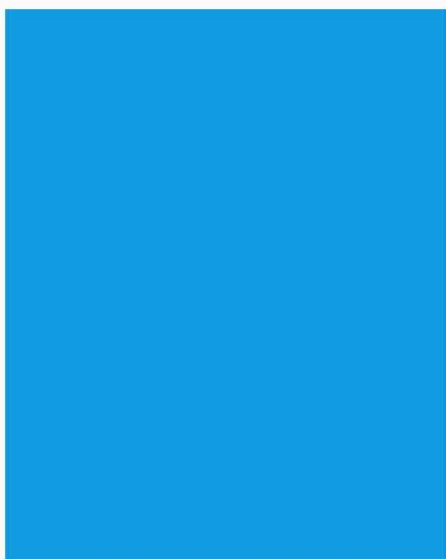


Towards establishment:

Creating responsive and  
accountable clinical  
commissioning groups



# **Towards establishment:**

*Creating responsive and accountable clinical commissioning groups*

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# Contents

Introduction .....	4
Chapter 1: Establishing a clinical commissioning group.....	7
Chapter 2: Developing a clinical commissioning group constitution .....	11
Chapter 3: The importance of good governance to clinical commissioning groups.....	16
Chapter 4: Transparency: demonstrating public accountability and probity, and managing conflicts of interest.....	24
Chapter 5: Governance structures within the clinical commissioning group.....	31
Chapter 6: Key leadership roles .....	37
Chapter 7: Governance for collaborative arrangements across clinical commissioning groups .....	44
Chapter 8: Next steps .....	50

See separate document:

- **Technical Appendix 1** – Managing conflicts of interest

# Introduction

The Government's ambition for the NHS to deliver health outcomes among the best in the world is rooted in the three principles of giving patients more information and choice, focusing on healthcare outcomes and quality standards, and empowering frontline professionals with a strong leadership role. At the heart of these proposals are clinical commissioning groups (CCGs).

CCGs will be different from any predecessor NHS organisation. Whilst statutory NHS bodies, they will be built on the GP practices that together make up the membership of a CCG. These member practices must decide, through developing their constitution, and within the framework of legislation, how the CCG will operate. They must ensure that they are led and governed in an open and transparent way which allows them to serve their patients and population effectively.

It will be vitally important that CCGs are clinically led, with the full ownership and engagement of their member practices, so that they can bring together advice from the broadest range of health and care professionals to influence patterns of care and focus on patients' needs. At the same time they will need to demonstrate probity and governance commensurate with their considerable responsibilities for their patients' healthcare and taxpayers' money. This will require ensuring that they have open, robust and transparent processes which will give the communities they service the confidence that, through the appropriate governance arrangements, they can demonstrate how they will plan their part in ensuring that the services their patients receive are safe and delivered with care and compassion.

These new organisations will be vital to delivering the quality and productivity agenda which is so essential as we move into an era of increasing healthcare need and lower growth in NHS resources. They will need to deliver the highest quality and outcomes for patients within the resources available to them.

CCGs will have to be effective and safe statutory bodies that embody Nolan principles.

This guidance is intended to support GP practices, and all those with whom they work as they put in place the arrangements they need in order to apply to the NHS Commissioning Board to be established as a CCG.

It sets out in particular:

- the steps GP practices need to take to establish the CCG;
- why good governance is essential for CCGs;
- how to develop the CCG's constitution, which will enshrine the ways in which the organisation will operate, its processes and the committee structures, including the role of the governing body;
- how to develop robust arrangements for accountability, transparency and probity, including managing conflicts of interest;
- the key leadership roles in CCGs and how they can be discharged; and

- how to ensure effective governance where CCGs adopt collaborative commissioning arrangements.

Running through the whole document is the emphasis on creating an open, transparent and responsive culture, where relationships are as important as having the right structures in place and where public and patient involvement will become fundamental in everything a CCG will need to do.

CCGs will have to account to the patients and population they serve as well as being accountable to the NHS Commissioning Board. This will require a comprehensive and effective patient and public engagement strategy with systems and processes to assure the governing body that this is taking place throughout the organisation. They will need to play a full role on their local Health and Wellbeing Boards including co-operating, in preparing joint strategic needs assessments, and agreeing a joint Health and Wellbeing Strategy. They will also work in partnership with Local Authorities and (as members of the Health and Wellbeing Boards) have a role in encouraging health and social care commissioners with the aim of securing better integrated health and social care for their patients. They will have a responsibility to ensure that relevant health and care professionals are involved in the design of services and that patients and the public are actively involved in the commissioning arrangements.

Using the right systems and processes will not only help CCGs meet all their statutory duties. It will also help ensure that they are securing the highest quality services with the best outcomes for their patients and the best value for their population. It is important that governance is seen as a means to an end, and not the end in itself. Organisations that practise great governance use their processes to adapt and change, to seek feedback and take actions, to challenge their leadership and to place accountability right at the heart of their push for continuous improvement.

All the structures within the CCG, including the governance structures, need to be designed in order to ensure that the organisation is built for sustainability and that continuous improvement and effectiveness are integral.

Having great processes to achieve this change is important. But of equal importance is creating a culture that sees great governance as an essential driver for change rather than a bureaucratic chore. This is particularly important in organisations that take decisions that have an immediate public impact, such as the NHS. CCGs should demonstrate that their approach to governance and accountability is 'front and centre' of their organisational planning.

Although this document focuses specifically on the internal governance arrangements in CCGs, the active role they play on their Health and Wellbeing Board and other collaborative arrangements will also depend on strong foundations of governance.

*Developing clinical commissioning groups: Towards authorisation and Clinical commissioning group authorisation: Guide for applicants*<sup>1</sup> describe the proposed ways in which the NHS Commissioning Board will assess applications for establishment as a CCG including how it will determine if the proposed governance arrangements meet the legislative requirements and are

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<sup>1</sup> *Developing clinical commissioning groups: Towards authorisation* (Department of Health, September 2011) [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_130293](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293), *Clinical Commissioning Group Authorisation: Guide for applicants* <http://www.commissioningboard.nhs.uk/files/2012/04/ccg-auth-app-guide.pdf>

otherwise appropriate. Operationally, we refer to establishment of CCGs to mean the formal establishment of the statutory body, and authorisation as the process of assessing the extent to which an established CCG should exercise statutory responsibility itself. This guidance will assist proposed CCGs as they submit their application for establishment and should be read in conjunction with *Towards Authorisation* and the *Authorisation Guide for applicants*.

This document has been developed in the context of the legislative framework set out in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012<sup>2</sup> and the National Health Service (Clinical Commissioning Groups) Regulations 2012<sup>3</sup>. Within the parameters of this framework, we want CCGs to have flexibility to determine the arrangements that they judge will enable them to be effective organisations.

In summary, creating a responsible and accountable CCG with good governance will lead to good management, good performance, good stewardship of public money, good public engagement and our ultimate goal - good outcomes for patients.

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<sup>2</sup> <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

<sup>3</sup> <http://www.legislation.gov.uk/uksi/2012/1631/made>

# Chapter 1: Establishing a clinical commissioning group

This chapter:

- sets out the relationship between a CCG and the GP practices that make up its membership; and
- suggests the areas that CCGs will wish to consider in deciding their governance arrangements.

General practice already plays a pivotal role in coordinating patient care, connecting patients with wider health services, and acting as an advocate for patients. GPs are already community leaders who are well known and highly respected within their local communities. Clinical commissioning will build on these strengths. Each GP practice, whilst retaining its individual identity and independent status as a provider of primary medical care, will also be a member of a new type of statutory body – a clinical commissioning group. Working with patients, with the full range of health and care professionals, and with local authorities and other community partners, CCGs will commission most healthcare services for their local populations. This means understanding patients' needs, agreeing the services that will be provided to meet those needs, and ensuring that those services deliver high quality and good outcomes.

These new community based organisations are designed to bring far greater clinical leadership to the commissioning of services, give greater say to local people in how services are delivered and greater influence for patients over the pattern of their care.

The Government and the British Medical Association (BMA) have agreed in principle, subject to secondary legislation, that it will be a contractual requirement for all holders of primary medical services contracts in England that provide essential services to registered patients during core hours (that is, providers of essential primary medical services under General Medical Services contracts or arrangements for Personal Medical Services or Alternative Provider Medical Services), to be a member of a CCG. This does not mean that all GPs will have to be actively involved in every aspect of commissioning, or the day to day running of the CCG. Their predominant focus will continue to be on providing high quality primary care to their patients. But all GP practices, as members of a CCG, will need to contribute to its goals by using their holistic understanding of patients' needs to help shape the design of services – and by working across GP practices to understand how services can be provided in ways that enhance quality and promote the most effective use of NHS resources.

CCGs will need to have effective arrangements to bind together the contribution of their member practices in this way and to involve them in decision-making. All GPs and their GP practice colleagues will need a broad understanding of how the CCG works. There will be a smaller group of GPs and other healthcare professionals involved in the leadership of the CCG



who will need a much deeper understanding of the CCG's duties as a statutory NHS body and the requirements of good governance.

As with the other aspects of good governance described in this document, proposed CCGs will be able to draw on the high quality management expertise that already exists in the NHS to develop these effective decision-making arrangements.

To support the effective involvement of all member practices, clinical leadership needs to be built into the structure and governance of CCGs, both in the senior leadership roles and in the distributed leadership that empowers patients and local people through their local GP practices. The CCG's clinical leaders will also need to have a visible profile in their local community, both with the public and with local community partners.

## Coming together as a CCG

In the first instance, GP practices will have worked together to identify which groupings of practices are best placed to come together collectively as a clinical commissioning group to meet the needs of their local population. Every prospective CCG<sup>4</sup> will have had the opportunity to undertake, with their SHA cluster, a risk assessment of their proposed configuration arrangements.

Many proposed CCGs have already begun to develop the necessary governance arrangements to ensure they would be able to discharge their responsibilities in the most effective and efficient way. Discussions in some areas will be more advanced in considering how they could operate as a CCG, what relationships they need to build and what systems and structures would help deliver the best services for patients within the resources available.

## Identifying GP practice representatives

The Health and Social Care Act and regulations will require each member of a CCG (i.e. each GP practice) to appoint an individual to act on its behalf in dealings with the CCG. The intention is that the regulations will require that this person has to be a GP or other healthcare professional.

This means that all GP practices will need to identify a GP or other healthcare professional to represent their practice's views and act on behalf of the practice. This representative will need to be able to work effectively with GPs, including sessional and locum GPs, and with other practice staff, to ensure that the views of the practice as a whole are obtained and played in to discussions.

## Ensuring effective participation

The effective participation of each member practice will be essential in developing and sustaining high-quality commissioning arrangements.

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<sup>4</sup> incorporates pathfinder CCGs and applies to developing bodies that are working towards making an application to the NHS Commissioning Board to be formally established as a CCG



The engagement of member practices and the strength of the distributive leadership model will be fundamental in many areas, including:

- shaping the culture of a CCG;
- giving voice to patients, carers and local communities;
- driving forward improvements in the design of services; and
- enabling the CCG to fulfil its duty in relation to supporting continual improvement in the quality of primary medical care.

It would be good practice for an agreement to be developed between the GP practices, identifying what they would be able to expect from one another as members of the CCG.

### Identifying clinical leaders

The member practices are then likely to identify a relatively small number of individuals who will take on key leadership roles in the CCG, including those who will sit on the CCG's governing body alongside its other clinical members (at least one registered nurse and one secondary care doctor) and its lay members.

In deciding how these leaders are identified, member practices will need to consider a number of matters including:

- the number of individuals to be identified;
- who will be eligible for leadership positions in the CCG;
- what kind of appointment process to adopt, i.e. how they will ensure that individuals are competent to undertake these roles as well as having the confidence of their peers;
- who will be eligible to participate in this process;
- who will run the process;
- tenure of roles;
- skills and competencies;
- equal opportunities and diversity;
- how often the leadership team will meet; and
- how the rest of the CCG will be kept engaged, informed and empowered to participate.

Whatever process is adopted, it should have widespread support within and across all member practices especially clinical support including sessional and locum GPs, and any non-GP partners and should conform to the general principles that it is democratic, inclusive, fair, open and transparent, and avoids conflicts of interest. CCGs may wish to seek the support of their Local Medical Committee on this process.

## Drawing up a constitution

In line with the guidance set out in the rest of this document, each group will then need to develop its proposed constitution (see chapter 2) and other proposed governance arrangements (chapters 3-4), appoint prospective external members to their governing body (chapter 5) and identify the accountable officer whose nomination will need to be confirmed as part of the establishment process and other key leaders (chapter 6) and consider what collaborative arrangements they may wish to enter into (chapter 7).

Through the establishment process, the NHS Commissioning Board will be responsible for assessing (amongst other matters) whether these proposed arrangements are appropriate to ensure the CCG will be able to discharge its functions and take on leadership and accountability for commissioning health services and managing the healthcare budget for its local population.

When member practices have agreed their configuration, they will be able to make progress on their proposed constitution which will describe the way they work and this is described in the next chapter.

### **Questions for a proposed CCG to consider**

- Working together, have you agreed your configuration?
- Has each member practice identified a GP or other healthcare professional to act on its behalf with the CCG?
- Have you agreed how all member practices will come together and participate?
- Have you identified your main clinical leadership team?

# Chapter 2: Developing a clinical commissioning group constitution

This chapter:

- sets out the CCG's duty in relation to the NHS Constitution;
- describes why a CCG's own constitution is important;
- defines the key elements of a CCG constitution; and
- illustrates to CCGs the importance and value of engaging with their GP practice members, other partners and key stakeholders, local authorities and patient groups, when developing their constitution.

As set out in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), each CCG will be required to have its own constitution that sets out various matters. These include the arrangements made for how it will discharge both its functions and that of its governing body, its key processes for decision-making, including arrangements for transparency in the decision-making of the CCG and its governing body, and provision for managing conflicts of interest.

The Act places each CCG under a duty when exercising all of its functions to act with a view to securing that health services are provided in a way which promotes the NHS Constitution,<sup>5</sup> and to promote awareness of the NHS Constitution among patients, staff and members of the public.

## NHS Constitution

The NHS Constitution sets out **seven key principles** that guide the NHS in all it does.

- The NHS provides a comprehensive service, available to all.
- Access to NHS services is based on clinical need, not an individual's ability to pay.
- The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on the patient experience.
- NHS services must reflect the needs and preferences of patients, their families and their carers.

<sup>5</sup> The NHS Constitution: The NHS belongs to us all (NHS, March 2010)  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_113613](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613)

- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
- The NHS is committed to providing best value for taxpayers' money and the most cost-effective, fair and sustainable use of finite resources.
- The NHS is accountable to the public, communities and patients that it serves.

The NHS Constitution applies to all NHS staff and their employers. NHS staff have extensive legal rights embodied in general employment and discrimination law, which the CCG needs to be aware of, particularly as an employer.

### The CCG's own constitution

As organisations that will rely on the engagement of their member practices, CCGs will want to ensure that all their member practices have been widely involved in designing how they are set up. They will also wish from the outset to involve patients and the public, local community partners - particularly local authorities - and other members of shadow health and wellbeing board(s), and other local health professionals (e.g. through existing clinical networks), whose views will all be key to ensuring improvements in care for patients.

A copy of the CCG's proposed constitution will need to be submitted as part of a proposed CCG's application to the NHS Commissioning Board for establishment. The CCG must publish its constitution; and if it is varied the new version must also be published.

In accordance with Schedule 1A of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), as a minimum the constitution must include:

- The name of the clinical commissioning group. CCGs must have a name that meets requirements set out in regulations. These include that the name begins with "NHS" and ends with the words "Clinical Commissioning Group". It must also include a geographical reference that fairly and accurately represents the area of the CCG.
- The members of the group. The GP practices that make up the CCG.
- The area of the group. All CCGs will need to have a defined geographic area. This is relevant to a CCG's responsibilities for:
  - commissioning services (other than those that must be commissioned by the NHS Commissioning Board) that meet the reasonable needs of all patients registered with its member GP practices. It is expected that the majority of these patients will live within the CCG's area.
  - commissioning services (other than those that must be commissioned by the NHS Commissioning Board) for unregistered patients in this area i.e. people who are usually resident within the area and are not registered with a member of any CCG.
  - commissioning emergency care for anyone present in the area.

- co-operating with the Local Authority (or Local Authorities) in the area and being a member of the relevant Health and Wellbeing Board(s).
- The arrangements which will be made by the CCG for the discharge of its functions including determining the terms and conditions of its employees and delegation of any functions to members or employees, governing body or a committee or sub-committee of the group. These arrangements should describe how the organisation will operate, including the role of the governing body, and the appointment of any committees or sub-committees, and the role or specific duties of senior individuals such as the Chair, Accountable Officer and Chief Finance Officer.
- The procedures to be followed by the CCG and its governing body in making decisions.
- How the CCG will deal with conflicts of interests of members, employees, other members of the governing body, and members of committees or sub-committees of the group or its governing body. These must include the arrangements made to maintain, and grant public access to, registers of interests, and to ensure that declarations of conflicts, or potential conflicts, of interest are made, and made within certain timescales. The arrangements must be made in such a way as to ensure that any conflicts or potential conflicts of interest do not, and do not appear to, affect the integrity of the CCG's decision-making process.
- The arrangements made by the CCG for securing that there is transparency about the decisions of the group and of its governing body and the manner in which they are made. This must include provision for meetings of governing bodies to be open to the public, except where the CCG considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting.
- the arrangements made by the clinical commissioning group for the discharge of the functions of its governing body. These arrangements:
  - must include provision for the appointment of the audit committee and remuneration committee of the governing body. For the audit committee, this may include provision for this committee to include individuals who are not members of the governing body; and
  - may include provision for the appointment of other committees or sub-committees of the governing body, and these may include individuals who are not members of the governing body but who are members of the clinical commissioning group or individuals of a description specified in the constitution.
  - may include delegation of governing body functions (and CCG functions that have been delegated to the governing body) to a committee or sub-committee or member of the governing body, a member of the CCG who is an individual (but not a member of the governing body) or an individual of a of a description specified in the constitution.
- A description of the arrangements to secure patient and public involvement and consultation in relation to its commissioning functions and a statement of the principles it will follow in implementing these.

The CCG may also describe within its constitution anything else which it feels is appropriate, for example how the CCG will approach its general duties regarding promoting the NHS Constitution; or promoting the involvement of patients and their carers in their individual care.

The arrangements made must also secure that there is effective participation by each member of the CCG in the exercise of its functions.

CCGs, once established, will also need to meet the requirements placed on public authorities by the Equality Act 2010. It would be appropriate for the constitution to describe how they will do this. To prepare themselves CCGs will wish to use the Equality Delivery System<sup>6</sup> at an early stage.

During the process of developing their constitution, CCGs should be mindful of what they are trying to achieve and how they will know or be able to demonstrate that the arrangements have been successful.

The CCG's constitution will need to enshrine the arrangements for identifying how member practices will appoint those who will represent them and how they will identify others in key roles, together with other key operating, decision making and governance arrangements. Through this process the member practices will agree and sign off the way the CCG will:

- develop a vision for commissioning local health and health care services, with member practices; also involving other professionals, key partners and stakeholders alongside patients and the public;
- identify all the key structures within the CCG and how they will operate. This will include the make-up and process for identifying the governing body and any other committee or sub-committee the CCG will have. For example, the constitution could determine locality arrangements and how authority could be delegated to them. It may outline how an executive team or committee should operate. It will need to include the operation of audit and remuneration committees. It should also describe the way that senior leadership roles are discharged;
- identify how the CCG will involve patients and the public in their commissioning decisions;
- identify how the CCG will ensure the full range of health and care professionals as well as patients and their representatives are involved in the design of services;
- identify how the CCG, working with the Local Authority, will promote partnership working and play a full part as a member of the Health and Wellbeing Boards;
- shape the culture, behaviours and relationships in their area, and put in place proposed structures and systems to safeguard transparency and good governance;
- consider the processes that will help arrive at the right decisions for them locally, in setting themselves up both as a member-led organisation and a new statutory body; and

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<sup>6</sup> Equality Delivery System (NHS East Midland, November 2011)  
<http://www.eastmidlands.nhs.uk/about-us/inclusion/eds/?locale=en>

- build the group on the foundation of effective local relationships and good communications with prospective member practices, and key stakeholders, including other shadow health and well being board members, patients' and carers' groups.

#### **Questions for a prospective CCG to consider**

- Does your constitution cover all the areas set out in this chapter?
- Have the member practices, alongside other partners, been engaged in developing your constitution?
- Have you reviewed and completed a baseline assessment for the Equality Delivery System?
- And, underpinning everything: have you created an organisational development plan to support you in creating your culture, relationships and ways of working?



# Chapter 3: The importance of good governance to clinical commissioning groups

This chapter:

- sets out a definition of good governance and explains why this is fundamental for all organisations, and especially statutory NHS bodies;
- explains why good governance is particularly important to patients, the public and to clinicians;
- sets out clearly how all relevant aspects of governance can be delivered through one overarching integrated governance framework; and
- summarises what this all means for CCGs, and the specific aspects they should consider.

Good governance is important:

- **to patients** because they depend on the quality of the judgements that CCGs make;
- **to the public** as it will give them confidence that the best decisions are taken for the right reasons, that the quality of healthcare services is protected and that public money is being spent wisely; and
- **to clinicians** because it supports them to make the best possible decisions, reduces the likelihood of things going wrong and protects them in the event that things do go wrong.

**Good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. It builds public and stakeholder confidence that health and healthcare is in good hands.**

As set out in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012, CCGs will be required to exercise their functions with a view to securing continuous improvements in the quality of healthcare services and healthcare outcomes. They must exercise the best possible stewardship of NHS funds for the services they are responsible for commissioning. In order to be established, CCGs will need to demonstrate that they have developed:

*“proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commission all the services for which they are responsible.”*

*Developing clinical commissioning groups: Towards Authorisation, Domain 4*

Governance describes the ways in which organisations conduct themselves to ensure they carry out their duties successfully and to the standards expected of them. It is concerned with accountability and responsibilities and describes how an organisation is directed and controlled.

In practical terms, good governance is about setting the right policies and procedures for ensuring that things are done in a systematic and proper way – with transparency and public accountability built in. This is particularly important for health services where governance procedures must cover clinical as well as other corporate aspects and so must ensure that patients receive the highest quality services. In addition, as statutory NHS bodies, NHS organisations must be seen to be acting transparently, promote continuous improvements in quality and have the proper checks and balances (including managing conflicts of interests) in place to provide assurance that decisions are being made in the best interest of patients and that public money is well managed. A failure of governance puts patients at risk of poor quality care.

This is enshrined in *Good Governance Standards for Public Services*<sup>7</sup>, and should be considered by each CCG when developing its constitution.

Adapted from *The Good Governance Standard for Public Services*

**Good governance means focusing on the organisation's purpose and on outcomes for citizens and service users**

- Being clear about purpose and intended outcomes for citizens and service users
- Making sure that patients receive a high quality service
- Making sure that taxpayers receive value for money

**Good governance means performing effectively in clearly defined functions and roles**

- Being clear about the functions of the governing body
- Being clear about the responsibilities of individual roles and making sure that those responsibilities are carried out
- Being clear about relationships between the organisation and the public

**Good governance means promoting values for the whole organisation and demonstrating the values of good governance through behaviour**

- Putting organisational values into practice
- Individuals in leadership roles behaving in ways that uphold and exemplify effective governance

<sup>7</sup> The Good Governance Standard for Public Services (OPM and CIPFA, 2004)  
[http://www.cipfa.org.uk/pt/download/governance\\_standard.pdf](http://www.cipfa.org.uk/pt/download/governance_standard.pdf)

**Good governance means taking informed, transparent decisions and managing risk**

- Being rigorous and transparent about how decisions are taken
- Having and using good quality information, advice and support
- Making sure that an effective risk management system is in operation

**Good governance means developing the capacity and capability of the governing body to be effective**

- Making sure that members of the governing body have the skills, knowledge and experience they need to perform well
- Developing the capability of people with governance responsibilities and evaluating their performance, as individuals and as a group
- Striking a balance, in the membership of the governing body, between continuity and renewal

**Good governance means engaging stakeholders and making accountability real**

- Understanding formal and informal accountability relationships
- Taking an active and planned approach to dialogue with, and accountability to, the public
- Taking an active and planned approach to responsibility to staff
- Engaging effectively with stakeholders

The First Report of the Committee on Standards in Public Life (1995)<sup>8</sup> established **seven principles to promote high standards of behaviour** in the public sphere which we recommend are included in CCG constitutions.

**NOLAN PRINCIPLES**

The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. They provide a good description of the way in which clinical commissioners might be expected to conduct themselves when making decisions about the use of public resources, and give a clear steer regarding the need to declare and be honest about any potential conflicts. The seven principles are:

- **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** – Holders of public office should promote and support these principles by leadership and example.

<sup>8</sup> <http://www.public-standards.gov.uk/>

## What does good governance mean for CCGs?

Governance arrangements need to combine the public accountability of an organisation responsible for commissioning services with the aim of improving quality and outcomes, and spending public money wisely, with the flexibility, culture and ways of working of a member-led organisation.

Working with emerging CCGs and stakeholders, we have developed a number of suggested design principles – that governance arrangements need to be:

- true to the vision – clinically led to enable quality improvement and delivery of outcomes;
- designed to fit the new, and different, organisational arrangements;
- capable of securing maximum probity, transparency and accountability within processes that are proportionate and defensible;
- rigorous enough to withstand challenge, and flexible enough to enable local ownership from the clinical community;
- bureaucracy-light, yet water-tight - keeping all parties safe; and
- capable of building from the arrangements emerging CCGs have already put in place, where these are sound.

## Bringing it all together: the importance of integrated governance

Organisations need to have a body which is responsible and accountable for ensuring delivery of the organisation's aims and objectives and must have in place a comprehensive set of structures that reflect the organisation's roles and responsibilities. These structures must be capable of considering each individual aspect of governance in the right level of detail but also in drawing them all together in a way that gives the organisation the appropriate assurance. It must ensure that the full range of systems and processes are in place so that it can assure itself, and hence provide assurance to others, that the services they commission are of the highest quality, deliver the best possible outcomes, that public money is being wisely spent and that, in all their dealings, they demonstrate an open and proper approach to all their business.

To deliver good governance, CCGs will need to recognise that the key elements are interdependent and ensure that they are interconnected, by putting in place an overarching integrated governance approach, drawing together as a minimum:

- Corporate governance – including strategic risk management;
- Clinical governance;
- Financial governance;
- Information governance; and
- Research governance.

This holistic system constitutes integrated governance. For NHS organisations, integrated governance provides an umbrella for all NHS governance approaches, combining the

principles of corporate and financial accountability with clinical and managerial accountability. It describes the systems and processes by which they lead, direct and control their functions in order to achieve organisational objectives, safely, and quality services through which they relate to patients, the wider community and partner organisations.

## Corporate governance

Corporate governance is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. It is the mechanism through which the body itself brings together all the aspects of the way it works to deliver one coordinated approach to assurance and the management of risk. It is the way in which all the other aspects of integrated governance are brought together so that the organisation can discharge its accountability in a holistic and coordinated way. Fundamental to effective corporate governance is having the means to ensure the effectiveness of this direction and control through strategic and operational risk management. For a CCG, this corporate role will be overseen by its governing body.

## Clinical governance

Clinical governance is the framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. It applies to all healthcare organisations, whether commissioning services or providing them.

CCGs will have a statutory duty to exercise their functions with a view to securing continuous improvements in the quality and outcomes of services which they commission. CCGs need to determine and monitor the overall strategy for quality improvement, in partnership with patients, carers and the wider community.

A CCG with good clinical governance will create a culture which supports continuous improvement in quality and outcomes which show clinical effectiveness, patient safety and patient experience, in relation to the services they commission. Some of the attributes which will support this are:

- leadership with a relentless focus on continuous improvement in all aspects of quality and safety;
- actively seeking the views of patients, carers and the wider community about the services they need and how they can be improved;
- systems to quickly detect adverse events, for example, encouraging early reporting of errors and near misses and using them as the basis of continuous learning and quality improvement;
- receiving complaints (from users and carers) and concerns (from members of staff) sympathetically, investigating promptly and using them to improve the quality of services and to protect patients;
- actively learning from patients' experiences;
- promoting a culture of continuous improvement in provider organisations through contracting and monitoring arrangements;

- having in place systems and processes that secure continuous learning, throughout the commissioning cycle – including securing assurance that the provider organisations from which they commission services have effective systems for identifying and minimising risk to clinical quality, handling safety incidents and managing concerns over professional performance, and
- mechanisms for sharing good practice with, and learning from, other commissioning organisations.

As part of their overall governance and reporting arrangements, it would be good practice for CCGs to review regular reports on the quality of services commissioned, on specific quality improvement initiatives, and on any serious failures in quality. CCGs may wish to delegate responsibility for detailed scrutiny of these issues to a sub committee (e.g. a clinical governance committee or quality sub committee) but the decision-making body must maintain a strategic overview and be assured that clinical governance is effectively discharged.

## Financial governance

It is essential that there is effective financial governance throughout the NHS to ensure that the significant amount of public money spent by the NHS is used effectively. It is important to recognise that financial governance cannot be separated from the overall governance framework; good governance will include the effective stewardship of public funds and the delivery of high quality services. CCG finance staff should be well managed, adequately resourced and appropriately trained.

However, there are certain elements of financial governance that can be specifically identified. In particular, the basis of good financial governance is a set of robust financial procedures, appropriate and effective management structures and financial systems operated by well managed, adequately resourced, and appropriately trained staff. This must be backed up by effective internal and external audit arrangements and all of these elements must be subject to continual professional review and evaluation by the Chief Financial Officer or equivalent office holder.

Good financial governance cannot be achieved unless all the basics of financial control are done well. The governance framework must ensure that financial risk assessment is built in to all levels of financial planning as well as being a routine component when assessing operational financial systems and controls.

CCGs will need to ensure they have an effective financial governance framework based on best practice that will enable the CCG to fulfil its statutory and management responsibilities and duties. Included within this framework will be:

- details of the financial reporting arrangements in place to ensure that high quality financial information is provided in a timely manner;
- financial procedures and processes that enable the CCG to meet its statutory financial responsibilities and local and national financial management and reporting duties;



- a system of internal control that will safeguard public funds and the organisation's assets;
- an effective system of internal control that, through managing risk to an acceptable level, will safeguard public funds and the organisation's assets and support the CCG in achieving its aims and objectives; and
- an effective audit committee that critically reviews the organisation's financial reporting and internal control principles and that ensures an appropriate relationship with both internal and external auditors.

## Information governance

Information governance supports the provision of high quality care through the effective and appropriate use of information. It provides a set of rules with which organisations must comply in order to maintain comprehensive and accurate records and keep those records confidential and secure.

Each CCG will be accountable for ensuring that it has adequate Information Governance measures in place covering all aspects of information handling, including information security and risk management, data protection and confidentiality, information quality and corporate records. The area which receives greatest media and public attention is the loss or inappropriate use of confidential patient information and recent legislation allows an organisation to be fined up to £500,000 for a serious breach of the Data Protection Act 1998. However, it will be essential for CCGs to discharge their functions effectively so they have robust arrangements supporting all aspects of the effective and appropriate use of information, underpinned by clear communications at all times.

## Research governance

The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) sets out that, in exercising their functions, CCGs will have a duty to promote research on matters relevant to the health service, and the use in the health service of evidence obtained from research. There is therefore a need for CCGs to understand, support and promote research and development in their own organisations and those from whom they commission services including by ensuring that treatment costs are funded through normal NHS commissioning arrangements.

In doing so, CCGs will not typically take on responsibility for research governance; the individual organisations which are sponsoring and conducting the research will be responsible for its governance - ensuring it is set up and delivered appropriately. In this respect CCGs will differ from PCTs, some of whom are responsible for the governance of research undertaken by GP practices. GP practices, like other providers, will in future, be responsible for the governance of research in which they participate and they may wish to work together on this. It is expected that CCGs themselves will have formal responsibility for research governance only in specific, limited circumstances.

The National Institute for Health Research will continue to have responsibility for



commissioning research on behalf of the NHS, to address issues which are identified by the NHS. This will include commissioning research to address issues identified by CCGs. It is not anticipated that CCGs will often wish to conduct research themselves, or to act as sponsors for research. However, if CCGs do engage in these activities, they will need to have in place appropriate systems for research governance, linked in with their overall approach.

## Conclusion

In summary, every element of governance described in this chapter is fundamental to the overall integrated governance of a CCG, and needs to be manifested through the right culture, systems and processes to enable the CCG to do its job well and be transparent and accountable. The constitution needs to define how all this will be drawn together and overseen at corporate level by the governing body.

### Questions for a prospective CCG to consider

- Have you reflected on best practice and key principles, and drawn on those to inform the design of the CCG's governance arrangements?
- Will the planned overall governance arrangements embrace clinical, financial, information and research governance, as well as corporate governance?
- Have you worked through how you will plan to discharge your key functions, linked to your CCG priorities?
- Have you designed the necessary infrastructure, secured access to the skills and expertise, and developed the documents to support you?

# Chapter 4: Transparency: demonstrating public accountability and probity, and managing conflicts of interest

This chapter sets out:

- why transparency is so important to CCGs;
- that CCGs must operate in an open and transparent manner in all their business in order to discharge their accountability; and
- the importance of ensuring appropriate and proportionate safeguards are in place to manage conflicts of interest (real and perceived).

## Why is transparency important for public accountability?

CCGs not only need good governance to ensure that they are making decisions in the right way to secure the best possible services for the local community, they must also ensure everything is done in an open and transparent way in order to demonstrate to all those to whom they account, and in particular the public, that this is the case.

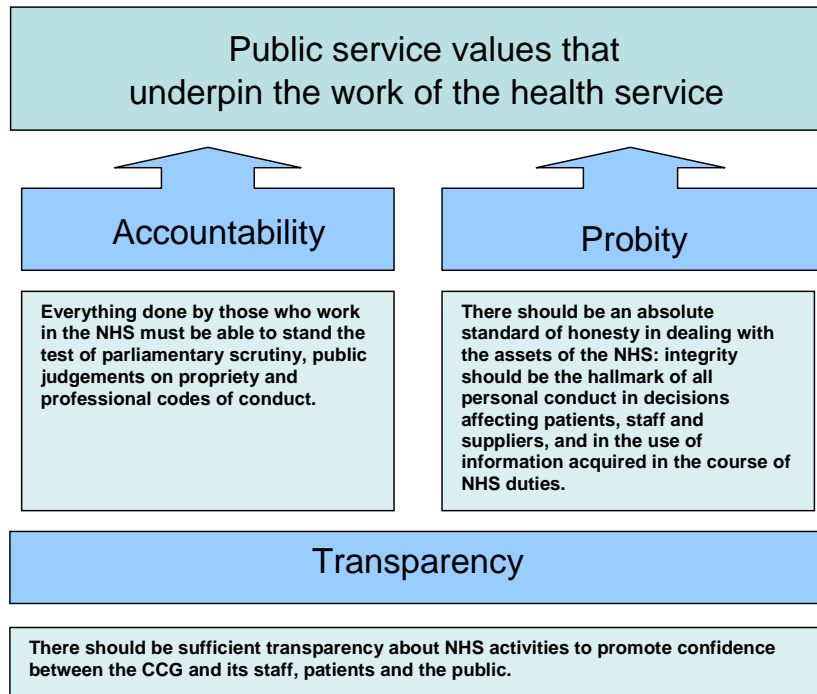
The NHS Future Forum emphasised these points in its report on patient involvement and public accountability.

*“In a democratic country, with taxpayer funded public services, public accountability is vital to secure quality, integrity, value for money and public confidence. There has to be good governance at every level of the system, in every organisation dealing with taxpayers’ money, and amongst those individuals accountable within those organisations.”<sup>9</sup>*

As CCGs become established as statutory NHS bodies, public service values and principles will need to be enshrined in their organisation, as they are at the heart of the National Health Service. High standards of corporate and personal conduct, based on the principle that patients come first, have been a requirement throughout the NHS since its inception. The NHS is accountable to Parliament for the quality of services it commissions and provides and for the effective and economical use of taxpayers' money.

<sup>9</sup> Patient Involvement and Public Accountability. A Report for the NHS Future Forum  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_127544.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127544.pdf)

This chapter looks at how CCGs can demonstrate their accountability and probity through transparent processes.



Stakeholders and emerging CCGs have told us they want to see organisations with robust governance arrangements for accountability, transparency and probity. This will be key to the ability to carry out corporate and commissioning responsibilities and will be a significant feature of authorisation.

## Accountability

CCGs will be accountable to the NHS Commissioning Board for how they fulfil their statutory duties.

They will also account to their local community for how they are commissioning high quality health services contributing to improvements in healthcare and health and well being. Over time, the members of the Health and Wellbeing Board, including CCGs will hold each other to account for delivering the Joint Health and Wellbeing Strategy that they have developed together, based on their Joint Strategic Needs Assessment.

CCGs will also need to be able to give account to local authorities in their overview and scrutiny role, for the services that they are commissioning.

All these key partners and stakeholders need to be able to see that the organisation is properly governed and that all decisions have been made in an inclusive and open way - good quality communications will be integral to making this happen.

## Probity

Integrity and honesty are key public service values, and it will be essential for these to be central to all the operations of the CCG, and those who work within it. It needs to be recognised that it will be important for a CCG not only to act with probity in relation to the way each and every process is carried out, but for it also to be perceived to have so acted.

CCGs, as member organisations, built from general practice, need to put in place very clear safeguards. Potential and actual conflicts of interest need to be identified and managed effectively and openly to prevent any problems arising. This is explored further below.

## Transparency

The Government has pledged greater transparency across the public sector. It is publishing a much greater range of data so that citizens can see more clearly the quality of public services and the basis on which decisions are made.

As statutory NHS bodies, CCGs will wish to promote transparency at all times by:

- ensuring early engagement on proposed commissioning plans with patients and the public, Health and Wellbeing Boards, current and potential providers and clinical networks;
- setting out clearly in the CCG's constitution the way in which decisions will be made;
- holding governing body meetings in public and publishing meeting papers (except where this would not be in the public interest), holding a public meeting to present the annual report and considering whether they wish to hold any other meetings in public;
- publishing details of contracts held;
- publish certain information relating to determinations it makes on remuneration, fees and allowances for employees or persons providing services to the CCG;
- publish determinations on allowances paid under any pension scheme established by the CCG, unless the governing body considers that it would not be in the public interest to publish it;
- having a Register of Interests; and
- having systems to declare interests.

These and other forms of transparency will help build and maintain confidence with patients and local communities. They will also show that CCGs are conducting business in an appropriate and legally sound manner. Patients will be able to see what services are being commissioned to meet their needs, how the quality of those services is being continuously improved, and how public money is being spent on their behalf.

Having clear, open and transparent communications will also be key in achieving good relationships and ensuring clarity about the CCG's aims, objectives and outcomes. CCGs will want to consider developing a written communication strategy covering practice members, partners, providers, patients and the public.

## Managing conflicts of interest

Managing conflicts of interest appropriately will be essential for protecting the integrity of the overall NHS commissioning system and to protect CCGs and GP practices from any perceptions of wrong-doing. CCGs will need the highest levels of transparency so they can demonstrate that conflicts of interest are managed in a way that cannot undermine the probity and accountability of the organisation. This will be particularly important when dealing with member practices.

It will not be possible to avoid conflicts of interest. They are inevitable in many aspects of public life, including the NHS. However, by recognising where and how they arise and dealing with them appropriately, CCGs will be able to ensure proper governance, robust decision-making, and appropriate decisions about the use of public money.

CCGs should make arrangements for managing conflicts and potential conflicts of interest so as to ensure that they do not, and do not appear to, affect the integrity of the CCG's decision-making processes<sup>10</sup>.

The NHS Commissioning Board will publish guidance for CCGs on the management of conflicts of interest, and CCGs will be under a duty to have regard to this guidance.<sup>11</sup>

## What is a conflict of interest?

A conflict of interest occurs where an individual's ability to exercise judgement or act in one 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. A *potential* for competing interests and/or a *perception* of impaired judgement or undue influence can also be a conflict of interest.

Conflicts can arise from an indirect financial interest (e.g. payment to a spouse) or a non-financial interest (e.g. kudos or reputation). Conflicts of loyalty may also arise (e.g. in respect of an organisation of which the individual is a member or has an affiliation). Conflicts of interest 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.

## Safeguards to manage conflicts of interest

The safeguards that will be needed to manage conflicts of interest will vary to some extent, depending on which stage in the commissioning cycle decisions are being made. The following features will need to be integral to the commissioning of all services:

- **openness:** ensuring early engagement with patients, the public and with health and wellbeing boards in relation to proposed commissioning plans;

<sup>10</sup> In accordance with the duties imposed on CCGs by section 14O(4) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)

<sup>11</sup> See section 14O(5) and (6) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)

- **transparency:** documenting clearly the approach that will be taken at every stage in the commissioning cycle;
- **responsiveness and best practice:** ensuring that commissioning intentions respond to local health needs and reflects evidence of best practice – securing ‘buy in’ from patients and clinicians to the clinical case for change
- **securing expert advice:** ensuring that plans take into account advice from appropriate health and social care professionals, e.g. through clinical networks; and draw on commissioning support, for example for more 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 contact will be awarded;
- **following proper procurement processes** and legal arrangements, including even handed approaches to providers;
- **ensuring sound record-keeping, including an up to date register of interests:** applying best practice in sound record-keeping, making appropriate information available and accessible, and maintaining a register of interests with a clear system for declaration of interests in accordance with the duties placed on CCGs under new section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012);
- **dispute resolution:** having systems for resolving disputes, clearly set out in advance.

These general processes and safeguards will need to apply at all key stages of **the commissioning process**, including:

- **planning** which services or pathways need to be commissioned differently or de-commissioned e.g. engaging with a wide range of providers, securing independent clinical advice and specifying services on the basis of best practice and outcomes;
- **agreeing** which services or pathways should be commissioned or de-commissioned e.g. identifying potential conflicts, designing the decision making processes to avoid such conflicts and using contractual mechanisms to mitigate any residual risk; and
- **monitoring** the services commissioned, to ensure they are delivering to the agreed specification, e.g. securing patient involvement and independent clinical advice in monitoring the quality of the services commissioned.

These safeguards will be particularly important in relation to the key commissioning decision-making points leading up to, during, and after the actual procurement of services, and/or in deciding not to go out to procurement. To assist this, the NHS Commissioning Board is working with the Department of Health to refine the minimum standards governing procurement and contracting of health services that will be reflected in secondary legislation for commissioners, which will come into effect from April 2013 and build on the current ‘PCT Procurement Guide’<sup>12</sup> and ‘The Principles and Rules of Collaboration and Competition’<sup>13</sup>.

<sup>12</sup> Procurement Guide for Commissioners of NHS-Funded Services (NHS & Department of Health, July 2010)  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_118218](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118218)



CCGs will need to ensure<sup>14</sup> that all member practices, and all individuals who hold positions of authority or who can make or influence decisions are in a position whereby:

- it is clear to everyone from the outset that they have this interest and/or potential conflict through their public register of interest and the register is kept up to date. Any change in circumstances should be included as soon as practicable (or within 28 days);
- their systems and processes ensure that at any time in discussions or proceedings where an individual feels that their interest may be relevant, they have a mechanism for declaring and recording this so that any comments they make are fully understood by all others to be within that context – Declaration of Interest; and
- where this conflict could have a material impact on any decision or process, the individual will play no part in influencing or making the relevant decision. This will be absolutely essential in instances where the individual or interest they represent may derive pecuniary gain from the decision.

The most obvious area in which CCGs will need to manage conflicts of interest is where a CCG commissions either healthcare services or commissioning support services from providers in which a member of the CCG has a financial or other interest, including GP practices.

### Additional safeguards for CCGs with regard to member practices

The NHS Commissioning Board will be responsible for commissioning primary care services under the GP contract. However, CCGs will be able to commission community-based services where the provider might be a GP practice, provided that those services:

- clearly meet local health needs;
- have been planned appropriately;
- go beyond the scope of the GP contract, and
- the appropriate procurement approach is used.

Generally speaking, those community-based services that could potentially be provided by a number of providers will need to be commissioned either through competitive tender or through the 'Any Qualified Provider' route. Under the current PCT Procurement Guide (which will form the basis for future procurement regulations), commissioners can also commission services through a single tender process where there is only one capable provider (or group of providers).

Where CCGs commission services from GP practices, the general safeguards described above will need to be supplemented by additional safeguards which could form a separate

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<sup>13</sup> Principles and Rules for Cooperation and Competition (NHS & Department of Health, July 2010)

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_118221](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118221)

<sup>14</sup> in accordance with the duties imposed on CCGs by section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)



Code of Conduct<sup>15</sup> to ensure maximum transparency and probity and provide reassurance that commissioning decisions have been made fairly and in the best interests of patients. This Code of Conduct will also cover how the system can be assured that these extra services are not part of the 'core' primary medical services contract.

As part of the work to develop the future regulations, and to support CCGs in developing robust governance systems, the NHS Commissioning Board intend to build on a range of work already carried out with prospective CCGs and other stakeholders, to explore what additional safeguards may be needed in specific scenarios. These will aim to provide further clarification in relation to competitive tendering, the use of the 'Any Qualified Provider' route, and the appropriate use of single tenders. This work will also help in the development of a Code of Conduct. Further information on managing conflicts of interest including principles and best practice and steps to addressing them is available at Technical appendix 1.

### Questions for a proposed CCG to consider

- Do you have a process to identify, manage and record potential (real or perceived) conflicts of interest?
- What arrangements will you develop for maintaining a register of interests, including making this accessible to the public, and making declarations of interest?
- Have you set out how you will ensure fair, open and transparent decisions about:
  - priorities for investment in new services
  - the specification of services and outcomes
  - the choice of procurement route (e.g. competitive tender, AQP, single tender)?
- How will you involve patients and the public, and work with your partners on the shadow Health and Wellbeing Boards in informing these decisions?
- Will your plans ensure early engagement with both incumbent and potential new providers?
- What process will you use to resolve disputes with potential providers?
- 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?

<sup>15</sup> A draft code of conduct was published by the NHSCB Authority <http://www.commissioningboard.nhs.uk/files/2012/07/c-of-c-conflicts-of-interest.pdf>. This is likely to form part of the final conflicts of interest guidance that the NHS CB has a duty to publish.

# Chapter 5: Governance structures within the clinical commissioning group

This chapter:

- describes the general governance arrangements needed by organisations, such as clarity on delegation and the role of committees and sub-committees;
- sets out the overarching role of the governing body in overseeing governance and decision-making and ensuring that CCGs exercise their functions effectively, efficiently and economically; and
- describes the need for audit and remuneration committees.

## Governance arrangements

As a member organisation, the CCG will need to describe, through its constitution, the governance arrangements it proposes to put in place to ensure it can discharge its functions. The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) makes some express provision about what those arrangements may, or in some cases, must cover. It might be expected that the constitution would make provision about the following (although this is not an exhaustive list):

- all appropriate stakeholders and experts have been involved in the discussions which lead to final decisions;
- those in a decision making capacity have all the relevant information on which to base their decisions;
- all decisions are made in a fair and equitable fashion;
- decisions are made in an open and transparent way so that all stakeholders, including patients and the public, can observe or be party to the process and understand the rationale for any decision;
- no-one who has a conflict of interest is party to a decision without that conflict being properly managed;
- there are appropriate checks, balances and scrutiny in decision making processes;
- all financial arrangements meet those of best practice;

- it is clear what levels of responsibility and authority are delegated to individuals and groups of individuals;
- the internal policies and processes within the organisation are clear, fair, open and well understood; and
- the methods by which the CCG will develop and assess its effectiveness and sustainability of its governance arrangements.

The constitution must describe the framework through which all this will happen so that everyone within the CCG, its member practices, patients and the public, and external stakeholders, are clear how the organisation works.

This process is generally discharged through a range of processes and structures:

- a body that has overall responsibility for ensuring the organisation delivers its objectives and duties and for putting in place everything needed to discharge those duties and receive assurance that the objectives are being met; this body will also oversee a range of other structures and sub-committees;
- clear terms of reference, role, scope and levels of delegated authority for each committee or sub-committee;
- clear roles and responsibilities for the senior individuals in the organisation and the limit of their delegated authority: this is particularly important for the CCG Accountable Officer who has a specific set of responsibilities for which he or she is accountable;
- the processes and policies under which the organisation operates, including all policies relating to staff and equality and diversity; and
- all the financial processes and controls, especially for managing financial risk.

Usually, governance arrangements also describe how the organisation manages risk, identifying the organisation's corporate objectives, the controls and assurance processes which give confidence that they will be delivered, the risks to delivery and how any risk is mitigated.

The way in which the governing body oversees these arrangements is described in the organisation's Scheme of Delegation, Standing Orders and Standing Financial Instructions (or similar documents). These documents describe all the powers and responsibilities exercised by the governing body and those delegated to committees, sub-committees and individuals, including the budgets they control. In the case of CCGs, this may include delegation of budgets and some decision making to localities, recognising that the CCG membership as a whole retains full accountability.

## The governing body

The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) sets out that:

A clinical commissioning group must have a governing body. The main function of the governing body will be to ensure that CCGs have appropriate arrangements in place to

ensure they exercise their functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it.

The governing body has the function of determining the remuneration, fees and allowances payable to the employees of the CCG, or to other persons providing services to it and such other functions connected with the main function described above, as may be specified in the group's constitution or by regulations.

This will include:

- assurance, including audit and remuneration;
- assuring the decision-making arrangements; and
- oversight of arrangements for dealing with conflicts of interest.

The constitution should describe which other key decisions (connected with its main function) will be the province of the governing body. This could include areas such as:

- leading the setting of vision and strategy;
- approve commissioning plans, on behalf of the CCG (if the CCG choose to delegate this function in its constitution);
- monitoring performance against plan; and
- providing assurance of strategic risks.

The constitution should describe the arrangements for delegation of decisions to committees, sub-committees or individuals (see next section) and how the governing body can scrutinise that an appropriate process has been followed in making these decisions.

Under the provisions in the Act, membership of the governing body may include a member of the CCG who is an individual (as opposed to a partnership or limited company), an individual of a description set out in the CCG's constitution (provided that that description is not excluded by regulations) or an individual appointed by virtue of regulations.

In terms of good governance, it will be important that all members are appointed in line with good practice and regulations as described in the next chapter.

## GP practice members of the governing body

It will be for the CCG member practices to decide how they will be represented on the governing body. Prospective CCGs will want to work with Local Medical Committees on this.

## Other members of the governing body

The National Health Service (Clinical Commissioning Groups) Regulations 2012 require that governing body membership will include at least one registered nurse, one secondary care doctor and at least two lay people (one with knowledge about the CCG's area such as to enable them to express informed views about the discharge of the CCG's functions - which

would encompass a lead role in championing patient and public involvement - and the other with qualifications, expertise or experience such as to enable them to express informed views about financial management and audit matters – which would give rise to a lead role in overseeing key elements of governance such as audit, remuneration, and managing conflicts of interest).

It is important to recognise that all those members of the governing body are not there to represent any specific interest but as individuals bringing their perspective to support the decisions made by the body as a whole.

### Accountable Officer and Chief Finance Officer

The National Health Service (Clinical Commissioning Groups) Regulations 2012 also prescribe that all CCG governing bodies must include the Accountable Officer and an employee of the CCG who has a professional qualification in accountancy and the expertise or experience to lead the financial management of the CCG, who is to be known as the Chief Finance Officer.

### Audit and Remuneration Committees

The governing body must have an **audit committee and a remuneration committee**.

The **audit committee** will have such functions as the governing body deems appropriate in helping the governing body to discharge its functions relating to CCG financial duties.

The **remuneration committee** will have the function of making recommendations to the governing body on decisions about pay and remuneration for employees of the CCG and people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

A CCG's constitution may make provision for these committees to have additional functions in connection with the governing body's main function of overseeing efficiency, effectiveness, economy and governance.

Although not stipulated in legislation, CCGs may wish to consider establishing a **quality committee** to provide assurance on the quality of services commissioned and promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience.

### Other committees, sub-committees and individuals

The constitution must set out all arrangements for how the CCG's functions and that of its governing body are to be discharged. The arrangements may include provision for any functions to be exercised on the CCG's behalf by any of its members or employees, its governing body, or a committee or sub-committee of the CCG. The arrangements in the constitution may provide for any functions of the governing body to be exercised on its behalf by a committee or sub-committee of the governing body, a member of the governing body, a member of the CCG who is an individual, or another individual of a description specified in the constitution.

## Formal arrangements for delegation to ‘localities’

In some CCGs the members may choose to operate in groups smaller than the whole CCG, often described as localities. Some CCGs have developed this model from the outset, with the intention of keeping decisions as close to the level of the practices as possible. In other circumstances, proposed CCGs have been formed from neighbouring pathfinders applying for establishment together as a single CCG and retaining clearly identified localities.

Prospective CCGs that are considering developing locality arrangements will want to ensure that they have a clear understanding of what that means in terms of their wider governance arrangements and how their statutory duties will be carried out.

CCGs that decide to operate a locality model will need to have additional elements included in their constitution that describe what decisions will be taken where, how these will be reported and how performance will be assessed and managed.

Having decided to operate a locality model and agreed the **locality structures**, the CCG will need to determine what decisions will be delegated to localities and what will be reserved at the level of the whole CCG. This would be most appropriately documented in the **scheme of delegation** for the CCG.

For a locality to be ready to accept delegated responsibilities there will need to be a decision-making mechanism at locality level, which will include details about:

- who takes part in making decisions;
- how decisions are made; and
- whether there are any exclusions or limitations to the decisions that can be made by the locality.

The decision-making mechanism chosen may be influenced by the size of the locality and the history of the formation of the locality. Typically it might mirror the arrangements in the CCG as a whole, with a shared decision making body (such as a locality committee) made up of representatives that have been chosen by the members. The CCG may decide to establish leadership roles within the locality and these should be defined along with the mechanism to select the leaders. The CCG may decide that the locality leaders should also play a role in the running of the whole CCG. The committee (or other mechanism) will operate within a defined set of rules that will have been agreed by the whole CCG. These rules would typically be called **terms of reference**. The terms of reference for the localities must be consistent with the agreed Standing Orders and Standing Financial Instructions.

Whilst there are advantages, to the CCG as a whole, if each locality operated with the same arrangements and terms of reference, there is no requirement for such consistency. However, all arrangements must be documented clearly within the CCG constitution and must therefore have been agreed by the whole of the CCG membership.

The delegation of authority brings with it additional responsibilities. The localities will need to agree with the CCG membership as a whole how they will report the decisions they have taken, how they will monitor the progress they make and report this to the membership and



what sanctions and other actions will be applied in the event of failure. The details of this, once formally agreed between the CCG as a whole and the locality must be documented in a clear and unambiguous form. This document would usually be called an **accountability agreement** and will form part of the CCG's suite of governance documents.

CCGs that decide to operate a locality model will also need to consider:

- how the localities relate to the governing body of the CCG;
- how risk will be managed between localities;
- the extent to which resources (such as expertise and money) will be shared or devolved;
- the degree to which consistency is important and when the need for consistency might outweigh the desire for local decision making; and
- the degree to which the proposed locality structure fits with other local arrangements (such as those in local authorities and other agencies) and how these arrangements ensure good governance and patient participation locally.

At all times, the CCG itself must be assured that it can discharge all its duties and the way that localities operate must be in line with this.

#### Questions for a proposed CCG to consider

- Have you set out your governance arrangements in your constitution?
- Have you set out what functions your governing body will discharge itself and which will be delegated to committees, sub-committees or permitted individuals?
- Have you agreed the CCG committees and sub-committees, and clearly set out what responsibilities will be delegated to each?
- Have you agreed how practices will be represented on the CCG governing body?
- Does your constitution set out how the lay and (non-GP) clinician members of the governing body will be appointed?
- Does your constitution set out the method for appointment to the audit and remuneration committees of the governing body?
- If appropriate, have you designed your locality arrangements to reflect good governance?



## Chapter 6: Key leadership roles

This chapter:

- outlines some of the different ways in which specific leadership roles may be discharged; and
- suggests the issues that CCGs will wish to consider when agreeing their arrangements for identifying and recruiting to these key roles.

This chapter describes the specific leadership roles in the CCG leadership team either required under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 or The National Health Service (Clinical Commissioning Groups) Regulations 2012. *Clinical commissioning group governing body members: Role outlines, attributes and skills* which is published on the NHS Commissioning Board website should be read in conjunction with this chapter.

CCGs are different from any predecessor NHS organisation. Whilst statutory NHS bodies, they are built on their member practices who must decide, through developing their constitution, how they will make decisions and be governed in an open and transparent way which allows them to serve their patients and local population effectively.

Complementing the important distributed leadership across practices, the CCG leadership team will be key in driving improvements in health and healthcare services for local people.

It is vitally important that CCGs remain clinically led, able to stay in touch with their member practices and bring together the broadest range of clinical professionals to influence patterns of care and focus on patients needs, yet at the same time include a broader range of leaders who will give the appropriate assurances about probity and governance.

In order to preserve this important, bottom up approach, CCGs will identify their own leaders, both those who will have a place on any decision-making body and those who will run the organisation on a day-to-day basis.

The NHS Commissioning Board will have a key role, through the authorisation process, in assessing whether the nominated Accountable Officer is competent and will make the appointment of the Accountable Officer. It will also provide support to ensure prospective CCGs develop a better understanding of the readiness and potential development needs of their other leaders to take on their key roles.

CCGs will need a broad range of leaders who will be vital to their success, leaders in member practices, senior clinicians leading specific redesign work, senior managers who are taking on responsibility for major strategic and operational issues.

This document, however, focuses on those who will have a leadership role as part of the formal governance process, i.e. those who will be on the governing body.

A number of these individuals will be appointed from the member practices, others will be from external organisations. All these individuals will need a core set of qualities and skills in order to contribute effectively.

Member practices will need to come together to determine how they will then each identify a GP or other healthcare professional to represent them in the decision-making processes. We would expect that those GPs or healthcare professionals going forward into decision making roles in the CCG will have proved their competence to undertake such a role as well as being able to demonstrate the support of their colleagues. Similarly, all others on the governing body will need to be able to demonstrate this level of competence. The NHS Commissioning Board will wish to assure itself, through the establishment process, that this has been taken into account.

In addition, the following specific roles are identified:

- Accountable Officer;
- Chair of governing body;
- Chief Finance Officer; and
- Other members specified in The National Health Service (Clinical Commissioning Groups) Regulations 2012 (two lay members, a registered nurse, and a secondary care doctor).

### The accountable officer role

From these leaders, one or two will emerge as the overarching clinical leader(s) of the organisation. Some of these GP or other healthcare professionals will wish to take on the responsibility of the accountable officer role. In line with the naming convention, the NHS Commissioning Board is likely to refer to clinicians who take on the accountable officer role as the Chief Clinical Officer.

The National Health Service Act 2006 as amended by the Health and Social Care Act 2012 specifies that each accountable officer is charged with ensuring that their CCG:

- complies with:
  - its duty to exercise its functions effectively, efficiently and economically
  - its duty to exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis, or treatment of illness;
  - its obligations to provide financial information to the Board;
  - its obligations relating to accounting and auditing; and
  - its duty to provide information to the Board following requests from Secretary of State; and
- exercises its functions in a way which provides good value for money.

The Act also specifies that certain people can be an Accountable Officer. These are:

- an individual who is a member of the CCG (e.g. a GP), or a member of any body which is a member of the CCG (such as a partner in a GP practice);
- an employee of the CCG, or of any member of the CCG;
- in the case of a joint appointment, an employee or member of any of the CCGs in question or an employee or member of any of the bodies which are members of the CCGs in question.

An applicant CCG will nominate its preferred accountable officer as part of the application for establishment. If the NHS Commissioning Board then considers that the nominee is appropriate, when the CCG is established the Board will formally appoint that person as accountable officer.

The role of accountable officer can be discharged on a less than full time basis, and GPs or other healthcare professionals are encouraged to consider taking up this role. It is not the same role as a Chief Executive which includes a much broader range of managerial duties. The accountable officer will take responsibility for ensuring all the necessary managerial and leadership arrangements are in place so that all duties and obligations are discharged. Whilst remaining accountable, they will not necessarily carry them out personally, perhaps discharging much of the day-to-day management to others.

It is nonetheless a very senior and responsible role which demands a clearly defined level of ability, and a commitment to continuous personal development within the role. Irrespective of whether this role is undertaken by a clinician or a senior manager, there are certain key skills and competencies, which will be assessed through authorisation, which will be necessary to discharge a role with such responsibility. It is expected that the leader who undertakes this role will be expected to demonstrate:

- outstanding leadership ability;
- sound judgement;
- the ability to understand the limits of his or her management competencies and to ensure all these competencies are available within the CCG or any commissioning support the CCG secures, and the wisdom to seek advice from all sources when a deeper knowledge and understanding is required to make a judgement;
- an understanding of corporate governance as well as the key principles required to take on this responsible role and an outline understanding of the main functions of the organisations such as finance, human resources, and risk management; and
- that they have the full range of management expertise available to them through their senior team, who are able to oversee the day-to-day management of the organisation.

Where the accountable officer role is fulfilled by a clinician, the organisation will need a senior manager or managers who take on the operational responsibility across the CCG, although accountability for proper exercise of the duties will rest with the accountable officer role.

## Senior management

CCGs will need a senior manager or managers responsible for the day-to-day running of the organisation<sup>16</sup>. Using the term 'Chief Executive' is discouraged, as it may create confusion about the leadership role. Ensuring that the organisation has high quality senior management will be key, and the accountable officer role, whether a clinician or a manager by background, will wish to ensure the full range of managerial skills are available. The Act identifies that one individual could fulfil the role of accountable officer on behalf of more than one CCG. This is particularly likely if fulfilled by a full-time manager. Similarly, two CCGs with Chief Clinical Officers may choose to share some management.

Further details have been made available containing the core competencies expected for an individual fulfilling the accountable officer role and other key roles<sup>17</sup>. Details regarding the process for assessing whether an individual has these skills and the full range of development available to support individuals who wish to take on this role have also been made available.

Of course, some clinical leaders may not wish to take on the role of accountable officer but clinical leadership must be central.

Therefore, in order to demonstrate that these are clinically led organisations the clinical leader should undertake either the role of accountable officer or Chair of the governing body, as these are the defined leadership roles of the CCG.

## Chair of the governing body

As already described, the CCG will have a governing body.

Specific competencies are needed to chair the governing body irrespective of the background of this individual and the proposed assessment process for this role has been described in supporting documentation .

Irrespective of whether or not the individual fulfilling the accountable officer role is a GP, the role of Chair of the governing body may be filled by another GP or any member of the governing body other than the *accountable officer*, *Chief Finance Officer*, secondary care specialist doctor, registered nurse or the lay member with the lead role in overseeing key elements of financial management and audit. The chair of the governing body may also be the *Clinical Leader* of the CCG.

If the Chair is a GP or other health care professional, the Deputy Chair must be a lay member who would take the Chair's role for discussions and decisions involving a conflict of interest for the Chair.

Under provisions made in the National Health Service (Clinical Commissioning Groups) Regulations 2012, and in line with the principles of good governance, the same individual cannot hold both the roles of accountable officer and Chair of governing body.

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<sup>16</sup> Further details of the naming convention adopted by the NHS Commissioning Board can be found in chapter 3 of *Clinical commissioning group governing body members: Role outlines, attributes and skills*

<sup>17</sup> *Clinical commissioning group governing body members: Role outlines, attributes and skills*

## Chief Finance Officer

The National Health Service (Clinical Commissioning Groups) Regulations 2012 provide that the governing body must include an employee of the CCG who has a professional qualification in accountancy and the expertise or experience to lead the financial management of the CCG. This role - which is to be known as “Chief Finance Officer” - will be a key leadership role in the organisation. Further details about this role can be found in *Clinical commissioning group governing body members: Role outlines, attributes and skills* published on the NHS Commissioning Board website.

He or she would be responsible for ensuring the discharge of obligations under relevant Financial Directions which are likely to include:

- implementing the CCG's financial policies and co-coordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the CCG's transactions, in order to disclose the financial position of the CCG at any time; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the CCG may require for the purpose of carrying out its statutory duties in accordance with relevant accounting convention.

Prospective Chief Finance Officers will undertake an assessment to identify whether they have the right skills to carry out this role. It will however be a matter for the CCG to decide who is formally appointed to the role. It is likely that the NHS Commissioning Board will consider the capability of Chief Finance Officers when considering applications for establishment and is likely to look at the assessment in doing so.

The Chief Finance Officer will be a full member of the CCG governing body.

The roles of accountable officer and Chief Finance Officer should not be undertaken by the same individual in line with the principles of good governance, but where the Accountable Officer role is undertaken by the clinical leader, the Chief Finance Officer may also undertake the senior managerial role in the organisation and in these circumstances would be known as the Chief Finance and Operating Officer. Equally, one Chief Finance Officer could undertake the role for more than one CCG.

## Other specified members of the governing body

The National Health Service (Clinical Commissioning Groups) Regulations 2012 also prescribe four specific roles for individuals as members of the governing body. These roles are:

- At least **two lay members**:
  - one must be a person who has knowledge about the CCG's area such as to enable them to express informed views about the discharge of the CCG's functions, which would encompass a lead role in championing patient and public involvement, the other must have qualifications, expertise or experience such as to enable them to express informed views about financial management and audit matters – which would give rise to a lead role in overseeing key elements of governance such as audit, remuneration and managing conflicts of interest.
  - The lay member with financial expertise is disqualified from being chair of the governing body. If the chair is a GP or other health care professional, the deputy chair must be a lay person, and it is expected that, in those circumstances, the lay member who is deputy chair would take the chair's role for discussions and decisions where the chair had made a declaration of interest
- At least **two other clinicians**: at least one registered nurse, and a secondary care doctor. The Regulations specify essential criteria for these individuals as well as detailing those that are not eligible<sup>19</sup>. Whilst knowledge of local health services would be an asset, it is more important that the nurse and doctor on the governing body bring an understanding of nursing and of secondary care. They will need to be appointed on the basis of their professional expertise and knowledge, and the additional perspectives that they will bring to the governance of the CCG. They are likely to play an important role in helping make sure that the CCG has effective systems in place for involving a range of healthcare professionals in decision-making.

To support CCGs, we have made available additional material which identifies:

- A description<sup>18</sup> of all the roles on the governing body and the skills and quality set which will be needed for each. This will include the core set for all members with the specific additional skills, competencies, experience or qualification needed to undertake any of the specific roles.
- An outline of how a CCG could demonstrate, through local processes they have undertaken, that all members of the governing body have the core set of qualities and skills.
- A framework describing how the specific criteria for the roles of Accountable Officer, Chair of the governing body and Chief Finance Officer will be assessed, and how this process will operate.
- Support for the appointment of lay members and the non-GP clinical members<sup>19</sup>
- The development opportunities we will ensure are in place to help those who are assessed as having the potential to undertake these roles and the support needed to

<sup>18</sup> *Clinical commissioning group governing body members: Role outlines, attributes and skills* published on the NHS Commissioning Board website

<sup>19</sup> <http://www.commissioningboard.nhs.uk/tk-appoint-lay-mem-ccg/>



meet their development needs. This will help to put them in a position to develop all the necessary criteria before the full authorisation process for the CCG is completed.

### **Questions for a proposed CCG to consider**

- Have you identified your GP (or other health care professional) leaders through a process which demonstrates competencies and peer support?
- Have you identified your Clinical Leader to take on the role of accountable officer or Chair of the governing body?
- Have you identified your senior managerial leaders, including a Chief Finance Officer, to discharge the full range of duties and complement the clinical leadership?
- Have you developed a clear process to identify lay members and the nurse and secondary care doctor with the right skills to undertake their roles on the governing body?
- Have you reflected the development of these key leadership roles in your Organisational Development Plan?



# Chapter 7: Governance for collaborative arrangements across clinical commissioning groups

This chapter:

- explores collaboration between CCGs and when collaborative arrangements might be desirable;
- sets out the governance considerations for collaboration between CCGs; and
- explores some specific circumstances where CCGs will need to collaborate with other organisations.

To commission improvements in health and healthcare for their local populations and drive the integration of services around the needs of individuals, it will be important for CCGs to have robust collaborative arrangements between themselves and with other organisations. This will be particularly important when CCGs commission jointly with Local Authorities, either across health and social care or for services which influence the broader determinants of health. It will also be important when CCG and NHS Commissioning Board commissioners need to work on pathways where integration across tertiary, secondary and primary care is key (and there will be further supporting material on these in due course).

Equally importantly, proposed CCGs are recognising that there are a number of reasons why strong collaborative arrangements between CCGs will derive tangible benefits for patients, for example, where services need to be commissioned across a wider geography or where skilled management expertise can be shared. The CCG will retain liability for the exercise of the function under these arrangements.

*Developing clinical commissioning groups: Towards authorisation* set the clear expectation that CCGs will put in place:

*“Collaborative arrangements for commissioning with other clinical commissioning groups, local authorities and the NHS Commissioning Board, as well as the appropriate external commissioning support” (Domain 5)*

The National Health Service Act 2006 as amended by the Health and Social Care Act 2012 encourages collaboration and makes provision to enable CCGs to establish appropriate collaborative arrangements with other CCGs and local authorities.

Whilst the prime focus of this document is on collaboration across CCGs, the principles and core issues apply equally to developing effective arrangements with other partners. Integrated

commissioning arrangements between the NHS and Local Authorities are already well established in many places, underpinned by formal section 75 agreements. CCGs will want to acquaint themselves with these arrangements, ensure they are maintained effectively during the transition to CCGs and consider which section 75 agreements they may wish to take on.

As CCGs develop their relationship with their local government partners, they will want to consider further opportunities for integrated commissioning, including the pooling of budgets. They will also want to explore the opportunities for other aspects of joint working, including integrated provision (for example for older people with complex health and social care needs) and in tackling the determinants of health and wellbeing.

The governance arrangements for CCGs will need to reflect the handling of existing formal partnerships agreements that are inherited from PCTs and any new arrangements that will be set up from 2013.

### When might collaborative arrangements between CCGs be beneficial?

Our work with pathfinder CCGs suggests that the following benefits can be secured, depending on local circumstances:

#### **Clinical improvements:**

- Consistent, evidence based pathway development
- Effective and consistent performance management, clinical governance and risk management
- Service integration

#### **Efficiency:**

- Leverage with providers
- Keeping low transaction costs
- Sharing (potentially scarce) expertise and capacity

#### **Resilience and risk management:**

- Managing financial risks
- Enabling diversity in CCG configuration and size
- Managing regulatory and legal change
- Managing extended absence of key staff
- Improved risk management and intelligence systems
- Business continuity arrangements

The main risk for CCGs to address is the need to manage local accountability, ensuring that member practices remain involved and able to influence decisions, whilst ceding authority to any pan-CCG arrangement.

### Which functions, activities and circumstances lend themselves to collaboration?

#### **Securing a single representative voice**

- Have a greater voice which avoids being ignored for being 'small'

**Shared staff and expertise**

- Share access to rare and/or expensive resources
- Improve the cost efficiency of running the CCGs functions
- Reduce bureaucracy

**Support services**

- Increase efficiency
- Reduce expenditure on management /infrastructure costs

**Risk pooling/sharing**

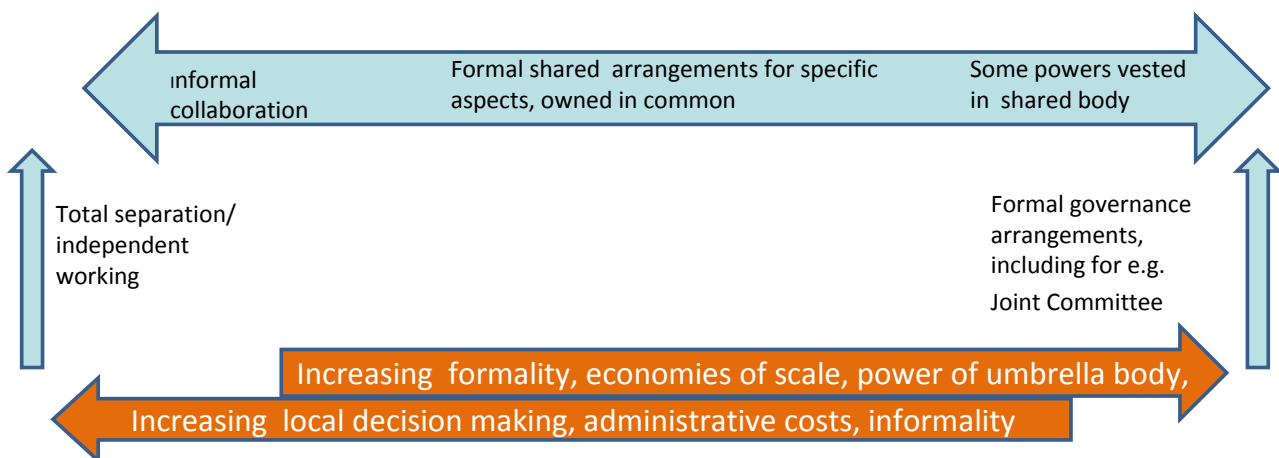
- Develop greater resilience
- Undertake a joint and coordinated response in the event of a major incident or emergency
- Reduce risks associated with finances, staff and other key resources.

**The collaboration continuum**

Whilst there are many possible ways in which CCGs might collaborate with each other, it is vital that the nature of the relationship is clearly defined:

- Formal or informal?
- Extensive or limited to one function or a single purpose?
- With one other CCG or with many others as part of a group?
- A temporary arrangement or a permanent way of working?

# Collaboration Continuum



The range of possible models to support collaboration between CCGs has been described across a continuum, and the approach taken by each CCG should be selected on the basis of their assessment of local context.

At the left hand side of the continuum, there is no collaboration and CCGs exist entirely independently of one another and are fully self-resourcing.

Moving to the right hand side of the continuum there are a range of increasingly formal arrangements, from informal networks to joint committees with delegated powers.

## Good governance when collaborating between CCGs

### Secure shared objectives

Each participating CCG will want to understand how the collaborative arrangement will contribute to delivering own **objectives**. The motives (which are likely to be less explicit than objectives) for each CCG taking part in a collaborative arrangement should also be compatible.

### Explicit alignment of vision and values for the area of collaboration

This may be a development of specific **vision and values** for the purpose of the collaboration or may be recognition that vision and values of the CCGs taking part are similar and/or compatible. Values would extend to expected **standards** for corporate and individuals' behaviours and the prevailing cultures within the CCGs.

### An agreement regarding scope of collaboration

At the informal end of the collaboration continuum this may be little more than agreed **terms of reference** for a working group which has no decision making powers. In a more formal environment, this would extend to a **memorandum of understanding** between participating CCGs. There should also be clarity regarding what is not included within the scope of the collaboration.

A **memorandum of understanding** or similar may also be used to detail the agreement between two or more CCGs regarding shared staff. In this case, it will detail HR arrangements, which organisation will undertake which aspects of the employer's responsibilities and will also ensure clarity regarding lines of reporting and accountability.

### Clarity regarding the extent to which decisions can be taken by the collaborative arrangement

If authority to take decisions is delegated, then it should be clearly documented in the **scheme of delegation** for the participating CCGs and the **terms of reference** for the body/committee to which the authority is delegated.

Alternatively, if formal authority is not delegated under the collaborative arrangement, it should be clear in the **terms of reference** that any collective judgements made only have the status of recommendation, until the decision has been considered by each of the CCGs involved.

**Process for taking decisions** e.g. will voting be used (and if so how) or, will a consensus be sought. This should be detailed in **terms of reference** for decision making bodies/ committees and these should also include clear 'rules' regarding membership arrangements, quoracy, meeting arrangements and dispute management.

### How the delegated body will report

With the freedom to make decisions comes responsibility for ensuring that the decisions are both implemented and deliver the stated objective. Where this is the case, **performance criteria** may be set and **reporting arrangements** should be put in place so that each accountable body is always fully appraised of progress and risks.

### **Clarity regarding the scope and scale of a hosted or shared service arrangement**

This may be required when CCG functions are hosted by one CCG on behalf of others. Details of what is included or excluded and what performance is required and/ or acceptable and what will happen when things go wrong will be detailed in an agreement which may take the form of a **service level agreement** or similar.

### **An understanding of what happens when things go wrong**

This could range from a simple paragraph in **terms of reference** to a full **disputes resolution process** that extends to detailing how, if necessary, the collaborative arrangements will be dissolved. Critically, all parties need to understand what happens when there is lack of agreement or disappointment regarding performance.

In summary, formally established collaborative relationships will be underpinned by agreements and a suite of documents that describe the relationship and the systems and processes for operating it. This will set out the rules for collaboration and what this contains will depend on the type of collaboration a CCG chooses.

Regardless of the formality or breadth of the collaborative arrangement, the nature of the relationships established over time will be a significant determinant of success and CCGs will want to pay due attention to the relationship management aspects of their collaborative arrangements.

## **Next steps**

Prospective CCGs will need to work through when and how they need to collaborate according to their local circumstances. An early priority will be to secure clear collaborative arrangements for contracting with individual provider organisations. The NHS Commissioning Board has published a collaborative commissioning framework to assist CCGs to make necessary preparations for this.<sup>20</sup>

Specific arrangements will also need to be established in partnership with proposed CCGs, SHA clusters and PCT clusters to secure robust arrangements for collaboration in the new commissioning system for priority services, to secure:

- the need for resilience for priority services during transition and in the early years of the new system;
- the ultimate primacy of CCGs in decision making.

SHA and PCT clusters, in supporting the development of CCGs will want to ensure that the right collaborative arrangements are in place, with the relevant commissioning support, for all services where collaboration is necessary. This will ensure that there is a clear understanding of which services need a collaborative approach, which CCGs need to be involved and the arrangements that need to be in place to secure effective governance and management arrangements. SHA and PCT clusters will work through a managed process with CCGs to align this with the authorisation process.

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<sup>20</sup> <http://www.commissioningboard.nhs.uk/files/2012/03/collab-commiss-frame.pdf>

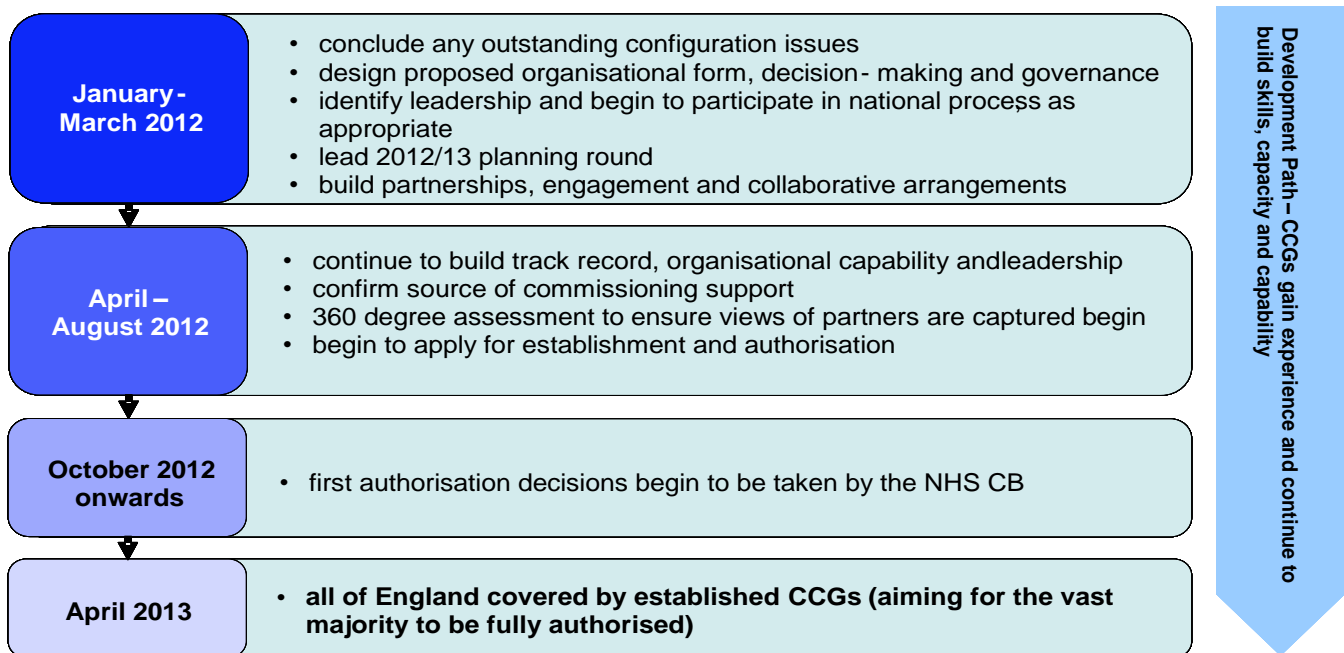
### **Questions for a proposed CCG to consider**

- How will you engage in collaborative effort with other CCGs?
- What resilience risks face your CCG?
- When would collaborating with others be beneficial?
- Would you be more efficient if you collaborated with other CCG(s)?
- Would you drive improvements in outcomes by doing some things jointly?
- To what degree, and in what circumstances, would you be willing to consider delegating power to make decisions?
- Do your plans for collaboration ensure that your member practices continue to have influence and remain involved?
- Have you described the model you will use for collaboration, and have you drafted the relevant underpinning governance documentation?

## Chapter 8: Next steps

Prospective CCGs are taking on increasing responsibilities for commissioning, using powers and budgets delegated to them by PCTs within the current statutory framework. This has involved PCT clusters establishing a pathfinder or prospective CCG as a sub-committee to its board, and using this as the basis to delegate and transfer responsibility for commissioning and associated budgets for agreed areas of current commissioning portfolio. The PCT remains ultimately liable for the commissioning decisions, as well as for the budget, but much of the day-to-day commissioning work is increasingly being undertaken by prospective CCGs.

This provides a sound foundation to build from, enables tangible clinically driven service and quality improvement and helps to create a track-record. Prospective CCGs, who have participated in the national or regional pathfinder programme, have shared their learning and good practice and shaped emerging policy. The diagram below sets out the timeline for establishment.



In addition, many prospective CCGs are based on existing practice based commissioning arrangements, with strengthened clinical engagement – and have taken the opportunity, as part of the national pathfinder programme, to rapidly build from their strengths. Some of these have been built from more formal organisational arrangements, like Community Interest Companies and Limited Liability Partnerships. The legal status of pathfinders was clarified last year<sup>21</sup> and an important step in preparing for formal CCG establishment would be to ensure that legacy arrangements are addressed – and that there is a clear transition plan in place.

<sup>21</sup> [https://www.wp.dh.gov.uk/healthandcare/files/2011/09/20110824-dear-colleagues-clarification-note\\_gateway16529.pdf](https://www.wp.dh.gov.uk/healthandcare/files/2011/09/20110824-dear-colleagues-clarification-note_gateway16529.pdf)



## What happens next?

At a national level, work has continued with prospective CCGs and stakeholders to put in place the development and support needed.

Collectively, there is also much we can do to prepare for the new system, as prospective CCGs come into being, continue their development, establish their governance arrangements and prepare for establishment.

It is recognised that many prospective CCGs have already put in place governance arrangements to ensure their new clinically led commissioning organisations operate in the most effective way, offering them, their members, patients and taxpayers assurance and confidence that their duties and functions are delivered well.

Many prospective CCGs have already considered how they would wish to operate and what systems and structures they would aim to have in place to enable this. In many instances, practices who have come together to form prospective CCGs, have already begun to identify the clinical leaders for the future and are well on with considerations of how the new organisation might operate on a day to day basis.

Consideration of governance builds on the discussions that prospective CCGs and SHA clusters undertook in December 2011 to assess the risks associated with the proposed configuration of CCGs, and all prospective CCGs have now settled on a configuration and have a plan in place to deal with any outstanding risks.

The resolution of configuration issues means that most prospective CCGs are well placed to be ready for authorisation by the NHS Commissioning Board, increasingly building their track record of delivery and working in partnership with their local communities.

### **Prospective CCGs, supported by PCT clusters, can use this guidance to take the final steps on leadership and governance**

- Conclude discussions on CCG configuration including proposed membership, geography and size.
- Agree overarching governance arrangements, drawing on the questions at the end of each chapter in the guide.
- Involve all member practices in developing and agreeing a constitution.
- Agree internal governance arrangements and structures, including staffing structures, which will ensure the prospective CCG is able to deliver its duties and exercise its powers in accordance with recognised governance standards.
- Identify and agree the proposed leadership for the CCG, including clinical and senior leadership and the governing body.
- Work with the local population, Local Authority(ies), shadow health and wellbeing boards and providers to establish principles for involvement and engagement in commissioning decisions.

The Operating Framework, and subsequent planning guidance (*The Integrated Approach to Planning and Assurance between DH and the NHS for 2012/13*), set out the requirements of the NHS for 2012/13.

**Local Authorities should expect prospective CCGs supported by their PCT cluster to engage with them in relation to:**

- The principles for involvement and engagement in commissioning decisions.
- Joint commissioning opportunities.
- The development of Health and Wellbeing Boards, Joint Strategic Needs Assessments, and Joint Health and Wellbeing Strategies.

### The national role

We will continue to work with prospective CCGs, PCT and SHA clusters to determine what further national support is needed. We have also, as part of preparation for establishment and authorisation, created the framework which prospective CCGs, supported by PCT clusters and SHA clusters, can work through to identify their readiness for authorisation. These build on the actions CCGs will need to take as identified in the earlier publications *Developing clinical commissioning groups: Towards authorisation*, *Clinical commissioning group authorisation: Draft guide for applicants*, and this document, *Towards establishment: Creating responsive and accountable clinical commissioning groups*.

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