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TABLED ITEMS FOR

HEALTH AND WELLBEING BOARD MEETING

Date: Tuesday, 6 January 2015

Time: 6.30 pm

Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford M32 0TH

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THERESA GRANT
Chief Executive

Membership of the Committee

Dr. N. Guest (Chairman), Cllr M. Young (Vice-Chairman), D. Banks, Cllr J. Bennett, D. Brownlee, Cllr M. Cornes, A. Day, B. Humphrey, G. Lawrence, Supt Liggett, A. Razzaq, A. Vegh, S. Webster, C. Yarwood and M. McCourt

Further Information
For help, advice and information about this meeting please contact:

Health and Wellbeing Board - Tuesday, 6 January 2015

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This agenda was issued on 7th January 2015 by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford M32 0TH.

TRAFFORD COUNCIL

Report to: Health and Wellbeing Board
Date: 6 January 2015
Report for: Information
Report of: Gina Lawrence, Chief Operating Officer, NHS Trafford Clinical Commissioning Group

Report Title

Trafford Adult Safeguarding Board Annual Report

Summary

The report provides the annual report of the Trafford Adult Safeguarding Board for 2013-14.

Recommendation(s)

The Health and Wellbeing Board is asked to note the annual report.

Contact person for access to background papers and further information:

Name: Gina Lawrence, Chief Operating Officer, NHS Trafford Clinical Commissioning Group

Extension: 0161 873 9692

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TRAFFORD COUNCIL NHS

Trafford Adult Safeguarding Board

Working in partnership with agencies across Greater Manchester

Trafford Adult Safeguarding Board Annual Briefing

2013 – 2014

"A year of consolidation"

Safeguarding adults: If you don't do something, who will?

Contents

No single agency can deal with adult safeguarding alone...

NHS England
NHS Trafford Clinical Commissioning Group
Central Manchester University Hospitals NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
Cheshire & Wirral Partnership NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
North West Ambulance NHS Trust
Phoenix Futures — Ending dependency, transforming lives
TRAFFORD COUNCIL
NATIONAL PROBATION SERVICE GREATER MANCHESTER
Trafford age UK
Trafford CYPS
THT Trafford Housing Trust

Foreword

By the Chair, Trafford Safeguarding Adults Board

I am delighted to write a few words on introduction to this year's annual report of the Trafford Adult Safeguarding Board.

Following on from our "Year of Transformation", this has been a "Year of Consolidation", in the adult safeguarding arena and across public services, be they statutory, independent sector or voluntary sector based.

Locally, our adult safeguarding panel hearings continue to be hugely successful and feedback from professionals, service users and their relatives and friends who have been involved in these panels remains overwhelmingly positive. We have transformed the role and function of the Strategic Adult Safeguarding Board, which I am privileged to Chair, and we have created a functional Operational Adult Safeguarding Board. We have written a comprehensive set of documents to support the work of the Boards and are well placed to implement the changes required by the introduction of the Care Act, 2014, which will become law in 2015. These documents are available on the Council "My Way" web pages and the NHS Trafford CCG web pages.

Nationally, we have seen an increasing number of stories in the national media regarding terrorism and the radicalisation of vulnerable adults during the past year. Her Majesty's Government has implemented the national Prevent Strategy and the Department of Health has decided that counter-terrorism and preventing the radicalisation of vulnerable adults should be mainstreamed within local safeguarding structures. We have been taking steps to ensure that safeguarding system in Trafford is ready, responsive and adapting quickly to these new requirements and we will begin Prevent training for local authority, NHS and Independent sector staff in 2014/15. Colleagues from criminal justice agencies have already completed their Prevent training.

At the end of this "Year of Consolidation" we are able to look forward to 2014/15, a "Year of Opportunity". The new Care Act will provide us with the opportunity to build on our existing systems, process and practices and allow us to continue, to ensure we remain "fit for purpose" and that we continue, through our multi-agency partnership "Team Trafford", to grasp those opportunities to improve, to challenge and to continue to work together to safeguard and protect vulnerable adults.

Gina Lawrence

Gina Lawrence
Chair, Trafford Adult Safeguarding Board

1. Introduction

The Adult Safeguarding Board is a partnership which provides a framework within which agencies and professionals collectively share a responsibility for the welfare and protection of vulnerable adults in Trafford.

We work together as a Board of Commissioners and Providers to ensure, and seek assurances, that we have effective, fit for purpose services, which place citizens at their heart.

The Board has comprehensive representation from agencies across Trafford, and recognises that our partnership and multi-agency approach is essential to ensure the delivery of effective outcomes for vulnerable people who have been subjected to harm or radicalisation or those who have experienced crime or abuse.

This is the seventh annual report from Trafford Adult Safeguarding Board and this year it takes the form of a briefing report. As such, it is a brief record of the work of the agencies that form the Board. This work has led to the strengthening of safeguarding adults' functions and associated services across Trafford.

This report covers the developments from the period April 2013 – March 2014 and has been produced for the purpose of informing the public, users of services, member agencies and the wider Greater Manchester health and social care economy of achievements over this period. It provides local information within the national context of Safeguarding adults.

This year the work of the Board has focused on six key priorities:

1. *Reducing the levels of neglect, harm and exploitation by putting in place ways of avoiding it happening*

2. *Increasing the levels of public awareness across the Borough*

3. *Improving the ways in which agencies respond to reports of harm*

4. *Improving the skills and knowledge of all those involved in dealing with adult safeguarding*

5. *Improving the levels of resources allocated for safeguarding vulnerable adults*

6. *Improving the links between adult and children's safeguarding*

2. New Safeguarding Adults Procedures

The Adult Safeguarding Procedures are now well embedded and are functioning well. They will be further revised in 2014/15 to ensure they remain current, relevant and "fit for purpose".

*There has been excellent feedback given on the procedures which have increased transparency and placed service users in the driving seat of the safeguarding process and support service users to get the outcomes **they** want from the process.*

3. Making Safeguarding Personal

Trafford Adult Safeguarding Board has been participating in the "Making Safeguarding Personal" programme run by the Association of Directors of Adult Social Services. This has been a really positive experience and has confirmed for us that locally, we have taken the right steps and made great strides toward ensuring that we are outcome focussed and delivering on our promises to "make safeguarding personal."

4. Increasing community engagement

We have, as part of the reform of the Adult Safeguarding Board, considered how we can increase community engagement in adult safeguarding. We have established a series of engagement groups which include members of the public, alongside practitioners and managers from a range of public services. These engagement groups will help shape, form and influence the future development of adult safeguarding in the Borough.

We are opening up the Adult Safeguarding Board to public attendance, in the same way that Council, NHS Board meetings and Health & Well Being Board meetings are accessible. By doing this, we aim to improve transparency and engagement with the Adult Safeguarding Board.

4. The Deprivation of Liberty Safeguards

The has been a small increase in the use of the Deprivation of Liberty Safeguards across public services, where they apply. The Adult Safeguarding Board has ensured, through its member agencies, that the use and application of both the Mental Capacity Act and the Deprivation of Liberty Safeguards remains high on the local adult safeguarding agenda.

5. Safeguarding Children

We have continued to strengthen our relationship with Trafford Children's Safeguarding Board and have established a joint children and adult safeguarding committee. This committee addresses issues common to both boards e.g. Prevent, transitions between children and adult safeguarding and domestic abuse. This joint committee is beginning to significantly improve connections between adult and children's health, social care and criminal justice services and is another way in which we in Trafford are approaching our "think family" agenda.

3. Incidence and outcomes data

Our introduction of "five harms" has been very positive and enabled us to focus our attention on low and moderate level harm, supporting our prevention agenda, while focusing the finite statutory resources required for complex investigations definitions of harm where they are needed most.

Level 1 Harm – Low level harm

Level 1 Harm – Moderate harm

Level 3 Harm – Serious harm

Level 4 Harm – Significant harm

Level 5 Harm – Catastrophic harm

Full definitions of each level of harm are available to view in the Trafford Adult Safeguarding Board Policy and Procedures

Using our five levels of harm has resulted in an increase in effective screening and proportionate responses to the levels of harm identified. There were 167 referrals that went on into the investigation stage at in 2013/14. This is a net decrease of 89 cases based on 2012/13 figures.

The introduction of the five levels of harm has been supported by comprehensive workforce development activity, including the continued training of Root Cause Analysis methodology to undertake investigations.

In this year's report we are again presenting headline data. We have used the data collated in 2013/14 to inform workforce development needs, support Commissioning and contract monitoring arrangements and to seek assurance from individual member agencies.

For all adults – abuse by category:

1	Neglect	101
2	Physical abuse	36
3	Financial abuse	21
4	Emotional abuse	8
5	Sexual abuse	12
6	Institutional abuse	4

NB: Some episodes of abuse will have more than one category; therefore the total will be greater than the total number of episodes for the year.

Of the 138 safeguarding episodes that have been concluded:

Department of Health Outcome Indicator	Episodes
Substantiated	21
Partially Substantiated	3
Not Substantiated	19
Inconclusive	14
Investigation ceased at individuals request	1

Substantiated – all of the allegations of abuse are substantiated on the balance of probabilities.

Partially Substantiated – This would apply to cases where it has been possible to substantiate some but not all of the allegations made on the balance of probabilities. For example *'it was possible to substantiate the physical abuse but it was not possible to substantiate the allegation of financial abuse'*.

Not Determined/Inconclusive – This would apply to cases where it is not possible to record an outcome against any of the other categories. *For example, where suspicions remain but there is no clear evidence.*

Not Substantiated – It is not possible to substantiate on the balance of probabilities any of the allegations of abuse made.

Outcomes

As a result of multi-agency adult safeguarding intervention, the outcomes for adults who have experienced harm, exploitation or abuse are:

Outcome for adults involved in adult safeguarding process	Number
Increased Monitoring	21
Adult removed from property or service	4
Community care assessment and service provision	2
Application to Court of Protection	1
Referral to counselling / training	1
Moved to increase / alternative care provision	8
Management of access to finances	6
Guardianship/Use of Mental Health Act	1
Restrict/mgmt. of access to alleged perpetrator	2
Other	17
No further Action	75

(NB: there can be more than one outcome per safeguarding episode)
The outcomes for the perpetrators are as follows:

Perpetrator Outcome	Number of Records
Criminal Prosecution	1
Police Action	4
Community Care Assessment	4
Removal from property	3
Management of access	1
Referred to DBS	2
Disciplinary Action	14
Continued Monitoring	25
Counselling/Training	22
Exoneration	2
No Further Action	60
Not Known	5
Action by contract compliance	3

A full breakdown of activity is available on request, in a variety of results and formats. Please see rear of document for whom to contact.

Summary

It is clear from the information contained within this report that the Board, through the offices of its member agencies, has achieved a significant amount in the year 2013/14. However, there is still much left to do and we must not rest on our laurels.

The 2015/16 year will be our "Year of Opportunity" and will bring with it new and different challenges, both financial and operational. There will be new statutory responsibilities for the Board to consider and implement and new requirements for member's agencies to meet.

The introduction of new legislative requirements, ushered in by the Care Act, 2014 will bring new challenges, new opportunities and new ways of working across public services.

Whatever the challenges are that we face in the future, we will face them with a solid foundation, a clear direction of travel and the commitment to succeed. We will seize the moment and take those opportunities which arise to continue to work to safeguard the people of Trafford and Greater Manchester.

Team Trafford

Produced by
NHS Trafford Clinical Commissioning Group
on behalf of the Trafford Adult Safeguarding Board
Trafford Town Hall
Greater Manchester
M32 0TH

TRAFFORD COUNCIL

Report to: Health and Wellbeing Board
Date: 6 January 2015
Report for: Information
Report of: Gina Lawrence, Chief Operating Officer, NHS Trafford Clinical Commissioning Group

Report Title

Report from Trafford CCG on its proposed co-commissioning arrangements for primary care.

Summary

The report provides an overview on the future co-commissioning arrangements for Trafford CCG. It includes the consideration of the CCG and the readiness assessments. With a recommended level of entry into co-commissioning of primary care as agreed by the CCG members.

Recommendations

The Health and Wellbeing Board is asked to support the recommendations of the CCG to move forward with model two joint commissioning of primary care.

The Health & Wellbeing Board is also asked to nominate a representative to attend the Trafford CCG Primary Care Co-Commissioning Committee. This representative will be able to play an active role in discussions but will not form part of the committee and will have no voting rights.

Contact person for access to background papers and further information:

Name: Gina Lawrence, Chief Operating Officer, NHS Trafford Clinical Commissioning Group

Extension: 0161 873 9692

PROPOSED CO-COMMISSIONING ARRANGEMENTS FOR PRIMARY CARE

1.0 INTRODUCTION

1.1 In the summer of 2014 CCGs were given early indication that as part of NHS England's five year forward view there would be a need for CCGs to become involved in primary care commissioning that had previously been done through the local area teams. Work was scoped out at Greater Manchester level and was described as a number of functions and levels that you could look to express an interest in.

1.2 The CCG completed an internal readiness assessment and felt that level three was the best option (this was the highest option and gave the CCG the most scope to act autonomously) **see appendix 1**.

1.3 On the 20th June 2014 after consulting with the CCG members and wider stakeholders including the Local Medical Committee and Local Area Team we agreed to express an interest in what at the time was described level 3 **see appendix 2.**

2.0 PRIMARY CARE CO-COMMISSIONING MODELS

2.1 In November 2014 NHS England published "Next steps towards primary care co-commissioning" in which three models for primary care commissioning are described. **see appendix 3**

2.2 The models are:

- Model one – Greater involvement in primary care decision-making which is best described as Co-commissioning of primary care
- Model two – Joint commissioning of primary care
- Model three – Delegated commissioning of primary care

2.3 Across GM a number of principles were agreed that Trafford ensured we had taken into account when considering the options

- Subsidiary
  - Planning of primary care services should be done as locally as possible
  - Improving quality of primary care

2.4 Options appraisal

See table below

Models	Governance	Infrastructure	Finances	Opportunity
Model 1	Changes required to constitution	Minimal changes required	Low risk. LAT continue with responsibility	This model is very similar to the current working arrangements. It requires some time to ensure local solutions are considered and may not always be the priority within the wider GM economy
Model 2	New governance and constitution changes required	Additional staff required at CCG level – closer working with LAT core team	LAT continue to be responsible; will give time to make a full assessment of risk on moving to model 3	This option allows the CCG to develop capacity and skill while still having joint arrangements in place with the LAT. We can continue to pursue our five year strategy in integration and moving more care into primary care Disadvantages are that it lacks the level of autonomy that is given in model 3
Model 3	New governance and constitution changes required	Far greater infrastructure required – gaps in skills set	High risk. The CCG would have delegated authority for the budget – not in a position to complete due diligence in the time frame	Autonomy to make decisions and manage funds in the best way for the local population

2.5 The CCG held a number of internal workshops to consider the best model for Trafford at this point in time. The teams all felt that the best model to aim for in April 2015 was model 2 – joint commissioning.

2.6 The Council members met in December 2014 where a workshop was held for the members to consider which model if any they wished to support.

2.7 The members unanimously agreed they wanted to support model two joint commissioning but then with a move to delegated commissioning (model three within a year).

3.0 CURRENT SITUATION

3.1 In December 2014 further guidance was issued in relation to conflicts of interest and co-commissioning. **This is attached at appendix 4**

3.2 The CCG considered this guidance and have responded by developing a potential structure which will complement the existing structures but ensure transparency of decision making. **This is attached at appendix 5**

4.0 RECOMMENDATIONS

The CCG is keen to develop co-commissioning arrangements with the Local Area Team and see the opportunities in being able to commission primary care at local level. The CCG is however cautious in taking on full delegated power in year one as we feel we would want to embed the governance in, ensure we can recruit the right skill mix to support the work and also understand better the financial impact

We therefore are looking to submit a request in January 2015 to go ahead with joint commissioning – we would ask the members of the HWBB to support this.

The Health & Wellbeing Board is also asked to nominate a representative to attend the Trafford CCG Primary Care Co-Commissioning Committee. This representative will be able to play an active role in discussions but will not form part of the committee and will have no voting rights.

NHS Trafford Clinical Commissioning Group

Trafford CCG Co-Commissionng Assessement.

	Co-Commissioning Area	Corporate & Governance Position	Finance Position	Primary Care Team Position	Contracts and performance Position	Actions needed/ comments	Map to Co-commissioning Principles	Patient Involvement
1	**Managing a devolved primary care budget for local GMS/PMS contracts inc DES's**	CCG Governance Team in place with current constitution, corporate structures, and management of conflicts of interest policies to manage all conflicts. The CCG will link into GM or National work via e.g heads of governance group to develop the required changes to the CCG constitution, acknowledging the greater need for transparency and accountability connected with co-commissioning responsibilities. National co-commissioning developments and guidance will be incorporated into the governance operations as appropriate. Terms of reference of the CCG committees and sub-committees will be reviewed in accordance with National guidance to reflect the requirements of co-commissioning. The CCG would consider developing new reciprocal arrangements with neighbour CCGs where this will deliver enhanced governance and a greater robustness to manage conflict of interests. In addition we are aware of recently issued advice on LRO which provides opportunities to develop joint committees with NHS England and would expect to have discussions the AT on the feasibility of this The CCG will undertake a review in	Financial risk re budget Dual running this year Devolved budget April 2015 Due Diligence to be undertaken to assess financial risk Confirmation on effect to RCA Transparency required as to the level of funding available. Trafford proposed consideration for section 75 arrangement or run shadow budgets for at least the first 12 months to minimise risk Clarification on NHS Property services support and access to capital.	Existing team manages locally commissioned services (LCS), this includes the operational DES elements via the CCG LCS Group. This constitution of this may need review in light of co-commissioning The Clinical commissioning and finance committee would be the body which will approve all commissioning intentions including those related to Primary Care. CCFC TOR v1 Approved July 2014.c To provide greater transparency, the LCS group has representation from the patient reference and advisory panel within its membership. The primary care team is recruiting to deliver	Complete impact assessment to be undertaken as to what NHS E currently deliver. Impact on additional resource requirement on RCA .	Define TUPE implications. Resourcing assurance in CCG. Further clarity on the role of CSU in co-commissioning National guidance on co-commissioning still waited and may impact further. Due diligence in respect of each delegated area. Enhanced governance arrangements Clarity and Impact on running cost allowance. Clarity on additional recruitment needed across CCG functions given PCT resources to deliver same agenda. Impact on Delegated arrangements? Changes required to SFI's to reflect new delegations.	1) Co-commissioning with LA and Des portfolio to achieve greater integration via design of new locally commissioned services (LCS). 2) Raise standards by increasing access, quality, and patient experience via DES management and LCS development. 3) Reduced variation due to new LCS contacts at locality/population level 4) Links to health inequalities via improved DES take up and management. 5) Reduced health inequalities due to locality LCS contracts and increased range of services to the locality population. SMT will oversee Primary Care delivery and contribution to strategic objectives. CCFC will authorise expenditure QPC will monitor performance of Primary	Patient reference and advisory panel representative incorporated as a member of the locally commissioned services group overseeing the contract portfolio. PRAP ToR v1 Approved Septembe

		regard to the role of lay members across all Governance arrangements and group.		increased capacity to accommodate DES portfolio. Interim band 6 recruited. **RESOURCE IMPLICATION** DES's managed via existing primary care team with additional capacity under recruitment.			Care	
2	**Contract management of GMS/PMS/ APMS including any contractual sanctions resulting from performance issues**	Strategic change would be delivered by the Primary Care Strategy Steering Group (PCSSG) and overseen by the senior management team. The PCSSG will report into the senior management team, clinical commissioning and finance committee (CCFC) and quality and performance (Q&PC) committee as constituted. SMT will oversee Primary Care delivery and contribution to strategic objectives. CCFC internal governance will authorise expenditure in line with other priorities Q&PC will monitor performance of primary care. As highlighted in the governance arrangements in section 1, greater transparency and governance arrangements are being developed and implemented to reflect the responsibilities under co-commissioning.	Financial risk on contract budget position and resources required. Need to assess the current arrangements in place for monitoring currently undertaken by NHS England. Financial risk around over activity connected to APMS contracts.	APMS contracts will be managed by PCIT operating under revised terms of reference. Decisions on contracts will be overseen by the primary care strategy steering group reporting to the performance and quality committee. Draft Primary Care Strategy Steering Grc Issues arising from contract quality will be addressed via primary care quality Improvement group ToR for Primary Care Quality Improvement which in turn is accountable to the Quality and performance Committee	Assessment of impact and additional resources to be determined. Consideration needed with regard to CCG running cost allowance.	Definition of interaction between CCG team and AT as it relates to contract breech etc Assumption here is the CCG would address issues around the contract management Statutory issues to be considered around level of delegation.	1)Increased integration of health and social care through contract management via redesigned APMS contracts. 2) Raised standards via inclusion of contract performance into CCG local scorecard and inclusion into the primary care quality improvement programme. 5) Reduced health inequalities via management of APMS contracts.	Role of PRAP in contract decisions

				(QPC)  Quality and Performance TOR.do Updated to reflect new co-commissioning responsibilities, CCG managed contract portfolio will manage all aspects relating to quality. Where contract compliance and breech issues arise CCG will operate to agreed co-commissioning agreements with AT around contract notices etc. **RESOURCE IMPLICATION –** confirmed via existing PCIT with additional band 6 interim recruited.				
3	**Decisions on merges/splits /vacancies/ and management of associated contractual process**	Governance and Conflict issues managed via existing structures with reviews and developments CCG Corporate team to hold responsibility overseeing links to accountancy and legal services. CCG level/associated CCG level/GM CCG level processes to be developed as part of co-commissioning, decision path to determine governance support as part of transparency. All CCG governance part of ongoing review and development as outlined above in conjunction with national guidance.	Due diligence required initially to avoid financial pressure. Need to clarify CCG position regarding accountancy. Additional costs involved around legal expenditure.	The CCG Primary Care strategy group is in place and would oversee this area reporting to senior management team.  Snr Mgt Team ToR.docx Estates issues will be addressed through the existing CCG estates group reporting to primary care strategy	Impact on legal services, and costs. GM Wide CCG legal advice discussions required. Review of in house expertise around primary care contracts.	Clarity needed to remap engagement and support of Prop Co to the CCG. Clarity on legal support and costs impact. New relationships with NHS Property services established and to be further developed in line with estates and contract strategy Links to LMC demonstrable. Will build on these LMC links in connections with this	1)New determination of contract splits merges etc. gives CCG greater scope to progress integrated models. 2) Responsibility to determine contract landscape for quality improvement. 3) Contract management to remove unwarranted variation 5) Scope to reduce inequalities via contract management merging etc.	Role of PRAP

		RESOURCE IMPLICATION To be considered in the light of guidance and the role defined for the CCG. This currently implies we have a role as commissioner to fund and provide services to Practices for their own business development purposes. This may give rise to a conflict.		steering group which reports into the primary care strategy steering group CCG will review the constitution of the Estates Group to report into the CCFC. **RESOURCE IMPLICATION** Delivered via existing PCIT with additional band 6 interim recruited supported by named clinical directors Potential for CCG in respect to actions relating to Norris Road. Merger decisions - current Caplan/Stamp merge jointly progressed with AT		work area. CCG Estates group in place to oversee estates issues arising reporting through CCG corporate structures under reviews ToRs. Condition surveys of primary care estates currently being progressed to complete commissioner investment and asset management.	to improve access/service provision.	
4	**Market management of the GP primary care market, leading on procurement of new services**	Governance arrangements described above with regard to market management and conflicts of Trafford Provider Health. CCG revisions to constitution and terms of references for committees to reflect further need for transparency and conflict management. Adoption of mandatory completion of NHS Commissioning board template for declaration of conflicts of interest for all co-commissioned services (or similar should there be any revision of this in the light of national guidance on co-commissioning) The CCFC will be central to the governance of this.	Additional costs around legal and procurement of contracts expected.	GM Primary Care leads to oversee co-commissioning operational aspects Capacity via existing primary care team and heads of primary care functionality	Managed via own CCG procurement team with responsibility for market management. Additional resource via NWCSU. Where support arrangements/capacity change call off support on a project basis will be utilised. Additional Band 7 recruited and in place	Collaborative arrangements utilised where appropriate for GM wide schemes e.g out of hours.	2) CCG Market management to raise standards via a broader diverse range of providers from which to commission, managed to ensure FFP market place for future commissioning intentions. 5)Reduced health inequalities through targeted market management for service provision in hard to reach sectors.	Role of PRAP in procurement decisions.

		Note the absence of clear procurement strategy/policies creates a risk as without them we are unable to give full assurance as to how we will conduct procurement/commissioning of activities.						
5	**Management of EPRR for GP services**	Governed via exiting arrangements with revisions as required. Primary Care representation on Trafford HERG group Resources via existing CCG resources Responsibility for EPRR with corporate team and account officer. NW CSU support already in place.	All practices have responsibility to complete self-declaration for business continuity Assessments to be undertaken by CCG and aligned to CCG plans. May have additional financial impact.	PCIT would oversee and manage business continuity and resilience plans from general practice operating under revised HERG ToR Head of PCIT to join HERG Revisions of terms of reference of HERG to account of wider primary care.	Resourced from within current CCG resources, to be reviewed dependent on requirements.	Collaborative approach shared resources	2) Increased patient safety via CCG management of EPRR through improved standard of business continuity planning and preparedness of primary care.	
6	**Safeguarding**	Revised safeguarding governance to reflect change in responsibility. Dedicated resource already in place. Named CCG leads for adult and child safeguarding. Named CCG GP for Adult Safeguarding in place linked to CCG lead. Named CCG GP for Children's Safeguarding in place linked to CCG lead. Lead nurse in place. Linked with Pennine paediatric lead. Revised safeguarding governance to reflect change in responsibility	Consideration of corporate responsibility and impact in connection with revised safeguarding responsibilities.	Resource review needed to reflect work programme. Transfer of Prevent and Safeguarding training responsibilities to CCG can be delivered via existing resources. Section 11 compliance and adult safeguarding compliance responsibilities transferred to CCG may require additional resources.	No noted resource implications for safeguarding through co-commissioning.	Collaborative approach shared resources Clarify role of NHS England in assurance and oversight role.	2) Increased accountability for safeguarding locally via CCG Governing Body and Safeguarding Boards. Increased monitoring of quality and performance related directly to safeguarding.	Patient reference and advisory panel representatives incorporated into developing Safeguarding Reference Groups.
7	**Complaints management function for**	Responsibility within CCG Governance team. CCG complaints processes and systems	System cost Resource cost dependent upon system chosen. Options to utilise	Quality issues addressed via primary care team through existing processes, reporting to CCG quality and	Current governance includes quality dashboard for each practice. Impact on trends and complaints	Consideration of platform for complaint reporting	2) Increased standards for primary care with the inclusion of complaints management function. This currently is a gap in	Role of PRAP and PPGs in complaints.

	AT	in place. Conflicts managed via revised governance outlined above. **Resource Implication** This may require direct receipt of complaints through national systems or implementation of local process or collaboratively with partner CCGs. Link to AT for trend analysis. Resource implications would need to be considered following assessment of existing and predicted workloads	Datix/Ulysses or via local reporting scheme.	performance committee. Trafford CCG complaints manager in place and overseen by CCG patient experience manager.	would be included in this process.		quality monitoring process which should be greatly improved through a range of improved processes. Shared learnings through complaints via CCG education events 4) Enhanced patient and public involvement via PRAP inclusion in governance process. Increased patient involvement at practice level through complaints feedback to PPG's. CCG level sharing of trends.	
8	**PMS reviews**	CCG Governance structures reviews for absolute clarity around PMS reviews. Link to emerging national guidance. CCG will make revisions to manage conflicts as it relates to PMS reviews following national guidance issues October 2014. Option to undertake collaborative/reciprocal reviews with neighbour CCGs or at Association of CCG level **RESOURCE IMPLICATION** Via existing teams.	Only undertaken following due diligence and conditional on funding remaining within Trafford economy as per National guidance Section 75 arrangements to be considered.	Resource within existing Primary care team.	Utilisation of existing contract teams with possible additional support	PMS reviews would follow National Guidance (Oct 2014) and support maintenance of savings at locality level PMS reviews in scope subject to conditions around freed up resources remaining in Trafford CCG	2) Raised standards through reinvestment of funds from reviewed PMS contracts. 3)Reduced variation in quality via contract reviews. 5) Reduced health inequalities via reinvestment decisions follow PMS reviews.	Oversight by PRAP and Audit committee to ensure transparency.
9	**Devolved budget and responsibility for APMS contracts**	Governance via existing arrangements With reciprocal CCG support to manage conflicts. **RESOURCE IMPLICATION** Procurement of APMS undertaken via in house procurement team supported by NW CSU and call off project/accountancy/legal where required. This needs to be built into work programs.	**RESOURCE IMPLICATION** Risk of budget allocation and resource transfer Assumption that cost savings remains at locality level.	APMS Contracts managed via the existing PCIT reporting into revised Governance structures.	**RESOURCE IMPLICATION?** Development of primary care contracting support? Supported via CCG procurement team. Additional support required from legal and contracts. Call off arrangements by project could be required.	Primary care team budget?	1)Greater integration via renegotiated APMS contracts, and link to APMS contract and OOH contract. 2) Raised quality through decommissioned contracts with quality KPIs 3)Reduced unwarranted variation in quality via enhanced access through APMS 4) Involvement of patients	

							and public in redesign work around APMS. 5)Reduced inequalities through improved access and services through APMS contracts	
10	**Contract management of Directed enhanced services, alongside join up of LA led services**	Existing Governance structure to oversee portfolio. Revisions to processes developed to ensure enhanced transparency **RESOURCE IMPLICATION** Via existing team	Risk of under-funded budget for enhanced services RESOURCE IMPLICATION dependent on budget position.	Complete enhanced service portfolio managed via PCIT existing resource. Additional resource being recruited – Interim GM Primary care leads already undertaking stocktake of all co-commissioning activities to the various levels Existing locally commissioned services group xLCS ToR July 2014 Final.pdf reporting into existing governance structures. This includes local authority membership and could progress co-commissioning across local authority services.	Impact on contracting function to support PCIT	Redefined CCG contracting functions to support primary care	1) Co-commissioning with LA and DES portfolio to achieve greater integration via design of new locally commissioned services (LCS). 2) Raise standards by increasing access, quality, and patient experience via DES management and LCS development. 3) Reduced variation due to new LCS contacts at locality/population level 4) Links to health inequalities via improved DES take up and management. 5) Reduced health inequalities due to locality LCS contracts and increased range of services to the locality population.	
11	**Management of discretionary payments**	COI managed via existing governance arrangements with possible reciprocal arrangements with neighbour CCG/AT Trafford CCG Audit Committee under revised terms of reference would oversee all discretionary payments made.	Budget risk. Due diligence required of historic levels to budget Payment made under revised CCG scheme of delegation	No resource implication identified	No resource implication identified	Review of current scheme of delegation arrangements to ensure fitness for purpose. Acknowledgement of conflicts of interest require CCG revised governance		

						arrangements		
12	**Primary Care Education and Training**	Draft CCG education and training strategy in place. Strategy group level determination for education programme. Education working group with oversight by the primary care strategy steering group, reporting into existing corporate structures. Dedicated clinical lead with nurse educators and admin support in place. Corporate leadership, Development and succession planning currently undertaken by the CCG. Existing clinical director with AQUA role and links to GM quality work, linking to internal programmes. CCG clinical structures in place via directors and associates which would require further development to support co-commissioning.	Budget risk dependant on scope to co-commissioning.	The CCG supports primary care with education and training events and small focused team. This is being developed to support the CCG strategic plan and the primary care strategy. The strategy is overseen and developed via existing clinical lead education working group. Education Workgroup TOR 26.(**RESOURCE IMPLICATION** Education and training undertaken via existing educational team consisting of GP lead, nurse educators, practice manager. Existing CCG education strategy in place and links to quarterly education events. Lack of capacity to undertake a wider educational remit than current	No resource implication identified	Understand detail? MPETT LPN HEE etc. Appraisal is not expected to be part of Trafford CCG co-commissioning arrangements. Large agenda Collaborative approach	1) Increased integration via education and training arrangements designed around need with links to workforce planning and CCG needs assessment. 2) Raised standards via education and training to primary care focussed and training needs. 3) Reduced unwarranted variations through targeted education and training for quality improvement based on education needs assessment. 4) Reduced health inequalities through education and straining strategy.	
13	**Estates – strategic planning and**	Governed via existing CCG Estates Group linking to existing Governance structure to be fully developed and constituted. Resources need to be built into work	Risk of budget Capital/revenue Estate legal cost pressure	Primary Care estate project manager in place. Primary Care Estates Steering Group already	Link to NHS Property services	Requires re-negotiated support from Prop Co Clarity needed to remap engagement and	1)Greater integration through determination of estates designed to integrate services.	Role of PRAP Role of lay members on groups to enhance governance

	prioritisation of investment	plans. Existing CCG estates groups in place linking to AT capital pipeline groups in order to prioritise. Link to Trafford CCG primary Care Strategy and locality model development with health and wellbeing hubs across Trafford.	Need for due diligence Resources for legal/contracts/surveys etc required.	in place. Draft Primary Care Estates Group ToR v5 The primary care estate group already links into area team pipeline group on capital and investment decisions.		support of Prop Co to the CCG. Clarity on legal support and costs impact. New relationships with NHS Property services established and to be further developed in line with estates and contract strategy Links to LMC demonstrable. Will build on these LMC links in connections with this work area. CCG Estates group in place to oversee estates issues arising reporting through CCG corporate structures under reviews ToRs. Condition surveys of primary care estates currently being progressed to complete commissioner investment and asset management.	2) Raised standards via estate improvement and investment decisions. Improved fitness for purpose primary care estate. Improved infection prevention and control status through CCG development and investment decisions. 3) Reduced variation in quality of the estate through equitable investment and estate development. 4) Enhanced patient and public involvement through inclusion in strategy setting and decision making. Improved patient experience through improved primary care estates provision. 5) Health inequalities reduced through CCG targeted investment in estates in high need areas.	
14	**Workforce planning**	Responsibility for workforce planning will be within CCG Corporate team. Locality planning for workforce/skills and competency.	No resource implication identified	**RESOURCE IMPLICATION?** Federated localities currently under PCIT support. Existing localities in place to inform workforce plans at a local level. Trafford high GM return on national workforce survey. Locality federation group in place	No resource implication identified	Collaborative approach New area requiring large resource depending on how wide agenda Local planning – retirements etc Locality skills and competency linked to corporate strategy and service development needs. Links to HEE and professional networks	1)Improved integration through workforce development planning based on locality needs assessment. Local ownership of workforce planning to deliver improved workforce data. 2) Improved quality, safety and patient experience through increased staffing, skills and competencies. 5) Reduced health inequalities through	

				LFG ToR Aug 2014 v5.docx to oversee locality plans reporting to PCSSG			improved workforce numbers, skills and competencies.	

The co-commissioning agenda forms part of the Trafford CCG primary care strategy, and is seen as a key enabler for the achievement of the outcomes within the Trafford CCG commissioning strategic plan.

Trafford-CCG-Strategic-Plan.pdf

Primary Care Strategy 2014-2018.

Co-commissioning within Trafford is underpinned by the following co-commissioning principles;

1) To achieve greater integration of health and social care

2) To raise standards of quality in GP including, clinical effectiveness, patient experience, patient safety

3) To reduce unwarranted variations in quality

4) To enhance patient and public involvement

5) To reduce health inequalities

6) Due diligence undertaken for each co-commissioning activity

7) National guidance may impact on Trafford assessment and may require revisions accordingly

The following highlights key themes to concentrate on under the umbrella of governance over the medium-long term towards April 2015;

- Delegated/Joint governance arrangements with NHS England - current governance structure to undergo significant review with consideration for either or both delegated and joint arrangements throughout the various operational aspects at the level of co-commissioning, in ensuring the appropriate level of assurance is achieved and retained to NHS England's satisfaction moving forward.
- Conflict of Interest – Add further control around co-commissioning decision making, with the re-drafting of our existing policies and factoring into the governance arrangements from the beginning of the process at procurement/commissioning to its conclusion at decision and the involvement (and not where necessary) of GPs along that process.
- GP Federations - Co-Commissioning needs to work in tandem with GP federation development to ensure that we can provide assurance on delivery overall but also on specifics e.g. sustainable economies of scale in Primary Care, estates development etc. in providing ongoing assurances.

Fundamental principles to how Primary Care is governed across our governance structure are as follows:

- Public Reference Advisory Panel - Public Engagement of Primary Care (ToR embedded above)
- Senior Management Team - Oversee Primary Care design (ToR embedded above)
- Clinical Commissioning & Finance Committee - Authorise expenditure and delivery of Primary Care (ToR embedded above)
- Quality & Performance Committee - Monitor performance of Primary Care (ToR embedded above)

Key Discussion Areas.

Clarity on levels of co-commissioning

Which areas are co-commissioned at CCG/associate CCG/Association of CCG/ level

National Guidance

In scope/out of scope

Budgets/due diligence

Running cost allowance

GM CCG constitutional changes

Conflicts of interest

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Our Ref: GL/JC/JY14/010NHSE

20 June 2014

Dear Colleagues,

Re: Co-commissioning of Primary Care Services - Trafford CCG Primary Care Commissioning Expression of Interest

Please find attached Trafford CCG's Primary Care Commissioning Expression of Interest.

This has been developed in response to the letter communicated by Simon Stevens. If you wish to discuss further, please contact me at gina.lawrence@nhs.net or 0161 873 9692.

Yours sincerely

G. Lawrence

Gina Lawrence
Chief Operating Officer
Trafford Clinical Commissioning Group

cc:	Rob Bellingham	Director of Primary Care, NHS England
	Nigel Guest	Chief Clinical Officer, Trafford CCG
	Julie Crossley	Associate Director of Commissioning, Trafford CCG
	Jason Swift	Head of Primary Care Interface, Trafford CCG

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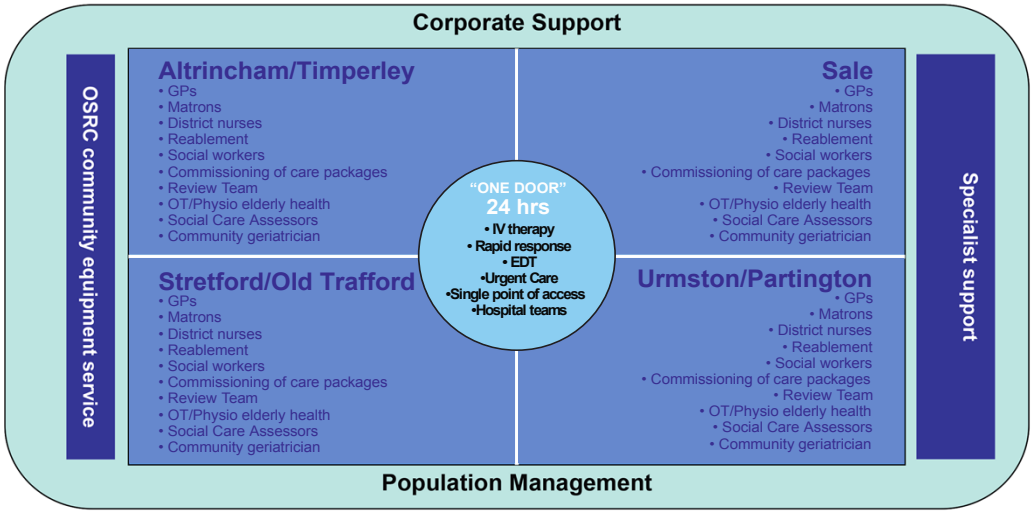
Expression of interest for co- commissioning of primary care in Trafford

Background

The Trafford story

Trafford has been developing its integrated services for the last five years. The community services are well established with a wide range of services including 24 hour rapid response teams, community geriatrians and matrons to name but a few. The services are well utilised and we are starting to impacts on acute services. Trafford community services are integrated with health and social care working as single team in both adult and children's services.

As part of this work Trafford has developed a neighbourhood model approach with four localities. This foot print matches the Borough council and also the polices delivery model. The four localities have integrated services that support and wrap around the practises offering early intervention and extended support to all patients.



In order to ensure services are used to their full potential Trafford CCG is developing a primary care co-ordination centre. This will house the latest technology which will track patients through the systems of health and social care. This is centre with the commissioned jointly by the CCQ council and ensures that people are sign posted through the system. The centre will have clinicians available who will work closely with the practices ensuring high quality referrals are made and where required, any additional services are booked these include transport, self care advice, and social care. The centres will co-ordinate the risk stratification and complex patients and alert primary care that will put in place care planning and where appropriate integrated community services.

Primary care the story so far

To continue the Trafford story of integration we have been developing the primary care offer to respond to the changing service provision in the area. As a CCG we have been somewhat restricted by not having the scope to change and alter primary care at pace due to the constraints within the local area team with their small primary care team . We therefore are really keen to take on a wider role within the co-commissioned services so we can continue with our implementation of integration at scale and pace.

The practices have been working together to agree a model for primary care which involves a collaborative approach that is underpinned by new and aligned infrastructure and support from existing community provision such as out of hours services. The model focuses on intra and inter support and advice, as well as innovative new ways of working. This is all reflected in our primary care strategy and also the 5 yr strategic plan

As outlined in the Call to action improving general practice (May 2014) a key action is defining, measuring and publishing information on quality. Trafford CCG has a well embedded system of quality reviews with local GPs. This includes a state of the art electronic score card system that allows GP to measure and benchmark their performance and data against other practices and peers within their own practice this is supported by practice visits. The CCG has an experienced primary care education team that develop programmes of work to match the needs of the local clinicians

Below we have outlined the models of care we are looking to bring in

Locality Risk Stratification – Risk stratified general practice populations, which are integrated with health and social care teams. This development identifies those patients most at risk of an unplanned hospital contact. Approximately 4,000 will be placed on a register and identified to both general practice and multidisciplinary teams (MDT). The response from which will be a care coordinated approach to MDT patient centred management, which rapidly responds to the patient needs both in and out of hours to deliver one stop 24 hours response to manage the patient outside of hospital where this is appropriate.

Enhanced Access – Patients will be able to access planned bookable appointments for patients until 8 pm each weekday evening, and Saturday and Sunday till 6pm. This locality development will provide patients with enhanced level of access previously not available.

Neighbourhood locally commissioned services for minor surgery, near patient testing, diabetic services, phlebotomy, physiotherapy, primary care diagnostics, cardiology/ECG's, musculo-skeletal, dermatology, integrated district nursing and social care, screening clinics and paediatric clinics, and minor injury/ailment clinics will be developed. These new services could be delivered from new locality health and wellbeing hubs which will see a shift in care delivered closer to patients homes. Due to the services being provided at locality population level, previous inequality of service provision will be addressed.

Locality Patient Information Solution

The CCG will look to deliver an integrated patient information solution to deliver enhanced access, and integrated care 7 days a week across Trafford. Patient information in the form of a single care record, accessible by all stakeholders in the patients care multidisciplinary team, will be able to see a full record and be able to record care interventions to ensure continuity of care across provider organisations.

Primary Care Standards

To underpin the new model, Trafford CCG aspires to deliver the Greater Manchester standards for primary care, namely,

By the end of next year, (2015), all children across GM under the age of 5 will be able to access same day appointments within general practice

By the end of 2016, (sooner in many parts of Greater Manchester), all patients will be able to:

- get advice from a doctor or nurse 24 hours a day
- be seen within 2 hours for an urgent problem
- be seen on the same day if necessary
- be seen within 48 hours if requested
- Have seven day access to GP and associated services

By 2015, every patient with a long term condition or multiple conditions requiring a care plan, will have a care plan accessible by the patient and all those treating and caring for him/her to develop greater personal resilience and enable greater collaborative working of care professionals

By 2016, all residents will be able to see how their general practice performs against key local and national quality indicators and use this information to ensure they are receiving optimum care

By 2016, all patients who wish to access their own electronic record will be able to do so

By 2017 Patients will be able to access a greater range of health services within their communities easily and those services will work together to ensure care remains within primary and community care wherever appropriate

Estate Provision

Under the proposed co-commissioning arrangements, new locality hubs will house integrated care teams and provide for the coordination of patient care. Greater localized arrangements under a CCG estate strategy and governance will better determine the landscape and help secure the future model of enhanced primary and community care in Trafford.

Our plans and aspirations for co-commissioning

As stated above the CCG have looked towards doing more primary care work for some time. The relationship we have had with the local area team is extremely good and we have always worked in a co-commissioning way on an informal basis. We see this as a way of strengthening and legitimising that bond. We are keen to pursue new models of care that align to the integrated care strategy.

The expression of interest is from NHS Trafford CCG as an individual CCG. However, discussions with NHS England Greater Manchester local area team have defined four levels of co-commissioning (attached) ranging from level one planning, level two jointly designing, reviewing and managing contracts, level three delegated budget for aspects of primary care contracts and associated contract management and level four managing a devolved primary care budget for local APMS/PMS/GMS contracts.

It is the intention of NHS Trafford CCG to co-commission at level four for the whole Trafford population.

Level of commissioning aspired to by the CCG

We believe that we are in a strong position as commissioners to manage a range of primary care functions. We have considered the GM primary care commissioning document (see attached) and believe we can commit to integrating a range of functions in to our already well established skilled primary care team. The scope and nature of co-commissioning arrangements in Trafford is outlined below.

Trafford CCG currently doing	Trafford CCG interested in taking on	Trafford CCG would not want to take on
▪ Assessing needs ▪ Designing services/models ▪ Developing strategic direction for services ▪ Liaison with partners ▪ Strategic Planning of local Estates with prioritisation of investment via GM governance arrangements ▪ Improving quality and reducing variation	▪ APMS contracts ▪ Jointly deciding appropriate arrangements for practice splits/mergers ▪ Jointly agreement priorities for discretionary spend on premises etc ▪ Jointly reviewing APMS contracts and deciding strategic direction and scope ▪ Contract management of Directed Enhances Services alongside Locally commissioned services ▪ (Potential to also join up commissioning of LA led Enhanced services ▪ This would include decisions on practice mergers/splits/vacancies and management of associated contractual process ▪ Managing the GP primary care market by leading on procurement of new	▪ Contract management of core Optical/Dental/Pharmacy ▪ GMS/PMS contracts ▪ Contract management of PMS/GMS contracts, including any contractual sanctions resulting from performance issues ▪ Jointly reviewing PMS contracts and deciding strategic direction and scope

	services ▪ Possibly provision of complaints management function for AT ▪ Management of EPRR for GP services ▪ Safeguarding ▪ Managing discretionary payments (pending Area Team clarification) ▪ Primary Care Education & Training (pending Area Team clarification)	

Intended benefits

Under the co-commissioning arrangements outlined in this expression of interest, the implementation of the new model for integrated primary care is expected to deliver the following benefits which align with the CCG commissioning strategy plan;

- 15% reduction in unplanned admissions to hospital, attendances to A&E departments and unplanned admission excess bed days.
- Greater integration of general practice and multi-disciplinary teams will deliver improved quality of care. Patients will experience a more cohesive journey through the health system and see greater amounts of care delivered within or closer to home.
- Integrated patient information under a single system will reduce duplication of record taking, and asking the patient for the same information by different providers within the same episode of care.
- A single care plan accessible by all care providers who need access, along with patient access to the record, will deliver improved continuity of care with out of hour's providers or community service providers being able to see the full record to support a quality intervention.
- Greater improved access into the evenings mid week and at weekends will give a vastly improved service to the population.
- Locality collaborative working will see an increase in the range of services offered to patients. Historical inequality of service provision due to variation in local enhanced service provision will be reduced as greater access to services is offered by services at locality population level.

Timescale

Working with GM local area team colleagues, Trafford CCG would look to secure the expected benefits of the new co-commissioning arrangements as soon as practicable and within 2014/15.

Any newly delegated budgets would be expected to be in place for 2015/16 financial year.

Governance

NHS Trafford already operates under strict governance guidelines and under a published constitution. This includes robust arrangements with an audited conflict of interest process which extends beyond the CCG to include all member practices, not just those within the governing body.

It is not envisaged that this expression of interest for new co-commissioning arrangements affects the commissioning process such that any change is required, and that the CCG will manage any conflicts within current policy.

Engagement with member practices and stakeholders

As part of this expression of interest the CCG has undertaken the following engagement activities;

- Engagement with all member practices at the council of members and local medical committee meetings
- Discussion with local authority colleagues and health and wellbeing board stakeholders
- Patient groups

Monitoring and Evaluation

NHS Trafford has a productive working relationship with the GM LAT and through existing meeting structures will regularly review the delivery of the intended benefits and issues arising from the new co-commissioning arrangements. This will be secured through Chief Operating officers meetings, GM Primary Care Leads meetings and planned meetings to address emergent issues.

Next steps towards primary care co-commissioning

November 2014

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	**Commissioning Strategy**
Finance		

Publications Gateway Reference:	**02501**
Document Purpose	Implementation Support
Document Name	Next steps towards primary care co-commissioning
Author	NHS England and NHS Clinical Commissioners
Publication Date	10 November 2014
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, NHS England Regional Directors, NHS England Area Directors, GPs, NHS Commissioning Assembly
Additional Circulation List	National Association of Primary Care, Monitor, NHS Alliance, BMA (GP Committee), GMC, RCGP, DH, Healthwatch England, National Voices, All NHS England Employees
Description	This document aims to provide clarity and transparency around co-commissioning options, providing CCGs and area teams with the information and tools they need to choose and implement the right form of co-commissioning for their local health economy.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	Submit proposals, if required, in January 2015
Timing / Deadlines (if applicable)	**Implementation from 01 / 04 / 15**
Contact Details for further information	Julia Simon Co-commissioning of primary care Skipton House London Road SE1 6LH 01138 248 413

Document Status

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Next steps towards primary care co-commissioning

First published: November 2014

Prepared by: Ian Dodge, National Director: Commissioning Strategy

Classification: Official

Foreword by Amanda Doyle and Ian Dodge

"General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain … Steps we will take include … [giving] GP-led clinical commissioning GPs more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services".

The NHS Five Year Forward View, October 2014

The introduction of co-commissioning is an essential step towards expanding and strengthening primary medical care.

Co-commissioning is recognition that clinical commissioning groups (CCGs):

- are harnessing clinical insight and energy to drive changes in their local health systems that have not been achievable before now;

but

- are hindered from taking an holistic and integrated approach to improving healthcare for their local populations, due to their lack of say over the commissioning of both primary care and some specialised services; and

- are unable to unlock the full potential of their statutory duty to help improve the quality of general practice for patients.

That's why NHS England is giving CCGs the opportunity to assume greater power and influence over the commissioning of primary medical care from April 2015.

Although we are confident that co-commissioning - or delegation to CCGs - is in the best interests of patients, the *offer* from NHS England is just that: it is for each and every CCG to consider carefully, and make up its own mind as to how it will respond.

We know that the imposition of a single national solution just won't work, and will fail to take into account different local contexts.

CCGs are GP-led organisations. CCGs understand primary care, and are passionate about improving its quality, across all practices in their own geographical areas.

At the same time, individual GPs will also be conflicted in specific decisions about primary care commissioning. So, in order to harness the benefits of co-commissioning, yet guard fully against the risks, we have developed robust new and transparent arrangements for managing perceived and actual conflicts of interest. NHS England is formally consulting on these before issuing as statutory guidance for the first time.

In progressing this agenda, we have sought to provide NHS England and CCG leadership that is genuinely joint and open - and which has also involved lay members and councils.

In our discussions, we have promoted vigorous debate and challenge. We intend our approach to serve as a model for wider collaboration across NHS England and CCGs, right across the breadth of our shared agenda.

Right across the country, we are confident that CCGs and NHS England regions and areas will approach co-commissioning in a spirit of openness, partnership and practical problem solving.

We are optimistic that the agreements we have reached and proposals we set out in this document pave the way for better services for patients, and better value for the taxpayer. The proof is, of course, only in the doing - and the public evaluation of the doing.

This piece of paper signals the next stage in co-commissioning. By no means is it the end of the story. We will continue to work together closely to pick up and resolve teething troubles and to assess progress.

Ian Dodge
National Director:
Commissioning Strategy,
NHS England

Dr Amanda Doyle
Chief Clinical Officer,
NHS Blackpool CCG;
Co-chair, NHS Clinical Commissioners

Contents

1 Executive summary

Next steps towards primary care co-commissioning gives clinical commissioning groups (CCGs) the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements. The document has been developed by the joint CCG and NHS England Primary Care Commissioning Programme Oversight Group in partnership with NHS Clinical Commissioners.

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning **models** CCGs could take forward:

The **scope** of primary care co-commissioning in 2015/16 is general practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

Under joint and delegated arrangements, CCGs will have the opportunity to design a **local incentive scheme** as an alternative to the Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DES). This is without prejudice to the right of GMS practices to their entitlements, which are negotiated and set nationally. In order to ensure national consistency and delivery of the democratically-set goals for the NHS outlined in the Mandate set for us by the government, NHS England will continue to set national standing rules, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing **contracts for primary care provision** or award new ones, depending on local circumstances. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest. In delegated

arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

With regards to **governance** arrangements, we have developed draft governance frameworks and terms of reference for joint and delegated arrangements on behalf of CCGs, as appended in annex D, E and F. CCGs are encouraged to utilise these resources when establishing their governance arrangements.

A significant challenge of primary care co-commissioning is finding a way to ensure that CCGs can access the necessary **resources** as they take on new responsibilities. Pragmatic and flexible local arrangements for 2015/16 will need to be agreed by CCGs and area teams.

Conflicts of interest need to be carefully managed within co-commissioning. Whilst there is already conflicts of interest guidance in place for CCGs, this will be strengthened in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. A national framework for conflicts of interest in primary care co-commissioning will be published as statutory guidance in December 2014.

The **approvals process** for co-commissioning arrangements will be straightforward. The aim is to support as many CCGs as possible to implement co-commissioning arrangements by 1 April 2015. Unless a CCG has serious governance issues or is in a state akin to “special measures”, NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs who wish to implement joint or delegated arrangements will be required to complete a short proforma (annex A and B) and request a constitution amendment. The approvals process will be led by regional moderation panels with the new NHS England commissioning committee providing final sign off for delegated arrangements.

We also intend to make it as simple as possible for CCGs to **change their co-commissioning model**, should they so wish. Should this need arise, CCGs should discuss their plans with the relevant area team in the first instance as part of the CCG assurance process.

On-going assurance of co-commissioning arrangements will form part of the wider CCG assurance process. NHS England intends to work with CCGs to co-develop a revised approach to the current CCG assurance framework. NHS England will also ensure it continually **evaluates** the implementation of co-commissioning arrangements to share best practice and lessons learned with CCGs and area teams.

We hope this document is useful in helping to inform CCG decision making around primary care co-commissioning models and in providing clarity on the next steps towards the implementation of new arrangements. If you require any further information, please email: england.co-commissioning@nhs.net.

2 Background and context

In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. There has been a strong response from CCGs wishing to assume co-commissioning responsibilities. We want to harness this energy and address the frustrations CCGs have expressed in the current primary care commissioning arrangements, to more effectively shape high quality local services.

There are three possible models of primary care commissioning that CCGs could pursue:

The purpose of this document is to give CCGs an opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each model, including associated functions; governance arrangements; resources; and any potential risks, with advice on how to mitigate these. The document then sets out the steps towards implementing co-commissioning arrangements, including the timeline and approvals process.

This document is accompanied by a suite of practical resources and tools which are appended to support local implementation of co-commissioning arrangements. In addition, a national framework for the handling of conflicts of interest management for primary care co-commissioning is under development in partnership with NHS Clinical Commissioners. Whilst there is already conflicts of interest guidance in place for CCGs, we are strengthening this in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. The conflicts of interest framework will be published as statutory guidance in December 2014.

This document has been jointly developed with CCGs and NHS England through the Primary Care Co-commissioning Programme Oversight Group. The group is co-chaired by Dr Amanda Doyle (Chief Clinical Officer, NHS Blackpool CCG and Co-chair, NHS Clinical Commissioners) and Ian Dodge (National Director: Commissioning Strategy, NHS England) with membership set out in annex G. It has also been developed in partnership with NHS Clinical Commissioners.

3 Vision and aims of co-commissioning

This section sets out the long term vision for co-commissioning and the potential benefits it could bring for local populations.

Co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. The *Forward View* emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will drive the development of new integrated out-of hospital models of care, such as multispecialty community providers and primary and acute care systems.

Co-commissioning will give CCGs the option of having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained.

Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities; and
- A better patient experience through more joined up services.

Co-commissioning could also lead to greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services. Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

Primary care co-commissioning is the beginning of a longer journey towards place based commissioning – where different commissioners come together to jointly agree commissioning strategies and plans, using pooled funds, for services for a local population.

From 1 April 2015 we will be extending personal commissioning through The Integrated Personal Commissioning (IPC) programme. The IPC programme aims to bring health and social care together, identifying the totality of expenditure at the level of the individual, giving people more control over how this is used and enabling money to be spent in a more tailored way.

Furthermore, from 2015/16 CCGs will have the opportunity to co-commission some specialised services through a joint committee. We have also been encouraging CCGs and local authorities to strengthen their partnership approach so they can jointly and effectively work to align commissioning intentions for NHS, social care and public health services.

4 Scope of co-commissioning models

This section aims to support CCGs to make an informed decision on which co-commissioning model they would like to take forward. For each co-commissioning model, it set outs :

- the primary care commissioning functions it includes;
- governance arrangements; and
- opportunities, potential benefits and risks.

4.1 Overview of co-commissioning functions

The first step on the co-commissioning journey is for CCGs to decide which form of co-commissioning they would like to assume. There are three forms of co-commissioning CCGs could adopt:

In this section we aim to provide clarity and transparency around what each co-commissioning model would entail to support CCGs in their decision making.

4.1.1 Scope of primary care co-commissioning

Primary care commissioning covers a wide spectrum of activity. We have engaged with a large number of CCGs to agree the functions each co-commissioning model will encompass. We have agreed that in 2015/16, primary care co-commissioning arrangements will only include general practice services. CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no formal decision making role.

However, we recognise the ambition in some CCGs to take on a greater level of responsibility in the commissioning of dental, eye health and community pharmacy services and we will be looking into this for 2016/17, with full and proper engagement of the relevant professional groups.

4.1.2 **Local flexibilities for incentive schemes and contracts**

The purpose of primary care co-commissioning is to enable clinically led, optimal local solutions in response to local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies. This will be done by delegating functions and decision making to the local level.

Under delegated arrangements, CCGs would have the ability to offer GP practices the opportunity to participate in a locally designed contract, sensitive to the diverse needs of their particular communities, above or different from the national requirements e.g., as an alternative to QOF or directed enhanced services (DES). Similarly under joint arrangements, NHS England and CCGs could explore the option of implementing a locally designed incentive scheme. This is without prejudice to the rights of practices to their GMS entitlements which are negotiated and agreed nationally. Any migration from a national standard contract could only be affected through voluntary action.

In designing their own approach, it would be useful for CCGs that wish to design a new local incentive scheme to review the evaluation of the Somerset Practice Quality Scheme, as we learn more about this pilot initiative.

There will be no formal approvals process for a CCG which wishes to develop a local QOF scheme or DES. However, any proposed new incentive scheme should be subject to consultation with the Local Medical Committee (LMC), and be able to demonstrate improved outcomes, reduced inequalities and value for money. On-going assurance of new schemes would form part of the CCG assurance process.

With the freedoms of co-commissioning arises the need for mitigation of the potential risks of inconsistency of approach in areas where national consistency is clearly desirable. There is already an ability to set out core national requirements in GMS, PMS and APMS contracts through regulations. In line with this, NHS England reserves the right to set national standing rules, as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets and IT intra-operability. The standing rules would become part of a binding agreement underpinning the delegation of functions and budgets from NHS England to CCGs.

4.1.3 **Commissioning and awarding contracts for primary care provision**

In joint arrangements, commissioning decisions would be taken by the CCG and NHS England area team. In delegated arrangements, CCGs would be responsible for taking these decisions.

In joint and delegated arrangements - as is the case for any services that they commission - CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances.

In delegated arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act. In delegated and joint arrangements, where a CCG or a CCG and NHS England are found to have breached public procurement regulations and/or statutory guidance on conflicts of interest, Monitor may direct a CCG or a CCG and NHS England to act. NHS England may, ultimately, revoke a CCG's delegation.

Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities. This applies to joint and delegated arrangements.

4.1.4 **Parameters of primary care co-commissioning**

For all forms of primary care co-commissioning, there has been clear feedback from CCGs that it would not be appropriate for CCGs to take on certain specific pseudo-employer responsibilities around co-commissioning of primary medical care. We have therefore agreed that functions relating to individual GP performance management (medical performers' list for GPs, appraisal and revalidation) will be reserved to NHS England. NHS England will also be responsible for the administration of payments and list management. CCGs must assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.

Furthermore, the terms of GMS contracts – and any nationally determined elements of PMS and APMS contracts – will continue to be set out in the respective regulations and directions and cannot be varied by CCGs or joint committees.

For the avoidance of doubt, CCGs will be required to adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

4.1.5 **Summary of co-commissioning functions**

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	Yes
Pharmacy, eye health and dental commissioning	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role
Design and implementation of local incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, revalidation	No	No	No

Further information on each co-commissioning model and the functions it encompasses is set out in section 4.2 to 4.4.

4.2 Greater involvement in primary care co-commissioning: scope and functions

Greater involvement in primary care co-commissioning is simply an invitation to CCGs to collaborate more closely with their area teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy. This form of co-commissioning will assist CCGs to fulfil their duty to improve the quality of primary medical care[1].

4.2.1 Scope of greater involvement in primary care commissioning

CCGs who wish to have greater involvement in primary care decision making could participate in discussions about all areas of primary care including primary medical care, eye health, dental and community pharmacy services, provided that NHS England retains its statutory decision-making responsibilities and there is appropriate involvement of local professional networks.

4.2.2 Governance arrangements for greater involvement in primary care decision making

No new governance arrangements would be required for a CCG to have greater involvement in the commissioning of primary care services and this involvement could be agreed between the CCG and its area team at any time. The effectiveness of these arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. It is in the CCG and area team's own interest to also engage local authorities, local Health and Wellbeing Boards and local communities in primary care decision making.

A CCG which adopts this model of co-commissioning is unlikely to encounter an increased number of conflicts of interest, as CCGs would not have formal accountability for decision making. However, they would need to remain mindful of conflicts of interests and follow prescribed guidance as set out in section 6.

In this model, CCGs have the opportunity - already available to them - to invest in primary care services. Annex H contains a series of frequently asked questions (FAQs) on investing in primary care for CCGs and area teams. Further details on the next steps to take forward this form of co-commissioning can be found in section 7.2.

[1] Section 14S NHS Act 2006 (as amended by the Health and Social Care Act 2012).

4.3 Joint commissioning arrangements: scope and functions

A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". Joint commissioning arrangements give CCGs and area teams an opportunity to more effectively plan and improve the provision of out-of hospital services for the benefit of patients and local populations. Within this model CCGs also have the option to pool funding for investment in primary care services as set out in section 4.3.3.

4.3.1 Joint commissioning functions

In 2015/16, joint commissioning arrangements will be limited to general practice services. The functions joint committees could cover are:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

Joint commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS

England will also be responsible for the administration of payments and list management.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.3.2 **Joint commissioning governance arrangements**

CCGs could either form a joint committee or "committees in common" with their area team in order to jointly commission primary medical services.[2] With regards to joint committees, due to the passing of a Legislative Reform Order (LRO) by parliament, CCGs can now form a joint committee with one or more CCGs and NHS England. Further information on the LRO can be found here. NHS England's scheme of delegation is being reviewed and will be revised as appropriate to enable the formation of joint committees between NHS England and CCGs i.e., where NHS England invites one or more CCGs to form a joint committee.

A model terms of reference for joint commissioning arrangements, including scheme of delegation, are appended at annex D. This model applies to the establishment of a joint committee between the CCG (or CCGs) and NHS England. If CCGs and area teams intend to form a joint committee, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures. The joint committee structure allows a more efficient and effective way of working together than a committees-in-common approach and so this is the recommended governance structure for joint commissioning arrangements.

In joint commissioning arrangements, individual CCGs and NHS England always remain accountable for meeting their own statutory duties, for instance in relation to quality, financial resources, equality, health inequalities and public participation[3]. This means that in this arrangement, NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. CCGs and NHS England must ensure that any governance arrangement they put in place does not compromise their respective ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making. Arrangements should also comply with the conflicts of interest guidance – please refer to section 6 for further information.

The effectiveness of joint arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. NHS England and CCGs need to ensure that any governance arrangements put in place enable them to collaborate effectively.

[2] A joint committee is a single committee to which multiple bodies (e.g. NHS England and one or more CCGs) delegate decision-making on particular matters. The joint committee then considers the issues in question and makes a single decision. In contrast, under a committees-in-common approach, each committee must still make its own decision on the issues in question.

[3] In the CCG's case these duties are set out in sections 14R, 14R, 14Z1, 14Z11, 14Z15, 223H, 223I, 223J and 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012; the Equality Act 2010.

Membership of joint committees

It is for area teams and CCGs to agree the full membership of their joint committees. In the interests of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the joint committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. It will be important to retain clinical leadership of commissioning in a joint committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.3.3 Pooled funds for joint commissioning

CCGs and area teams may wish to consider implementing a pooled fund arrangement under joint commissioning arrangements as per section 13V of Chapter A1 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Establishing a pooled fund will require close working between CCG and area team finance colleagues to ensure that the arrangement establishes clear financial controls and risk management systems and has clear accountability arrangements in place.

The funding of core primary medical services is an NHS England statutory function. Although NHS England can create a pooled fund which a CCG can contribute to, the CCG's contribution must relate to its own functions and so could not relate to core primary medical services. However, CCGs are able to invest in a way that is calculated to facilitate or is conducive or incidental to the provision of primary medical care and provided that no other body has a statutory duty to provide that funding. For example,

Where an area team currently commissions services using an APMS contract they could consider pooling funds with a CCG to secure a wider range of services, for example, enhanced care for vulnerable older people.

Further details on the next steps to take forward joint commissioning can be found in section 7.3.

4.4 Delegated commissioning arrangements: scope and functions

Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. Naturally, CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation[4].

4.4.1 Delegated commissioning functions

There was considerable variation in the range of primary care commissioning functions that CCGs proposed to assume in their initial expressions of interest. Following discussions with CCGs, we have agreed that a standardised model of delegation would make most sense for practical reasons. CCGs have expressed a strong interest in assuming the following primary care functions which will be included in delegated arrangements:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

[4] Section 14Z2 of the NHS Act (2006), as amended by the Health and Social Care Act (2012).

Delegated commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management.

CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.4.2 **Delegated commissioning governance arrangements**

NHS England has developed a model governance framework for delegated commissioning arrangements in order to avoid the need for CCGs to develop their own model. The recommendation is that CCGs establish a primary care commissioning committee to oversee the exercise of the delegated functions. A model terms of reference for delegated commissioning arrangements including scheme of delegation are appended at annex F. If CCGs intend to assume delegated responsibilities, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures.

A draft delegation is also appended at annex E. This is the formal document which records the delegation of authority by NHS England to CCGs. NHS England will issue a formal delegation agreement once the approvals process is completed.

In delegated commissioning arrangements, CCGs will remain accountable for meeting their own pre-existing statutory functions, for instance in relation to quality, financial resources and public participation[5]. CCGs must ensure that any governance arrangement they put in place does not compromise their ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making.

Membership of CCG primary care commissioning committees

It is for CCGs to agree the full membership of their primary care commissioning committee. CCGs will be required to ensure that it is chaired by a lay member and have a lay and executive majority. Furthermore, in the interest of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the delegated committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

[5] Sections 14R, 223H, 223I, 223J and 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012.

CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. Furthermore, it will be important to retain clinical involvement in a delegated committee arrangement to ensure the unique benefits of clinical commissioning are retained.

In this model new steps will be needed to manage potential conflicts of interest and these are set out in section 6.

Further details on the next steps to take forward delegated commissioning can be found in section 7.4.

5 Support and resources for co-commissioning

This section sets out how CCGs can access support and resources to deliver primary care co-commissioning.

A significant challenge involved in implementing primary care co-commissioning is finding a way to ensure that all CCGs can access the necessary resources as they take on new co-commissioning responsibilities. Both CCGs and NHS England recognise the difficulties of managing this fairly and in a way that both supports those CCGs which want to take on co-commissioning responsibilities and allows area teams to continue to safely and effectively deliver their remaining responsibilities.

Primary care commissioning is currently delivered by teams covering a large geography normally spanning several CCGs, and also covering all parts of primary care not just limited to general practice. There is no possibility of additional administrative resources being deployed on these services at this time due to running cost constraints.

Pragmatic and flexible local solutions will need to be agreed by CCGs and area teams to put in place arrangements that will work locally for 2015/16. These local agreements will need to ensure that:

- CCGs that take on delegated commissioning responsibilities have access to a fair share of the area team's primary care commissioning staff resources to deliver their responsibilities; and
- Area teams retain a fair share of existing resources to deliver all their ongoing primary care commissioning responsibilities.

There will be no nationally prescribed model: this will be a matter for local dialogue and determination. However, NHS England is committed to supporting local discussions in any way deemed helpful, and the current Primary Care Co-Commissioning Programme Oversight Group will continue to operate during the implementation period to help address practical issues.

5.1 Potential approaches for staffing

Where CCGs intend to take on joint or delegated responsibility for primary care commissioning, they should have a conversation with the area team regarding accessing support through the existing primary care team.

Given the limited size of existing primary care teams, potentially only part-time capacity would be available for individual CCGs taking on delegated commissioning responsibility, so it may be that collaborative arrangements between CCGs would be desirable to achieve greater critical mass. Staffing models for these arrangements will vary across the country and will require careful discussion to ensure that the practical, legal and staff engagement issues are clearly understood.

However, it is for CCGs to agree whether and how they would wish to work together. Where like-minded CCGs in an area team patch wish to collaborate, they need not necessarily be contiguous. In instances where they are not contiguous, the area team and CCGs would need to consider geographical practicalities for the staff concerned. These arrangements will need to take into account the size of the CCG, the number of primary care contracts held and the need for the area team to continue to deliver primary care commissioning functions not being delegated to CCGs and for areas where CCGs do not opt to take on delegated responsibilities.

Alternatively, some CCGs may wish to integrate primary care commissioning support with wider commissioning support from their Commissioning Support Unit (CSU). Again, in this scenario, arrangements should be agreed and implemented locally with particular attention to the practicalities.

It will be critical that local conversations are handled with maturity and due regard for members of staff involved to ensure transparent and mutually workable solutions.

5.2 Financial arrangements for co-commissioning

5.2.1 Financial information sharing

NHS England will ensure transparency in sharing financial information on primary care with CCGs. All CCGs will have the opportunity to discuss the current financial position for all local primary care services with their area team. CCGs will be provided with an analysis of their baseline expenditure for 2014/15 broken down between GP services and other primary care services by the end of November 2014. Final decisions regarding allocations for 2015/16 will be made by the NHS England Board in December 2014. An example of the level of detail area teams will be able to share can be found in the financial plan template – direct commissioning section of the NHS England website.

5.2.2 Financial allocations and running costs

We recognise that it will be challenging for some CCGs to implement co-commissioning arrangements, especially delegated arrangements, without an increase in running costs. Whilst it is not within our gift to increase running costs in 2015/16, NHS England will keep this situation under review. CCGs should discuss

with area teams options for sharing administrative resource to support the commissioning of primary care services.

In delegated arrangements, CCGs will receive funding for known future cost pressures within current allocations e.g. net growth in list sizes. In such circumstances, there may be a linked efficiency requirement which will need to be delivered in order for budgets to balance. Furthermore, if supported by clear strategies, CCGs would also have greater flexibility to "top up" their primary care allocation with funds from their main CCG allocation. For example:

A CCG currently commissions district nursing services from its community provider. The CCG could consider pooling the funding for this service with its primary care funding and arrange for district nursing services to be commissioned as part of primary care linked to GP practice nursing.

Full details on how area team allocations for primary care for 2014/15 and 2015/16 were calculated are published in the Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams. Annex F of this technical guide also sets out the detailed pace of change for each area team primary care allocation for 2014/15 and 2015/16.

Work is also currently underway to develop a target formula and place based allocations. Further information on the target formula will be available in early 2015 and the 'place-based' target in late 2015. It is anticipated that in 2015/16 the actual allocations for primary care will be made at CCG level rather than area team level.

5.2.3 **Variations in primary care funding**

It is recognised that there are historic variations in primary care funding across England and localities and we are taking steps to move towards a fair distribution of resources for primary care, based on the needs of diverse populations. The GMS Minimum Practice Income Guarantee (MPIG) will be phased out by April 2020, and a review of local PMS agreements is underway as set out in the Framework for Personal Medical Services (PMS) Contracts Review. Area teams should ensure that any decisions relating to future use of PMS funding are agreed with CCGs.

We envisage that CCG and primary care allocations will continue to move towards a fair distribution of resources and reflect inequalities, as in the current CCG formula. As part of any delegation of primary care commissioning responsibilities, area teams will provide details of any differential funding levels across localities.

6 Conflicts of interest

This section provides advice on conflicts of interest management for CCGs that implement co-commissioning arrangements.

Conflicts of interest, actual and perceived, need to be carefully managed within co-commissioning. Conflicts of interest are a matter of public interest, and it is also in the interest of the profession that this issue is robustly and transparently handled. CCGs are already managing conflicts of interests as part of their day-to-day work and there is formal guidance on Managing conflicts of interests and a Code of conduct in place for CCGs and General Practitioners in commissioning roles.

However, without a strengthened approach, co-commissioning could significantly increase the frequency and range of potential conflicts of interest, especially for delegated arrangements. Therefore, NHS England, in partnership with NHS Clinical Commissioners, has developed a significantly enhanced framework for conflicts of interest management with clear minimum expectations for CCGs which assume co-commissioning responsibilities.

6.1 Current conflicts of interest guidance

There is a legal requirement for CCGs to have arrangements in place for managing conflicts of interest. Section 14O of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) sets out minimum requirements including:

NHS England must:

- Publish guidance to CCGs on the discharge of their duties.

CCGs must:

- Maintain appropriate registers of interests;
- Publish or make arrangements for the public to access those registers;
- Make arrangements requiring the prompt declaration of interests by the persons specified (members and employees) and ensure that these interests are entered into the relevant register;
- Make arrangements for managing conflicts of interest and potential conflicts of interest (e.g. developing appropriate policies and procedures); and

- Have regard to guidance published by NHS England in relation to conflicts of interest.

NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013

- A relevant body (including a CCG) must not award a contract for NHS health care services where conflicts, or potential conflicts of interest affect, or appear to affect, the integrity of the award.

6.2 Forthcoming guidance on managing conflicts of interest in primary care co-commissioning arrangements

A national framework for conflicts of interest management in primary care co-commissioning is being developed in partnership with NHS Clinical Commissioners and with formal engagement of Monitor and HealthWatch England. The guidance will:

- build on existing guidance;
- have regard to any statutory guidance issued by Monitor; and
- continue to facilitate clinically-led decision-making as far as possible within the important constraint of the effective management of conflicts of interests.

The guidance will include a strengthened approach to:

- **the make-up of the decision-making committee**: the committee must have a lay and executive majority and have a lay chair;
- **national training for CCG lay members** to support and strengthen their role;
- **external involvement of local stakeholders**: the local HealthWatch and a local authority member of the local Health and Wellbeing Board will have the right to serve as observers on the decision-making committee;

- **register of interest**: the public register of conflicts of interest will include information on the nature of the conflict and details of the conflicted parties. The register would form an obligatory part of the annual accounts and be signed off by external auditors; and

- **register of decisions**: CCGs will be required to maintain and publish, on a regular basis, a register of procurement decisions.

The guidance will be published in December 2014 as statutory guidance in accordance with section 14Z8 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The guidance will be specifically aimed at CCGs exercising delegated authority but all CCGs will be required to have regard to the principles set out in the guidance.

The CCG's audit committee chair and CCG Accountable Officer will be required to provide direct formal attestation that the CCG has complied with conflict of interest guidance.

7 Approvals and implementation process 2014/15

This section sets out the approvals and implementation process for co-commissioning arrangements including the:

- process for reviewing your preferred co-commissioning approach;
- approvals process for co-commissioning arrangements; and
- implementation timeline for 2014/15.

7.1.1 Principles of the approvals process

Based on feedback from CCGs and area teams, and in recognition that CCGs undertook a robust authorisation process in their establishment as statutory bodies, the approvals process for co-commissioning arrangements will be as straightforward as possible. The process will be governed by the following principles:

- It will be conducted openly and transparently and contain no surprises;
- It will minimise the administrative demands placed on CCGs and area teams; and
- On-going assurance of co-commissioning arrangements will form part of the CCG assurance process.

Unless a CCG has serious governance issues or is in a state akin to “special measures,” NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs must also be able to demonstrate appropriate levels of sound financial control and meet all statutory and business planning requirements to progress delegated arrangements.

7.1.2 Opportunity to review your preferred co-commissioning arrangement

CCGs have requested a fresh opportunity to decide upon their preferred approach to primary care commissioning. We are therefore inviting CCGs to review their intentions and indicate their preferred co-commissioning arrangement in **January 2015**. As membership organisations, CCGs should fully engage with their members when considering co-commissioning options. It would also benefit CCGs and local stakeholders such as patients, local authorities, Health and Wellbeing Boards and HealthWatch to have an open and inclusive conversation about options and possible arrangements.

CCGs and area teams are asked to complete a short proforma should they wish to assume joint or delegated arrangements, as set out in the table below.

Co-commissioning model	Proforma	Submission date
Greater involvement in primary care commissioning decision making	There is no proforma to complete. Please liaise with your area team to take forward these arrangements, as set out in section 7.2.	Not applicable.
Joint commissioning	CCGs and area teams are asked to complete a proforma for joint arrangements (annex A). This proforma focuses upon the proposed governance arrangements for joint committees.	**30 January 2015**
Delegated commissioning	CCGs and area teams are asked to complete a proforma for delegated arrangements (annex B). This proforma focuses upon the CCG's approach to conflicts of interest management.	**12 noon on 9 January 2015**

Proformas for joint and delegated arrangements should be emailed to england.co-commissioning@nhs.net along with the requested supporting documentation which includes constitution amendment requests.

All delegated proformas must be submitted by **12 noon** on **9 January 2015** for arrangements to be implemented on **1 April 2015**. This is to allow sufficient time for financial transfers to be made. It would be preferential if arrangements were put in place on 1 April 2015 in the interests of agreeing staffing arrangements with area teams, although it may be possible to enable CCGs to implement delegated arrangements in-year in 2015/16.

Whilst these are formal deadlines, we know that in many areas CCGs and area teams are already engaging about co-commissioning, including financial arrangements and resources. We consider this to be good practice and would encourage all CCGs and area teams to adopt this approach.

7.1.3 **Procedure to agree a change to a CCG constitution**

Proposals for joint and delegated commissioning arrangements will require an amendment to a CCG's constitution. A suggested form of words for joint commissioning constitutional amendments, which can be tailored to individual circumstances, is included in annex C. Other minor amendments may also be

required in relation to delegated commissioning arrangements and these will be considered on an individual CCG basis.

The procedure for making an amendment is set out in the following guidance: Procedures for clinical commissioning group constitution change, merger and dissolution. As membership organisations, CCGs should consult with their members on any constitutional changes. CCGs also have a duty to consult with relevant stakeholders, such as local authorities, on constitutional changes.

The deadline for constitution amendment requests has been extended from 1 November 2014 to **12 noon** on **9 January 2015**. There is a further extension till 30 January 2015 for constitution amendments that relate solely to joint commissioning arrangements.

Co-commissioning form	Submission date for CCG constitutional changes
Joint commissioning	30 January 2015
Delegated commissioning	9 January 2015
All other constitution amendment requests	9 January 2015

All requests for constitution amendments should be emailed to england.co-commissioning@nhs.net **and the relevant regional team**. NHS England will acknowledge all applications for constitutional variations within two weeks of receipt and will notify the CCG in writing of the outcome of its decision within 8 weeks.

7.1.4 Governance arrangements for joint and delegated commissioning models

This document is accompanied by a suite of practical tools to support CCGs to implement co-commissioning arrangements locally including:

- Joint commissioning model governance structure, including model terms of reference for joint commissioning arrangements and scheme of delegation (Annex D)
- Draft delegation by NHS England (Annex E)
- Delegated commissioning model-draft terms of reference (Annex F)

NHS England has developed the governance frameworks on behalf of CCGs. CCGs are encouraged to use the template documents when developing co-commissioning arrangements. They can be amended to reflect local arrangements and to ensure consistency with the CCG's particular governance structure. They contain a number of points where the detail will need to be discussed and agreed as co-commissioning proposals are developed.

7.1.5 **Overview of the approvals process**

The approvals process for primary care co-commissioning is intended to be straightforward:

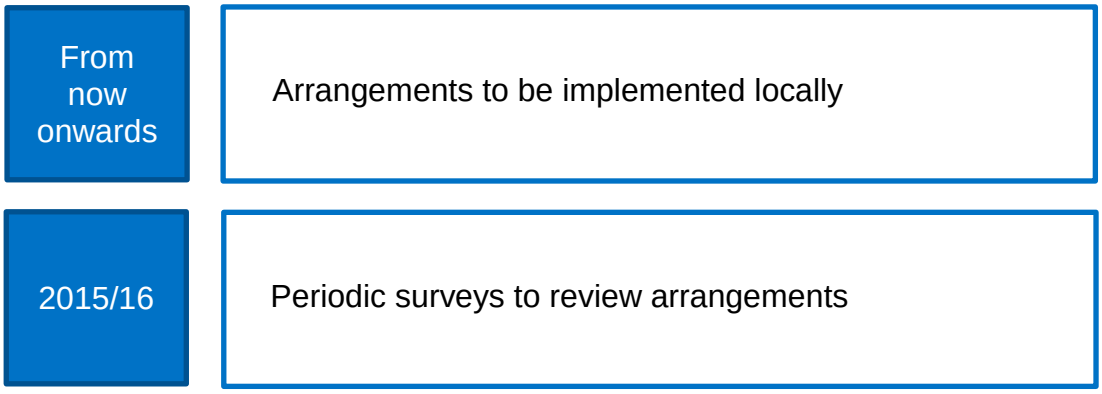
Co-commissioning model	Approvals process
Greater involvement in primary care commissioning decision making	No formal approvals process. Arrangements should be taken forward locally.
Joint commissioning	Proposals should be submitted to england.co-commissioning@nhs.net by 30 January 2015. Proposals will be agreed by regional teams, if they are assured that arrangements comply with the governance framework, for instance through the creation of a joint committee or "committee in common".
Delegated commissioning	Proposals should be submitted to england.co-commissioning@nhs.net by **12 noon** on **9 January 2015** for initial review by regional moderation panels. Final sign off will be undertaken by the proposed new Commissioning Committee of NHS England's Board.

Further information on the approvals process is set out in sections 7.2 to 7.4. On-going assurance of arrangements will form part of the CCG assurance process.

7.2 Greater involvement in primary care co-commissioning: approvals process and timeline

There is no formal approvals process for any CCG which wishes to have greater involvement in primary care decision making. Many CCGs are already working closely with their area teams to influence and shape primary care decision making and NHS England will continue to work with CCGs to establish effective arrangements. Periodic surveys will be conducted to provide an opportunity for CCGs and area teams to feedback on local arrangements. More information on the surveys will be provided in due course.

7.2.1 Summary of the approvals process and timeline



7.3 Joint commissioning proposals: approvals process and timeline

7.3.1 Joint commissioning proforma

CCGs that wish to assume joint commissioning responsibilities should work with their area teams to complete a short proforma (annex A) to confirm the agreed governance arrangements. Proformas should be submitted to england.co-commissioning@nhs.net by **30 January 2015** along with requested supporting information, including the proposed governance structure and constitution amendment request. A draft governance structure for joint commissioning arrangements is appended at annex D and can be amended to reflect local arrangements.

7.3.2 Approvals process

Regional moderation panels will convene in early February 2015 to review all submitted proposals, focusing upon the proposed governance arrangements and ensuring consistency of area team approach. Where a joint commissioning arrangement involves a pooled fund, the arrangement would need to comply with financial instructions (please refer to section 4.3.3). This is also an opportunity to take stock of the practical arrangements put in place locally by CCGs and area teams and to highlight and share best practice in this area.

Once regional teams are satisfied that the proposed arrangements comply with the legal framework and constitution amendments have been approved, arrangements can be implemented by **1 April 2015**. Area teams will inform CCGs once proposals have been approved and CCGs and NHS England will be required to sign a legally binding agreement to confirm how NHS England and CCGs will operate under the joint arrangement. Where proposals are not recommended for approval, regional teams will work with CCGs and area teams to support the development of joint arrangements.

All new arrangements for information handling as a result of joint commissioning arrangements must meet relevant information governance standards. CCGs are encouraged to review their Information Governance Toolkit assessment to ensure compliance with Department of Health Information Governance policies and standards.

7.3.3 **Summary of the approvals process and timeline**

November 2014 to January 2015	• CCGs and area teams should work together to further develop joint commissioning proposals.
30 January 2015	• Submission of proposal for joint arrangements (annex A). • Submission of constitutional amendment (annex C).
February to March 2015	• Regional moderation panel reviews proposals and makes recommendations for approval. • CCGs informed of the outcome of their constiutional amendment request. • If required, regional teams support the further development of proposals.
From 1 April 2015 onwards	• Arrangements implemented in full locally.

7.4 Delegated commissioning arrangements: approvals process and timeline

7.4.1 Delegated commissioning proforma

CCGs that wish to assume delegated commissioning responsibilities are asked to submit a short proforma (annex B) which focuses on the CCGs approach to conflicts of interest management. Proformas should be submitted to the national support centre team (england.co-commissioning@nhs.net) by **12 noon** on **9 January 2015** along with the requested supporting information, including the proposed delegated governance structure and constitution amendment request.

7.4.2 Approvals process

Regional moderation panels will convene in **mid-January 2015** to review all delegated proposals, specifically the CCG's proposed approach to conflicts of interest management. This is also an opportunity to take stock of the practical arrangements put in place locally by CCGs and area teams and to highlight and share best practice in this area.

A national moderation panel, in place to ensure consistency of approach across the country, will make final recommendations to the relevant new NHS England committee (likely to be the proposed new Commissioning Committee) on which proposals are ready to be taken forward from 1 April 2015. The committee will provide final sign off for delegated proposals in **February 2015**. Once proposals are approved, CCGs will need to set out their plans as per the 2015/16 NHS planning guidance which will be published in December 2014. Proposals will then be implemented on **1 April 2015**.

Where proposals are not recommended for approval, an appropriate plan will be developed between the CCG and area team, supported by regional teams, to either further develop proposals or to establish joint arrangements for 2015/16, if this is agreed to be the preferred approach. It would be preferential if arrangements were put in place on 1 April 2015 in the interests of agreeing staffing arrangements with area teams. However, there may be some flexibility to enable CCGs, who submit delegated arrangement proposals for 2016/17 to implement delegated arrangements in year in 2015/16.

Once delegated arrangements have been established, their effectiveness will be monitored as part of the CCG assurance process.

7.4.3 **Implementation arrangements**

Once delegated commissioning proposals have been signed off by the proposed new Commissioning Committee, CCGs will be required to sign a legally binding agreement to confirm the detail of how NHS England will delegate its general practice functions to CCGs.

NHS England's finance directorate will arrange for funds to be transferred on **1 April 2015** to enable CCGs to take forward arrangements thereafter**.** Funds will be transferred via an inter authority transfer in 2015/16. When discharging their duties, CCGs must comply with the Statement of Financial Entitlement (SFE) directions which set out the payments to be made under general medical services contracts. Business rules, which CCGs currently adhere to, will also apply to primary care commissioning. The 2014/15 business rules can be found in annex B of the financial plan template – direct commissioning section of the NHS England website.

All new arrangements for information handling as a result of delegated commissioning arrangements must meet relevant information governance standards. CCGs are encouraged to review their Information Governance Toolkit assessment in compliance with Department of Health Information Governance policies and standards. Information sharing will form part of the formal delegation agreement once arrangements have been approved.

7.4.4 **Summary of the approvals process and timeline**

November 2014 to January 2015	• CCGs and NHS England work together to further develop delegated commissioning proposals.
9 January 2015 (12 noon)	• Submission of proposal for delegated arrangements (annex B). • Submission of constitutional amendment (annex C).
February 2015	• Regional moderation panel review proposals and make recommendations for approval. • NHS England Commissioning Committee approves proposals
March 2015	• Subject to approval, NHS England's finance directorate arrange the transfer of delegated budgets. • CCGs informed of the outcome of their consitutional amendment request.
From 1 April 2015 onwards	• Arrangements implemented in full locally.

8 Changing a co-commissioning arrangement from 2015/16 onwards

This section sets out the process for changing a co-commissioning arrangement from 2015/16. This includes the approvals process and timeline.

CCGs are at different stages of their developmental journey and are facing a variety of local challenges. Therefore it is likely that the appetite to take on further responsibilities for primary care co-commissioning will vary across the country. We want CCGs to be able to move at their own pace, whilst also indicating that we see co-commissioning as a needful development towards mitigating current health inequalities and securing better integrated, more easily accessed, high quality care for patients. We expect that many CCGs may wish to enter into joint commissioning arrangements for 2015/16 to see how the agenda develops, before deciding to take on delegated responsibilities for 2016/17.

We intend to make it as straightforward as possible for CCGs to assume greater commissioning responsibilities from 2015/16 onwards, should they wish to. For example:

- CCGs which have no co-commissioning arrangements in place or opted for greater involvement, could apply for joint or delegated arrangements; or
- CCGs in joint arrangements could apply for delegated arrangements.

CCGs should discuss any plans to change their co-commissioning model with their area team in the first instance and new proposals should be discussed and planned as part of the CCG assurance process.

Future co-commissioning model	Approvals process *from 1 April 2015/16 onwards* to assume a new co-commissioning arrangement
Joint commissioning	CCGs should discuss their proposals with their area team and regional team. Any requests should be reviewed and agreed within the quarterly CCG assurance review meetings. The approvals process will follow the process set out in section 7.3 and the timeline will be confirmed by the area team.
Delegated commissioning	CCGs should discuss their proposals with their area team and regional team. NHS England and NHS Clinical Commissioners will in due course be developing the timetable for applications for 2016/17.

In the circumstance that a CCG wishes to terminate their co-commissioning arrangement, this would need to be by mutual agreement with NHS England. In these circumstances, it is expected that the CCG would move either from delegated arrangements to joint arrangements or joint arrangements to greater involvement.

9 Ongoing assurance

This section sets out on-going assurance arrangements for co-commissioning.

9.1 Overarching approach

NHS England is committed to working with CCGs to co-develop a revised approach to the current CCG assurance framework for 2015/16. The new assurance framework will be published in 2015. The on-going assurance of primary care co-commissioning arrangements will be managed as part of this wider CCG assurance process.

9.2 Principles

NHS England requires on-going assurance that its duties are being discharged effectively. The assurance process will be adapted according to the commissioning function that the CCG is undertaking. NHS England will look at ways of reducing the burden of assurance on the service whilst implementing a robust process that is mindful of the legislative framework.

There are three key principles governing the assurance process:

- It will be simplified to reduce unnecessary bureaucratic processes for both CCGs and NHS England;
- It will be based on a supportive conversation and the process will reflect the flexibility of NHS England to intervene differently in different circumstances; and
- There will be clear interventions for failing CCGs.

In particular, for co-commissioning the new assurance process will:

- test that core governance arrangements are working successfully, with specific attention to the effective local management of conflicts of interest;
- be specific about the achievement of local outcomes, with a particular focus on service delivery across the local health economy; and it will
- be co-designed and developed in strong partnership with CCGs and other key stakeholders prior to publication.

10 Development support and evaluation

This section sets out the support available to CCGs to implement co-commissioning and the on-going evaluation of co-commissioning arrangements.

10.1 Implementation roadshows and legal support

A series of roadshows will take place across the country to support CCGs and area teams to move towards implementing primary care co-commissioning arrangements. The purpose of these events is to:

- Set out the vision for the future as we move towards place-based commissioning, taking into account the vision described in the Five Year Forward View;
- Provide an opportunity for CCGs and area teams to raise any questions they may have about primary care co-commissioning and the impact of the changes;
- Provide technical advice to support the implementation of co-commissioning, specifically on the timeline and approvals process, the legalities of joint and delegated arrangements and conflicts of interest management; financial arrangements and HR and resources, and
- Offer a further opportunity for area teams and CCGs to work together on their joint proposals if they so wish.

The workshops will take place between 19 November and 2 December 2014. Further information and registration details can be found here. Due to high demand, CCGs are asked to only send one representative to the events. The events are not open to private businesses.

Further legal advice will also be available for CCGs that intend to implement joint and delegated arrangements. Your regional team will provide further information on how this can be accessed.

10.2 Learning and continuous development

It will be important that we review and share learning from the implementation of co-commissioning arrangements in real time in order to support CCGs' continuous development and improvement. We will evaluate the following:

- what is and is not working;
- any unforeseen perverse incentives and system blockages; and
- examples of good practice.

This will help us to improve the policy for future years. In addition, we are exploring options on how best to do the following:

- provide technical support where required;
- enable the dissemination of 'lessons learned' and supporting a network of practitioners to problem solve and share learning and experiences; and
- provide a web-based interactive platform for exchange and ideas.

Further information will be shared in due course.

11 Next steps

We hope this document is useful in helping to inform CCG decision making around primary care co-commissioning models and in providing clarity on the next steps towards the implementation of co-commissioning arrangements. If you require any further information, please email: england.co-commissioning@nhs.net.

We will be keeping the arrangements set out in this document under review in the light of the experience of their operation during 2015/16.

Furthermore, as primary care co-commissioning is the start of a longer journey towards place based commissioning, we recognise there is much work to be done to achieve this goal. NHS England is therefore committing to the following in 2015/16:

- We will look at options for the co-commissioning of dental, eye health, community pharmacy and public health services (such as immunisation and vaccinations), as we know some CCGs are keen to assume commissioning responsibilities in these areas. This will be done with full and proper engagement of the relevant professional groups.
- We will continue to work on arrangements for involving CCGs in the commissioning of specialised services.
- We will continue to monitor running cost allowances and resources to ensure that co-commissioning arrangements are sustainable.
- We will look into GP premises development, as part of the implementation of the NHS Five Year Forward View.

12 Glossary

APMS	Alternative Provider Medical Services
CCGs	Clinical Commissioning Groups
CSU	Commissioning Support Unit
DES	Directed Enhanced Services
FAQs	Frequently Asked Questions
GMS	General Medical Services
GPs	General Practitioners
IPC	Integrated Personal Commissioning Programme
JSNAs	Joint Strategic Needs Assessments
LES	Local Enhanced Services
LMC	Local Medical Committee
LRO	Legislative Reform Order
MPIG	Minimum Practice Income Guarantee
PMS	Personal Medical Services
QIPP	Quality Innovation Productivity and Prevention
QOF	Quality Outcomes Framework
SFE	Statement of Financial Entitlement

13 References

Department of Health, Information Governance Toolkit

Department of Health, 16 July 2008, End of Life Care Strategy

Department of Health, 29 September 2014, Statement of Financial Entitlement

HM Government, 2012, Health and Social Care Act 2012

NHS, 23 October 2014, NHS Five Year Forward View

NHS England, October 2012, Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services

NHS England, 28 March 2013, Managing conflicts of interests: Guidance for clinical commissioning groups

NHS England, 7 May 2013, CCG Assurance Framework 2013/14

NHS England, 24 May 2013, Procedures for clinical commissioning group constitution change, merger and dissolution

NHS England, September 2013, Transforming Participation in Health and Care guidance

NHS England, 25 March 2014, Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams

NHS England, September 2014, Framework for Personal Medical Services (PMS) Contracts Review

NHS England, 4 September 2014, Integrated Personal Commissioning (IPC) programme

NHS England, 29 September 2014, Update on the Legislative Reform Order (letter)

NHS England, Financial plan template – direct commissioning 2014/15 to 2018/19

14 Annexes

This document is accompanied by a suite of practical tools to support CCGs to implement co-commissioning arrangements locally including:

Annex A: Submission proforma for joint commissioning arrangements

Annex B: Submission proforma for delegated commissioning arrangements

Annex C: Model wording for amendments to CCGs' constitutions

Annex D: Model terms of reference for joint commissioning arrangements, including scheme of delegation

Annex E: Draft delegation by NHS England

Annex F: Delegated commissioning model - draft terms of reference

Annex G: Members of the Primary Care Co-commissioning Programme Oversight Group

Annex H: CCG investment in primary care frequently asked questions (FAQs)

MANAGING CONFLICTS OF INTEREST: STATUTORY GUIDANCE FOR CCGs

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	**Commissioning Strategy**
Finance		

Publications Gateway Reference:	**02726**
Document Purpose	Guidance
Document Name	Managing conflicts of interest: statutory guidance for CCGs
Author	NHS England/Commissioning Strategy/Co-Commissioning
Publication Date	18 December 2014
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, CSU Managing Directors, NHS England Regional Directors, NHS England Area Directors, Directors of Finance, GPs
Additional Circulation List	Local Authority CEs, Healthwatch England, Monitor, DH, GPC, RCGP, GMC,BMA, NAO, National Association of Primary Care , NHS Alliance, National Voices, NHS Commissioning Assembly, Emergency Care Leads
Description	This statutory guidance sets out how CCGs should manage conflicts of interest. It contains specifc provisions in relation to co-commissioning primary care services but the guidance is relevant to CCG responsibilites generally.
Cross Reference	Next steps towards primary care co-commissioning (November 2014)
Superseded Docs (if applicable)	Managing conflicts of interest: guidance for CCGs
Action Required	CCGs must have regard to this guidance
Timing / Deadlines (if applicable)	**For CCGs seeking delegated or joint commissioning responsiiblities-January 2015.**
Contact Details for further information	Julia Simon Co-commissioning of primary care Skipton House London SE1 6LH 0113 824 8413 www.england.nhs.uk/commissioning/pc-co-comms/

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Managing conflicts of interest: statutory guidance for CCGs

Version number: 2

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Contents

Introduction

> "If conflicts of interest are not managed effectively by CCGs, confidence in the probity of commissioning decisions and the integrity of clinicians involved could be seriously undermined. However, with good planning and governance, CCGs should be able to avoid these risks."
>
> *RCGP and NHS Confederation's briefing paper on managing conflicts of interest*
> *September 2011*[1]

1. Clinical commissioning groups (CCGs) manage conflicts of interest as part of their day-to-day activities. Effective handling of such conflicts is crucial for the maintenance of public trust in the commissioning system. Importantly, it also serves to give confidence to patients, providers, Parliament and tax payers that CCG commissioning decisions are robust, fair, transparent and offer value for money.

2. In May 2014, NHS England offered CCGs the opportunity to take on an increased responsibility for the commissioning of primary care. Those CCGs who opt to do so will be able to commission care for their patients and populations in more coherent and joined-up ways — but they are also exposing themselves to a greater risk of conflicts of interest, both real and perceived, especially if they are opting to take on delegated budgets and functions from NHS England. The details of this policy initiative can be found in *Next steps towards primary care co-commissioning.*[2]

3. In light of this new development, NHS England, in consultation with national stakeholders, has developed strengthened guidance for the management of conflicts of interest. This guidance builds on and incorporates relevant aspects of existing NHS England guidance, and supersedes the extant NHS England guidance[3]. In other words, this guidance will supplant the previously issued NHS England guidance for CCGs.

4. Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to:

- Reduce health inequalities in access and outcomes of healthcare services
- Integrate services where this might reduce health inequalities

[1] '*Managing conflicts of interest in clinical commissioning groups*: http://www.rcgp.org.uk/~/media/Files/CIRC/Managing_conflicts_of_interest.ashx
[2] http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf
[3] http://www.england.nhs.uk/wp-content/uploads/2013/03/manage-con-int.pdf and http://www.england.nhs.uk/wp-content/uploads/2012/09/c-of-c-conflicts-of-interest.pdf

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

5. In its own commissioning decisions and day-to-day business, NHS England is bound by the code set out in the Standards of Business Conduct[4] (and supplemented by the Standing Orders). However, when serving on a joint committee with one or more CCGs, NHS England staff also need to adhere to the guidance set out in this document.

6. This guidance also builds on guidance issued by other national bodies, in particular Monitor's guidance on the Procurement, Patient Choice and Competition Regulations[5], and guidance issued by GP professional bodies such as the British Medical Association (BMA), the General Medical Council (GMC) [6] and the Royal College of General Practitioners (RCGP).

7. This document is issued as statutory guidance under sections 14O and 14Z8 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the Act"). This means that CCGs must have regard to such guidance with the onus on them to explain any non-adherence.

8. The Act sets out clear requirements for CCGs to make arrangements for managing conflicts of interest and potential conflicts of interest, to ensure they do not affect, or appear to affect, the integrity of the CCG's decision making processes. These requirements are supplemented by procurement-specific requirements in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.

When a CCG is seeking to take on delegated or joint commissioning responsibilities, their audit committee chair and accountable officer will be required to provide direct formal attestation to NHS England that the CCG has complied with this guidance. Subsequently, this attestation will form part of an annual certification. CCG approaches to management of conflicts of interest will also be considered on an ongoing basis as part of CCG assurance. Further details will be issued early in 2015 as to the forms that the initial attestation, the annual certification and ongoing assurance will take.

[4] http://www.england.nhs.uk/wp-content/uploads/2012/11/stand-bus-cond.pdf
[5] Substantive guidance on the Procurement, Patient Choice and Competition Regulations: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf
[6] GMC | Good medical practice (2013) http://www.gmc-uk.org/guidance/good_medical_practice.asp and http://www.gmc-uk.org/guidance/ethical_guidance/21161.asp

Aims of the guidance

9. The aims of this guidance are to:

- enable CCGs and clinicians in commissioning roles to demonstrate that they are acting fairly and transparently and in the best interest of their patients and local populations;
- ensure that CCGs operate within the legal framework, but without being bound by over-prescriptive rules that risk stifling innovation;
- safeguard clinically led commissioning, whilst ensuring objective investment decisions;
- provide the public, providers, Parliament and regulators with confidence in the probity, integrity and fairness of commissioners' decisions; and
- uphold the confidence and trust between patients and GP, in the recognition that individual commissioners want to behave ethically but may need support and training to understand when conflicts (whether actual or potential) may arise and how to manage them if they do.

10. In developing this guidance, NHS England has worked closely with NHS Clinical Commissioners, and has engaged with the following stakeholders:

- HealthWatch England;
- Monitor;
- the National Audit Office (in an informal capacity;
- General Practitioners Committee;
- Royal College of General Practitioners;
- General Medical Council; and
- CCG representatives.

11. The guidance incorporates the safeguards for the management of conflicts of interest set out in the previously issued guidance, including:

- the nature of conflicts of interest;
- arrangements for declaring interests;

- maintaining a register of interests;
- keeping a record of the steps taken to manage a conflict;
- excluding individuals from decision-making where a conflict arises; and
- engagement with a range of potential providers on service design.

12. In addition, it sets out:

- the additional factors that CCGs should address when commissioning primary medical care services, either under joint commissioning or delegated commissioning arrangements. This includes the factors CCGs should consider when drawing up plans for services that might be provided by GP practices; and it also includes the necessary aspects of the make-up of the decision-making committee which must have a lay and executive member majority;

- the steps that CCGs should take to assure their Audit Committee, Health and Wellbeing Board(s), NHS England and, where necessary, their auditors, that these services are appropriately commissioned from GP practices;

- procedures for decision-making in cases where all the GPs (or other practice representatives) sitting on a decision-making group have a potential financial interest in the decision;

- arrangements for publishing details of payments to GP practices;

- the potential role of commissioning support services; and

- the supporting role of NHS England.

What are conflicts of interest?

13. A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur.

"For the purposes of Regulation 6 [*National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013*[7]], a conflict will arise where an individual's ability to exercise judgement or act in their role in the **commissioning of services** is impaired or influenced by their interests in the **provision of those services**."

Monitor - Substantive guidance on the Procurement, Patient Choice and Competition Regulations (December 2013)

14. As well as direct financial interests, conflicts can arise from an indirect financial interest (e.g. payment to a spouse) or a non-financial interest (e.g. reputation). Conflicts of loyalty may arise (e.g. in respect of an organisation of which the individual is a member or with which they have an affiliation). Conflicts can arise from personal or professional relationships with others, e.g. where the role or interest of a family member, friend or acquaintance may influence an individual's judgement or actions, or could be perceived to do so. Depending upon the individual circumstances, these factors can all give rise to potential or actual conflicts of interest.

15. For a commissioner, a conflict of interest may therefore arise when their judgment as a commissioner could be, or be perceived to be, influenced and impaired by their own concerns and obligations as a provider. In the case of a GP involved in commissioning, an obvious example is the award of a new contract to a provider in which the individual GP has a financial stake. However, the same considerations, and the approaches set out in this guidance, apply when deciding whether to extend a contract.

16. NHS Clinical Commissioners has carried out a review of current guidance on conflicts of interest management and, together with the Royal College of General Practitioners and the British Medical Association, has developed a set of key principles that apply in this context. These principles are set out in Annex 1.

17. CCGs should provide clear guidance to their members[8] and employees on what might constitute a conflict of interest, providing examples of situations that may arise. Pertinent issues to bear in mind include:

- a perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring;

[7] http://www.legislation.gov.uk/uksi/2013/257/contents/made

[8] Following the linguistic convention of the Act, within this guidance 'member' generally refers collectively to the members of a CCG, members of its governing body and to members of the committees or sub-committees of the CCG or its governing body. Where a member of a specific body is being referred to, this is made clear within the context. However the appropriate actions for a CCG to take in managing conflicts of interest will vary according to the role of particular members, including their role in influencing decision-making processes.

- if in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it; and
- for a conflict of interest to exist, financial gain is not necessary.

Legislative framework

18. The starting point for CCGs is section 14O of the Act. This sets out the minimum requirements in terms of what both NHS England and CCGs must do in terms of managing conflicts of interest. For CCGs, this means that they must:

- Maintain appropriate registers of interests;
- Publish or make arrangements for the public to access those registers;
- Make arrangements requiring the prompt declaration of interests by the persons specified (members and employees) and ensure that these interests are entered into the relevant register;
- Make arrangements for managing conflicts and potential conflicts of interest (e.g. developing appropriate policies and procedures); and
- Have regard to guidance published by NHS England and Monitor in relation to conflicts of interest.

19. Section 14O also imposes a duty on NHS England to publish guidance for CCGs on the discharge of their functions under this section.

20. Section 14O is supplemented by the procurement specific requirements set out in the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013[9]. In particular, regulation 6 requires the following:

- CCGs must not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract; and
- CCGs must keep a record of how it managed any such conflict in relation to NHS commissioning contracts it enters into. (As set out in section 8 below, details of this should also be published by the CCG.)

[9] http://www.legislation.gov.uk/uksi/2013/500/contents/made

21. An interest is defined for the purposes of regulation 6 as including an interest of the following:

- a member of the commissioner organisation;
- a member of the governing body of the commissioner;
- a member of its committees or sub-committees or committees or sub-committees of its governing body; or
- an employee.

22. As with section 14O, regulation 6 sets out the basic framework within which CCGs must operate. The detailed requirements are set out in the guidance issued by Monitor (*Substantive guidance on the Procurement, Patient Choice and Competition Regulations*) and, in particular, section 7 of that statutory guidance (included as Annex 6 to this guidance).

23. Monitor's view is that care must be taken to ensure that conflicts do not affect, or appear to affect, the integrity of the award of commissioning contracts. It is important to ensure that the management of conflicts of interest includes the management of perceived conflicts and that there is an appropriate record of how such issues are managed, particularly in the context of specific procurement decisions. Please see below for further guidance on how such information should be recorded and published. Clear and robust decision-making processes must be put in place to deliver co-commissioning and give the public and providers confidence in the integrity of the decisions made.

24. Finally, as explained bove, section 14Z8 gives NHS England the ability to issue statutory guidance regarding commissioning. CCGs must have regard to such guidance with the onus on them to explain any departure from the guidance.

Principles and general safeguards

25. The general safeguards that will be needed to manage conflicts of interest will vary to some extent, depending on at what stage in the commissioning cycle decisions are being made. The following principles will need to be integral to the commissioning of all services, including decisions on whether to continue to commission a service, such as by contact extension.

26. Conflicts of interest can be managed by:

- **Doing business appropriately.** If commissioners get their needs assessments, consultation mechanisms, commissioning strategies and

procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid and/or manage, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny;

- **Being proactive, not reactive.** Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by:

    - considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making bodies;
    - ensuring individuals receive proper induction and training so that they understand their obligations to declare conflicts of interest.

  They should establish and maintain registers of interests, and agree in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise;

- **Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest.** Rules should assume people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, but there should also be prompts and checks to reinforce this;

- **Being balanced and proportionate.** Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair, but not constrain people by making it overly complex or cumbersome;

- **Openness.** Ensuring early engagement with patients, the public, clinicians and other stakeholders, including local Healthwatch and Health and Wellbeing Boards, in relation to proposed commissioning plans;

- **Responsiveness and best practice.** Ensuring that commissioning intentions are based on local health needs and reflect evidence of best practice – securing 'buy in' from local stakeholders to the clinical case for change;

- **Transparency.** Documenting clearly the approach taken at every stage in the commissioning cycle so that a clear audit trail is evident;

- **Securing expert advice.** Ensuring that plans take into account advice from appropriate health and social care professionals, e.g. through clinical senates and networks, and draw on commissioning support, for instance around formal consultations and for procurement processes;

- **Engaging with providers.** Early engagement with both incumbent and potential new providers over potential changes to the services commissioned for a local population;

- **Creating clear and transparent commissioning specifications** that reflect the depth of engagement and set out the basis on which any contract will be awarded;
- **Following proper procurement processes and legal arrangements**, including even-handed approaches to providers;
- **Ensuring sound record-keeping, including up to date registers of interests;** and
- **A clear, recognised and easily enacted system for dispute resolution.**

27. These general processes and safeguards should apply at all stages of the commissioning process, but will be particularly important at key decision points, e.g., whether and how to go out to procurement of new or additional services.

28. Particular considerations pertain to CCGs who hold responsibilities for delegated or joint commissioning of primary care. These are set out later in this guidance.

Maintaining a register of interests and a register of decisions

Statutory requirements

CCGs must maintain one or more registers of interest of: the members of the group, members of its governing body, members of its committees or sub-committees of its governing body, and its employees. CCGs must publish, and make arrangements to ensure that members of the public have access to these registers on request.

CCGs must make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the group as soon as they become aware of it, and in any event within 28 days. CCGs must record the interest in the registers as soon as they become aware of it.

29. CCGs must ensure that, when members declare interests, this includes the interests of all relevant individuals within their own organisations (e.g. partners in a GP practice), who have a relationship with the CCG and who would potentially be in a position to benefit from the CCG's decisions.

30. When entering an interest on its register of interests, the CCG should ensure that it includes sufficient information about the nature of the interest and the details of those holding the interest.

31. CCGs will need to ensure that, as a matter of course, declarations of interest are made and regularly confirmed or updated. This includes the following circumstances:

On appointment:
Applicants for any appointment to the CCG or its governing body should be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests should again be made and recorded.

At meetings:
All attendees should be asked to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent. Even if an interest is declared in the register of interests, it should be declared in meetings where matters relating to that interest are discussed. Declarations of interest should be recorded in minutes of meetings.

Quarterly:
CCGs should have systems in place to satisfy themselves on a quarterly basis that their register of interests is accurate and up to date.

On changing role or responsibility:
Where an individual changes role or responsibility within a CCG or its governing body, any change to the individual's interests should be declared.

On any other change of circumstances:
Wherever an individual's circumstances change in a way that affects the individual's interests (e.g. where an individual takes on a new role outside the CCG or sets up a new business or relationship), a further declaration should be made to reflect the change in circumstances. This could involve a conflict of interest ceasing to exist or a new one materialising.

32. In keeping with the regulations, individuals who have a conflict should declare this as soon as they become aware of it, and in any event not later than 28 days after becoming aware.

33. Whenever interests are declared, they should be reported to the person designated with responsibility for the register of interests (as identified by the CCG or its governing body), who should then update the register accordingly.

Note: CCGs will need to set out the process that they will follow if an individual fails to comply with its polices on managing conflicts of interest as set out in its constitution. This could include that individual being removed from office.

See Annexes 2 and 3 for declaration of interests templates

34. CCGs must update their register of interests whenever a new or revised interest is declared.

Register of procurement decisions

35. CCGs also need to maintain a register of procurement decisions[10] taken, including:

- the details of the decision;
- who was involved in making the decision (i.e. governing body or committee members and others with decision-making responsibility); and
- a summary of any conflicts of interest in relation to the decision and how this was managed by the CCG.

36. The register should be updated whenever a procurement decision is taken.

37. In the interests of transparency, the register of interests and the register of decisions will need to be publicly available and easily accessible to patients and the public including by:

- ensuring that both registers are available in a prominent place on the CCG's website; and
- CCGs making both registers available upon request for inspection at their headquarters.

38. CCGs will also need to consider any particular access needs that their stakeholders have. For example, individuals without internet access could be directed to the local library or invited to view the register(s) at the CCG's headquarters.

39. The registers will form part of the CCG's annual accounts and will thus be signed off by external auditors. Further work will be carried out by NHS England on the specific arrangements for this.

Procurement issues

40. CCGs will need to be able to recognise and manage any conflicts or potential conflicts of interest that may arise in relation to procurement.

[10] Regulation 9 of the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 requires that a record of procurement decisions is maintained on an NHS England website. The register of decisions described above is intended to supplement this as a more detailed record of the decision.

41. The NHS Act, the Health and Social Care Act ("the HSCA") and associated regulations[11] set out the statutory rules with which commissioners are required to comply when procuring and contracting for the provision of clinical services. They need to be considered alongside the Public Contract Regulations[12] and, where appropriate, EU procurement rules. Monitor's *Substantive guidance on the Procurement, Patient Choice and Competition Regulations* advises that the requirements within these create a framework for decision making that will assist commissioners to comply with a range of other relevant legislative requirements.

42. The Procurement, Patient Choice and Competition Regulations place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare.

43. The regulations set out that commissioners must:

- manage conflicts and potential conflicts of interests when awarding a contract by prohibiting the award of a contract where the integrity of the award has been, or appears to have been, affected by a conflict; and
- keep appropriate records of how they have managed any conflicts in individual cases.

44. Monitor has a statutory duty under section 78 of the HSCA to produce guidance on compliance with any requirements imposed by the regulations and how it intends to exercise the powers conferred on it by these regulations. Monitor's *Substantive guidance on the Procurement, Patient Choice and Competition Regulations* is the relevant statutory guidance. NHS England works closely with Monitor with regard to these matters and has engaged with Monitor in developing this revised guidance.

General considerations and use of the template

45. The most obvious area in which conflicts could arise is where a CCG commissions (or continues to commission by contract extension) healthcare services, including GP services, in which a member of the CCG has a financial or other interest. This may most often arise in the context of co-commissioning of primary care, particularly with regard to delegated or joint arrangements, but it will also need to be considered in respect of any commissioning issue where GPs are current or possible providers. CCGs are advised to address the

[11] The NHS (Procurement, Patient Choice and Competition) Regulations (No. 2) 2013, issued under section 75 of the HSCA

[12] http://www.legislation.gov.uk/uksi/2006/5/contents/made . It is also important to bear aware that, at the time of issuing this guidance, draft new public contract regulations have been issued (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/356494/Draft_Public_Contracts_Regulations_2015.pdf). CCGs should ensure that they observe the final version of these when they come into effect.

factors set out in the procurement template at annex 4 when drawing up their plans to commission services where this potentially is the case.

46. CCGs will be expected to make evidence of their deliberations on conflicts publicly available. The template is one way of CCGs evidencing this and will support CCGs in fulfilling their duty in relation to public involvement. It will further provide appropriate assurance:

- that the CCG is seeking and encouraging scrutiny of its decision-making process;
- to Health and Wellbeing Boards, local Healthwatch and to local communities that the proposed service meets local needs and priorities; it will enable them to raise questions if they have concerns about the approach being taken;
- to the audit committee and, where necessary, external auditors, that a robust process has been followed in deciding to commission the service, in selecting the appropriate procurement route, and in addressing potential conflicts; and
- to NHS England in their role as assurers of the co-commissioning arrangements.

Designing service requirements

47. It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient need. Such engagement, done transparently and fairly, is entirely legal. However, conflicts of interest can occur if a commissioner engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid.

48. Commissioners should seek, as far as possible, to specify the outcomes that they wish to see delivered through a new service, rather than the process by which these outcomes are to be achieved. As well as supporting innovation, this helps prevent bias towards particular providers in the specification of services.

49. Such engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all.

50. Other steps include:

- advertise the fact that a service design/re-design exercise is taking place widely and invite comments from any potential providers and other interested parties (ensuring a record is kept of all interactions);
- as the service design develops, engage with a wide range of providers on an ongoing basis to seek comments on the proposed design, e.g. via the commissioner's website or via workshops with interested parties;
- use engagement to help shape the requirement to meet patient need but take care not to gear the requirement in favour of any particular provider(s);
- if appropriate, engage the advice of an independent clinical adviser on the design of the service;
- be transparent about procedures;
- ensure at all stages that potential providers are aware of how the service will be commissioned; and
- maintain commercial confidentiality of information received from providers.

51. When engaging providers on service design, CCGs should bear in mind that they have ultimate responsibility for service design and for selecting the provider of services. Monitor has issued guidance on the use of provider boards in service design[13].

52. CCGs will also need to ensure that they have systems in place for managing conflicts of interest on an ongoing basis, for instance, by monitoring a contract that has been awarded to a provider in which an individual commissioner has a vested interest.

Governance and decision-making processes

Statutory requirement

CCGs must make arrangements for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group's decision-making.

13 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284832/ManchesterCaseClosure.pdf)

53. CCGs should review their governance structures for managing conflicts of interest to ensure that they reflect current guidance and are appropriate, particularly in relation to any co-commissioning roles which the CCG proposes to undertake. This should include consideration of the following:

- the make-up of their governing body and committee structures (including, where relevant, the approach set out below for decision-making in delegated or joint commissioning of primary care);
- whether there are sufficient management and internal controls to detect breaches of the CCG's conflicts of interest policy, including appropriate external oversight and adequate provision for whistleblowing;
- how non-compliance with policies and procedures relating to conflicts of interest will be managed (including how this will be addressed when it relates to contracts already entered into). As well as actions to address non-compliance, CCGs should also have procedures in place to review any lessons to be learned from such cases, e.g., by the CCG's audit committee conducting an incident review;
- reviewing and revising approaches to the CCG's registers of interest, together with the introduction of a record of decisions, as set out above;
- whether any training or other programmes are required to assist with compliance, including participation in the training offered by NHS England, as set out below.

Appointing governing body or committee members

54. CCGs will need to consider whether conflicts of interest should exclude individuals from being appointed to the governing body or to a committee or sub-committee of the CCG or governing body. These will need to be considered on a case-by-case basis but the CCG's constitution should reflect the CCG's general principles.

55. The CCG will need to assess the materiality of the interest, in particular whether the individual (or a family member or business partner) could benefit from any decision the governing body might make. This will be particularly relevant for any profit sharing member of any organisation but should also be considered for all employees and especially those operating at senior or governing body level.

56. The CCG will also need to determine the extent of the interest. If it is related to an area of business significant enough that the individual would be unable to make a full and proper contribution to the governing body, that individual should not become a member of the governing body.

57. Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to a CCG (either as a provider of healthcare or commissioning support services) should not be a member of the governing body if the nature of their interest is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively operate as a governing body member. Specific considerations in relation to delegated or joint commissioning of primary care are set out below.

Decision-making when a conflict of interest arises: general approaches

58. Where certain members of a decision-making body (be it the governing body, its committees or sub-committees, or a committee or sub-committee of the CCG) have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (i.e., not have a vote).

59. The chair of the meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. In making such decisions, the chair may wish to consult the member of the governing body who has responsibility for issues relating to conflicts of interest. All decisions, and details of how any conflict of interest issue has been managed, should be recorded in the minutes of the meeting and published in the registers.

60. CCGs will need to decide in advance who will take the chair's role for discussions and decision-making in the event that the chair of a meeting is conflicted, or how that will be decided at a meeting where that situation arises.

61. Depending on the nature of the conflict, GPs or other practice representatives could be permitted to join in discussions by the governing body, or such other decision-making body as the CCG has created, about the proposed decision, but should not take part in any vote on the decision.

62. In many cases, e.g., where a limited number of GPs have an interest, it should be straightforward for relevant individuals to be excluded from decision-making. In the context of delegated and joint commissioning, the committee structure set out below in relation to decision making for primary medical care below has been designed to ensure that lay member and executive involvement ensures that robust decisions can be taken even where there are actual or potential conflicts of interest identified.

63. In some cases, all of the GPs or other practice representatives on a decision-making body could have a material interest in a decision, e.g., where the CCG is proposing to commission services on a direct award basis from all GP practices in the area, or where it is likely that all or most practices would wish to be qualified providers for a service under AQP. Where such a situation relates to primary medical services, the arrangements set out below provide a mechanism for decision-making. (It could also be used for any other CCG

responsibilities where decision-making has been delegated to the committee responsible for primary medical care decision making and where such a conflict of interest arises).

64. For decision making where such a conflict arises and which are not covered by the primary medical care arrangements, CCGs are advised to:

- where the initial responsibility for the decision does not rest with the governing body, refer the decision to the governing body and exclude all GPs or other practice representatives with an interest from the decision-making process, i.e., so that the decision is made only by the non-GP members of the governing body including the lay and executive members and the registered nurse and secondary care doctor;

- where the decision rests with the governing body, consider

  a) co-opting individuals from a Health and Wellbeing Board or from another CCG onto it (although care should be taken to ensure, particularly if the other CCG is from a nearby locality, that their representatives do not also have a conflict of interest and are not excluded from governing body membership under the relevant regulations. It would also be necessary for the CCG's constitution to allow such an arrangement); or
  b) inviting the Health and Wellbeing Board or another CCG to review the proposal – to provide additional scrutiny. Any such arrangements would need to be compliant with the CCG's constitution; and

- ensure that rules on quoracy (set out in the CCG's constitution) enable decisions to be made.

65. CCGs will need also to have arrangements in place where more than 50% of the members of a governing body or committee are prevented from taking a decision because of conflicted interests. Decisions could still be made by the remaining members of the governing body or committee (assuming that the meeting remains quorate), especially if constituted with lay, executive or other independent members. CCGs may need to have arrangements to secure additional external involvement in these decisions, perhaps through the involvement of a neighbouring CCG. These arrangements should be set out in the CCG's constitution.

66. Specific issues and potential approaches in relation to delegated or joint commissioning of primary care are set out below.

Decision-making when a conflict of interest arises: primary medical care

67. Procurement decisions relating to the commissioning of primary medical services should be made by a committee of the CCG's governing body. This should:

- for joint commissioning take the form of a joint committee established between the CCG (or CCGs) and NHS England; and
- in the case of delegated commissioning, be a committee established by the CCG.

68. In either case, the membership of the committee should be constituted so as to ensure that the majority is held by lay and executive members. In addition to existing CCG lay members, members may be drawn from the CCG's executive members, except where these members may themselves have a conflict of interest (e.g. if they are GPs or have other conflicts of interest). Provision could be made for the committee to have the ability to call on additional lay members or CCG members when required, for example where the committee would not be quorate because of conflicts of interest. It could also include GP representatives from other CCG areas and non-GP clinical representatives (such as the CCG's secondary care specialist and/or governing body nurse lead).

69. Any conflicts of interest issues would need to be considered on an individual basis. CCGs could also consider reciprocal arrangements with other CCGs in order to support effective clinical representation within the committee. The specific composition is a matter of determination for individual CCGs, subject to the provisions of their constitution. However, the chair and vice-chair must always be lay members of the committee.

Examples

- Regulations require that a CCG governing body has at least 6 members, including its chair and deputy chair. The members must include the CCG's Accountable Officer, chief financial officer, registered nurse, secondary care specialist and two lay members. The committee with responsibility for commissioning primary care could consist of the above plus GP members. If GP members had to withdraw from decision making for conflict of interest reasons, the committee would still be quorate with a lay and executive majority.
- Alternatively the committee could be made up of the CCG's two lay members, two additional lay people (not members or employees of the CCG), the chief financial officer, a GP member of the governing body and one other CCG member (executive or otherwise). That would create a committee of seven people and ensure that lay and executive membership was in the majority.

70. A standing invitation must be made to the CCG's local Healthwatch and Health and Wellbeing Board[14] to appoint representatives to attend commissioning committee meetings, including, where appropriate, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These representatives would not form part of the membership of the committee.

71. As a general rule, meetings of these committees, including the decision-making and the deliberations leading up to the decision, should be held in public (unless the CCG has concluded it is appropriate to exclude the public).[15]

72. In joint commissioning arrangements, the joint role of NHS England in decision-making will provide an additional safeguard in managing conflicts of interest. However, CCGs should still satisfy themselves that they have appropriate arrangements in place in relation to conflicts of interest with regard to their own role in the decision-making process.

73. CCGs may wish to include decisions on other commissioning issues within the remit of the committee. They also may wish to designate an existing committee to incorporate the above responsibilities within their remit. Where a CCG does this, they should ensure that the membership and chairing arrangements are compliant with the above requirements, or that, when dealing with primary care procurement issues, the participating membership and chairing arrangements are adjusted to meet these requirements. Where an existing committee is so designated, the above requirements on Healthwatch and Health and Wellbeing Board participation and on meeting in public would apply for co-commissioning decisions.

74. The arrangements for primary medical care decision making do not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest. They apply to decision-making on procurement issues and the deliberations leading up to the decision.

Record keeping

75. As set out above a clear record of any conflicts of interest should be kept by the CCG in its register of interests. It must also ensure that it records procurement decisions made, and details of how any conflicts that arose in the context of the decision have been managed. These registers should be available for public inspection as detailed above.

[14] Where there is more than one local Healthwatch or Health and Wellbeing Board for a CCG's area, the CCG should agree with them which should be invited to attend the committee.
[15] As per the process for governing body meetings in paragraph 8(3), Schedule 1A of the NHS Act 2006 (as amended). In joint commissioning arrangements, NHS England should follow the process in the Public Bodies (Admission to Meetings) Act 1960.

76. CCGs should ensure that details of all contracts, including the contract value, are published on their website as soon as contracts are agreed.[16] Where CCGs decide to commission services through Any Qualified Provider (AQP), they should publish on their website the type of services they are commissioning and the agreed price for each service. Further, CCGs should ensure that such details are also set out in their annual report. Where services are commissioned through an AQP approach, they should ensure that there is information publicly available about those providers who qualify to provide the service.

Role of commissioning support

77. Commissioning support services (CSSs) can play an important role in helping CCGs decide the most appropriate procurement route, undertake procurements and manage contracts in ways that manage conflicts of interest and preserve integrity of decision-making. CCGs are advised to ensure that any services they commission from CSSs, or that they secure through in-house provision, include this type of support. When using a CSS, CCGs should have systems to assure themselves that a CSS' business processes are robust and enable the CCG to meet its duties in relation to procurement (including those relating to the management of conflicts of interest).

78. Where a CCG is undertaking procurement, one way to demonstrate that the CCG is acting fairly and transparently is for the CSSs to prepare and present information on bids, including an assessment of whether providers meet pre-qualifying criteria and an assessment of which provider provides best value for money.

79. A CCG cannot, however, lawfully delegate commissioning decisions to an external provider of commissioning support. Although CSSs are likely to play a key role in helping to develop specifications, preparing tender documentation, inviting expressions of interest and inviting tenders, the CCG itself will need to:

- determine and sign off the specification and evaluation criteria;
- decide and sign off decisions on which providers to invite to tender; and
- make final decisions on the selection of the provider.

Role of NHS England

80. NHS England will support CCGs, where necessary, in meeting their duties in relation to managing conflicts of interest. In the context of co-commissioning,

[16] In doing so, CCGs will need to comply with the requirements of regulation 9 of the Procurement, Patient Choice and Competition Regulations.

NHS England will work with NHS Clinical Commissioners to develop a governance training programme for lay members to assist them with their role as members of joint or delegated commissioning committees. It will be important for CCGs to support their lay members to attend this training.

81. NHS England will also need to assure itself that CCGs are meeting their statutory duties in managing conflicts of interest, including having regard to the statutory guidance published by Monitor and NHS England. Where there are any concerns that a CCG is not meeting these duties, NHS England or Monitor could ask for further information or explanation from the CCG or take such other action as is deemed appropriate.

82. During 2015/16, NHS England will work with a randomly selected sample of a small number of CCGs who have taken on delegated or joint commissioning responsibilities in order to jointly review with them the effectiveness of this guidance and the practical experiences in implementing it. Further details of this process will be issued early in 2015.

Transparency of GP earnings

83. As previously advised[17], in line with commitments on transparency of GP earnings, there will be a new contractual requirement for GP practices to publish on their practice website by 31 March 2016, the mean net earnings of GPs in their practice (to include contractor and salaried GPs) relating to 2014/15 financial year. Alongside the mean figure, practices must publish the number of full and part time GPs associated with the published figure. The figure will include earnings from NHS England, CCGs and local authorities for the provision of GP services that relate to the contract and which would have previously been commissioned by PCTs. Costs relating to premises will not be included. Fuller details will be included in the implementation guidance for the 2015/16 GP contract, due to be published in February 2015. This is an interim solution until arrangements are finalised for publishing individual GP net earnings in 2016/17.

Statement of conduct expected of individuals in the CCG

84. We recommend that CCGs set out in their constitution a statement of the conduct expected of individuals involved in the CCG, e.g. members of the governing body, members of committees and employees, which reflect the safeguards in this guidance. This should reflect the expectations set out in the *Standards for Members of NHS Boards and Clinical Commissioning Groups.*[18]

See Annex 4 for the procurement template

[17] http://www.england.nhs.uk/commissioning/gp-contract/

[18] http://www.professionalstandards.org.uk/docs/psa-library/november-2012---standards-for-board-members.pdf?sfvrsn=0

Annexes

Annex 1: NHS Clinical Commissioners, Royal College of General Practitioners and British Medical Association principles on conflicts of interest

Annex 2: Declaration of conflict of interests for bidders/contractors template

Annex 3: Declaration of interests for members/employees template

Annex 4: Procurement template

Annex 5: 10 key questions for commissioners

Annex 6: Section 7 of Monitor's *Substantive Guidance on the Procurement, Patient Choice and Competition Regulations*

Annex 1: NHS Clinical Commissioners, Royal College of General Practitioners and British Medical Association - Shared principles on conflicts of interest when CCGs are commissioning from member practices

December 2014

1. Introduction

The ability for CCGs to become involved in co-commissioning General Practice and primary care services has the potential to bring many benefits but it also brings with it the potential for perceived and actual conflicts of interest.

NHS Clinical Commissioners (NHSCC), the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) have decided to collectively outline their high level starting principles in managing conflicts of interest when CCGs commission from member practices. In large part this has brought together principles articulated in previous lines/guidance/steer from the above organisations and NHS England.

Our principles are applicable to each of the three primary care commissioning models open to CCGs and should not be seen as being directive or be interpreted to mean that we prefer one model over another. These decisions need to remain a local, professionally led, decision.

In developing these shared principles we would like them to sit alongside NHS England's updated guidance on Managing Conflicts of Interest (December 2014). We are on a journey regarding the co-commissioning of primary care and we will review these principles when needed and as CCGs work through the guidance.

It should be noted that this paper is not designed to address the issue of perceived or actual conflicts of interest in CCGs holding and performance managing GP contracts under co-commissioning arrangements.

2. Our headline shared principles around conflicts of interest

We collectively agree the following in relation to managing conflicts of interest when CCGs commission from member practices:

- If CCGs are doing business properly (needs assessments, consultation mechanisms, commissioning strategies and procurement procedures), then the rationale for what and how they are commissioning is clearer and easier to withstand scrutiny. Decisions regarding resource allocation should be evidence-based, and there should be robust mechanisms to ensure open and transparent decision making.
- CCGs must have robust governance plans in place to maintain confidence in the probity of their own commissioning, and maintain confidence in the integrity of clinicians.
- CCGs should assume that those making commissioning decisions will behave ethically, but individuals may not realise that they are conflicted, or lack awareness of rules and procedures. To mitigate against this, CCGs should ensure that formal prompts, training and checks are implemented to make sure people are complying with the rules. As a rule of thumb, 'if in doubt, disclose'
- CCGs should anticipate many possible conflicts when electing/selecting individuals to commissioning roles, and where necessary provide commissioners with training to ensure individuals understand and agree in advance how different scenarios will be dealt with.
- It is important to be balanced and proportionate – the purpose of these tools is not to constrain decision-making to be complex or slow.

3. Addressing perceived as well as actual conflicts of interest

Conflicts of interest in the NHS are not new and they are not always avoidable. The documents we reviewed to produce this paper were all clear that the existence of a conflict is not the same as impropriety and focus on how to avoid potential or perceived wrongdoing. Most importantly all acknowledge that perceived wrongdoing can be as detrimental as actual wrongdoing, and risks losing confidence in the probity of CCGs and the integrity of wider clinicians such as GPs in networks/federations, individual practices and partners.

The RCGP/NHS Confederation also notes evidence from the BMJ that people think they aren't biased by potential conflicts but often are so the common theme is - *if in any doubt it's important to disclose.*

The RCGP/NHS Confederation and NHS England Guidance identify four types of potential conflict of interest:

- direct financial;
- indirect financial (for example a spouse has a financial interest in a provider);
- non-financial (i.e. reputation) and;
- loyalty (i.e., to professional bodies).

The BMA recognises that for CCGs there will be situations where the best decision for the population and taxpayers is not in the best interest of individual patients (for

whom GPs are required to advocate) and that this can create a perceived conflict. The RCGP/NHS Confederation paper acknowledges this but in terms of the governance when commissioning services.

4. Planning for populations

CCGs must always demonstrate that their commissioned services meet the needs of their local populations, as such CCGs will need to work with their Health and Wellbeing Board's or other local strategic bodies to ensure there is alignment to local strategic plans.

What is clear from all the existing guidance is that CCGs will need to identify the situations where they are involving their governing body clinicians to strategically plan for their population, and situations where their governing body clinicians need to be separated from procurement, planning and decision-making processes. In the former it is critically important to secure clinical expertise. In the latter, the CCG will need to manage risks around perceived and actual conflicts in relation to the tendering of services.

The BMA outlines that decisions regarding resource allocation should be evidence based, and there should be robust mechanisms to ensure open and transparent decision making. As such, GP involvement must be agreed at each stage of the commissioning and procurement process so that potential risks of conflicts are appropriately defined and mitigated early on.

5. Good practice – for CCGs

All the guidance suggests CCGs must have robust governance plans in place to maintain confidence in the probity of their own commissioning, and maintain confidence in the integrity of clinicians.

The RCGP/NHS Confederation suggests using existing NHS guidance as a starting point:

- Identify potential conflicts
- Declare interests in a register
  Exclude individuals from discussion or decision making if financial interest exceeds 1% equity in the provider organisation - depending on the nature of the discussion (we would also add that includes considering the share of the contract value to make sure there are no loopholes, this might also apply to practices with profit sharing arrangements).
- Continue to manage conflicts post-decision i.e. contract managing (carefully separating overall strategy development for populations from individual procurement processes. The former will be important for CCG lay involvement will be important and include secondary care clinicians and non-executive board nurses, the latter can be managed by managers).

NHS England guidance also says that an individual with a 'material interest' in an organisation which provides or is likely to provide significant business should not be member of CCG governing body. The BMA suggests anything above 5% equity is a material interest. The RCGP/NHS Confederation reference this threshold but also

say that something lower than a 1% stake could also be a material interest (if the size of the bid is significant).

Clearly these thresholds need to be considered in relation to individual practices and GP partners once co-commissioning is in place. The perceived risks must be recognised early on and we feel some worked case study examples would be helpful for CCGs as they work through the updated guidance. NHSCC, the RCGP and the BMA are planning to work with NHS England and Monitor to identify these examples.

NHSCC believe that CCG lay members, secondary care doctors and nurses on governing bodies play a vital role in both the design, implementation, leadership and monitoring of conflicts of interest systems and processes. They can provide robust challenge and ultimately a protection for GPs working in both the commissioning and provision of health care. Enabling them to carry out their roles in this regard is vital.

CCGs should also be proactive in their approach when considering conflicts when electing/selecting people, doing a proper induction (i.e. include continuous training and review at both Governing Body and membership (assembly level) and ensuring understanding from individuals, and agree in advance how different scenarios will be dealt with. The CCG should ensure individuals are prompted to declare an interest but not absolved from their responsibility to declare as well. Again, CCG lay members, secondary care doctors and nurse members of the governing body have a critical role in this process, as an independent arbiter and as those providing appropriate scrutiny and oversight.

NHS England's *Code of Conduct* guidance specifically explores when CCGs are commissioning services from their own GP member practices. When CCGs are commissioning from federations of practices, the same guidance should apply.

As practical support NHS England have also produced an updated code of conduct template for use when drawing up local plans (see their updated guidance). The template asks a series of questions to provide assurance to Health and Wellbeing Boards that the service meets local needs, and to the Audit Committee or external auditors that robust process was used to commission the service, select the appropriate procurement route and address potential conflicts of interest.

6. Good practice - for individuals

The current guidance suggests that individuals making decisions in CCGs do so with the Nolan principles of public life in mind: selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

They also refer to the guidance the General Medical Council (GMC) has produced for doctors including:

- You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.
- If you are faced with a conflict of interest, you must be open about the conflict, declaring your interest informally, and you should be prepared to exclude yourself from decision making.

- You must not try to influence patients' choice of healthcare services to benefit you, someone close to you, or your employer. If you plan to refer a patient for investigation, treatment or care at an organization in.

NHS England guidance indicates that individuals must declare an interest as soon as they come aware of it, and within 28 days. More informally, the RCGP/NHS Confederation also suggested the simple 'Paxman test' - whether explaining the situation to an investigative reporter/journalist like Jeremy Paxman would cause embarrassment. We think it would be helpful to develop this type of text into a tool for CCGs to use locally.

NHS England guidance indicates that individuals must declare an interest as soon as they come aware of it, and within 28 days.

Finally, the BMA suggested that commissioner doctors:

- Declare all interests, even if they are potential conflicts or the individual is unsure whether it counts as a conflict, as soon as possible.
- Update a register of interests every three months.
- Doctors must be familiar with their organisation's formal guidance.
- If individual doctors have any questions, they should seek advice from colleagues, err on the side of being open about conflicts of interest, or seek external advice from professional or regulatory bodies.

In addition to the above, the RCGP suggests there should also be a requirement to update the register of interests if a material difference arises in the circumstances of an individual at any point.

7. Procurement processes – CCGs and member practices

According to the BMA guidance, when CCGs are procuring community level services, these contracts are often below threshold requiring a competitive tender process.

There are a number of procurement options for CCGs in this situation – for example a few may include:

1. Competitive tender where GP practices are likely to bid
2. AQP where GP providers are likely to be among the qualified providers
3. Single tender from GP practices

From the guidance that exists different questions arise around conflicts of interest when the above procurement processes are used. For example:

- Identifying whether approaches such as AQP are being used with the safeguards to ensure that patients are aware of the choices available to them.
- If single tender is the route used, CCGs will need to demonstrate a few things – depending on the nature of the procurement. For example that there are no other capable providers, why the successful bid was preferred to the others and the impact of disproportionate tendering costs. (Monitor's procurement guidance provides many useful steers on what CCGs will need to demonstrate)

For primary care co-commissioning, NHSCC believes one of the elements to include on procurement processes are the issues around standing financial orders and schemes of delegation which should not allow CCGs to divide primary care budgets into smaller budgets to circumvent the procurement process. NHSCC's lay member network will have examples/steer on the correct wording to use from previous local experiences.

Regardless of what the local application is the most important part of this process is transparency. NHS England says to set out the details, including the value of all contracts on the CCG website. If they are using AQP, the types and prices of services they are commissioning should be on the website. All of this information should also be in the CCG's annual report.

When making procurement decisions, the current guidance suggests that anyone with a perceived or material conflict should be excluded from decision making, either both excluded from voting or from discussion and voting. What is not clear in the guidance is how far back this rule goes – i.e. to the planning stage or just the development of the specification and procurement. CCGs will need to agree that line locally.

According to the reviewed guidance if all GPs and practice representatives due to make a decision are conflicted, then the CCG should be:

- Referring decisions to the governing body, so that lay members / the nurse / the secondary care doctor can make the final decision. However this may weaken GP clinical input into decision making.
- Co-opting individuals from the HWB or another CCG onto the governing body, or invite the HWB / another CCG to review proposal to provide additional scrutiny (these individuals would only be able to participate in decision making if this was set out in the CCG constitution)
- Ensure that quoracy rules enable decisions to be made in this circumstance
- Plan ahead to ensure that agreed processes are followed.
- Use an appropriately constituted arms-length external scrutiny committee to ensure probity (recommended by the BMA)

CCGs can use commissioning support services (CSS) to reduce potential conflicts, for example a CSS can help select the best procurement route and prepare bids etc. However, this cannot completely eliminate the conflict as CCGs are responsible for signing off specification and evaluation criteria, signing off which providers to invite to tender, and making the final decision on the selection of the provider. The CCG is responsible for ensuring that their CSS or other third parties are compliant with regulations in the same way that the CCG must be.

NHS England also suggest any questions about the service going beyond the scope of the GP contract should be discussed with NHS England area teams, clearly that would need review in light of new delegated co-commissioning arrangements.

Networks and Federations

We note that the increasing number of GP networks and federations could potentially present an added complication to local procurement processes. If most or all CCG

member practices are part of the local federation, then this could mean that a practice not part of the federation/excluded from a federation may not have the opportunity to win contracts through competitive tender – because the process is more suited to federated organisations. One way to mitigate this would be for the CCG to always design and procure service specifications according to best practice (with openness and transparency), thereby supporting all practices to bid. One area to be careful about is when all the GPs on a governing body have a declared interest in local federations – this makes decision making and accountability complex and the CCG will need to work that through carefully with the input of its lay members and wider clinicians on the governing body. Again, an external scrutiny committee with non-conflicted clinicians such as from a neighbouring CCG may be helpful.

8. Local engagement

Separately, the BMA suggests that LMCs should be involved in CCGs either by formal consultation, a non-voting seat on governing body, or as an observer on governing body. They indicate that a non-voting governing body seat would be the best option. Neither of the other two papers we reviewed address this.

9. Other conflicts of interest issues for consideration

Personal conflict

The RCGP/NHS Confederation highlight that in CCG governing bodies a personal conflict can arise because CCG leaders are elected by their constituent GP members. There could be a perception that CCG governing bodies are favouring the most vocal or influential of their GP practice members. Related to this is the potential indirect interest for elected GPs to build a constituency of supporters within their CCG.

The CCG is responsible for ensuring that their CSS or other third parties are compliant with regulations in the same way that the CCG must be.

NHS England guidance suggests that in the case of every GP governing body member being conflicted, the lay members, registered nurse and secondary care doctor make the decision (and that the constitution is written so that this is quorate). This could however mean that decisions would be taken without a GP perspective. Alternatively, CCGs may bring in members of the Health and Wellbeing Board or another CCG to provide oversight, or as the BMA suggests use an external scrutiny committee to make decisions.

Use of primary care incentive schemes

In its guidance, the BMA highlights its concerns about the professional and ethical implications of CCGs applying incentive schemes to reduce referral or prescribing activity. The BMA urges any doctor, whether commissioner or provider, to consider the schemes carefully and ensure that scheme is based on clinical evidence. NHSCC suggests that one solution is to ensure the expertise of secondary care clinicians and nurses on governing bodies plays an important part in providing clinical input and lay members can scrutinize commercial/ financial and performance data.

The RCGP acknowledge that it is not ethical to under-treat or under-refer for financial gain, but is not unethical to 'review and reflect' on variations in referral/prescribing rates and try to reduce referrals in line with evidence or best practice.

Note to the reader:

This paper has been developed from a review of three guidance documents and brings together previous lines/guidance from NHSCC, NHS England, the RCGP and the BMA.

- BMA 'Conflicts of interest in the new commissioning system: Doctors in commissioning roles' April 2013
- RCGP/NHS Confederation 'Managing conflicts of interest in clinical commissioning groups' September 2011
- NHS England 'Managing conflicts of interest: guidance for clinical commissioning groups.' March 2013 (includes Commissioning Board Document that precedes it). We have also read across the paper to the new version of this document published December 2014.

NHSCC have also supplemented the principles raised in this paper with some points for steer that have been raised by members of its lay member network.

Annex 2: Declaration of conflict of interests for bidders/contractors template

NHS [*geographical reference*] Clinical Commissioning Group
Bidders/potential contractors/service providers declaration form: financial and other interests

This form is required to be completed in accordance with the CCG's Constitution, and s140 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the NHS (Procurement, Patient Choice and Competition) (No2) Regulations 2013 and related guidance

Notes:

- All potential bidders/contractors/service providers, including sub-contractors, members of a consortium, advisers or other associated parties (Relevant Organisation) are required to identify any potential conflicts of interest that could arise if the Relevant Organisation were to take part in any procurement process and/or provide services under, or otherwise enter into any contract with, the CCG, or with NHS England in circumstances where the CCG is jointly commissioning the service with, or acting under a delegation from, NHS England. If any assistance is required in order to complete this form, then the Relevant Organisation should contact [*specify*].
- The completed form should be sent to [*specify*].
- Any changes to interests declared either during the procurement process or during the term of any contract subsequently entered into by the Relevant Organisation and the CCG must notified to the CCG by completing a new declaration form and submitting it to [*specify*].
- Relevant Organisations completing this declaration form must provide sufficient detail of each interest so that the CCG, NHS England and also a member of the public would be able to understand clearly the sort of financial or other interest the person concerned has and the circumstances in which a conflict of interest with the business or running of the CCG or NHS England (including the award of a contract) might arise.
- If in doubt as to whether a conflict of interests could arise, a declaration of the interest should be made.

Interests that must be declared (whether such interests are those of the Relevant Person themselves or of a family member, close friend or other acquaintance of the Relevant Person), include the following:

- the Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation (Relevant Person) has provided or is providing services or other work for the CCG or NHS England;

- a Relevant Organisation or Relevant Person is providing services or other work for any other potential bidder in respect of this project or procurement process;
- the Relevant Organisation or any Relevant Person has any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgements, decisions or actions.

Declarations:

Name of Relevant Organisation:	
Interests	
Type of Interest	**Details**
Provision of services or other work for the CCG or NHS England	
Provision of services or other work for any other potential bidder in respect of this project or procurement process	
Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgements, decisions or actions	

Name of Relevant Person	[*complete for all Relevant Persons*]	
Interests		
Type of Interest	**Details**	**Personal interest or that of a family member, close friend or other acquaintance?**
Provision of services or other work for the CCG or NHS England		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		
Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgements, decisions or actions		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:

On behalf of:

Date:

Annex 3: Declaration of interests for members/employees template

NHS [*geographical reference*] Clinical Commissioning Group
Member / employee/ governing body member / committee or sub-committee member (including committees and sub-committees of the governing body) [*delete as appropriate*] declaration form: financial and other interests

This form is required to be completed in accordance with the CCG's Constitution and section 14O of *The National Health Service Act 2006, the NHS (Procurement, Patient Choice and Competition) regulations 2013 and the Substantive guidance on the Procurement, Patient Choice and Competition Regulations*

Notes:

- Each CCG must make arrangements to ensure that the persons mentioned above declare any interest which may lead to a conflict with the interests of the CCG and /or NHS England and the public for whom they commission services in relation to a decision to be made by the CCG and/or NHS England or which may affect or appear to affect the integrity of the award of any contract by the CCG and/or NHS England.
- A declaration must be made of any interest likely to lead to a conflict or potential conflict as soon as the individual becomes aware of it, and within 28 days.
- If any assistance is required in order to complete this form, then the individual should contact [*specify*].
- The completed form should be sent by both email and signed hard copy to [*specify*].
- Any changes to interests declared must also be registered within 28 days by completing and submitting a new declaration form.
- The register will be published [*specify how, or how otherwise made available to the public and whether there will be any circumstances where information will be redacted].*
- Any individual – and in particular members and employees of the CCG and/or NHS England- must provide sufficient detail of the interest, and the potential for conflict with the interests of the CCG and/or NHS England and the public for whom they commission services, to enable a lay person to understand the implications and why the interest needs to be registered.
- If there is any doubt as to whether or not a conflict of interests could arise, a declaration of the interest must be made.

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- roles and responsibilities held within member practices;
- directorships, including non-executive directorships, held in private companies or PLCs;

- ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG and /or with NHS England
- shareholdings (more than 5%) of companies in the field of health and social care;
- a position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;
- any connection with a voluntary or other organisation (public or private) contracting for NHS services;
- research funding/grants that may be received by the individual or any organisation in which they have an interest or role;
- any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgment or actions in their role within the CCG.

If there is any doubt as to whether or not an interest is relevant, a declaration of the interest must be made.

Declaration:

Name:		
Position within or relationship with, the CCG or NHS England:		
Interests		
Type of Interest	**Details**	**Personal interest or that of a family member, close friend or other acquaintance?**
Roles and responsibilities held within member practices		
Directorships, including non-executive directorships, held in private companies or PLCs		
Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG and/or with NHS England		

Shareholdings (more than 5%) of companies in the field of health and social care		
Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care		
Any connection with a voluntary or other organisation contracting for NHS services		
Research funding/grants that may be received by the individual or any organisation they have an interest or role in		
[Other specific interests?]		
Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgment or actions in their role within the CCG and/or with NHS England.		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the CCG's Constitution and published accordingly.

Signed:

Date:

Annex 4: Procurement template

Template

[To be used when commissioning services from GP practices, including provider consortia, or organisations in which GPs have a financial interest]

NHS [*geographical reference*] Clinical Commissioning Group

Service:	
Question	**Comment/Evidence**
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities? How does it comply with the CCG's commissioning obligations?	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposals?	
How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	

Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available? Have you recorded how you have managed any conflict or potential conflict?	
Why have you chosen this procurement route?[19]	
What additional external involvement will there be in scrutinising the proposed decisions?	
How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	

Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
How have you determined a fair price for the service?	

Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	

Additional questions for proposed direct awards to GP providers	
What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	

[19] Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and guidance (e.g. that of Monitor).

What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

Annex 5: 10 key questions

These questions are provided as a prompt to CCGs in considering key issues when reviewing their current arrangements for managing conflicts of interest.

1. Do you have a process to identify, manage and record potential (real or perceived) conflicts of interest that could affect, or appear to affect, the integrity of an award of a contract, including those that could arise in relation to co-commissioning of primary care?

2. How will the CCG make its final commissioning decisions in ways that preserve the integrity of the decision-making process?

3. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers, including an explanation of how the conflict has been managed?

4. Have you made arrangements to make registers of interest accessible to the public?

5. Have you set out how you will you ensure fair, open and transparent decisions about:
   - priorities for investment in new services
   - the specification of services and outcomes
   - the choice of procurement route?

6. How will you involve patients, and the public, and work with your partners on the Health and Wellbeing Boards and providers (old and new) in informing these decisions?

7. What process will you use to resolve disputes with potential providers?

8. Have you summarised your intended approach in your constitution, and thought through how your governing body will be empowered to oversee these systems and processes – both how they will be put in place and how they will be implemented?

9. What systems will there be to monitor the patterns of decision making and how any conflicts of interest were managed?

10. Has your decision making body identified and documented in the constitution the process for remaining quorate where multiple members are conflicted?

Annex 6: Section 7 of Monitor's *Substantive Guidance on the Procurement, Patient Choice and Competition Regulations*

7.1 Introduction

This section provides guidance for commissioners on handling conflicts of interest. Regulation 6(1) of the Procurement, Patient Choice and Competition Regulations prohibits commissioners from awarding a contract for NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests in providing them affect, or appear to affect, the integrity of the award of that contract.

Regulation 6(2) requires commissioners to maintain a record of how any conflicts that have arisen have been managed.

S.14O of the National Health Service Act 2006 includes further requirements relating to conflicts of interest. Guidance on how to comply with these requirements (including managing conflicts of interest) has been published by NHS England and is available on NHS England's website.

Members of commissioning organisations that are registered doctors will also need to ensure that they comply with their professional obligations, including those relating to conflicts of interest. These are described in the General Medical Council's guidance, *Good Medical Practice* and *Financial and commercial arrangements and conflicts of interest.* These are available on the General Medical Council's website.

7.2 What is a conflict?

Broadly, a conflict of interest is a situation where an individual's ability to exercise judgment or act in one role is/could be impaired or influenced by that individual's involvement in another role.

For the purposes of Regulation 6, a conflict will arise where an individual's ability to exercise judgment or act in their role in the **commissioning of services** is impaired or influenced by their interests in the **provision of those services**.

7.3 What constitutes an interest?

Regulation 6 of the Procurement, Patient Choice and Competition Regulations makes it clear that an interest includes an interest of:

- a member of the commissioner;

- a member of the governing body of the commissioner;
- a member of the commissioner's committees or sub-committees, or committees or sub-committees of its governing body; or
- an employee.

Other interests that might give rise to a conflict include the interests of any individuals or organisations providing commissioning support to the commissioner, such as CSUs, who may be in a position to influence the decisions reached by the commissioner as a result of their role.

7.4 What interests in the provision of services may conflict with the interests in commissioning them?

A range of interests in the provision of services may give rise to a conflict with the interests in commissioning them, including:

- **Direct financial interest** - for example, a member of a CCG or NHS England who has a financial interest in a provider that is interested in providing the services being commissioned or that has an interest in other competing providers not being awarded a contract to provide those services. Financial interests will include, for example, being a shareholder, director, partner or employee of a provider, acting as a consultant for a provider, being in receipt of a grant from a provider and having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
- **Indirect financial interest** - for example, a member of a CCG or NHS England whose spouse has a financial interest in a provider that may be affected by a decision to reconfigure services. Whether an interest held by another person gives rise to a conflict of interests will depend on the nature of the relationship between that person and the member of the CCG or NHS England. Depending on the circumstances, interests held by a range of individuals could give rise to a conflict including, for example, the interests of a parent, child, sibling, friend or business partner.
- **Non-financial or personal interests** - for example, a member of a CCG or NHS England whose reputation or standing as a practitioner may be affected by a decision to award a contract for services or who is an advocate or representative for a particular group of patients.
- **Professional duties or responsibilities.** For example, a member of a CCG who has an interest in the award of a contract for services because of the interests of a particular patient at that member's practice.

Commissioners will also need to consider whether any previous or prospective roles or relationships may give rise to a conflict of interest. A conflict of interest may arise, for example, where a person has an expectation of future work or employment with a provider that is bidding for a contract.

7.5 Conflicts that affect or appear to affect the integrity of an award

Even if a conflict of interest does not actually affect the integrity of a contract award, a conflict of interest that appears to do so can damage a commissioner's reputation and public confidence in the NHS. Regulation 6 of the Procurement, Patient Choice and Competition Regulations therefore also prohibits commissioners from awarding contracts in these circumstances.

As well as affecting the decision to award a contract and to which provider, a conflict of interest may affect a variety of decisions made by a commissioner during the commissioning cycle in a way that affects, or appears to affect, the integrity of a contract award decision taken at a later point in time. For example, conflicts of interest might affect the prioritisation of services to be procured, the assessment of patients' needs, the decision about what services to procure, the service specification/design, the determination of qualification criteria, as well as the award decision itself.

Conflicts might arise in many different situations. A conflict of interest might arise, for example where the spouse of a staff member of a local area team at NHS England is employed by a provider that is bidding for a contract. A conflict could also arise where a CCG is deciding whether to procure particular services from GP practices in the area or from a wider pool of providers, or where it is deciding whether to commission services that would reduce demand for services provided by GP practices under the NHS General Medical Services contract.

Depending on the circumstances of the case, there may be a number of different ways of managing a conflict or potential conflict of interest in order to prevent that conflict affecting or appearing to affect the integrity of the award of the contract.

It will often be straightforward to exclude a conflicted individual from taking part in decisions or activities where that individual's involvement might affect or appear to affect the integrity of the award of a contract. The commissioner will need to consider whether in the circumstances of the case it would be appropriate to exclude the individual from involvement in any meetings or activities in the lead up to the award of a contract in relation to which the individual is conflicted, or whether it would be appropriate for the individual concerned to attend meetings and take part in discussions, having declared an interest, but not to take part in any decision-making (not having a vote in relation to relevant decisions). It is difficult to envisage circumstances where it would be appropriate for an individual with a material conflict of interest to vote on relevant decisions.

Where it is not practicable to manage a conflict by simply excluding the individual concerned from taking part in relevant decisions or activities, for example because of the number of conflicted individuals, the commissioner will need to consider alternative ways of managing the conflict. For example, depending on the circumstances of the case, it may be possible for a CCG to manage a conflict affecting a substantial proportion of its members by:

- involving third parties who are not conflicted in the decision-making by the CCG, such as out-of-area GPs, other clinicians with relevant experience, individuals from a Health and Wellbeing Board or independent lay persons; or

- inviting third parties who are not conflicted to review decisions throughout the process to provide ongoing scrutiny, for example the Health and Wellbeing Board or another CCG.

Whether a conflict of interests affects or appears to affect the integrity of a contract award (such that the commissioner may not award the contract) will depend on the circumstances of the case. The list of factors in the box below is not exhaustive, but covers some of the core factors that a commissioner is likely to need to consider in deciding whether it is appropriate to award a contract. See box below.

Conflicts that affect or appear to affect the integrity of a contract award: Examples of factors that a commissioner is likely to need to consider in deciding whether or not it can award a contract:

- the nature of the individual's interest in the provision of services, including whether the interest is direct or indirect, financial or personal, and the magnitude of any interest;

- whether and how the interest is declared, including at what stage in the process and to whom;

- the extent of the individual's involvement in the procurement process, including, for example, whether the individual has had a significant influence on service design/specification, has played a key role in setting award criteria, has been involved in deliberations about which provider or providers to award the contract to and/or has voted on the decision to award the contract; and

- what steps have been taken to manage the actual or potential conflict (or example, via an external review of the decisions taken throughout the procurement process, including whether a conflict of a member of a CCG has been dealt with in accordance with the CCG's constitution).

7.6 Recording how conflicts have been managed

Regulation 6 of the Procurement, Patient Choice and Competition Regulations also requires commissioners to maintain a record of how any conflicts that have arisen have been managed.

Commissioners will need to include all relevant information to demonstrate that the conflict was appropriately managed. See box below.

Examples of what information a record might contain:
Commissioners might include the following information in a record of how a conflict of interest has been managed:

- the nature of the individual's interest in the provision of services, including whether the interest is direct or indirect, financial or personal, and the magnitude of any interest;

- whether and how the interest is declared, including at what stage in the process and to whom;

- the extent of the individual's involvement in the procurement process, including, for example, whether the individual has had a significant influence on service design/specification, has played a key role in setting award criteria, has been involved in deliberations about which provider or providers to award the contract to and/or has voted on the decision to award the contract; and

- what steps have been taken to manage the actual or potential conflict (or example, via an external review of the decisions taken throughout the procurement process, including whether a conflict of a member of a CCG has been dealt with in accordance with the CCG's constitution).

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NHS Trafford Clinical Commissioning Group

Agenda Item No. 8

Part 1 [X] Part 2 [ ]

NHS TRAFFORD CLINICAL COMMISSIONING GROUP GOVERNING BODY 16th December 2014

Title of Report	Next Steps towards Primary Care Co-Commissioning incorporating constitutional change
Purpose of the Report	This report is to update the Governing Body on the NHS England updated guidance "*Next steps towards co-commissioning"* published in November 2014, highlighting key points, risks and issues and support a recommended model for co-commissioning in Trafford.

Actions Requested	**Decision**	✓	**Discussion**		**Information**	
Strategic Objectives Supported by the Report	1. Consistently achieving local and national quality standards.					✓
	2. Delivering an increasing proportion of services from primary care and community services from primary care and community services in an integrated way.					✓
	3. Reduce the gap in health outcomes between the most and least deprived communities in Trafford.					✓
	4. To be a financial sustainable economy.					✓

Recommendations	The Governing Body is asked to support a proposal for joint commissioning arrangements, subject to the CCG's membership approval and the changes to its constitution regarding joint commissioning arrangements.

Discussion history prior to the Governing Body	Primary Care Co-Commissioning has been discussed by the Senior Management Team and the Council of Members.
Financial Implications	No additional allocation for primary care co-commissioning is expected. The co-commissioning agenda needs to be resourced from internal resources, redefined role of area team primary care resources and working differently with existing groups and stakeholders.
Risk Implications	The main issues with the new process and guidance are the timescale imposed on Trafford CCG in undertaking the

	following: • Required financial diligence and governance • Engagement with all stakeholders including CCG member practices, Local Medical Committee, Health and Wellbeing Board, HealthWatch • Constitution amendment process The CCG potentially could also not have the appropriate level of capacity, skills and competencies to undertake all elements of the co-commissioning model chosen, resulting in the inability to realise the expected benefits.
Impact Assessment	N/A
Communications Issues	N/A
Public Engagement Summary	The Public Reference Advisory Panel will be presented with Primary Care Co-Commissioning at its January meeting. HealthWatch are to be engaged in the process of Primary Care Co-Commissioning with a representative to be invited to attend the newly created Primary Care Commissioning Committee. Consideration can also be given to PRAP representation on the Committee.

Prepared by	Jason Swift, Head of Primary Care Interface Mike Taylor, Head of Governance, Planning & Risk
Responsible Director	Gina Lawrence, Chief Operating Officer/Director of Commissioning & Operations

NEXT STEPS TOWARDS PRIMARY CARE CO-COMMISSIONING INCOPORATING CONSTITUTIONAL CHANGE

1.0 INTRODUCTION AND BACKGROUND

1.1 On the 1st May 2014 Simon Stevens, NHS England Chief Executive, issued an announcement detailing new co-commissioning arrangements for the NHS in England.

1.2 Following the 1st May announcement, Dame Barbara Hakin, NHS England Managing Director for Commissioning Development, wrote out to CCG's on the 9th May 2014 asking for expressions of interest to undertake co-commissioning at local level working with area teams.

1.3 Work began across Greater Manchester (GM) to define the levels of co-commissioning to obtain a consistent approach across GM. This work concluded with a stepped model for co-commissioning from level 1 (lowest) to level 4 (highest).

1.4 Trafford CCG engaged with member practices, local medical committee (LMC), NHS England area team and other stakeholders to formulate the Trafford response to the co-commissioning agenda.

1.5 Nationally, and owing to the huge variation in models of co-commissioning across England proposed by CCG's, new guidance "Proposed next steps towards primary care co-commissioning: an overview was produced in September 2014.

1.6 This was followed on the 10th November 2014 with further NHS England guidance "Next steps towards primary care co-commissioning.

1.7 The guidance document issued on the 10th November 2014 "Next steps towards primary care co-commissioning" changed the parameters of the co-commissioning agenda. It defines three models of co-commissioning and requires Trafford CCG to resubmit a proposal for co-commissioning of primary care.

2.0 GUIDANCE SUMMARY

2.1 The 10th November guidance "Next steps to towards primary care co-commissioning" outlines a revised model and process for co-commissioning, giving Trafford CCG the opportunity to choose afresh its model, and requires the submission of a new proposal within a template return.

2.2 Linking to the NHS Five Year Forward View, the guidance defines **three** new models of co-commissioning.

1. Greater involvement in primary care decision making	2. Joint commissioning arrangements	3. Delegated commissioning arrangements

2.3 The scope of primary care co-commissioning in 2015/16 is general practice only. For delegated arrangements this includes GP performance management, budget management and complaints management, but excludes performer lists for GPs, appraisal and revalidation.

2.4 Dental, eye health and community pharmacy are possible developments for co-commissioning for 2016/17.

3.0 GREATER INVOLVEMENT IN PRIMARY CARE DECISION-MAKING

3.1 This model would require no new governance arrangements, and simply requires a CCG to have greater involvement in decision making, and could be agreed between CCG and area team at any time.

4.0 JOINT COMMISSIONING ARRANGEMENTS

4.1 Joint commissioning arrangements will require new governance arrangements with a new joint committee. This model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with the area team. Within this model CCGs have the option to pool funding for investment.

4.2 Joint commissioning arrangements in 2015/16 are limited to GP services. The functions operating under joint committees for 2015/16 are

- GMS, PMS & APMS contracts (inc. design, monitoring, issuing breech/remedial notices and removing a contact).
- Enhanced services (Local and Directed enhanced services)
- Design of local incentive scheme as an alternative to QOF
- Establishment of new practices, and approving mergers
- Making decisions on discretionary payments

4.3 Following legislative reform Trafford CCG could form a joint committee with the area team, with meetings held in public.

4.4 Model terms of reference for joint commissioning arrangements including scheme of delegation are supplied in the guidance.

4.5 Membership of the new joint committee will be for both CCG and area team to agree, but a local HealthWatch representative and a local authority representative from the Health and Wellbeing Board will have the right to join as a non-voting member.

4.6 CCG and area team may wish to consider implementing a pooled fund arrangement under joint commissioning arrangements.

5.0 DELEGATED COMMISSIONING ARRANGEMENTS

5.1 Delegated commissioning arrangements require new governance arrangements, with a new primary care commissioning committee. This model offers an opportunity for Trafford CCG to assume full responsibility. Legally NHS England retains the residual liability, therefore requires robust assurance that statutory functions are being discharged effectively.

5.2 The new guidance highlights a standardised model of delegation (unlike the previous Trafford CCG co-commissioning expression of interest which operated a more pick and mix method of determining functions) and included in delegated arrangements are:

- GMS, PMS & APMS contracts (inc. design, monitoring, issuing breech/remedial notices and removing a contact).
- Enhanced services (Local and Directed enhanced services)
- Design of local incentive scheme as an alternative to QOF
- Establishment of new practices, and approving mergers
- Making decisions on discretionary payments

5.3 Under delegated commissioning arrangements the guidance provides a model governance framework. A recommendation is that Trafford would establish a primary care commissioning committee to oversee the delegated functions.

5.4 It is for the CCG to agree the full membership of this group, however there is a requirement that it is chaired by a lay member and have a lay and executive majority. Furthermore a local HealthWatch representative and a local authority representative from the Health and wellbeing Board will have the right to join as non-voting attendees.

5.5 This would also be a meeting conducted in public.

6.0 SUPPORT AND RESOURCING FOR CO-COMMISSIONING

6.1 Discussions with area team (AT) colleagues indicate that the AT primary care team will remain in place and not be devolved on a pro rata basis into CCG's rather the co-commissioning operations sub-group will define how this resource supports co-commissioning across GM, albeit that the November guidance suggests CCG's have a fair share of the staffing resource. There will be no nationally prescribed operating model of this.

6.2 Across GM the co-commissioning agenda is being developed under the umbrella of the primary care co-commissioning steering group (COOs), which has four sub-groups, finance (CFOs), Governance (headed by Rob Bellingham), Quality and Standards (headed by Raj Patel), and Operation (under GM Primary care leads).

7.0 FINANCIAL ARRANGEMENTS FOR CO-COMMISSIONING

7.1 Financial arrangements for co-commissioning across GM will be progressed via the co-commissioning finance sub-group (CFOs).

7.2 CCGs are to be provided with a co-commissioning primary care allocation based on historical plus target formula. CFOs will need to sign off on this for full delegation. It is expected this will be an allocation not an expenditure budget. This will include funding for future known pressures, with CCG able to "top up" allocation from CCG funds.

7.3 Due to timescale of the release of financial information and planning details the timescale is extremely tight in order to undertake necessary governance checks and meet submission deadlines.

7.4 There is to be no change to running cost allowance(RCA) in respect to co-commissioning in 2015/16, however, discussion with AT may be needed to discuss resources outside of RCA, given RCA was determined without consideration for co-commissioning therefore resourcing costs should sit outside of RCA.

7.5 National guidance requires the submission of a financial budget template along with full delegated CCG proposal. This poses timescale difficulties in undertaking the required financial work and due diligence checks given the timescale of the release of information.

8.0 CONFLICTS OF INTEREST

8.1 Formal guidance already exists for CCGs in managing conflicts of interest (COI). However, under co-commissioning, these have been developed with a significantly enhanced framework with clear minimum expectations. This guidance will be enacted so that CCGs will need to justify where they operate outside of the guidance.

8.2 The guidance, expected out in December 2014 as statutory guidance, will include a strengthened approach to:

- The make-up of the decision-making committee
- National training for lay members
- External involvement of stakeholders
- Register of interest
- Register of decisions

8.3 Trafford CCG audit committee chair and Accountable Officer will be required to provide direct formal attestation the CCG has complied with the COI guidance.

9.0 TIMESCALES AND APPROVALS

9.1 The following national timescales are attached to co-commissioning:

Co-commissioning Model	Proforma	Submission Date
Joint & Delegated commissioning	CCG/NHS England work to develop proposals	November 2014 to January 2015
Joint commissioning	CCG & AT to complete national proforma for joint arrangements	30 January 2015
Delegated commissioning	CCG & AT to complete national proforma (annex B) for delegated arrangements and annex C for constitution	12 noon 9 January 2015
All other constitution amendment requests		6 January 2015
Delegated arrangements	Moderation panels determine	15&16 January 2015
Delegated arrangements	National moderation panel	Late January 2015
Delegated arrangements	Committee sign off	February 2015
Delegated commissioning	Subject to approval, NHS E Finance transfer delegated budget	March 2015
Delegated & Joint arrangements	Implementation in full locally	1st April 2015

9.2 The guidance does make clear that the model of co-commissioning is flexible in escalating the level of required co-commissioning, but gives little information on how a CCG would de-escalate the level if required.

10.0 ISSUES & RISKS

10.1 The main issues/risks with the new process and guidance are the timescale imposed on Trafford CCG in effectively undertaking the following:

- Required financial diligence and governance
- Engagement with all stakeholders including CCG member practices, Local Medical Committee, Health and Wellbeing Board, HealthWatch
- Constitution amendment process

10.2 In addition, there is a risk that the CCG does not have the appropriate level of capacity, skills and competencies to undertake all elements of the co-commissioning model chosen, resulting in the inability to realise the expected benefits.

10.3 Any proposal to co-commission at delegated level would require a proposal submission by the 9th January 2015 and joint commissioning by 30th January. Given the timescales of the release of CCG allocations and planning guidance make delegated commissioning the greater risk given the holiday period forms part of the timescale.

11.0 CONSTITUTION CHANGES

11.1 In relation to whichever model is agreed upon by the CCG's membership, constitution changes are required to enable the CCG in future to create, if it so wishes:

- Joint Commissioning Arrangements with other CCGs
- Joint Commissioning Arrangements with NHS England for the exercise of CCG functions
- Joint Commissioning Arrangements with NHS England for the exercise of NHS England functions

11.2 An upcoming example of this is the proposed replacement of the 'committees in common' approach to Healthier Together governance, with joint commissioning arrangements.

11.3 Legal advice across the Greater Manchester commissioning health economy has been sought on this, with the revised wording inserted in appendix 1.

11.4 Governing Body endorsement of these constitutional changes will, pending approval from the Council of Members at their forthcoming meeting on 11th December, allow for future Primary Care Co-Commissioning requirements to be considered.

11.5 The Governing Body's attention is therefore drawn to the future need to consider and agree proposed terms of reference for any future joint commissioning committees, to ensure to its satisfaction the application of the CCG's governance. As an example model proposed model terms of reference are provided for Primary Care Co-Commissioning joint commissioning and delegated arrangements (appendix 2).

12.0 NEXT STEPS

12.1 The next steps towards co-commissioning now require Trafford CCG to;

- Continue the work at GM level through the primary care co-commissioning steering group and the sub-groups for finance, governance, operations and standards and quality.
- Undertake engagement and communications activities with member practices, local medical committee and other key stakeholders and obtain mandate
- Progress primary care co-commissioning though the CCG governance structure and conclude the appropriate application to NHS England.
- Plan for implementation

13.0 RECOMMENDATIONS

13.1 The Governing Body is asked to support a proposal for joint commissioning arrangements, subject to the CCG's membership approval and the changes to its constitution regarding joint commissioning arrangements.

Appendix 1

Summary of Amendments to Trafford CCG Constitution - January 2015

Section	Description	Proposed wording
6.4	Committees of the Group	6.4.1 The Governing Body on behalf of the Group may appoint such committees of the Group as it considers may be appropriate and delegate to them the exercise of any functions of the Group which in its discretion it considers to be appropriate except insofar as this Constitution has reserved or delegated the exercise of the Group's functions to its members, employees or a committee or sub-committee of the Group or Governing Body. 6.4.2 A committee of the Group may consist of or include persons other than members or employees of the Group. 6.4.3 A committee of the CCG includes a joint committee of the CCG and one or more other clinical commissioning groups and/or one or more local authorities and/or NHS England. 6.4.4 Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the Governing Body on behalf of the Group or the committee they are accountable to. 6.4.5 All decisions taken in good faith at a meeting of any committee or sub-committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of a member attending the meeting.
6.5	Joint Commissioning Arrangements with CCGs	6.5 Joint commissioning Arrangements with other Clinical Commissioning Groups

		6.5.1 The Group may work together with other Clinical Commissioning Groups in the exercise of its commissioning functions. 6.5.2 The Group may make arrangements with one or more Clinical Commissioning Groups in respect of: a) delegating any of the Group's commissioning functions to another Clinical Commissioning Group; b) exercising any of the commissioning functions of another Clinical Commissioning Group; or c) exercising jointly the commissioning functions of the Group and another Clinical Commissioning Group. 6.5.3 For the purposes of the arrangements described at paragraph 6.5.2, the Group may: a) make payments to another Clinical Commissioning Group; b) receive payments from another Clinical Commissioning Group; c) make the services of its employees or any other resources available to another Clinical Commissioning Group; or d) receive the services of the employees or the resources made available by another Clinical Commissioning Group. 6.5.4 Where the Group makes arrangements with one or more Clinical Commissioning Groups which involve all of the Clinical Commissioning Groups exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions. 6.5.5 For the purposes of the arrangements described at paragraph 6.5.2 above, the Group may establish and maintain a pooled fund made up of contributions by all of the Clinical Commissioning Groups working together pursuant to paragraph 6.5.2 c) above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made. 6.5.6 Where the Group makes arrangements with one or more other Clinical Commissioning Groups as described at paragraph 6.5.2 above, the Group shall develop and agree with that Clinical Commissioning

		Group/ those Clinical Commissioning Groups an agreement setting out the arrangements for joint working, including details of: • How the parties will work together to carry out their commissioning functions; • The duties and responsibilities of the parties; • How risk will be managed and apportioned between the parties; • Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund; • Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements. 6.5.7 Arrangements made pursuant to paragraph 6.5.2 above do not affect the liability of the Group for the exercise of any of its functions. 6.5.8 The Group shall have regard to any guidance published by the NHS Commissioning Board pursuant to Section 14Z8 of the 2006 Act in exercising its commissioning functions. 6.5.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Governing Body.
6.6	Joint Commissioning Arrangements with the NHS Commissioning Board for the exercise of CCG functions	6.6 Joint commissioning arrangements with the NHS Commissioning Board for the exercise of Clinical Commissioning Group functions 6.6.1 The Group may work together with the NHS Commissioning Board in the exercise of its commissioning functions. 6.6.2 The Group and the NHS Commissioning Board may make arrangements to exercise any of the Group's commissioning functions jointly. 6.6.3 The arrangements referred to in paragraph 6.6.2 above may include other Clinical Commissioning Groups. 6.6.4 Where joint commissioning arrangements are entered into pursuant to paragraph 6.6.2 above, the parties may establish a joint committee to exercise the commissioning functions in question. 6.6.5 Arrangements made pursuant to paragraph 6.6.2 above may be on

		such terms and conditions (including terms as to payment) as may be agreed between the NHS Commissioning Board and the Group. 6.6.6 Where the Group makes arrangements with the NHS Commissioning Board (and one or more other Clinical Commissioning Groups if relevant) as described at paragraph 6.6.2 above, the Group shall develop and agree with the NHS Commissioning Board a framework setting out the arrangements for joint working, including details of: • How the parties will work together to carry out their commissioning functions; • The duties and responsibilities of the parties; • How risk will be managed and apportioned between the parties; • Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund; • Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements. 6.6.7 Arrangements made pursuant to paragraph 6.6.2 above do not affect the liability of the Group for the exercise of any of its functions. 6.6.8 The Group shall have regard to any guidance published by the NHS Commissioning Board pursuant to Section 14Z8 of the 2006 Act in exercising its commissioning functions. 6.6.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Governing Body.
6.7	Joint Commissioning Arrangements with the NHS Commissioning Board for the exercise of NHS Commissioning Board functions	6.7 Joint commissioning arrangements with the NHS Commissioning Board for the exercise of the NHS Commissioning Board's functions 6.7.1 The Group may work with the NHS Commissioning Board and, where applicable, other Clinical Commissioning Groups, to exercise specified NHS Commissioning Board functions. 6.7.2 The Group may enter into arrangements with the NHS Commissioning Board and, where applicable, other Clinical Commissioning Groups to:

		• Exercise such functions as specified by the NHS Commissioning Board under delegated arrangements; • Jointly exercise such functions as specified with the NHS Commissioning Board. 6.7.3 Where arrangements are made for the Group and, where applicable, other Clinical Commissioning Groups to exercise functions jointly with the NHS Commissioning Board a joint committee may be established to exercise the functions in question. 6.7.4 Arrangements made between the NHS Commissioning Board and the Group may be on such terms and conditions (including terms as to payment) as may be agreed between the parties. 6.7.5 For the purposes of the arrangements described at paragraph 6.7.2 above, the NHS Commissioning Board and the Group may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made. 6.7.6 Where the Group enters into arrangements with the NHS Commissioning Board as described at paragraph 6.7.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of: • How the parties will work together to carry out their commissioning functions; • The duties and responsibilities of the parties; • How risk will be managed and apportioned between the parties; • Financial arrangements, including payments towards a pooled fund and management of that fund; • Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements. 6.7.7 Arrangements made pursuant to paragraph 6.7.2 above do not affect the liability of the NHS Commissioning Board for the exercise of any

		of its functions. 6.7.8 The Group shall have regard to any guidance published by the NHS Commissioning Board pursuant to Section 14Z8 of the 2006 Act in exercising its commissioning functions. 6.7.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the Governing Body.
6.8	Joint Commissioning arrangements with Local Authorities	6.8 Joint commissioning arrangements with local authorities 6.8.1 The Group may enter into joint commissioning arrangements with one or more local authorities pursuant to Section 75 of the 2006 Act
6.9	The Governing Body	6.9 Functions - the governing body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations or in this constitution. The governing body may also have functions of the Clinical Commissioning Group delegated to it by the group. Where the group has conferred additional functions on the governing body connected with its main functions, or has delegated any of the group's functions to its governing body. The Governing Body has responsibility for: x) exercising any other functions of the Group which are not otherwise reserved or delegated.

Appendix 2(i)

Next steps towards primary care co-commissioning: Annex D

Model terms of reference for joint commissioning arrangements including scheme of delegation

November 2014

Model terms of reference for joint commissioning arrangements including scheme of delegation

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would jointly commission primary medical services.

2. The NHS England and **[insert name]** CCG **[or CCGs – amend as appropriate]** joint commissioning committee is a joint committee with the primary purpose of jointly commissioning primary medical services for the people of **[insert geographical area]**.

Statutory Framework

3. The National Health Service Act 2006 (as amended) ("**NHS Act**") provides, at section 13Z, that NHS England's functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

4. **[Include reference to statutory provisions used to jointly exercise CCG functions, if any have been delegated by the CCG to the joint committee. This is permitted by section 14Z9 of the NHS Act 2006 (as amended). If such arrangements are made, the CCG will need to formally delegate the functions in question to the joint committee. A draft delegation has been prepared and is set out as Schedule 1 to this document.]**

5. **[This paragraph only needs to be included if paragraph 4 above applies, i.e. the CCG has delegated CCG functions to the joint committee]** Section 14Z9 of the NHS Act was amended by Legislative

Reform Order (2014/2436) ("LRO") to enable the joint exercise by NHS England and a CCG of any of the CCGs commissioning functions and any other functions of the CCG which are related to the exercise of those functions. Where such arrangements are made, the LRO enabled them to be exercised by a joint committee established between the parties.

Role of the Joint Committee

6. The role of the Joint Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England **[and such CCG functions under sections 3 and 3A of the NHS Act as have been delegated to the joint committee]**.

7. This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

8. **[In performing its role the Joint Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and [insert name] CCG, which will sit alongside the delegation and terms of reference.] – [This is the proposed agreement to deal with such as information sharing, resource sharing, contractual mechanisms for service delivery (and ownership) and interplay between contractual and performance list management.]**

Geographical coverage

9. The Joint Committee will comprise NHS England **[insert Area Team name]**, and the **[insert name]** CCG. It will undertake the function of jointly commissioning primary medical services for **[insert geographical area]**.

Membership

10. The Joint Committee shall consist of:

    a) **[To set out make-up of joint committee]**
    b) The membership will meet the requirements of **[insert name]** CCG's constitution.

11. The Chair of the Joint Committee shall be the **[insert role]** of the **[insert organisation]**.

12. The Vice Chair of the Joint Committee shall be the **[insert role]** of the **[insert organisation]**.

13. **[To set out non-voting attendees. This should include a standing invitation to a HealthWatch representative and a Health and Wellbeing Board representative.]**

Meetings and Voting

14. The Joint Committee shall adopt the Standing Orders of **[insert name]** CCG insofar as they relate to the:

    a) Notice of meetings;

    b) Handling of meetings;

    c) Agendas;

    d) Circulation of papers; and

    e) [Conflicts of interest -to reflect Standing Orders provisions on this issue after review by CCG to take into account additional guidance to be issued by NHS England has taken place]

15. Each member of the Joint Committee shall have one vote. The Joint Committee shall reach decisions by (a simple majority of members present, but with the Chair having a second and deciding vote, if necessary). **(Position to be confirmed as part of the final arrangements for voting procedures and make-up of the committee).**

16. **[Insert provisions for quorum. This will need to be consistent with the CCG's Standing Orders and as agreed between the parties. Quoracy will also need to reflect conflicts of interest guidance.]**

17. **[Insert provisions for frequency of meetings. The suggested frequency is weekly for the first month and then as agreed after that.]**

18. Meetings of the Joint Committee:

    a. Shall, subject to the application of 7(b), be held in public.

    b. The Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

19. Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

20. The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

21. Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the joint committee in which event these shall be observed.

22. **[Insert secretariat provisions]**

23. The secretariat to the Joint Committee will:
    a) Circulate the minutes and action notes of the committee with 3 working days of the meeting to all members.
    b) Present the minutes and action notes to **[name of area team]** of NHS England and the governing body of **[insert name] CCG(s)**.

24. **[These Terms of Reference will be reviewed from time to time, reflecting experience of the Joint Committee in fulfilling its functions and the wider experience of NHS England and CCGs in primary medical services co-commissioning.]**

Decisions

25. The Joint Committee will make decisions within the bounds of its remit.

26. The decisions of the Joint Committee shall be binding on NHS England and **[insert name]** CCG.

27. Decisions will be published by both NHS England and **[insert name]** CCG**(s)**.

28. The secretariat will produce an executive summary report which will presented to **[insert name of area team]** of NHS England and the governing body of **[insert name]** CCG**(s)** each month **[could be longer period]** for information.

Key Responsibilities

[Insert details of key responsibilities – this will include areas such as planning, including carrying out needs assessments, primary medical care services for the geographical area in question; undertaking reviews as appropriate; co-ordinating a common approach to primary care commissioning as appropriate; managing relevant budgets].

Review of Terms of Reference

29. These terms of reference will be formally reviewed by **[insert name of the area team]** of NHS England and **[insert name]** CCG**(s)** in April of each year, following the year in which the joint committee is created, and may be amended by mutual agreement between **[insert name of the area team]** of NHS England and **[insert name]** CCG**(s)** at any time to reflect changes in circumstances which may arise.

[Signature provisions]

[Schedule 1 – Delegation by CCG to joint committee – CCG functions [include if relevant]

Schedule 2 - List of Members – populate once membership agreed]

NHS England

Next steps towards primary care co-commissioning: Annex F

Delegated commissioning model- draft terms of reference

November 2014

Draft terms of reference – [insert name] CCG Primary Care Commissioning Committee

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary **medical** care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to **[insert name]** CCG. The delegation is set out in Schedule 1.

3. The CCG has established the **[insert name]** CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

4. It is a committee comprising representatives of the following organisations:
   - **[insert name]** CCG
   - **[NHS England];**
   - **[insert others as relevant].**

Statutory Framework

5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.
6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG. **[insert details as relevant]**

7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

   a) Management of conflicts of interest (section 14O);

   b) Duty to promote the NHS Constitution (section 14P);

   c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

   d) Duty as to improvement in quality of services (section 14R);

   e) Duty in relation to quality of primary medical services (section 14S);

   f) Duties as to reducing inequalities (section 14T);

   g) Duty to promote the involvement of each patient (section 14U);

   h) Duty as to patient choice (section 14V);

   i) Duty as to promoting integration (section 14Z1);

   j) Public involvement and consultation (section 14Z2).

8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

   - Duty to have regard to impact on services in certain areas (section 13O);
   - Duty as respects variation in provision of health services (section 13P).

9. The Committee is established as a committee of the **[Governing Body]** of each named CCG ***[Individual agreements should include appropriate provisions consistent with overriding governance arrangements]*** in accordance with Schedule 1A of the “NHS Act”.

10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to **[for example]** make collective decisions on the review, planning and procurement of primary care services in **[insert name of area]**, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and **[insert name]** CCG, which will sit alongside the delegation and terms of reference.

13. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

15. This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

- Decision making on whether to establish new GP practices in an area;

- Approving practice mergers; and

- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

16. The CCG will also carry out the following activities:

    a) **[to be completed – examples listed below]**

b) **To plan, including needs assessment, primary [medical] care services in [insert area];**

c) **To undertake reviews of primary [medical] care services in [insert area];**

d) **To co-ordinate a common approach to the commissioning of primary care services generally;**

e) **To manage the budget for commissioning of primary [medical] care services in [insert area].**

Geographical Coverage

17. The Committee will comprise the **[insert name]** CCG **[and, if relevant, other named CCGs]**.

Membership

18. The Committee shall consist of:

[insert make-up of committee – list of members included as Schedule 3]

19. The Chair of the Committee shall be **[insert process for identification/appointment]**

20. The Vice Chair of the Committee shall be **[insert process for identification/appointment]**.

21. **[Consider whether others will be non-voting attendees. This should include a standing invite to a HealthWatch representative and a Health and Wellbeing Board representative.]**

Meetings and Voting

22. The Committee will operate in accordance with the CCG's Standing Orders. The Secretary **[amend as relevant to individual CCG arrangements]** to the

Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than **[x]** days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

23. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible. **[Reconsider voting procedures following a decision on the make-up of the committee].**

Quorum

[Insert provisions for quorum. This will need to be consistent with the CCG's Standing Orders and as agreed between the parties. Quoracy will also need to reflect conflicts of interest guidance]

Frequency of meetings

24. **[Insert provisions for frequency of meetings. The suggested frequency is weekly for the first month and then as agreed after that].**

25. Meetings of the Committee shall:
    a) be held in public, subject to the application of 23(b);

    b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

26. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide

objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

27. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest..

28. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

29. Members of the Committee shall respect confidentiality requirements as set out in the CCG's **[Constitution or Standing Orders, amend as relevant]**.

30. The Committee will present its minutes to **[insert name of relevant area team]** of NHS England and the governing body of **[insert name]** CCG each month **[could be longer]** for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 27 above.

31. The CCG will also comply with any reporting requirements set out in its constitution.

32. **[It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.]**

Accountability of the Committee

[Budget and resource accountability arrangements and the decision-making scope of the Committee to be included within this section as agreed]

[The CCG will need to review its Standing Financial Instructions and Standing Orders to ensure that are sufficient in the context of delegated commissioning.]

[For the avoidance of doubt, in the event of any conflict between the terms of this Scheme of Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the latter will prevail.]

[Allowance for consultation with members of CCGs / public]

Procurement of Agreed Services

[The detailed arrangements regarding procurement will be set out in the delegation agreement. Please refer to the *Next Steps in primary care co-commissioning document* for further guidance on this.]

Decisions

33. The Committee will make decisions within the bounds of its remit.

34. The decisions of the Committee shall be binding on NHS England and **[insert name]** CCG.

35. The Committee will produce an executive summary report which will be presented to **[insert name of area team]** of NHS England and the governing body of **[insert name]** of the CCG each month [could be longer period] for information.

[Signature provisions]

[Schedule 1 – Delegation-to be added when final arrangements confirmed]

[Schedule 2 – Delegated functions-to be added when final arrangements confirmed]

[Schedule 3 - List of Members-to be added when confirmed]

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Healthwatch Trafford Update
January 2015

The staff and Board of Healthwatch Trafford (HWT) continue to meet with local groups and residents of Trafford as well as having our scheduled meetings with stakeholders, local commissioners and providers of services.

We continue our regular, monthly drop-ins at

- Broomwood Wellbeing & Community Centre
- Trafford Centre for Independent Living
- LMCP drop in (Trafford Community Centre, Shrewsbury St)

We also continue our Face to Face Engagement with young people to promote Healthwatch Trafford and gain young people's experiences of using services by working with members of Trafford Youth Cabinet (consulted for guidance on engaging young people as young volunteers) and the young women attending Sale Moor Young Women's Project

Healthwatch staff and volunteers have attended the following events, meetings and forums:

Ongoing Events

- CCG Locally Commissioned Services Review Group (Previously Enhanced Services Review Group)
- CMFT Liaison Meeting
- Moorside MH Unit liaison meetings
- Safeguarding Adults Operational Board
- Safeguarding Adults Strategic Board
- CCG Public Reference and Advisory Panel (PRAP)
- HW Information & Signposting Group
- Personalisation Co-Production Group
- Locality Partnership Board (North)
- Greater Manchester Healthwatch Meeting
- North West Healthwatch Meeting
- External Reference Group of Healthier Together
- Youth Cabinet meeting
- Integrated Care Redesign Board
- PCCC Project Group
- Trafford Information network
- Health & Well Being Board
- Integrated Patient Reference Group
- Information & Signposting Meeting
- Trafford Signposting and Accessibility Delivery Group

- Diverse Communities Board
- Health Overview & Scrutiny Meeting
- Ageing Well Partnership Board
- Sale West Health Group Meeting
- Quality Surveillance Group (NHS England LAT)

Below is an update on specific areas of work and involvement since the last Health and Wellbeing Board update in November 2014.

Healthier Together

We continue our involvement with the Healthier Together Program. We continue to attend the External Reference Group meetings and are involved in the production of the ERG report to the Committees in Common.

Working with young people

We also continue our face to face Engagement with young people to promote Healthwatch Trafford and gain young people's experiences of using services by working with members of Trafford Youth Cabinet (consulted for guidance on engaging young people as young volunteers) and the young women attending Sale Moor Young Women's Project.

A young health champion's project has been commenced with pupils at a primary school in the Sale area. This is a pilot project and if the outcomes are successful it is hoped that it will be launched in other schools across Trafford.

CMFT/Trafford General

The first drop in at Trafford General Hospital Outpatients Department took place on 18th December. Healthwatch staff and volunteers were present in the Orthopaedic Outpatients area as well as General Outpatients. They had contact with 40 people on the day. Information gathered is still being collated and will be shared with CMFT and the CCG patient experience Team.

Care Quality Commission

In December, Healthwatch Chair and Chief Officer met with the regional manager for the GP inspection teams. We received an update on the inspections due to take place in Trafford in the coming months.

Patient Experience Platform (PEP)

The patient experience platform is now on the Healthwatch Trafford website. It is still in its testing stage. 60 residents have already accessed the site. A formal launch will take place in January.

Local Pharmaceutical Committee

We attended the December meeting of the Local Pharmaceutical Committee. Issues discussed were the NHS Flu service and 7 day prescription packs.

The Trafford Parkinson's Support Group.

Concerns about the lack of a Parkinson's Specialist Consultant at Trafford General are still being raised by the group. Patients are having follow up appointments cancelled and new patients are attending Manchester Royal Infirmary. This issue has been raised with CMFT but no resolution

seems imminent. HWT will be meeting with the group in January to discuss the implications of this loss of service.

Information and Signposting Function

- Since the last update there have been 320 contacts with the public.
- There have been 44 instances of signposting or information requests from the public.
- There have been 58 concerns / complaints logged with us in this time 6 of these are ongoing.

Ann Day
Chair Healthwatch Trafford
December 2014

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