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.

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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