NHS PETERBOROUGH

Peterborough Primary Care Trust

(Working in partnership with Peterborough City Council)

SUBJECT:	**TRANSFORMING COMMUNITY SERVICES - PROGRESS REPORT**
ACTION REQUIRED:	**FOR DECISION**
MEETING:	**PCT BOARD**
DATE OF MEETING:	**9 JUNE 2010**
REPORT OF:	**SHEILA BREMNER INTERIM CHIEF EXECUTIVE**

1 RECOMMENDATION

This report recommends that the Board

1.1 Note the conclusions of the appraisal process specifically that there is insufficient staff support for a PCS wide Social Enterprise (SE) and some support for integration with a local NHS provider

1.2 Note that 4 Social Enterprise "Right to Request" (R2R) expressions of interest have been submitted to NHSP Chief Executive and agree to support the development of detailed plans

1.3 Approve integration with a local NHS provider as the preferred organisational form for all or part of Community Services (subject to the outcome of the SE R2R)

1.4 Agree to a parallel process that includes SE R2R and integration proposals from local NHS providers selecting partner organisations by September 2010

1.5 Delegate authority to the Transition Board to oversee the selection process evaluating provider responses and SE business cases in order to make a recommendation to the NHSP Board in September 2010

1.6 Note that accepting these recommendations will be subject to support from PCC, specifically the requirement for cabinet and overview scrutiny committee consideration and the consequent impact on the Partnership agreement.

2 EXECUTIVE SUMMARY

2.1 NHSP considered the development of Community services at its meeting on May 19th 2010. This report updates the Board on progress since that meeting, at which NHSP ;

- Approved the establishment of a Transition Board, nominated a Non Executive Director as chair (this is now in place and is overseeing the TCS process on behalf of NHSP).
- Approved the evaluation criteria
- Agreed to receive a recommendation on the organisation form at this meeting June 9th

2.2 At the Transition Board's last meeting it reaffirmed that the key priorities for the future of Community service are to;

- improve quality and outcomes for patients,
- achieve value for money, greater efficiency and improved productivity
- contribute to the delivery on NHSP Turnaround plan reducing costs wherever possible

2.3 NHSP in February 2010 confirmed that Community Foundation Trust was no longer an option and in May 2010 agreed that Direct Provision from the PCT was not acceptable concluding that the remaining 2 options of Social Enterprise and integration with a local NHS organisation were to be appraised.

2.4 This report describes the conclusions of the appraisal against the criteria considered by NHSP in May and outlines the implications of integrating services via a block approach or as a single entity. Staff and stakeholders views are summarised and a recommendation for the future form and next steps to deliver the outcome by April 2011, the deadline set out by the Department of Health is given.

3 CURRENT POLICY CONTEXT

3.1 Social Enterprise policy including the "Right to Request" was announced in Autumn 2008 while Transforming Community Services policy was largely set out in documents published in January 2009 and more recently the "Assurance and Approvals process" in March 2010. Since the coalition government has been in place, there have been no announced or published changes to that policy this decision is therefore made in that context.

3.2 The timeline for implementation, April 2011 remains unchanged and while East of England SHA agreed an extension to the time needed for NHS Peterborough to

make a sound decision they are anticipating that NHSP will conclude its assessment of the options and agree the organisational form at the June meeting, and confirm the feasibility of completing or at least making substantial progress in implementation of the new form by end March 2011.

4 OPTION APPRAISAL

4.1 The two options assessed are the creation of a Social Enterprise(s) and integration with a local NHS organisation(s) the key features of each are as follows.

Option 1. Integration within the local NHS:

- Care can be more easily be commissioned along care pathways reducing the risks of patient handovers
- The Foundation Trust membership model can facilitate patient, public and staff involvement in the design and delivery of services
- Clinical synergies can make transformational change easier to achieve
- Is part of the NHS – a feature which is important to many staff, supports current terms and conditions and is supported by Trade Unions
- Foundation Trusts – have already undergone a rigorous assessment and registration process
- Likely to secure a reduction in management costs by merging back room functions, reducing duplication and transaction costs
- Offers the opportunity to transfer PCS as a whole or by service blocks.

The governance structures of the acquiring organisation will need to be adapted to incorporate the transferred services. If this option is approved referral to the Cooperation and Competition Panel (CCP) will need to be made[1] as a provider body is lost to the local health economy.

4.2 Option 2. Creation of a Social Enterprise

Social Enterprise is an organisation established for a social purpose, run on business lines where profits are reinvested in the community. The key features include:

- Carries the ethos of the NHS having a strong focus on the involvement of staff, communities, service users and patients in the design and delivery of services

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[1] The ten principles for cooperation and competition number 6 " Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients and taxpayers' interests"

- Shares the commitment to improve quality and can tailor services to patient needs
- Provides the opportunity to give staff more independence and flexibility to innovate and improve outcomes for patients
- As employees can be owners of the organisation empowering front line staff who are most familiar with patient needs
- Can provide value for money by keeping management and bureaucracy costs to a minimum
- Can more easily form partnerships with third sector organisations
- Are not part of the NHS but can retain the NHS brand as services are NHS funded and provided to NHS patients
- Can access most NHS Terms and conditions by meeting certain criteria and securing "Employing Authority" status
- Unpopular with Trade Unions who will oppose this model

The governance of a social enterprise is mostly likely to be a Community Interest Company together with an application for Employing Authority status which will make the best use of NHS pensions for transferring staff and new recruits. If Employing Authority Status is not obtained then the likely alternative is obtaining Direction Employer Status, under this guise the SE will need to provide alternative pension arrangements which are no less favourable than the NHS scheme. Referral to the CCP is not necessary in this case.

4.3. Additional Issues for Consideration

(i) The future of all services currently provided by Peterborough Community Services have been considered in this appraisal, including those delivered on behalf of Peterborough City Council under the section 75 agreement. PCC CMT considered a report on 1st June and concluded that the PCT board decision will need to be discussed at the Overview and Scrutiny and the final decision will be subject to Cabinet approval. PCC are seeking legal advice on the possible implications for their statutory responsibilities associated with the change in management of these services.

The relationship with PCC does mean that additional issues need to be addressed through this process. This includes

- The future partnership agreement and associated Section 75 agreement

- Different pension arrangements are still in place for local authority and NHS staff. These will need to be reconciled as part of the implementation process.
- The role of the DASS

Legal advice on these points has been sought from NHSP advisors Mills and Reeve and is summarised below, the detail is attached at Appendix 1 and will be addressed in future discussions with PCC.

- The current (2004) section 75 agreement may be transferred in its entirety to any of the local potential NHS integration partners identified in paragraph [4.4.6] BUT may not be transferred to a social enterprise.
- However the transfer of the entire current (2004) section 75 agreement to an NHS partner would not be appropriate because it includes the delegation of PCC's commissioning function for the population resident in NHSP's area and therefore to transfer the entire agreement would split the commissioning of social care services from the commissioning of community health services.
- NHSP is advised to extend the current (2004) section 75 agreement for a further year or replace it with a new section 75 agreement to terminate on the date of the transfer of NHSP provider services.
- With effect from the date of transfer of NHSP provider services, there should be two replacement section 75 agreements:
    - between PCC and NHSP delegating PCC's function of commissioning social services; and
    - between PCC and the NHS integration partner acquiring NHSP provider services delegating PCC's function of providing social services (including the arranging or micro-commissioning of services for individual service users)

Provided PCC continues to delegate its social services commissioning function to NHSP, the DASS can and should appropriately retain the position as an executive director of NHSP.

(ii) Consideration has been given to transferring all services as a whole or in blocks and there are some advantages to each approach. Early work in February grouped services into "Blocks", this has been discussed at the Transition Board and with NHSP Executive Directors. As a result the blocks have been rationalised by NHSP into 6 service areas which are more

consistent with NHSP Turnaround plans; the areas are Adult services, Children Services, Unscheduled Care (Out of Hours, Walk in Centre), Learning Disability services, Dental services and Public Health.

(iii) Contestability Plan. In all cases the PCT must have a robust contestability plan which clearly sets out the timeline for review of all community services and the likelihood of market testing a proportion of services. This will allow any Social Enterprises to develop their business acumen and establish themselves as competent bidders while at the same indicate to all providers that future competition will be open, transparent and fair, meeting the requirement of EU competition law.

4.4 **Appraisal Process**

4.4.1 Staff and Stakeholder Views

During April and May 2010 the 2 options have been fully appraised against a set of criteria agreed at May 19th board through a process designed to engage staff, trade unions and stakeholder groups. The health and social care needs of our population has been paramount in these discussions. Nine workshops with staff have been held with 299 staff attending (all staff were invited). In conjunction with this an awareness pack has been distributed to all staff outlining the key benefits and drawbacks of both options along with a Frequently Asked Questions section. Staff were asked to evaluate the options and state a preference in order that their views are known and taken into account.

The summary of high level responses is of the 299 staff attended who the workshops 154 evaluation responses of the evaluation were received of which 69 felt they needed more information in order to state a preference. Of those who expressed a preference 19 supported SE and 65 integration. Of those who expressed integration 17 gave no provider preference, 21 CPFT, 15 PSHFT and 13 CCS. All the returned staff evaluation forms are available for board members to review as required. The Staff Side formal response is in Appendix 2.

4.4.2 The key themes of staff feedback are :

- No groundswell of staff support for the creation of a single PCS wide Social Enterprise
- Feeling of insufficient information or understanding of implications of Social Enterprise in order to make an informed recommendation
- Requirement for additional information on local NHS organisations in order to make an informed recommendation

- Additional time needed to formulate a view, make any recommendation
- Perception that Social Enterprise was the favoured option and being "pushed"
- Desire to remain within the NHS
- Desire to retain NHS terms and conditions, particularly pension rights
- Interest for SE coming from support functions and the clinical services
- More support for integration within the NHS than Social Enterprise
- Where integration was the choice, the NHS partner preference was quite evenly distributed. The distribution was aligned by team who felt potential for synergy of service

4.4.3 In addition a wider stakeholder event was held for May 27th at which 38 parties attended including representatives from LINK, PCC, SHA and partnership boards. Other stakeholder engagement includes Joint Forum staff side local and regional union representation (who are opposed to Social Enterprise, see Appendix 2 for formal response), PCS sub committee, NHSP directors , PCS executives and management team and the SHA provider team.

Feedback from this event did not show a clear preference for any particular option with similar views to staff expressed.

4.4.4 The recent staff engagement has shown that although there was substantial interest in Social Enterprise in 2008 there is little interest in a PCS wide approach now. This is most likely as a consequence of leadership changes and no apparent champion to take the organisation in this direction. Given the implementation timescale it is unlikely that sufficient staff support could be secured to deliver this model. However specific groups of staff are interested in Social Enterprise with four Social Enterprise Right to Request Expressions of Interests from staff submitted to NHSP CEO, the detail is attached at Appendix 3 and in summary they are ;

1) Community rehabilitation and enablement which includes services such as Intermediate Care and Physiotherapy. This request has been made by the AHP Strategic Lead.

2) Dental Access Centre. This request has been made by the Dental Services Development Manager and clinical lead.

3) Unscheduled care and Adult services (which includes the Community Nursing teams, OOH and the WIC). This request has been made by the OOH Medical Director with the support of other doctors from General Practice and PCS staff.

4) Education and Training
There are four members of staff who provide training primarily to primary care nurses and this request has been made by jointly by two members of that team.

4.4.5 The requests have been submitted by service managers or senior clinicians and they are clear that should managed integration of services be the boards decision they will pursue their Right to Requests. Detailed proposals have not yet been developed but PCT's are expected to ensure that staff have sufficient support to develop a business case for assessment by the PCT Board. It is planned to encourage the aspirant SE's to work together to produce a single proposal which is more likely to be viable and potentially large enough to carry infrastructure costs and manage risks. If they are successful they could form part of a mix of organisation models, NHS providers alongside the creation of one of more Social Enterprises providing specific services avoiding a monopoly situation.

4.4.6 Local potential NHS integration partners that have expressed interest to date are :

- Peterborough & Stamford Hospitals NHS Foundation Trust
- Cambridgeshire Community Services (an aspirant CFT)
- Cambridgeshire & Peterborough NHS Foundation Trust

These providers have all indicated willingness to take on the management of the community services and have to a greater or lesser extent begun to outline their proposals to improve services. As such it is anticipated all would submit proposals if invited.

4.5 **Appraisal Conclusions**

4.5.1 Social Enterprise affords the opportunity to maintain competition in the local health economy system creating a new organisation(s) to replace PCS. It provides staff the opportunity to feel more empowered in a bureaucratically light organisation enabling greater scope for flexibility and change, with an ethos of serving and giving back to the community it serves. Being cautious the management costs are at best neutral and at worst likely to be more than PCS. There are ongoing tax liabilities, some of which can be mitigated they cannot be eliminated.

4.5.2 As there appears to be insufficient support for the creation of a single Social Enterprise and the rigorous assessment requirements of creating a new organisation it is unlikely that this can be achieved by April 2011. This will also be a concern for the Right to Request SEs who will have at the least show that they can make significant progress within that timescale.

4.5.3 Peterborough and Stamford Hospital Foundation Trust is a local organisation that has good alignment with some patient pathways and synergy of some services. They are experienced in managing a large complex organisation and offer NHS terms and conditions to staff. They are a major supplier to NHSP.

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4.5.4 Cambridgeshire & Peterborough NHS Foundation Trust offer some existing service synergy. CPFT have experience of an integrated health and social care environment and a record for service transformation. CPFT are within the NHS for staff terms and conditions.

4.5.5 Cambridgeshire Community Services have a large synergy in terms of current service provision, have previously integrated other NHS organisations and provide health and social care services. CCS are within the NHS for staff terms and conditions.

4.5.6 A process which invites transformation proposals from these 3 local NHS providers is recommended.

5 Financial Appraisal

5.1 The detailed financial appraisal is attached Appendix 4 and while the financial consequences of the transition programme are extremely important they should be considered alongside all other evaluation criteria. In summary the analysis concludes that full integration of the provider offers the biggest potential for savings in management and support costs £953k as opposed to a worse case increase in management costs through creating an SE of £152k.

All options offer the opportunity to drive down service costs by maximising efficiency and improving productivity, the Commissioner will plan to achieve this through the turnaround plan and in its contracts for services which become legally binding as new providers are established.

5.2 In social enterprise it is possible that staff commitment and sense of ownership as experienced by existing SEs will secure service redesign which will improve care

for patients and reduce cost as they work more closely with third sector organisations. The introduction of a number of small Social enterprises while allowing for a focussed approach to service delivery for a particular care group will need thorough analysis to secure the best financial outcome for the commissioner to assess their ability to secure the savings set out in the turnaround plan. Given the likelihood of a grant from the Social Enterprise Investment Fund (SEIF) the transition cost for SE is likely to be less than for integration, however as previously stated other recurrent costs will be incurred.

5.3 Integration on the other hand has the potential for service improvement along care pathways and as this is maximised can significantly reduce the demand on acute services. Larger organisations are likely to bring greater flexibility with a larger critical mass of staff and resource which is more able to withstand the reductions required and deliver improved quality for patients, productivity and efficiency.

5.4 As the creation of a single Social Enterprise is not recommended, of the 2 remaining options it would cost less both in terms of one off transition and ongoing costs to integrate with a single local NHS provider, rather than to have the mixed model potentially including a proliferation of 3 local NHS providers and 4 staff based Social Enterprises.

6 Conclusion

6.1 The report outlines the feedback from staff and stakeholders and concludes that there is insufficient support for a Peterborough wide Social Enterprise to make this a viable option. However there are 4 expressions of interest that cannot be reasonably eliminated at this stage. It is important to validate the staff support for these to ensure they are realistic proposals and to consider the potential for these to join together to form a single approach.

There is wide interest from local NHS providers to integrate with community services.

6.2 **Next Steps and Timescale**

6.2.1 NHSP will need to run a process whereby it can assess more thoroughly the integration opportunities alongside the offer from potential service specific social enterprises. A detailed implementation plan is attached in Appendix 5 which will achieve the DH timescale of April 2011.

The key steps are

- June 9th 2010 PCT board decision
- June 10th invite partners to express an interest
- June 2010 plans signed off with the SHA
- July 23 2010 provider responses and SE IBP's
- August 2010 review responses
- September 2010 select partners , approve SE IBP's
- October 2010 90 day CCP referral
- October 2010 Partners conduct due diligence
- October 2010 Monitor review
- October 2010 SE legal entity, corporate form agreed, Pension agency etc
- January 2011 TUPE Consultation with staff regarding future transfers
- April 2011 implementation of new organisational form complete

6.2.2 Local providers will be invited to submit proposals for all or service blocks which will transform services meeting a set of criteria determined by NHSP. These will be in addition to the "tests" set out by DH in the Assurance and Approvals process. The same criteria and tests will be applied to the Social Enterprise proposals.

7 TIMETABLE FOR DECISIONS

7.1 All recommendations to take place with immediate effect

8 PREVIOUS DECISIONS RELEVANT TO REPORT

8.1 Decision at November 2008 board to pursue an application for Community Foundation Trust (CFT) status as the preferred model for the provider arm of NHS Peterborough.

8.2 Decision at 3 February 2010 board to no longer pursue an application for Community Foundation Trust (CFT) status as the preferred model for the provider arm of NHS Peterborough.

8.3 Decision at May 19 2010 board agreeing the establishment of a Transition Programme Board operating as a sub-committee of the PCT board and approving the evaluation criteria for the two remaining organisational form options.

9 REFERENCE PCT STRATEGIC PLAN, GOALS, OUTCOMES AND WORLD CLASS COMMISSIONING COMPETENCIES :

9.1 This organisational form options analysis work links to the strategic direction of travel for the provision of community services nationally and is set within local turnaround context. New solutions have to be found which meet the requirement to transform Community Services whilst sustaining continual service improvement, safeguarding and increasing performance and cost efficiencies in 2010 – 2011 and beyond. Aligns to WCC competencies 1-4, 7, 8 & 10.

9.2 Decisions on the organisational form must evidence alignment to NHSP strategic goals to evidence reduction in health inequalities; support vulnerable people; promote healthy lifestyles; personalisation; choice and control and improve access to services, with an emphasis on care closer to ones home.

10 DIRECTOR RESPONSIBLE FOR ADVICE:

Helen Fentimen Interim Transition Director

Appendix 1

NHS Peterborough

Advice in relation to section 75 agreement with Peterborough City Council for adult social services

NHS Peterborough
Advice in relation to section 75 agreement with Peterborough City Council for adult social services

1 Background

1.1 NHS Peterborough ("NHSP") has requested advice on the legal implications for its section 75 agreement with Peterborough City Council ("PCC") (commencing 1 April 2004 - the "2004 section 75 agreement") following the separation of NHSP's provider services in 2011.

1.2 The advice is required in the context of the 'Transforming Community Services – Progress Report' ("the Report") to be considered by NHSP's Board on 9 June 2010.

2 Overview of section 75 agreements generally

2.1 Section 75 agreements (including those that encompass pooled fund arrangements) may be made by local authorities with the following NHS bodies: Primary Care Trusts, NHS Trusts and NHS Foundation Trusts[1].

2.2 Therefore any of the NHS bodies listed as 'local potential NHS integration partners' (NHS partners) in paragraph [4.4.6] of the Report could enter into a section 75 agreement with PCC and the 2004 section 75 agreement with PCC could, if appropriate, be transferred in its entirety to any of those bodies.

2.3 However, as social enterprises are not included in the list of 'NHS bodies' permitted to enter into section 75 agreements, PCC is precluded from entering into a section 75 agreement with any social enterprise that might ensue following the separation of NHSP provider services.

3 Transfer of the 2004 section 75 agreement to the acquiring NHS partner

3.1 The 2004 section 75 agreement does not anticipate or include any mechanism for transferring it from NHSP to another NHS body.

3.2 If the agreement is to be transferred in its entirety and in its current form, ie without amendment save as to the parties, this could be achieved by:

3.2.1 a statutory Transfer Order of the Secretary of State; or

[1] The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000

3.2.2 agreement between NHSP, PCC and the NHS partner, either:

(i) as part of the transfer agreement (relating to the assets and liabilities of the provider services); or

(ii) by a separate agreement.

In the latter case a short novation agreement, possibly in the form of a letter signed by the three parties, in which all parties consent to the transfer of NHSP's duties and obligations under the 2004 section 75 agreement to the NHS partner would be required.

3.3 However, the transfer of the 2004 section 75 agreement in its entirety to the NHS partner acquiring NHSP's provider services would only be appropriate if it provided solely for the delegation of PCC provider functions to NHSP. This is not the case, as the current section 75 agreement (at paragraph 2.4) provides for the delegation by PCC to NHSP of both its commissioning and provision of social care services.

3.4 For the avoidance of doubt the "commissioning services" function delegated by PCC to NHSP under the 2004 section 75 agreement relates to the commissioning of services "for the Resident Population" (defined as "people registered with GPs in NHSP's area"). This is wider than the process of arranging or 'micro-commissioning' services for individual service users, which falls properly within provision of social care services.

3.5 As the overriding purpose of the 2004 section 75 agreement is to bring together the commissioning and provision of community health and social care services under one roof, it would not be appropriate for PCC to delegate its commissioning function to the acquiring NHS partner, while the community health services commissioning function remained within NHSP. Nor would it be appropriate for NHSP to delegate its commissioning function to the acquiring NHS partner, as that would leave NHSP with neither a commissioning nor a provider function to perform.

3.6 For these reasons it is our advice that it would not be appropriate for the 2004 section 75 agreement to be transferred in its entirety to the acquiring NHS partner.

4 How can the current section 75 arrangements be continued following separation of NHSP provider services?

4.1 The most appropriate way of continuing with the 2004 section 75 arrangements, following the separation of NHSP provider services, is to replace the 2004 section 75 agreement with two new separate section 75 agreements:

4.1.1 one between PCC and NHSP delegating PCC's commissioning function in relation to social services to NHSP; and

4.1.2 one between PCC and the acquiring NHS partner delegating PCC's provision of social services to the acquiring NHS partner.

4.2 This would enable:

4.2.1 NHSP to continue to commission adult social services in conjunction with community health services (as per the current arrangements), and to enter into commissioning contracts with the acquiring NHS partner and/or appropriate social enterprises on the terms of the NHS standard contract for community services; and

4.2.2 the acquiring NHS partner to provide adult social services in conjunction with community health services commissioned from it under contract by NHSP.

5 Continuation of the current section 75 arrangements pending separation

5.1 Until the date that NHSP provider services separate from NHSP and are transferred to the acquiring NHS partner, one of two things needs to happen in order to preserve the current position:

5.1.1 either the 2004 section 75 agreement needs to be further extended – this may be done by an exchange of letters between the Chief Executives of NHSP and PCC as per clause 38.2 of the 2004 section 75 agreement; or

5.1.2 NHSP and PCC need to enter into a replacement section 75 agreement – we understand that a draft replacement agreement is under negotiation - BUT the duration of the replacement agreement should be limited to the period up until the separation of NHSP provider services.

6 Implications in relation to the statutory requirement on local authorities to appoint a Director of Adult Social Services

6.1 Local authorities are required by statute to establish a Director of Adult Social Services ("DASS")[2]. PCC has complied with this requirement by making arrangements with NHSP for the DASS appointment to be a joint appointment of PCC and NHSP.

6.2 These arrangements are reflected in NHSP's Standing Orders (January 2010) (at the second sub-paragraph of 2.1 (paragraph 4)) which also provide for the DASS to be an officer member of NHSP's Board.

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[2] Pursuant to the Children Act 2004 (which amended the Local Authority Social Services Act 1970)

6.3 We understand that the current DASS has also been appointed to the role of Deputy Chief Executive of NHSP's Board. However, this is not a requirement of either NHSP's Standing Orders nor of the 2004 section 75 agreement.

New section 75 agreement delegating PCC's commissioning function to NHSP

6.4 If there is to be a new section 75 agreement between PCC and NHSP delegating PCC's commissioning function to NHSP, to provide for the lead commissioning by NHSP of adult social services in conjunction with community health services, then it would continue to be appropriate for the DASS to remain on NHSP's Board. This would be consistent with the Department of Health's '*Guidance on the Statutory Chief Officer Post of the Director of Adult Social Services*' which provides that the individual appointed to this post should have strategic responsibility and accountability for the planning, commissioning and delivery of social services for all adult client groups, with "a leading role in delivering the wider vision for social care".

No new section 75 agreement delegating PCC's commissioning function to NHSP

6.5 However, in the event that PCC and NHSP do not enter a new section 75 agreement delegating PCC's commissioning function to NHSP, then it is unlikely that it would continue to be appropriate for DASS to retain a position on NHSP's Board. In this event, it would also be necessary for NHSP to amend its Standing Orders[3] and for PCC to make alternative arrangements to meet its statutory obligation to appoint a DASS.

6.6 If PCC wished to retain the right to appoint the DASS (or any other PCC officer) to the Board of the acquiring NHS partner in conjunction with the delegation to that entity of PCC's function of providing social services, it would also be necessary for PCC to agree this with the acquiring NHS partner.

6.7 If the acquiring NHS partner is an NHS Foundation Trust then its Constitution will determine who may be appointed as an executive director on its Board and it will depend on whether there is a vacancy at the time of the acquisition of NHSP provider services. For example, the constitution of Cambridgeshire and Peterborough NHS Foundation Trust provides for 5 and 7 executive directors at any one time of which 4 must be filled by individuals carrying out specific executive roles within the FT (eg, Chief Executive, Finance Director etc). Therefore, there are only 3 other available appointments for individuals carrying out non-specific executive roles and the DASS or other PCC nominee would have to be appointed to one of these positions. This limits the scope for the DASS or any other PCC nominee to be appointed to an executive position on the Board of an NHS Foundation Trust.

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[3] to remove the second sub-paragraph of 2.1 (paragraph 4)

6.8 However, there may be scope for an elected member of PCC to be appointed as a non-executive director of an NHS Foundation Trust as a member of the Public Constituency of the NHS Foundation Trust. However, this appointment would not be open to an executive officer of PCC, such as the DASS.

6.9 Any amendment to the Constitution of an NHS Foundation Trust to accommodate an additional Board position for the DASS would have to be approved by the current FT Board of Directors, a majority of the FT Board of Governors and Monitor.

6.10 If the acquiring NHS partner is an NHS Trust then its standing orders are likely to be consistent with the Department of Health's Model Standing Orders. These provide for up to 5 officer members, 2 of whom must be the Chief Executive and Director of Finance. Therefore, the potential scope for appointing the DASS or any other PCC nominee to Board of an NHS Trust is similarly restricted.

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