise as agreed with the PCT Board including advising the PCT Board on acquisition, disposal or change of use of land and/or buildings in relation to provider services. 2. To enter into a Memorandum of Occupation with landlords of facilities in which provider services has significant activities. 3. To introduce or discontinue any provider service activity or operation, albeit at all times acting in accordance with SLAs and any formal consultation requirements. Where such activity is significant the Community Health Services Committee shall consult in advance with the PCT CEO in the first instance. An activity or operation shall be regarded as significant, if it has a gross annual income or expenditure (that is before any set off) in excess of £100,000 4. To approve individual contracts of a capital or revenue nature relating directly to Community Health Services. Where such contracts are significant, the Community Health Services Committee shall consult with and secure the approval of the PCT Board. Contracts amounting to, or likely to amount to over £100,000 per annum shall be considered significant. 5. To advise on the determination of individual compensation payments where they relate to provider services. Approval up to £1000 and above that limit make recommendation to the Director of Resources. 6. To consider and make recommendations to the PCT Board on action on litigation against or on behalf of the PCT in relation to provider services. 7. To advise on individual cases relating to provider services for the write off of losses or making of special payments above the limits of delegation to the PCT Chief Executive and PCT Director of Finance (for losses and special payments) previously approved by the PCT Board. 8. To ensure that the Community Health Services Committee has appropriate HR strategies and employment policies and procedures in place.

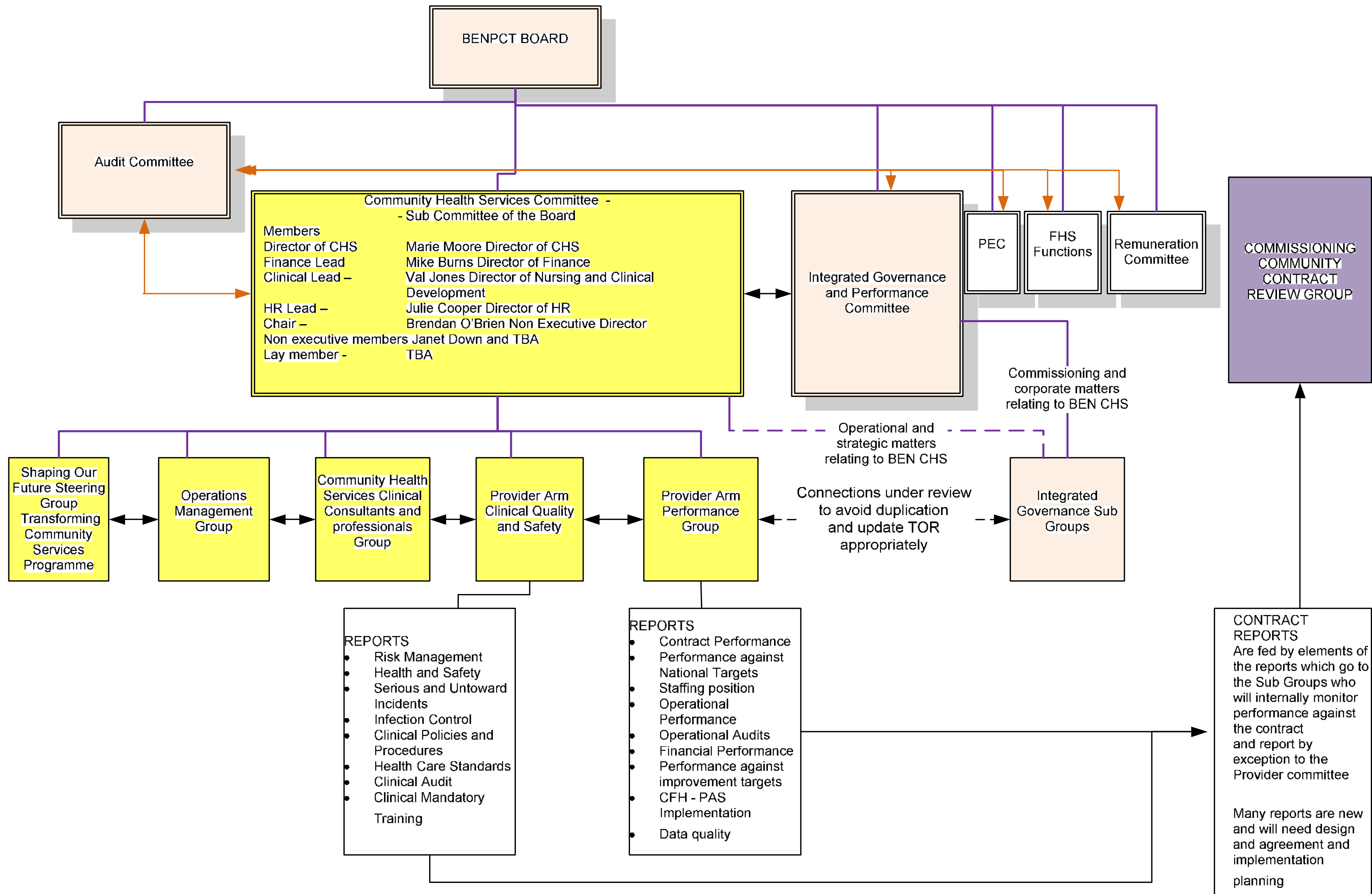
THE COMMUNITY HEALTH SERVICES COMMITTEE	**Financial and Performance Reporting Arrangements** 1. Continuous appraisal of the affairs of the provider services business of the PCT as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the PCT Board. 2. Approve the opening or closing of any bank account relating to Community Health Services. 3. Receive and approve a schedule of NHS service agreements signed relating to Community Health Services and in accordance with arrangements agreed with the PCT Chief Executive. 4. Advise on the PCT's draft Annual Report (including the annual accounts) for approval by the Board in respect of Community Health Services issues.

Annex 2d

NHS Birmingham East and North

Governance Structure

AGENDA ITEM 2.3



Annex 3

NHS Birmingham East and North

Community Health Services

The Management of Financial Surplus and Deficits

April 2009

1.0 Purpose of the Protocol for the Management of Financial Surplus and Deficits

Birmingham East and North Community Health Services will develop and agree with the Community Health Services Committee and PCT Board, a financial strategy for the Community Health Services which is in alignment with its Five Year Strategic Plan.

Management of financial resource within the Community Health Services of NHS Birmingham East and North is built on the principles of a zero tolerance approach to either a deficit or unplanned surplus position. Community Health Services will be expected to deliver value for money high quality services and meet financial targets in respect of CIP through efficiency savings.

This protocol defines the approach which will be taken to manage any surplus or deficit which is generated by the NHS Birmingham East and North Community Health Services. It underpins the Standing Financial Instructions which have been put in place to describe the delegated and reserved powers in relation to the Community Health Services Committee which is a sub committee to the PCT Board.

A formal DH community contract will be in place from 2009/10 between the NHS Birmingham East and North Commissioners and Community Health Services. This will be further developed during the 3 year term to move from a block contract basis to activity based costing using appropriately agreed currencies and assuring activity is correctly costed and counted. The implementation of activity based costing has a significant impact on the financial strategy of Community Health Services as payment for clinical services will be made in line with the activity completed verses through a block contract basis.

This protocol will be reviewed on at least an annual basis.

2.1 The Management of Financial Deficit

1. Deficits within year must be addressed.

2. The Community Health Services Committee is responsible for ensuring that a clear plan of action is in place to address such deficits and report issues to the PCT Board as they arise through the Community Health Services Assurance mechanisms.

3. The following activities are to be put in place to mitigate against the risk of a deficit position occurring:

   a) Strong budgetary control and reporting is put into place to manage the financial position within the budget and to adhere with SFIs and SOs.
   b) Mechanisms to address underperformance on clinical services contracts are in put into place to assure the funding for the operation is covered. Commissioners

will fund only delivered activity once currency and prices are agreed for each service.

c) Debt management mechanisms are carried out in line with financial procedures.
d) A monthly forecast out turn is calculated and reported. If a deficit is forecast clear reporting with action plans to mitigate the situation must be created and delivered upon. The position will be reported through the Community Health Services Committee to the board.
e) Internal controls and audit will be utilised in managing and assuring the financial and governance positions

4. Where a year end deficit is forecast and mitigation is not successful:

a) If action plans are failing to address the deficit position, or where action is not being implemented, the PCT will retain the right to question, clarify and where appropriate ask for additional measures.
b) Further audit and reporting may be initiated.
c) If additional measures are failing and if the governance and assurance arrangements are evidenced as a root cause the PCT will retain the right to review the functioning of the Community Health Services Committee and management arrangements.
d) The PCT reserves the right to suspend the Provider Services Committee and to step-in to its position if remedial action is not having the desired financial effect. This leaves the Community Health Services Committee apparatus in place so that it can be reactivated (ie the PCT can "step-out" at a later date) if and when the financial crisis passes.
e) Ultimate sanction is reserved for the Board to dissolve the Community Health Services Committee. As the PCT is the accountable body deficits are reflected within the organisations bottom line and the final year end position so action ahead of this would be reasonable.

2.2 **The Management of Financial Surplus**

1. Surplus created in year within Provider Services can be utilised in year by the directorate using the following criteria:

a) Surpluses created through improvement activity can be reinvested in the provider service to fund further service or operational development, improvement, research or activity which will improve healthcare. The PCT would expect the Provider Services Committee to take into consideration PCT commissioner priorities.
b) Surplus created through over performance where delivery of activity is evidenced will be retained in the Provider Services.
c) Surplus created by underperformance must be utilised to bring performance back into line with the activity based cost contract. If this fails to happen the commissioner will be entitled to only fund the activity delivered.

2. In year one when a block contract remains the basis for funding, the funding for implementation of new initiatives should, where possible, be phased in line with roll out to avoid a surplus being created.

3. Any deficit/surplus generated by the Provider Service will be carried forward into the following financial year subject to the overall PCT's financial position and agreement as to how the surplus will be reinvested or the deficit recovered.

Director of Operations NHS BEN CHS
Director of Finance NHS BEN
April 2009