NHS
Richmond
Clinical Commissioning Group

NHS Richmond Clinical Commissioning Group (CCG) Governing Body

18th Meeting in Public

Tuesday 23 February 2016
13:15 – 14:40

The Salon, York House
Richmond Road
Twickenham
TW1 3AA

NHS
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18th MEETING IN PUBLIC OF THE
NHS RICHMOND CLINICAL COMMISSIONING GROUP (CCG)
GOVERNING BODY

TUESDAY 23 February 2016
13:15 – 14:40

in the Salon, York House, Twickenham

PART 1 AGENDA

No.	Time	Item	Executive Lead	Attachment
1	13:15	Welcome and apologies for absence Confirmation of meeting quoracy	Chairman	
A	**STANDING ITEMS**			
2		Declaration of interests in matters covered on the agenda • GP members: Richmond General Practice Alliance participant *To note*	Chairman & Members	
3	13:20	• Minutes of the CCG Governing Body meeting on 19 January 2016 • Amended minutes of the CCG Governing Body meeting held on 17 November 2015 *For approval*	Chairman	Attachment Ai Attachment Aii
4	13:25	Matters arising and rolling action log BAF one page summary (*for reference*) *To note*	Chairman	Attachment Aiii Attachment Aiv
5	13:30	Items taken in private on 19 January 2016**:** • *Options for Continuing Healthcare (CHC) service provided by the South London Commissioning Support Unit (CSU)*	Chairman	Verbal report
B	**GOVERNANCE/BUSINESS**			
6	13:35	Primary Care Commissioning: Next steps to delegated commissioning, including: • Delegation Agreement *For approval*	Chief Officer	Attachment B
7	13:50	Recommendation for 12 month contract extension for AQP Services for MSK neck and back and podiatry *For approval*	Chief Officer	Attachment C

8	14:00	Outcomes Based Commissioning Contract Award *For approval*	Chief Officer	Attachment D
D	**TO NOTE**			
9	14:25	Any other business	Chairman	
10		Date of next meeting: **Tuesday 15 March 2016, 12:30 – 15:30,** Salon, York House, Twickenham		
E	**PUBLIC QUESTION TIME**			
11	14:30 – 14:40	Members of the public present are invited to ask questions of the CCG Governing Body relating to the business being conducted. Priority will be given to written questions that have been received in advance of the meeting.		

In accordance with the CCG's Constitution, paragraph 3.12.1 'Admission and exclusion on grounds of confidentiality of business to be transacted' the Chairman requests representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

NHS
Richmond
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Attachment Ai

17th MEETING IN PUBLIC OF THE RICHMOND CLINICAL COMMISSIONING GROUP'S GOVERNING BODY

HELD ON TUESDAY 19 JANUARY 2016 IN THE SALON, YORK HOUSE

MINUTES

Attendance Log:

Members:		**19.5.15**	**21.7.15**	**22.9.15**	**17.11.15**	**19.1.16**	**15.03.16**
Dr Graham Lewis	Chair	A	SA	A	A	A	
Kathryn Magson	Chief Officer (CO)	-	-	SA	A	A	
Charles Humphry	Vice Chair and Lay Member, Governance	A	A	SA	A	A	
Bob Armitage	Lay Member, Governance	A	A	A	A	A	
Susan Smith	Lay Member, Patient & Public Involvement	A	A	A	A	A	
Richard Thomas	Chief Finance Officer (CFO)	-	-	A	A	A	
Dr Kate Moore	Vice Clinical Chair (VCC)	A	A	A	A	A	
Dr Branko Momic	GP	A	SA	A	A	A	
Dr Nicola Bignell	GP	A	A	SA	SA	A	
Dr Stavroula Lees	GP	A	SA	A	A	A	
Dr Sean Gallagher	GP	A	SA	A	A	A	
Dr Alex Norman	GP	-	A	A	A	A	
Julie Sobrattee	Chief Nurse	A	SA	A	A	A	
Cathy Kerr	Director of Adult & Community Services (DACS), LBRuT	A	SA	A	SD	A	
Anne Dornhorst	Secondary Care Doctor	A	A	A	A	A	
Non-voting members:							
Victoria Otley-Groom	Director of Commissioning (DoC)	-	-	-	A	A	
Vicki Harvey-Piper	Director of Corporate Affairs (DCA)	-	-	-	A	A	
Dr Dagmar Zeuner	Director of Public Health (DPH)	A	A	A	A	A	
Kathy Sheldon	Healthwatch	-	A	SD	SD	A	
In attendance on 19 January:							
Lindsay Marshall (minutes) Kay McCulloch (KMcC), South West London Collaborative Commissioning Programme Director							

KEY: A = Attended, DNA = Did not attend, SA = Sent Apology, SD = Sent Deputy

		ACTION
1	**WELCOME, APOLOGIES FOR ABSENCE AND QUORACY** The Chair welcomed all members present to the 17th meeting in public of the Richmond Clinical Commissioning Group's governing body. There were no apologies for absence. It was confirmed that the meeting was quorate.	
A	**STANDING ITEMS**	
2	**DECLARATION OF INTERESTS IN RESPECT OF ITEMS ON THE AGENDA** The standard declaration of interest from GP members was noted: • Participant of the Richmond General Practice Alliance (Dr Graham Lewis, Dr Kate Moore, Dr Nicola Bignell, Dr Sean Gallagher, Dr Branko Momic,	

		ACTION
	Dr Stavroula Lees and Dr Alex Norman).	
3	**MINUTES OF THE CCG GOVERNING BODY ON 17 NOVEMBER 2015** The minutes were agreed as a correct record subject to amendments relating to attendance at previous meetings.	Attachment Ai
4	**MATTERS ARISING AND ACTION LOG** All matters arising and actions were either included on the agenda or were in hand. The governing body received the board assurance framework (BAF) which was appended for reference.	Attachment Aii
5	**ITEMS TAKEN IN PRIVATE ON 17 NOVEMBER 2015** It was noted that the following items were taken in private on 17 November 2015**:** • Delivering improved emergency care pathway performance: Operational support to Kingston Hospital Foundation Trust (KHFT) • Outcome based commissioning contracts: • Future of SECSU contract • Draft premises strategy update • Home support and residential care risks facing the Council and by implication the CCG	Verbal report
6	**CHAIR AND CHIEF OFFICER REPORT** The governing body received and noted the Chair and Chief Officer's Report.	Attachment B
B	**GOVERNANCE/BUSINESS**	
7	**Safeguarding adults annual report** The governing body welcomed Debbie Stuart-Angus, the Safeguarding Adults Lead, who highlighted the main points of the report. During discussion the following points were noted: • The OBC programme would provide opportunities to improve communications around safeguarding through its connections with local providers. • The risk rating was "high" due to the importance of safeguarding vulnerable adults, however robust processes were in place to mitigate the risk. It was agreed to leave it at amber pending feedback from the deep dive. • Once the future shared staffing arrangements were in place between Richmond and Wandsworth councils it was expected that there would be a joint safeguarding team but separate safeguarding boards, and the close partnership working between the CCG and local authority would continue. • In terms of volume of cases and how the CCG compared with other CCGs of similar demography, statistics were available from the local authority as it carried the statutory duty, and case numbers were in line with other CCGs. • Areas that needed strengthening were training in GP practices, and understanding of mental health and deprivation of liberties especially in care homes and with the public. **The governing body approved the annual report.**	Attachment C
8	**Safeguarding children annual report** The governing body welcomed Sian Thomas, the Safeguarding Children Lead, who highlighted the main points of the report. During discussion the following points were noted:	Attachment D

		ACTION

	• It was felt appropriate to keep the risk rating as "high", although robust processes were in place to mitigate the risk.
	• The following gaps and priorities were highlighted:
	  o supporting the recruitment process for a designated doctor for children looked after, which was currently being covered on an interim basis;.
	  o the chair of the local children's safeguarding board (LSCB) had written to chief officers to emphasise the importance of ensuring robust completion of case reviews for child protection. This was being followed up in conjunction with the local authority;
	  o There was a need to strengthen provider contracts.
	• In terms of the proportion of the split of children in different age groups, the chief nurse would provide a further breakdown of the age groups.
	• It was felt that there could be improvement in communications to GPs regarding requests to them for information, for example feedback on progress of cases. It was also felt that deadlines for GPs providing information were sometimes unreasonably short. The VCC undertook to send to the safeguarding children lead the details of any requests made to her practice where it was felt to be an unreasonable timescale.
	
	The governing body approved the annual report and the recommendations therein.
		Chief nurse

9	**Emergency preparedness, resilience and response self-assessment 2015** The governing body received and noted attachment E and the following points were noted: • The emergency preparedness, resilience and response (EPRR) self-assessment for 2015 had been rated as 'substantial', which was a marked improvement over the 2014 position. It was expected that most core standards would go from amber to green following the scheduled business continuity training and exercise sessions. Any amber core standards remaining should turn to green by the end of the financial year. • It was noted that the CCG did not have an agreement with the local authority for the local authority to re-house the CCG in the event that the Civic Centre was not able to be used. Staff would be able to work from home. • GP practices were expected to deal with their own business continuity and this would not change under the delegated commissioning arrangements in April. However, it was felt that NHS England (NHSE) must ensure that practices had plans in place and suggested that the local authority could cover this in the overview and scrutiny committee as part of its oversight duty. **The governing body noted the report.**	Attachment E
10	**Continuing healthcare service level agreement** The governing body received and noted attachment F and the following points were noted: • Continuing healthcare services (CHC) were currently commissioned through the South East London Commissioning Support Unit (SECSU) and the contract was due to finish on 31.03.16. The CCG was looking at alternative options for contracting the service. There would be a more detailed report in the confidential part 2 of the governing body meeting. • It was agreed that the risk rating would be upgraded to extreme. **The governing body approved the recommendations.**	Attachment F

		ACTION
11	**South West London Collaborative Commissioning Programme Update** Kay McCulloch (KMcC) South West London Collaborative Commissioning Programme Director, was welcomed to the meeting. **a) Governance proposals for next phase of progamme to deliver five year strategy** The governing body received attachment Gi and during discussion the following points were highlighted: • Decision-making would remain with the CCG but included a role for the tripartite. • Local authorities were being supported to be more actively engaged, for example through membership of the South London Partnership, and there was also a proposal for a meeting of council leaders and CCG chairs. • It was noted that although the terms of reference paper was not presented to the governing body the main points were contained in the presentation. **The governing body approved the proposed governance proposals** **b) Programme update** The governing body received attachment Gii and during discussion the following points were highlighted: • The programme would not impose upon the CCGs but would seek to understand and take account of the needs identified by each CCG. It would link in with the Healthy London Partnership (HLP). • The programme board needed to look at what was needed in primary care as well as the acute providers, in addition to the recommendations of the out of hospital strategy. The stocktake of beds may also need to happen in the community as well as in the acutes in order to start to understand the correct pathways for patients. • It was raised that there was no mention of Queen Mary's Hospital Roehampton, although its future would be of concern to patients and may impact on out of hospital care. Kay McCulloch undertook to follow it up. • It was noted that robust engagement would be needed even if there was no consultation. There was a SWL communications team but this would be increased in size if there was a consultation, and they would link in with NHSE and local engagement channels. Local MPs were being regularly engaged and updated on progress. • There would need to be robust engagement with local authorities to work together on the transformation plan which was a joint plan and intended to bring the NHS into sustainable balance by 2021. **The governing body noted the report.**	Attachment Gi Attachment Gii KMc
12	**Devolution collaboration agreement final document** The governing body received attachment H which included the London Health and Care Collaboration Agreement, which described the London devolution initiative, and the London Health Devolution Agreement which would significantly strengthen ongoing work by ensuring commitment by national bodies and central government in actively supporting the pilots. These documents had been developed and agreed by the 32 CCGs and 33 London Boroughs as well as NHS England and Public Health England. The executive management team and governing body had previously discussed an earlier draft of the collaboration agreement and had agreed that the CCG would not participate in the pilots at this stage, although it would give its full support to	Attachment H

		ACTION
	the principles of engagement. Chair's action had therefore been taken to meet the stipulated deadlines in December 2015 pending formal ratification at the governing body meeting in January. There was triangulation with the HLP as both programmes were managed by the Office of London CCGs. **The governing body ratified the devolution collaboration agreement.**	
13	**Annual report of the Director of Public Health 2016** The governing body received attachment I and it was noted that it was a statutory duty for the Director of Public Health to produce an independent Annual Public Health Report (APHR). During discussion the following points were highlighted: • There was greater pressure on resources than previously so priorities needed to be carefully examined and would be a mixture of services and prevention, looking at whole pathways. • The health and wellbeing role had a role in taking the leadership in influencing lifestyles in the borough. **The governing body agreed the recommendations of the report.**	Attachment I
C	**QUALITY, PERFORMANCE & FINANCE**	
14	**Quality & safety summary** The governing body received attachment J, which dealt with the matters considered at the Quality & Safety (Q&S) meeting on 12.1.16 in accordance with the committee's annual work plan. The main areas covered were: • Safeguarding Children (six-monthly report) • Medicines Optimisation (quarterly report) • Health & Wellbeing Strategy EINA • LAS Quality Summit **The governing body noted the report.**	Attachment J
15	**Finance & Performance summary** The governing body received attachment Gii, which dealt with the matters taken at the F&P meeting on 12.1.16 in accordance with the committee's annual work plan. The main areas covered were: • CCG Contracts Review • Retrospective Contract Renewals • November 2015 Finance Report • KPI Dashboard • Quality, Innovation, Productivity and Prevention (QIPP) During discussion the following was highlighted: • Attention was drawn to the section on West London Mental Health Trust cross border services and it was noted that the director of commissioning would be reviewing provision of MH inpatient beds. • The risk rating (extreme) would be reviewed to align it to the risk rating for the finance report (high) in order to ensure consistency.	Attachment K CFO

		ACTION
16	**Finance Report (Month 8)** The governing body received attachment L and during discussion the following points were highlighted: • There had been a significant deterioration in the position this month. The main pressure points were acute overspending (£4m), primarily by Kingston Hospital (KHFT), with whom it was hoped to sign a year-end deal. The other main financial pressure was relating to continuing healthcare (CHC). • The CCG had applied for support from the SW London risk share pool and was hoping to get £2m backup, which would reduce the deficit to the 1% needed under financial regulations. However, this was effectively a loan and the CCG would need to pay it back next year which would mean that QIPP targets would have to be even more robust. **The governing body noted the report.**	Attachment L
D	**TO NOTE**	
17	**Any Other Business** There was no other business.	
18	**Date of Next Meeting:** **Tuesday 15 March 2016, 12:30 – 15:30,** Salon, York House, Twickenham	
D	**PUBLIC QUESTION TIME**	
19	There were two questions raised by members of the public as follows. **1. Written questions submitted by Mr Dave Stieber, Business Development & Referrals Coordinator, Glenside (leaders in Neuro-rehabilitation)** Q. Where is the KPI Dashboard? A. The detailed KPI dashboard is a regular feature of the Finance & Performance Committee. Key information from this committee is reported to the governing body within the report from the F&P Committee. Q. The comment about Delayed Transfer of Care (DToC) talks about a "52 week waiter in month 7" which remains an issue. A. Richmond CCG had one incomplete 52 week wait at the end of October at SW London & St George's Mental Health NHS Trust. An investigation took place and found that the wait was the result of human error as the patient's referral was misplaced. The patient and family had been seen and a formal assessment was underway. The trust informed the CSU that no clinical harm had resulted from the wait, however; this would be formalised once the assessment had been completed. This 52 week wait did not relate to a delayed transfer of care or a cancer wait. Q. The last report stated that the DToC was 854 down to 566 in August. What is the current figure and how much financially does this impact on the CCG? A. DTOCs reduced to 483 in September (last reported figure). The financial impact of DTOC cannot accurately be calculated because of the way the tariff works. The Local Authority use an average of £120 per day in London based on the Care Act. Q. Can the private or charitable sector do more to reduce this? A. The CCG is working with other health partners and monitoring the high cost placements. There is a stringent process for DTOCs which has led to reduction in numbers.	

		ACTION
	2. Question from Alan Macmillan, member of the public Q. Mr Macmillan's first question referred to the finance report where it stated that two new schemes were being funded from the underspend of better care fund (BCF) monies, one of which was a diabetes locally commissioned service (LCS). Mr Macmillan asked where it was decided that the funding would be spent on diabetes and who decided where the contract was awarded. A. The chief officer explained that the underspend was due to schemes starting late and it had been agreed by the executive management team (EMT) and clinical executive team (CET) to put some funding into an enhancement to the LCS. This was decided through the strategic partnership group which managed pooled budgets and was jointly attended by the CCG and local authority CFOs. The contract was implemented through general practice as an enhancement to the LCS. Q. Mr Macmillan's second question related to a note on the accounts which stated that the CCG was due to take on delegated responsibility to commission primary care services from 2016. He asked if this meant that the CCG would deal with the individual practices and distribute their funding. A. The chief officer answered that section 4 in the chair and chief officer's report had contained information about delegated commissioning. There was a detailed piece of work to be carried out in relation to financial and legal due diligence before the CCG can proceed with delegated commissioning. This would be brought back to the March governing body meeting.	

The Meeting was closed at 15:15.

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Attachment Ai

**16th MEETING IN PUBLIC OF THE
RICHMOND CLINICAL COMMISSIONING GROUP'S
GOVERNING BODY**

**HELD ON TUESDAY 17 NOVEMBER 2015
IN THE SALON, YORK HOUSE**

MINUTES (*amended on 19.2.16*)

Attendance Log:

Members:		**19.5.15**	**21.7.15**	**22.9.15**	**17.11.15**	**19.1.16**	**15.03.16**
Dr Graham Lewis	Chair	A	SA	A	A		
Kathryn Magson	Chief Officer (CO)	-	-	SA	A		
Charles Humphry	Vice Chair and Lay Member, Governance	A	A	SA	A		
Bob Armitage	Lay Member, Governance	A	A	A	A		
Susan Smith	Lay Member, Patient & Public Involvement	A	A	A	A		
Richard Thomas	Chief Finance Officer (CFO)	-	-	A	A		
Dr Kate Moore	Vice Clinical Chair (VCC)	A	A	A	A		
Dr Branko Momic	GP	A	SA	A	A		
Dr Nicola Bignell	GP	A	A	SA	SA		
Dr Stavroula Lees	GP	A	SA	A	A		
Dr Sean Gallagher	GP	A	SA	A	A		
Dr Alex Norman	GP	-	A	A	A		
Julie Sobrattee	Chief Nurse	A	SA	A	A		
Cathy Kerr	Director of Adult & Community Services (DACS), LBRuT	A	SA	A	SD		
Anne Dornhorst	Secondary Care Doctor	A	A	A	A		
Non-voting members:							
David Sykes	Interim Head of the Joint Commissioning Collaborative	A	A	A	A		
Victoria Otley-Groom	Director of Commissioning (DoC)	-	-	-	A		
Vicki Harvey-Piper	Director of Corporate Affairs (DCA)	-	-	-	A		
Dr Dagmar Zeuner	Director of Public Health (DPH)	A	A	A	A		
Julie Risley	Healthwatch	-	SD	A	A		
In attendance on 17 November:							
Lindsay Marshall (minutes)							

KEY: A = Attended, DNA = Did not attend, SA = Sent Apology, SD = Sent Deputy

		ACTION
1	**WELCOME, APOLOGIES FOR ABSENCE AND QUORACY** The Chair welcomed all members present to the 16th meeting in public of the Richmond Clinical Commissioning Group's governing body. Apologies for absence were received from Nicola Bignell and Cathy Kerr. It was confirmed that the meeting was quorate.	
A	**STANDING ITEMS**	
2	**DECLARATION OF INTERESTS IN RESPECT OF ITEMS ON THE AGENDA** The standard declaration of interest from GP members was noted: • Participant of the Richmond General Practice Alliance (Dr Graham Lewis,	

		ACTION
	Dr Kate Moore, Dr Nicola Bignell, Dr Sean Gallagher, Dr Branko Momic, Dr Stavroula Lees and Dr Alex Norman).	
3	**MINUTES OF THE CCG GOVERNING BODY ON 21 JULY 2015** The minutes were agreed as a correct record subject to amendments relating to attendance at previous meetings.	Attachment Ai
4	**MATTERS ARISING AND ACTION LOG** All matters arising and actions were either included on the agenda or were in hand.	Attachment Aii
5	**ITEMS TAKEN IN PRIVATE ON 22 SEPTEMBER 2015** It was noted that the following items were taken in private on 22 September 2015**:** • The Acute Provider Collaborative response to commissioners: Delivering clinical and financial sustainability in the acute sector in South West London • Managing risk across South West London • Remuneration Committee report • Letter of support for SWL Success Regime Bid	Verbal report
6	**CHAIR AND CHIEF OFFICER REPORT** The report was presented and the following points were highlighted: **1) Recruitment Update** The chair formally welcomed Vicki Harvey-Piper to the governing body in her new role of director of corporate affairs, and the new director of commissioning, Victoria (Tori) Otley-Groom, and thanked David Sykes, the outgoing interim head of the JCC, for his work at the CCG. **2) Working with the Richmond General Practice Alliance (RGPA): Prime Minister's GP Access Fund Contract** The contract for the Prime Minister's GP Access Fund, EASTIR (extended access and system transformation in Richmond) project had been fully developed and signed off by the CCG and the RGPA, and the project successfully launched. The Rapid Access Team GP service would launch later in the month. **3) Delegated Commissioning of Primary Care Submission** RCCG had submitted its application to begin delegated commissioning from 1st April 2016 which would mean that it would assume full responsibility for commissioning GP services. A shadow primary care commissioning committee (PCCC) had been established which would meet in public from April. **4) Outcome based commissioning (OBC) Programme Update** The first co-ordinating provider (CP) group written submission had been received on 30 October, and the group had made good progress in working together. The CP group had agreed that Patricia Wright (CE HRCH) would be the senior responsible officer for the programme. **5) Locally Commissioned Services (LCS) Contracting for 2016/17 onwards** The CCG had given notice to its practices that it intended to recommission locally commissioned services differently from April 2016. Although practices would be able to continue to deliver individual services, payments would be linked to delivery of a bundle of population based services via the Richmond GP Alliance (RGPA).	Attachment B

		ACTION
	6) **London Health and Care Collaboration Agreement (Devolution)** The governing body had agreed at its seminar in October not to register interest to be involved in a pilot scheme for devolution. EMT had reviewed the draft collaborative agreement and comments had been collated for submission to the London office of CCGs. It was planned to develop a joint statement on devolution for the next Health & Wellbeing Board on 8 December 2015. **7) Healthy London Partnership (HLP) beyond 2015/16** The London Transformation Group had asked that longer term commitment for 2016/17 and beyond be considered by all London CCGs and NHS England (London). At its meeting in September the governing body had agreed to support longer-term commitment to the HLP, along with the financial planning assumption and the proposed ongoing governance arrangements. Further proposals on the planning process, timetable and financial assumptions for 2016/17 would be presented to the January governing body meeting for approval. **The governing body noted the Chair and Chief Officer's Report.**	GB agenda January
B	**GOVERNANCE/BUSINESS**	
7	**Organisation Development Plan 15/16** The governing body received and noted attachment C and the following points were noted: • Following approval of the organisation development (OD) plan by the governing body in May, the paper outlined OD activities and timelines for 15/16. The plan was designed to support the CCG through significant transition in the three areas of leadership, collaborative commissioning relationships and OBC implementation. • The plan identified the CCG's priorities for the current year and proposed development activities to address these. One of the priorities was staff and governing body development. There would be a move away from reliance on strategic partners to develop more in-house expertise. • It was agreed that, at their meeting in January, the membership group would be asked for their suggestions of ways to improve their engagement with the governing body. **The governing body approved the plan.**	Attachment C Mship agenda January VCC
8	**South West London Collaborative Commissioning Programme Update** The governing body received attachment D which outlined progress made by the South West London Commissioning Collaborative (SWLCC) on the five year plan to improve health services in South West London. During discussion the following points were highlighted: • A deliberative event had been held to engage patients and public, and it was intended to build on existing engagement in new ways. A report and equalities impact assessment would be going to the quality & safety committee. • There was a need to map out a more coherent plan across CCGs and clinical design groups (CDGs). • An application had been submitted to be part of the success regime with SWL and Surrey Downs. A governance structure was being developed and it was planned to form a programme board with an independent chair and attendance from all CCGs, stakeholders, provider chief officers and NHSE. The programme of work reflected the huge scale of the change that needed to be delivered. Local authorities would be engaged in the programme in due course. There would be an update report to the governing body at its January	Attachment D GB agenda January

		ACTION
	meeting. • The chief officer and chair would review the CCG's involvement with the CDGs in order to promote the CCG's influence. • In terms of resources in the SWLCC to take this programme forward, it was in the process of recruiting permanent staff and would rely on the outcomes of the success regime. It was important to ensure that work was not duplicated between the sector and local CCGs. **The governing body noted the report.**	CO/Chair
9	**Financial Control Environment Assessment** The governing body received attachment E which consisted of a review of Richmond CCG's financial and governance controls. The report had been reviewed by the CCG's internal auditors and approved by the Audit Committee prior to being submitted to NHS England in August. There were two areas highlighted in yellow with a "moderate" rating and therefore a cause for concern. One related to the fact that the CCG may not hit its QIPP target and the other related to the poor performance of the CSU around monitoring acute performance and continuing healthcare (CHC) reporting. The CCG was already monitoring both of these areas as potentially problematic and had benchmarked to check that the CCG was not an outlier. **The governing body approved the report.**	Attachment E
C	**QUALITY, PERFORMANCE & FINANCE**	
10	**Board Assurance Framework *(quarterly report)*** The governing body received attachment F, the Board Assurance Framework (BAF), which provided assurance to the governing body on the delivery of its corporate objectives through a number of priority programmes, with mitigating actions and timescales. During discussion the following points were highlighted: • The majority of risks pertained to finance or commissioning. Outcome based commissioning (OBC) was a high risk and was expected to remain high because of the scale of the programme. Deep dives were being carried out into continuing healthcare and the CSU due to concerns raised. • The subject of partnerships with the local authority and achieving best value from resources was raised as the local authority's funds were subject to austerity measures, and pressures in the social care provider market would also have financial implications locally. • Attention was drawn to the need to assess the overall cumulative risk position for the CCG and the capacity of the organisation to manage it, including mapping out the relative impact of risks and those which needed greater focus. It would also be useful to have a picture of what had changed in the quarter. • Clinical leads and staff would be helped to familiarise themselves with the BAF so that they could identify their role in managing risk, and committee report authors would be asked to link their reports back to BAF. **The governing body noted the report.**	Attachment F
11	**a) Report from the Quality & Safety Committee** The governing body received attachment Gi, which dealt with the matters	Attachment Gi

		ACTION
	considered at the Quality & Safety (Q&S) meeting on 3rd November in accordance with the committee's annual work plan. During discussion the following points were highlighted: • Mental health: ➢ The CQC inspection had shown that some areas had improved but other areas had been identified for improvement. The Richmond Wellbeing service had received a good report. ➢ Attention was drawn to injections carried out by the mental health service, and possible problems with capacity and capability. It was highlighted that mental health patients should not be discharged into primary care unless the GP takes responsibility. This was not funded under GMS so needed to be picked up through the CQRG. The chief nurse and mental health lead would pick up through amber warning cards and review the process. • HRCH: Recruitment and retention was still identified as a problem. • RRRT: Referrals had increased; the CCG was making recommendations to try to improve the rate for the patient surveys. • WMUH: There had been a poor response to the patient experience survey on maternity and another survey would be carried out. It was planned to present this in the early part of 2016, first to the CCG's Q&S committee and then to the governing body. **The governing body noted the report.**	Chief nurse & MH lead January Q&S January GB
	b) Report from the Finance & Performance Committee The governing body received attachment Gii, which dealt with the matters considered at the F&P meeting on 3rd November in accordance with the committee's annual work plan. During discussion it was highlighted that cancer and delayed transfers of care (DTOCs) had been raised by NHSE and would need reviewing.	Attachment Gii
12	**a) Finance Report (Month 6)** The governing body received attachment Hi and during discussion the following points were highlighted: • The CCG was on track to meet its forecast for the financial year despite the over-performance at Kingston Hospital. Reserves were being used to manage the position. • The three big areas of risk were: ➢ Continuing healthcare: This was a huge risk as it was forecasting an overspend of £1m. There were concerns over the standard of reporting and the figures were being examined. Four very expensive cases had come through late in the year and the CCG need to review the cases to ensure an appropriate level of care. Further information would be presented in the confidential part 2 of the meeting. ➢ Position on acutes (especially Kingston Hospital): The CCG was working with Kingston CCG to implement a robust process to look at pathways and possible challenges, and trying to progress a year-end deal with Kingston Hospital. ➢ QIPP: The shortfall would have an impact on the accounts. • Overheads and running costs were also overspending and being monitored. • Attention was drawn to the importance of resolving many of the over-performance including coding issues with KHFT, and the CHC position, and ensuring the governing body was kept updated on the projected year-end position.	Attachment Hi

		ACTION
	The governing body noted the report.	
	b) QIPP Recovery Plan The governing body received attachment Hii which outlined the QIPP recovery plan and included an analysis of the shortfall, an outline of new and existing schemes and benchmarking of schemes. The plan had been developed in response to the fact that the M5 forecast outturn (FOT) was showing a shortfall of £1.3m against the CCG's £4,336k QIPP saving target and several of the schemes forecast to deliver savings were at high risk of not delivering. The recovery plan identified the potential for a further £650k of QIPP savings. This number comprised £180k from enhanced and existing schemes, and £470k of new initiatives as follows: • Existing: additional savings from high cost CHC placement reviews, gynaecology 'double-first' outpatient challenges and high cost mental health placements. • New: A&E savings, reduced pathology spend through Ordercomms implementation, and challenges relating to paediatric assessment unit activity at Kingston Hospital FT. During discussion the following points were highlighted: • The QIPP recovery was an urgent priority for the CCG. • It was planned to maximise use of RCAS, and a communication would be circulated to GPs to ensure that GPs and patients had all the information to decide on the best pathway for patients and to facilitate the sharing of best practice. • In answer to a query concerning changes to the GP prescribing incentive scheme, it was noted that it was hoped to maximise savings but this would not mean any changes or increased risk for GP practices. • The newly appointed clinical lead for medicines optimisation would help to review how the medicines optimisation team could reduce duplication and the CCG could use the role of local pharmacists in supporting its wider direction of travel. The clinical lead would report back to CET in January.	Attachment Hii DoF/DCA Clinical lead For MO Agenda CET January
D	**TO NOTE**	
13	**Any Other Business** There was no other business.	
14	**Date of Next Meeting:** **Tuesday 19 January 2016, 12:30 – 15:30,** Salon, York House, Twickenham	
D	**PUBLIC QUESTION TIME**	
15	There were no questions raised by members of the public.	

The Meeting was closed at 15:40.

ACTION LOG for Richmond CCG GOVERNING BODY meeting - LIVE ACTIONS

Commenced: March 2014

Date of next meeting: 23.02.16. Last updated 18.02.16

Action No.	Action	Owner	Date raised	Date due	On track / Overdue / More than 4 weeks late	Comments (i.e. why action is not resolved / completed)
GB26	**SWL Collaborative Commissioning - Exploring an option on moving towards delegated commissioning:** It was hoped to include local enhanced services (LES), direct enhanced services (DES) and quality outcomes framework (QOF) under OBC and was suggested that the CCG should seek to retain funding for these areas so that the RGPA could use it to redesign primary care services across practices in order to ensure sustainability of general practice. This may be possible under full delegation, although delegated resources were minimal. The CFO undertook to check whether payments would continue as a centralised system and whether management costs would be excluded.	CFO	21/07/15	Sep-15	**Overdue**	We would expect that LES, DES and QOF payments would continue to be made through the centralised and system and that any funding for management costs would be passed on, although this would not be great and will need to be agreed formally. RT to provide update in due course.
GB31	**11a)Report from the Quality & Safety Committee:** Attention was drawn to injections carried out by the mental health service, and possible problems with capacity and capability. It was highlighted that mental health patients should not be discharged into primary care unless the GP takes responsibility. This was not funded under GMS so needed to be picked up through the CQRG. The chief nurse and mental health lead would pick up through amber warning cards and review the process.	Chief Nurse/ MH lead	17/11/15	Jan-16	**On track**	No amber warning cards received to review.
GB33	**Safeguarding children annual report:** In terms of the proportion of the split of children in different age groups, the chief nurse would provide a further breakdown of the age groups.	Chief Nurse	19/01/2016	Mar 16	**On track**	In hand with JS.
GB34	**South West London Collaborative Commissioning Programme Update: Programme update:** It was raised that there was no mention of Queen Mary's Hospital Roehampton, although its future would be of concern to patients and may impact on out of hospital care. Kay McCulloch undertook to follow it up.	SWLCC PD	19/01/2016	Mar 16	**On track**	Being taken forward as part of estates strategy
GB35	**Finance & Performance summary:** The risk rating for F&P summary (extreme) would be reviewed to align it to the risk rating for the finance report (high) in order to ensure consistency.	CFO	19/01/2016	Mar 16	**On track**	To be amended for March GB

ACTION LOG for Richmond CCG GOVERNING BODY - COMPLETED ACTIONS READY TO BE CLOSED AT THE FOLLOWING MEETING

Commenced: March 2014

	Date of next meeting: 23.02.16. Last updated 18.02.16					
Action No.	**Action**	**Owner**	**Date raised**	**Date due**	**Completed**	**Comments** *(i.e. why action is not resolved / completed)*
GB30	**8.South West London Collaborative Commissioning Programme Update:** The chief officer and chair would review the CCG's involvement with the CDGs in order to promote the CCG's influence.	CO/Chair	17/11/15	Jan-16	**Completed**	Work is underway to note only maximise opportunities from SWL but also London, (HLP) work streams. Appropriate attendance is being considered. Completed.

Richmond CCG Board Assurance Framework

Corporate objectives January 2016

NHS Richmond Clinical Commissioning Group

Area	Corporate objective	Priority areas	Target score	Current score	Last month	Change	Clinical lead	Exec lead
1. Commissioning	Work closely with our local health providers in primary, social and community care, the local authority, and community and voluntary sectors to secure the best services delivered in the best setting for local people	a. Out of hospital & LTC (Community) / OBC	*High*	*Extreme*	*Extreme*	↓	*SG*	*VOG*
		b. Mental health	*Moderate*	*High*	*High*	↔	*SL*	*VOG*
		c. Learning disabilities	*Moderate*	*High*	*High*	↑	*AN*	*VOG*
		d. Primary care commissioning & development	*High*	*Extreme*	*High*	↓	*KM*	*VHP/VOG*
		e. Urgent & emergency care and system resilience	*High*	*High*	*High*	↔	*BM*	*VOG*
		f. Planned care	*Moderate*	*High*	*High*	↓	*NB*	*VOG*
		g. Better Care Fund	*Moderate*	*High*	*High*	↔	*SG*	*VOG*
		h. Children, young people & maternity	*Moderate*	*High*	*High*	↔	*SI/NB*	*VOG*
		i. Continuing Health Care	*Moderate*	*Extreme*	*Extreme*	↔	*GL*	*JS*
2. Clinical leadership	Use the experience of GPs and other healthcare professionals to commission safe, efficient, sustainable secondary, tertiary and community health services	a. Clinical networks	*Low*	*Moderate*	*Moderate*	↔	*KM*	*VHP*
		b. GP practice & membership & engagement	*Low*	*Moderate*	*Moderate*	↔	*KM*	*VHP*
		c. Development of CCG GPs	*Low*	*Low*	*Low*	↔	*KM*	*VHP*
3. Governance & partnerships	Ensure appropriate constitutional and governance arrangements are in place to enable the CCG to become a highly effective membership organisation	a. JCC	*Low*	*High*	*High*	↔	*GL*	*VHP*
		b. Performance management	*Low*	*Moderate*	*Moderate*	↔	*GL*	*VHP*
		c. Governance and assurance framework	*Low*	*Low*	*Low*	↔	*GL*	*VHP*
		d. Organisational Development Plan	*Low*	*Moderate*	*Moderate*	↔	*GL*	*VHP*
		e. Medicines Review	*Low*	*Moderate*	*Moderate*	↔	*GL*	*VHP*
		d. Partnerships	*Low*	*High*	*High*	↔	*GL*	*KEM*
4. Finance	Ensure the most efficient use of resources to get the best value for patients	a. Achieve financial balance for FY15/16	*High*	*Extreme*	*N/A*	*N/A*	*GL*	*RT*
		b. QIPP	*Moderate*	*High*	*High*	↔	*GL*	*RT*
		c. SWL Financial Strategy	*Moderate*	*High*	*High*	↔	*GL*	*RT*
		d. OBC (finance)	*High*	*High*	*High*	↔	*GL*	*RT*
		e. Procurement strategy & contracts register	*Low*	*Moderate*	*N/A*	*N/A*	*GL*	*RT*
5. Quality & Engagement	Engage and involve the local population in the decisions we make in the planning, design, procurement and quality monitoring of services and ensure sustained focus on improving quality and safety of services	a. Equality and diversity	*Low*	*Low*	*Low*	↔	*GL/AN*	*JS*
		b. Patient experience & safety	*High*	*High*	*High*	↔	*GL/AN*	*JS*
		c. Safeguarding	*High*	*Moderate*	*High*	↑	*GL/AN*	*JS*
		d. Resilience	*Moderate*	*Moderate*	*Moderate*	↔	*GL/AN*	*JS*
		e. Development of public and patient engagement	*Moderate*	*Moderate*	*Moderate*	↔	*GL/AN*	*JS*

NHS
Richmond
Clinical Commissioning Group

Richmond Clinical Commissioning Group Report Summary

Meeting Title:	Governing Body in public		**Date:**	23.2.16	
Report Title:	Primary Care Commissioning Next Steps to Delegated Commissioning including Delegation Agreement				
Agenda Item:	6		**Attachment:**	B	
Purpose: *(please indicate with X)*	Approval/ Ratification	**X**	Discussion / Comment		Information	
Author: *(name & job title)*:	Sheila Jennings Governance & Business Lead		**Executive Leads (Clinical and Officer)** *(name & job title)*:	Kathryn Magson Chief Officer	
Presented by: *(name & job title)*:	Kathryn Magson Chief Officer		**Further Information contact** *(email address)*:	Sheila.jennings@richmond.gov.uk	
Executive Summary:	Richmond CCG's application to take on full delegated commissioning of primary care was approved subject to a few minor amendments which have been addressed. The application was made subject to the satisfactory outcome of a due diligence exercise in respect of financial, legal, governance and regulatory matters associated with delegation. The executive management team considered the financial due diligence report at its meeting on 11 January but concluded that further assurances were required from NHS England before it could make a recommendation to the governing body to proceed to delegated commissioning from 1.4.16. This paper identifies the opportunities and risks associated with taking on delegated primary care commissioning from April 2016, as well as detailing the next steps in the process to moving forward with delegated commissioning. This information will enable the governing body to make a final decision about whether to proceed towards full delegated commissioning from April 2016.				
Financial/Resource Implications:	The CCG has been advised that its primary care allocation for 2016/17 is £23.5m which allows for growth at 3.6%. However, the CCG will inherit a deficit budget of £0.2m in 2015/16 which, with business rules commitments to fund, could lead to a deficit of 2016/17 of £0.25m if no QIPP savings are delivered in year. There is a small contingency of £0.1m in the budget and little room for rent increases or investment, which could be addressed if higher QIPP savings are delivered. Applying projected funding growth to subsequent years show s that investment funding should be available, if costs are kept within inflation				

	assumptions which include demographic growth of 1.3%, premises and other inflation at 1%.
Communication plan and stakeholder involvement:	The outcome of the governing body's decision will be communicated to CCG staff and stakeholders
Committees that have previously discussed/agreed the report and outcomes:	Governing Body Membership Group Executive Management Team Shadow Primary Care Committee
Equalities Analysis	The CCG is dedicated to ensuring that equality, diversity and inclusion are central to the way it commissions and delivers healthcare services and supports its staff. It aims to reduce inequalities in health and healthcare for the people of the borough of Richmond.
Report Recommendation:	• Note the outcome of the due diligence exercise and request a side letter as an addendum to the Delegation Agreement with NHS England that will set out a process for agreeing local matters • Agree to continue with the application to take on delegated commissioning from April 2016 which will include the completion and submission of the Delegation Agreement • Note the final terms of reference for the Primary Care Commissioning Committee, considered by the shadow primary care committee and approved by the membership group (as per the Constitution's scheme of delegation)
Next Steps:	• Agree side letter as addendum to the Delegation Agreement • Complete and submit the Delegation Agreement

STRATEGIC OBJECTIVE(S) ***(please indicate with X against relevant strategic objective)***	**Clinical Leadership**:	
	Use the experience of GPs and other healthcare professionals to commission safe, efficient, sustainable secondary, tertiary and community health services	**X**
	Commissioning:	
	Work closely with our local health providers in primary, social and community care, the local authority, and community and voluntary sectors to secure the best services delivered in the best setting for local people	**X**
	Quality:	
	Engage and involve the local population in the decisions we make in the planning, design, procurement and quality monitoring of services and ensure sustained focus on improving quality and safety of services	**X**
	Governance:	
	Ensure appropriate constitutional and governance	**X**

	arrangements are in place to enable the CCG to become a highly effective membership organisation							
	Finance:							
	Ensure the most efficient use of resources to get the best value for patients						**X**	
BOARD ASSURANCE FRAMEWORK (BAF)	**Area(s):**	1	Commissioning					
	Priority Area(s):	1e	Primary Care Commissioning & Development					
Current Risk Status: ***(please indicate with X)***	**Extreme**		**High**	**X**	**Moderate**		**Low**	
Movement since last month: ***(please indicate with X)***		⟷		⟷		⟷		
Current position including action required:								

NHS
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Clinical Commissioning Group

Primary Care Commissioning
Next Steps towards Delegated Commissioning

1. Introduction

1.1 This paper follows on from previous papers and discussions which identified the opportunities and risks associated with taking on delegated primary care commissioning from April 2016. It provides a briefing to the governing body on our progress towards taking on delegated commissioning, including an update on the outcomes of the due diligence exercise, as well as detailing next steps in the process to enable the governing body to make a final decision about moving forward towards taking on full delegated commissioning from 1 April 2016.

1.2 In September 2015 the governing body agreed to pursue an application for delegated commissioning, reserving the right to take a final decision once the outcomes of the due diligence process had been reviewed, with an understanding that any significant risks should be identified and the impact understood before making a final decision. The due diligence reports were published in January 2016, providing an opportunity for a detailed review by the executive management team. The key outcomes of both the financial and legal due diligence reports are included within this paper.

1.3 Appended to this report are:

- NHS England's guide to the delegation agreement
- Terms of reference for Richmond CCG's Primary Care Commissioning Committee

2. Delegated Commissioning – Opportunities, Benefits and Risks

2.1 Delegated commissioning arrangements will give the CCG full responsibility for commissioning general practice services. Legally NHS England will retain the residual liability for the performance of primary medical care commissioning and as such will require assurance that its statutory functions are being discharged effectively by the CCG. The formal liability for primary care commissioning will remain with NHS England for legal reasons although individual CCGs remain accountable for meeting their statutory duties in relation to quality, financial resources and public participation. Delegated responsibilities will include:

- Contractual GP performance management
- Budget management
- Complaints management
- Design of local incentive schemes as an alternative to QOF and DES contracts

2.2 Functions that remain reserved to NHS England include:

- individual GP performance management
- administration of payments and performers list management
- Section 7A (Public Health) functions and funds
- capital expenditure functions and funds
- complaints management

2.3 Legally NHSE will also retain the residual liability for the performance of primary medical care commissioning. Therefore will require robust assurances that its statutory functions are being discharged effectively.

2.4 Whilst delegated commissioning excludes functions reserved to NHS England, CCGs are expected to work collaboratively to assist and support it to carry out its reserved functions.

2.5 Full delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Opportunities and benefits that exist within full delegation arrangements include:

- Building on the good work to progress and deliver the CCG's overarching primary care strategy
- Enabling full implementation of our plans in relation to the Five Year Forward View, including outcomes based commissioning (OBC).
- Benefiting our local population by improving primary care access, outcomes, patient experience and supporting our work to reduce inequalities
- Designing local schemes to replace QOF and DES, based on local knowledge and need
- Increasing our knowledge of current practice performance against contracts thus improving quality and reducing variation in care
- Giving GP members direct leadership to influence the development of investment in general practice
- Being best placed to commission primary, community and secondary care in an holistic and integrated way
- Creating greater freedom within the CCG to use primary care finances providing a better understanding and control of financial flows across the organisation
- Supporting the CCG's effectiveness in transforming healthcare services by directly commissioning tailored primary care services at a local level to meet our local population's needs
- Providing greater opportunity to use innovative commissioning to deliver local improvements whilst optimising resources to target more effectively

2.6 Other CCGs have reported early benefits and opportunities during the first six

months of delegated commissioning which include:

- Increased local appetite and energy to develop primary care services and new models of care
- Development of a clearer, joined-up vision for primary care, which is aligned to the CCG's wider system priorities
- Increased clinical leadership and public involvement in primary care commissioning, enabling more local decision-making
- Improved relationships with a wide range of local stakeholders, including member practices, as more conversations take place locally about primary care development and practice sustainability

3.0 Outcomes of the Due Diligence Exercise

- **Financial**

3.1 RSM accountants carried out due diligence on primary care budgets currently managed by NHS England. This involved discussions with NHS England (as commissioners), NHS Property Services and GP practices. Budgets over the past three years were considered in detail in relation to how they were set, their accuracy, the level of practice engagement that took place, the management of premises and estates, delivery of QIPP and overall financial management processes.

3.2 The review concluded that there is a level of financial risk to CCGs in taking on Level 3 delegated commissioning responsibility. This is related to the budget setting process, QIPP requirements and the historic approach to accruing for costs at a GP practice level. In addition, the GP practice survey highlighted some issues that NHS England was not aware of, primarily related to premises matters.

3.3 These risks need to be considered in the context of the opportunities that delegated commissioning may provide, for example; the scope for improved financial management is significant and should be weighed up against the likely short-term financial challenge that the CCG will inherit if it moves ahead with delegated commissioning.

3.4 The report highlighted the following key recommendations:

- Financial reporting: The CCG would need to invest so that a more robust reporting mechanism is in place to go live on 1 April 2016.
- Accruals: Improved systems for accruing a GP practice at CCG level would need to be developed and implemented to take effect from 1 April 2016.
- Financial Management: Practices should be aware of their budgets at the start of the year and there should be an on-going programme to monitor costs against this budget throughout the year.
- QIPP: The gap from 2015/16 would need to be eliminated through the financial strategy. Planning for 2016/17 should start now so that schemes are designed and implemented by 1 April 2016.

- Contract Management: A robust process of contract management should be put in place. A training programme for GP practices and CCG staff should be designed and implemented to support this change.
- Property: Meetings should take place with GP practices to ensure that all property issues with NHS Property Services (NHSPS) are flagged and an appropriate action plan put in place.
- Capacity: Additional capacity will be needed during the set-up phase. Dependent on how staff are allocated at a SW London and/or CCG level, there may be some economies of scale. Thereafter the levels of staff transferring could be adequate, although will require new ways of working, for example; better use of systems to reduce manual intervention
- Shared Services: CCGs should consider working together so that common standards are applied to the management of contracts going forward. A shared service approach would allow better staff structures and critical mass so that CCGs can build improvements into the current system, rather than risk going backwards if key skills are diluted.

3.5 In response to the findings of the report it is suggested that a review of every practice be undertaken within the CCG to validate the current contract and finance information, allowing the CCG to establish a baseline in order to set a model for ongoing management of contracts.

3.6 The CCG is awaiting the outcome of the pan-London OD review of primary care commissioning to further understand the resources available. We are in the process of appointing a substantive 8c head of primary care & urgent care and considering other options for increasing capacity and capability around primary care commissioning.

- **Legal**

3.7 Capsticks undertook the legal due diligence on behalf of SW London CCGs, focusing on PMS, GMS and APMS contracts through which primary medical services are provided. They provided an analysis of the general legal risks pertaining to CCGs taking on delegated commissioning responsibilities. As with the financial due diligence, a survey was conducted with local practices to provide a picture of GPs' perception of a range of contractual issues. The report also identified a number of 'legacy issues' which were not initially identified on NHS England's unresolved legacy list.

3.8 The following table provides an overview of the outcomes of the legal report and suggested actions that could be undertaken by both the CCG and NHS England to resolve such issues:

Issue	Summary of Suggested Actions
Primary Medical Contracts: documents in different states with regards to updates,	Due diligence exercise at practice level, variation agreements issued and signed

service detail and KPIs	where necessary
Performance Management: Differing schedules in lace, limited evidence of reviews completed	Develop a consistent performance monitoring framework which is manageable within resources
Legacy Issues: GP survey has highlighted several areas where there are live issues	CCG to ensure consistent processes are in place for future and consider in detail the list of outstanding information requested from NHSE
Breach and CQC: Limited evidence of action taken in response to breach notices etc	CCGs to find out what action has been taken by NHSE and ensure processes are in place for future
GP Survey: Wide range of issues from practices identified, raising concerns about legacy report	CCG to ensure consistent processes are in place for future and consider in detail the list of outstanding information requested from NHSE
Delegation Agreement: Difficulties accessing information due to poor sharing arrangements	Review delegation and information sharing arrangements with NHSE and agree timeframe
Delivery of QIPP: CCG must provide assurance of ownership and delivery	Explore with NHSE the possibility of local variations
Conflicts of Interest Management: Increased scrutiny and risk of challenge	Ensure best practice is adopted, actively review arrangements and ensure staff are trained
Joint Working: Governance needs to be clear to avoid risk of challenge	Ensure clear governance arrangements are developed to allow development of at scale solutions

3.9 As noted earlier individual practice reviews will be undertaken across the CCG which will also identify any contractual issues and enable the CCG to manage any outstanding issues accordingly. Reviews will be completed over time as part of a rolling programme and will be tailored to the level of financial risk experienced by each practice.

3.10 Work is ongoing with the local NHS England Regional team to work through and address some of the areas where there are outstanding issues, or further clarification is required in order to ensure that systems and processes are in place and are sufficient to take on the delegated functions. SW London CCGs agreed at a meeting of the joint committee for primary care commissioning on 4 February 2016 that a legal agreement be made with NHS England that provides indemnity to reflect the outcome of their negotiations following receipt of the financial and legal due diligence reports.

4. Operating Model for Delegated Primary Care Commissioning in SW London

4.1 Proposals for working collaboratively across SW London CCGs on areas of commissioning work where there is a potential benefit have been discussed at various collaborative groups. Key recommendations of an operating model for delegated primary care commissioning in SW London were agreed at the SWL Joint Committee for Primary Care commissioning on 4 February 2016 including:

- Following the establishment of individual CCG primary care commissioning committees, standing down the existing joint committee for primary care commissioning from 31 March 2016
- Re-assigning the three working groups currently reporting to the joint committee to other SW London-wide committees
- Retaining some scope to continue to work together on a collaborative basis in areas of common interest; for example creating an advisory panel comprised of clinical and managerial leaders to support colleagues in individual CCGs dealing with challenging or contentious local commissioning issues.
- The primary care delivery group continuing to lead collaborative work for the strategic transformation of primary care across SW London.
- Establishing a primary care commissioning support team for SWL under the direction of participating CCGs to ensure CCGs have sufficient capacity and capability in their workforce to manage the range of contract, financial and performance management issues related to the commissioning of primary care. SWL CCGs have indicated an interest to jointly operate a single commissioning support team, potentially hosted by one of the partner CCGs and/or an alternative host organisation. Managerial representatives from all CCGs would oversee the governance and performance of this team. Core workforce could be drawn from the current team employed by NHSE London on a 'fair shares' basis for SW London. It should be noted that further work on the location and operation of this team is subject to the outcomes of the current London-wide workforce review.

5. Delegation Agreement

5.1 The delegation agreement (see guide at Appendix 1) sets out the primary medical services functions that will be delegated to the CCG, and how these should be exercised. This is the next phase in the CCG's application to take on delegated commissioning from 1 April 2016. Should the governing body agree to move forward with delegated commissioning, this document will be completed and returned to NHS England by 26 February 2016.

5.2 The Delegation Agreement was developed in collaboration with CCGs and clinical commissioners alongside NHS England. To ensure consistency, there is one standard delegation agreement for all CCGs wishing to take on delegated commissioning arrangements, and as such NHS England will not accept any local

variations. Nevertheless, SWL CCGs are seeking a legal agreement be made with NHS England that provides indemnity to reflect the outcome of their negotiations following receipt of the financial and legal due diligence reports. This agreement would be expected to address explicit issues and confirm responsibility for managing some of the outstanding legacy issues; thus limiting the risks transferred as part of the delegated agreement.

5.3 In order to move towards full delegated commissioning, relevant sections of the agreement must be completed, signed and returned to NHS England by Friday 26 February. Following successful completion of the delegation agreement, NHS England will issue the final delegation documentation.

5.4 The delegation agreement provides the operational details on how the parties to the delegation will operate, with the content divided into three sections:

1) **The Particulars**: sections requiring local completion

2) **The Terms and Conditions**: terms and conditions governing the delegation of primary medical care commissioning functions to the CCG and how these are to be exercised by the CCG; and

3) **The Schedules**: further detailed provisions in relation to the delegated functions, reserved functions, finances, staffing and other provisions.

5.5 Work is underway to review the particulars in the delegated agreement so we are in a position to complete the form to meet NHS England deadlines.

6. Governance

6.1 The final version of the CCG's primary care commissioning committee's terms of reference is at Appendix 2. These are based on a national model, revised to reflect local discussions at the shadow primary care committee and approved by the membership group in line with the Constitution's scheme of delegation.

6.2 The committee will be established from April 2016 and will meet in public on a bi-monthly basis. The first meeting in public will be held after the delegation has been finalised and functions formally transferred to the CCG. In the interim period regular meetings of the shadow primary care committee will continue to ensure that the process is managed and the ongoing work programme implemented.

7. Next Steps

7.1 The shadow primary care committee will continue to ensure that the CCG is in a position to take on delegated commissioning, until such time as the delegation has been finalised and functions formally transferred to the CCG.

7.2 Work continues across SW London to understand the resource and workforce implications to support the management and transfer of delegated functions, which will then inform part of the discussions with NHS England on the resources and capacity transferred (as described in paragraph 4).

8. Recommendations

8.1 The governing body is asked to note the due diligence reports and the recommendation of the SW London joint committee for primary care commissioning that a legal agreement is made with NHS England that provides indemnity to reflect the outcome of negotiations with SW London CCGs.

8.2 Agree to continue with the CCG's application to take on delegated commissioning from 1 April 2016, which will include the completion and submission of the delegation agreement.

8.3 Note the terms of reference for the Primary Care Commissioning Committee, noting the ongoing work of the shadow primary care committee to ensure that we have robust governance arrangements in place to manage this process.

8.4 The CCG will begin a process of reviewing the financial positions of the practices to ensure they can operate within their allocated funding. This process will take some time, with a number of practices reviewed each year as part of a rolling programme.

NHS England

Guide to the Delegation Agreement

15 January 2016

NHS England INFORMA110N READER BOX

Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Icommissi oning Strategy
Finance		

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Document Narne	Guide to the Delegation Agreement
Author	NHS England
Publication Date	15 January 2016
Target Audience	CCG Clinical Leaders, CCG Accountable Officers
Additional Circulation List	NHS England Regional Directors, NHS England Directors of Commissioning Operations
Description	This document provides a summary of the Delegation Agreement and should be read in conjunction with the Delegation Agreement and Delegation Agreement Completion hstructions.
Cross Reference	Delegation Agreement and Delegation Agreement Completion hstructions
Superseded Docs (if applicable)	Gateway Ref 03255
Action Required	N/A
Timing / Deadlines (if applicable)	N/A
Contact Details for further information	england.co-commissioning@nhs.net

Document Status

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NHS ENGLAND
GUIDE TO THE DELEGATION AGREEMENT

1. Delegation and Delegation Agreement

1.1. The Delegation (a copy of which can be found at Annex E to NHS England's guidance *Next steps towards primary care co-commissioning*) will set out the statutory delegation of primary medical care commissioning functions to CCGs.

1.2. The Delegation will be supplemented by the Delegation Agreement, which sets out the detailed arrangements for how the CCG will exercise its delegated primary medical care commissioning functions. There is one standard form Delegation Agreement that NHS England and each relevant CCG receiving delegated functions will be required to sign.

2. Structure of the Delegation Agreement

2.1. The Delegation Agreement is divided into:

2.1.1. **The Particulars:** contain the sections which require local completion (including details of the parties to the Delegation Agreement, the addresses for notices and other information);

2.1.2. **The Terms and Conditions:** contain the terms and conditions governing the delegation of the primary medical care commissioning functions to the CCG and how these are to be exercised by the CCG; and

2.1.3. **The Schedules:** contain further detailed provisions including in relation to the Delegated Functions, the Reserved Functions, finances, staffing and other provisions.

3. About this Summary

3.1. For the sake of completeness, the Delegation Agreement is a lengthy document. It has been produced with, and reviewed by, CCG colleagues, but we are aware that it is a detailed and sometimes technical document. For ease of reading and reference, this summary guide has been produced.

3.2. A guide to each of the clauses in the Delegation Agreement is set out at Appendix 1 below. This guide is only a summary of the key provisions of

the Delegation Agreement to assist the CCG. It should not be viewed as an interpretation of the Delegation Agreement. In the event of a conflict between this guide and the Delegation Agreement, the terms of the Delegation Agreement will prevail.

Appendix 1

Guide to the Delegation Agreement

Clause	Clause Name	Description
Particulars		
1	Particulars	The Particulars contain elements of the Delegation Agreement for local completion (which must be completed prior to signing the Delegation Agreement). Information to be inserted here includes the name of the Local NHS England Team, the name of the CCG, the relevant Area and contact information for the Parties.
Terms and Conditions		
2	Interpretation	This clause confirms that the Delegation Agreement should be interpreted in accordance with the definitions set out in Schedule 1. In order to avoid disputes, clause 2.3 sets out an order of precedence to resolve any conflict or inconsistency. The Particulars and Terms and Conditions take precedence over the Schedules and any Local Terms.
3	Background	This clause contains background information on the delegation of functions by NHS England to the CCG. Clause 3.4 confirms that functions relating to the commissioning of primary care pharmacy, dental and optical contracts are not delegated to the CCG under the Delegation.
4	Term	This clause confirms that the Delegation Agreement will take effect from the date set out in paragraph 10 of the Delegation (1 April 2015) and will remain in force unless terminated under clause 17 *(Termination)*.
5	Principles	This clause describes certain overarching principles which NHS England and the CCG must adhere to in their dealings with each other under the Delegation Agreement. For example, NHS England and the CCG must at all times act in good faith, share information and best practice, eliminate duplication of effort, mitigate risk and reduce costs.
6	Performance of the	Clause 6 sets out the details of the primary medical care commissioning functions delegated to the CCG. Clause 6.1 confirms that the role of the CCG will be to exercise the Delegated Functions in the Area. Clause 6.2 sets out

Clause	Clause Name	Description
	Delegated Functions	the list of Delegated Functions – further detail on the functions is set out in Schedule 2 *(Delegated Functions)*. The CCG must perform the Delegated Functions in accordance with certain requirements, including the Delegation itself, the terms of the Delegation Agreement, all applicable Law, Guidance and Good Practice (clauses 6.4 and 6.4A). The CCG must also perform the Delegated Functions in such a manner as to ensure NHS England's compliance with its statutory duties (clause 6.5), as NHS England remains liable for the functions delegated to the CCG. The CCG must not act outside of its delegated authority (clause 6.6) and the CCG's decisions will be binding on the CCG and NHS England (clause 6.8).
7	Committee	The CCG must establish a committee to exercise its Delegated Functions. The structure and operation of the committee must take into account any Guidance issued by NHS England.
8	Performance of the Reserved Functions	Clause 8 sets out the details of the primary medical care commissioning functions that are reserved to NHS England (and so will not be performed by the CCG). The list of Reserved Functions is set out at clause 8.2 and includes management of the national performers list and the revalidation and appraisal process. The Delegation may be amended and additional functions may be delegated to the CCG in the future (clause 8.3). Any changes that need to be made to the Delegation Agreement following the delegation of additional functions will then be agreed with the CCG in accordance with clause 22 *(Variations)*. The CCG will provide some administrative and management services to NHS England in relation to certain Reserved Functions (as set out in clauses 8.8 and 8.9, in particular in relation to the Section 7A Functions). These arrangements are described in detail in clause 13.
9	Monitoring and	Clause 9 sets out the CCG's reporting requirements under the Delegation Agreement and confirms that the CCG

Clause	Clause Name	Description
	Reporting – General Requirements	must comply with its reporting obligations in the CCG Assurance Framework and its constitution (clause 9.1). The CCG must provide copies of the agenda and minutes from its primary medical services commissioning committee meetings to NHS England and must also provide NHS England with a monthly report (clause 9.2). The CCG must give NHS England 7 days' notice of all committee meetings and NHS England has the right to attend the committee meetings (clause 9.3).
10	Information Sharing and Information Governance	NHS England and the CCG will enter into a Personal Data Agreement (to govern the processing of Relevant Information under the Delegation Agreement). A template Personal Data Agreement is set out at Schedule 4 *(Further Information Sharing Provisions)*. NHS England and the CCG agree that, when sharing information under the Delegation Agreement, they will comply with relevant Information Law requirements, Good Practice and relevant guidance (clause 10.5).
11	IT inter-operability	NHS England and the CCG will work together to ensure that IT systems are inter-operable and that data may be transferred between systems securely, easily and efficiently.
12	Public Information and Access Targets	The CCG will provide such information to NHS England as is required in respect of the Delegated Functions to ensure NHS England's discharge of its statutory duties (clause 12.1).
13	Financial Provisions and Liability	***Notification of the Delegated Funds and Adjustments to the Delegated Funds (clauses 13.1 to 13.8)*** – NHS England will notify the CCG of the proportion of funds that will be allocated to the CCG for the purpose of meeting expenditure in respect of the Delegated Functions in each financial year (clause 13.1). Except in relation to pooled funds (see below) and subject to the CCG's compliance with its statutory financial duties, the CCG must use these allocated funds to carry out the Delegated Functions (clause 13.2). NHS England may make adjustments to the Delegated Funds, for example to take into account monthly adjustments and/or any Losses that NHS England suffers as a result of the CCG's negligence, fraud,

Clause	Clause Name	Description
		recklessness or deliberate breach of the Delegation Agreement (clause 13.3). Schedule 5 *(Financial Provisions and Decision Making Limits)* sets out financial and decision-making limits that apply in relation to the exercise of the Delegated Functions (clause 13.8).
		Payment and Transfer (clauses 13.9 to 13.12) – The Delegated Funds cannot form part of the funds used for the provision of the CCG's own functions (clause 13.9). NHS England will pay the Delegated Funds to the CCG on a monthly basis, using the same revenue transfer process that NHS England uses to transfer funds to the CCG annually (or using such other process as notified to the CCG from time to time) (clause 13.10). The CCG must comply with the requirements set out in clause 13.11 when dealing with the Delegated Funds (for example, the CCG must comply with any business rules set out in NHS England's planning guidance and the HM Treasury guidance *Managing Public Money*).
		Administrative and/or Management Services and Funds in relation to certain Reserved Functions (clauses 13.13 to 13.23) – the CCG will provide administrative services to NHS England in relation to the Section 7A Functions (i.e. the CCG will administrate payments made under section 7A of the NHS Act 2006 and will provide any other support or administrative assistance to NHS England that NHS England may reasonably request (clauses 13.17 to 13.19)). NHS England may also require the CCG to provide similar administrative services in relation the Capital Expenditure Functions (clauses 13.13 to 13.16), complaints management and other Reserved Functions (clauses 13.21 to 13.23).
		Pooled Funds (clauses 13.24 to 13.25) – the CCG has the flexibility to use any part of the Delegated Funds to establish and maintain a pooled fund with NHS England (under section 13V of the NHS Act 2006) (clause 13.24). NHS England must consent in writing to the establishment of the pooled fund and the details of any pooled fund (at the date of the Delegation Agreement) must be set out in Schedule 7 *(Local Terms)* (clause 13.25).
		Business Plan, Commissioning Plan and Annual Report (clauses 13.26 to 13.33) – the CCG is required to

Clause	Clause Name	Description
		provide NHS England with a business plan and annual report in relation to the Delegated Functions, to ensure that NHS England is able to comply with its financial reporting obligations under the NHS Act 2006.
		Risk Sharing (clauses 13.34 to 13.36) – NHS England retains liability in relation to the exercise of the Delegated Functions (section 13Z(6) of the NHS Act 2006) (clause 13.34). NHS England has a right to claim back from the CCG for any Losses that it suffers as a result of the CCG's negligence, fraud, recklessness or deliberate breach of the Delegation or the Delegation Agreement (clause 13.35). NHS England can either require payment from the CCG for any Losses, or NHS England can make adjustments to the Delegated Funds to reclaim the Losses under clause 13.3.
14	Claims and Litigation	The CCG is responsible for any Claims under the Primary Medical Services Contracts and will retain conduct of any Claims (clause 14.3). The CCG must comply with the requirements set out in clause 14.4 when dealing with any Claim or potential Claim (for example, the CCG must comply with any policies issued by NHS England from time to time about the conduct or avoidance of Claims and the pro-active management of Claims and must provide copies of any correspondence and claim documents to NHS England). Subject to Schedule 5 *(Financial Provisions and Decision Making Limits)* and clause 14.4, the CCG is entitled to conduct a Claim in the manner it considers appropriate and may pay or settle any Claim on such terms as it thinks fit (clause 14.6). Please note that, under Schedule 5, NHS England is required to authorise the settlement of any Claim where the value of the settlement exceeds £100,000. NHS England has a right to step-in and take over the conduct of any Claim (clause 14.7). If NHS England exercises this right, it can conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle the Claim. NHS England also has the right to "step-out" of any Claim after it has exercised its step-in rights and so transfer conduct of the Claim back to the CCG (clause 14.8).

Clause	Clause Name	Description
		T. NHS England can either require payment from the CCG for any Claim Losses, or NHS England can make adjustments to the Delegated Funds to take account of such Claim Losses (clause 14.11).
15	Breach	Clause 15 sets out NHS England's rights where the CCG does not comply with the Delegation or the Delegation Agreement. If the CCG breaches the Delegation or the Delegation Agreement, NHS England can exercise its escalation and termination rights under the Delegation Agreement and/or take steps (as it considers appropriate) under the CCG Assurance Framework (clause 15.1). NHS England can also choose to waive any non-compliance by the CCG, ratify any decision by the CCG, revoke the Delegation and terminate the Delegation agreement, exercise the Escalation Rights set out in clause 16 (see below) and/or exercise its rights under common law (clause 15.2). NHS England may only waive non-compliance by the CCG if the CCG provides a written report to NHS England setting out the reasons for its non-compliance and a plan for how the CCG proposes to remedy the non-compliance (clauses 15.3 and 15.4).
16	Escalation Rights	Clause 16 sets out further courses of action available to NHS England in the event of breach by the CCG – NHS England may require a suitably senior representative of the CCG to attend a review meeting with NHS England and may require the CCG to prepare an action plan and report (to include details of how the CCG proposes to remedy the non-compliance) (clause 16.1).
17	Termination	This clause describes how and when the CCG and NHS England can terminate the Delegation and the Delegation Agreement. The CCG may notify NHS England that it requires NHS England to revoke the Delegation and terminate the Delegation Agreement with effect from midnight on 31 March in any calendar year, provided that (i) on or before 30 September of the previous calendar year, the CCG sends written notice to NHS England of its requirement that NHS England revoke the Delegation and terminate the Delegation Agreement, and (ii) NHS England and the CCG meet to discuss arrangements for termination and transition of the Delegated Functions.(clause 17.1).

Clause	Clause Name	Description
		NHS England may revoke the Delegation at midnight on 31 March in any calendar year, provided that it gives notice to the CCG by 30 September of the previous calendar year (clause 17.2). The Delegation Agreement will terminate immediately if the Delegation is revoked or terminated (clause 17.4). NHS England may terminate the Delegation and the Delegation Agreement at any time under clause 17.3 (including if the CCG acts outside of its delegated authority or fails to perform a material obligation under the Delegation Agreement). Clause 17.5 sets out arrangements following revocation and termination of the Delegation and the Delegation Agreement. The Parties must agree a plan for transition of the Delegated Functions from the CCG to a successor commissioner and must comply with their obligations under the transition plan.
18	Staffing	Clause 18 sets out basic information on the three Staffing Models under which the CCG may engage staff to undertake the Delegated Functions. The CCG may only engage staff to undertake the Delegated Functions under one of these three models (assignment, secondment and employment) (clause 18.1). Within 6 months of the date of the Delegation Agreement, the CCG and NHS England must agree which Staffing Model the CCG will adopt (clause 18.2). Until NHS England and the CCG agree on a Staffing Model to be adopted, Model 1 (assignment – where the staff of NHS England remain in their current roles and locations and provide services to the CCG under a service level agreement) will apply (clause 18.3). Schedule 8 *(Assignment of NHS England Staff to the CCG)* sets out the terms that will apply under Model 1. The CCG must comply with any Guidance issued by NHS England in relation to the Staffing Models (clause 18.4). The Delegation Agreement confirms the understanding of the parties that TUPE will not operate to transfer the

Clause	Clause Name	Description
		employment of NHS England staff to the CCG on commencement of the delegated co-commissioning arrangements, but if TUPE does apply (by operation of law), NHS England and the CCG will cooperate and comply with their obligations under TUPE (clauses 18.6 and 18.7).
19	Disputes	Clause 19 sets out a mechanism for resolving any disputes that arise between the CCG and NHS England under the Delegation Agreement. The parties must first try to resolve any dispute between their two nominated representatives. The dispute will then be escalated to the CCG's Accountable Officer and a director or other person nominated by NHS England. The parties may then attempt to settle the matter by mediation in accordance with the CEDR model mediation procedure. If the dispute still cannot be resolved, it must be referred to the Secretary of State for Health, whose decision will be binding on NHS England and the CCG.
20	Freedom of Information	Under clause 20.1, NHS England and the CCG acknowledge that the other party is a public authority for the purposes of the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR). Each party must provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under the FOIA and the EIR (clause 20.2). NHS England may issue a protocol on dealing with and responding to FOIA or EIR requests in relation to the Delegated Functions (clause 20.3).
21	Conflicts of Interest	The CCG must have regard to all relevant guidance published by NHS England in relation to conflicts of interest in the co-commissioning context (clause 21.2). In addition, the CCG must comply with its statutory duties in relation to conflicts of interest and must perform its obligations under the Delegation Agreement in such a way as to ensure NHS England's compliance with its statutory duties (clause 21.1).
22	Variations	Clause 22 sets out the process for varying the Delegation Agreement. A variation of the Delegation Agreement is only effective if it is in the form of the template variation agreement set out at Schedule 6 *(Template Variation Agreement)* and is signed by NHS England and the CCG (clause 22.3). A variation must not contradict or conflict with the Delegation (clause 22.4).

Clause	Clause Name	Description
		NHS England has a general right (set out in clauses 22.5 to 22.10) to implement National Variations to the Delegation Agreement, for example to reflect any changes to the Delegation or changes in policy. NHS England must notify the CCG of a proposed National Variation (clause 22.5). The CCG must then confirm to NHS England whether it either accepts or refuses to accept the National Variation within 30 days (clause 22.8). If the CCG refuses to accept the National Variation, then NHS England has the right to terminate the Delegation Agreement and also revoke the Delegation (clause 22.10).
23	Counterparts	Clause 23 states that the Delegation Agreement may be executed in counterparts. This means that NHS England and the CCG can sign separate copies of the Delegation Agreement – each of these copies will be an original and together they will form one binding agreement.
24	Notices	Clauses 24.1 and 24.2 set out requirements for the delivery of notices under the Delegation Agreement. Notices must be in writing and may be sent by hand, post or email. NHS England may issue Contractual Notices and Guidance from time to time in relation to the Delegated Functions and how these should be exercised by the CCG (clauses 24.3 and 24.4).
Schedules		
1	Definitions and Interpretation	Schedule 1 sets out the meaning of all of the defined terms used in the Delegation Agreement.
2	Delegated Functions	Schedule 2 sets out further detail and obligations on the CCG in relation to the Delegated Functions. Part 1 sets out specific obligations and Part 2 sets out more general obligations relating to the Delegated Functions. Part 1 paragraph 2 sets out the CCG's obligations in relation to **Primary Medical Services Contract management**. For example, the CCG must manage the Primary Medical Services Contracts on behalf of NHS England and must perform NHS England's obligations under the contracts.

Clause	Clause Name	Description
		Part 1 paragraph 3 sets out the CCG's obligations in relation to **planning the provider landscape**, including establishing new GP practices in the Area, managing GP practices providing inadequate standards of patient care and agreeing variations to the boundaries of GP practices. Under paragraph 3.2, when the CCG is considering the form of contract (i.e. PMS, GMS or APMS) to use in relation to a new Primary Medical Services Contract, it must use the form of contract that will ensure compliance with NHS England's legal obligations (including procurement law obligations). Please note that, under Schedule 5 *(Financial Provisions and Decision Making Limits)*, NHS England's sign off is required before the CCG can enter into a new Primary Medical Services Contract with a term exceeding 5 years. Part 1 paragraph 4 sets out the CCG's obligations in relation to **approving GP practice mergers and closures**. The CCG must undertake the necessary consultation when making these decisions and must fully consider the impact of any decision on the GP practice's registered population and the population of surrounding practices. Part 1 paragraph 5 sets out the CCG's obligations in relation to **information sharing with NHS England in relation to the Delegated Functions**. The CCG must provide NHS England with information relating to GP practices in the Area so that NHS England can continue to gather national data about the performance of GP practices. Part 1 paragraph 6 sets out the CCG's obligations in relation to **making decisions in relation to management of poorly performing GP practices**, including decisions and liaison with the CQC where appropriate. Part 1 paragraph 7 sets out the CCG's obligations in relation to **Premises Costs Directions Functions**. The CCG must comply with the Premises Costs Directions and is responsible for making decisions in relation to the Premises Costs Directions. This includes applications for new payments and revisions to existing payments.

Clause	Clause Name	Description
		Part 2 sets out the CCG's more general obligations in relation to the Delegated Functions, for example planning and reviews (paragraph 2), procurement and new contracts (paragraph 3), integrated working (paragraph 4) and resourcing (paragraph 5).
3	Reserved Functions	Schedule 3 sets out further detail in relation to the Reserved Functions. The CCG will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions (paragraph 1.2). Paragraph 2 sets out further details in relation to **management of the national performers list**. NHS England will continue to perform its functions in relation to the national performers list, including considering applications and managing concerns, suspension, conditions and removal. NHS England may require a representative from the CCG to attend local Performance Advisory Group meetings to discuss complaints or concerns about a particular performer. The CCG must ensure that all complaints regarding a named performer are escalated to NHS England. Paragraph 3 sets out further details in relation to the **management of the revalidation and appraisal process**. NHS England will continue to perform these functions (including the funding of GP appraisers and quality assurance of the GP appraisal process). The CCG must not remove or restrict the payments made to GP practices in respect of GP appraisal. Paragraph 4 sets out further details in relation to the **administration of payments and related performers list management activities**. NHS England will continue to perform these functions and will continue to pay GPs who are suspended from the national performers list. Paragraph 5 sets out further details in relation to the **Section 7A Functions**. NHS England will continue to

Clause	Clause Name	Description
		perform the Section 7A Functions – however, the CCG will provide certain administrative services to NHS England. Paragraph 6 sets out further details in relation to the **Capital Expenditure Functions**. NHS England will retain and continue to be responsible for these functions. Paragraph 7 sets out further details in relation to **complaints management**. NHS England will continue to be responsible for complaints management (including complaints about GP practices and individual named performers, controlled drugs and whistleblowing). The CCG must notify NHS England of any complaints it receives and must co-operate with NHS England when responding to complaints. NHS England may ask the CCG to provide certain administrative services to NHS England in relation to complaints management. Paragraph 8 confirms that NHS England will carry out other ancillary activities that are necessary in order for NHS England to exercise the Reserved Functions.
4	Further Information Sharing Provisions	Schedule 4, together with the associated Personal Data Agreement, sets out the scope for the secure and confidential sharing of information between NHS England and the CCG under the Delegation and the Delegation Agreement. Paragraph 2.1 confirms that the Specified Purpose (for which the Relevant Information is shared and processed) is to facilitate the exercise of the CCG's Delegated Functions and NHS England's Reserved Functions. Details of the Relevant Information to be shared and the lawful basis for sharing this information will be set out in the accompanying Personal Data Agreement (paragraphs 4 and 5). NHS England and the CCG agree to only to process the Relevant Information as necessary to achieve the

Clause	Clause Name	Description
		Specified Purpose (unless agreed otherwise in writing) and staff should only have access to Personal Data on a "Need to Know" basis, i.e. if the staff member's function cannot be achieved without access to the information (paragraph 6). In sharing information, NHS England and the CCG must comply with the requirements of the Data Protection Act 1998, the Human Rights Act 1998, and the common law of confidentiality to the extent these are relevant to the information shared as well as other information law requirements, and wherever possible only anonymised information should be shared (paragraph 9). NHS England and the CCG must have appropriate technical and organisational measures in place to protect Personal Data against unauthorised or unlawful processing. Transfer of Personal Data between NHS England and the CCG should be done through secure mechanisms (paragraph 10).
5	Financial Provisions and Decision Making Limits	The table in Schedule 5 sets out financial limits for decisions that the CCG takes in respect of the Delegated Functions – where a decision needs to be made which exceeds one of these limits, the CCG must obtain approval from the individuals at NHS England listed in the table. NHS England may update the table from time to time by sending a notice to the CCG. The relevant decisions, where the CCG must obtain NHS England approval are: • settlement of a Primary Care Contract Claim where the value of the settlement exceeds £100,000; • any matter in relation to the Delegated Functions which is novel, contentious or repercussive; and • entering into any Primary Medical Services Contract which has or is capable of having a term which exceeds 5 years.
6	Template	A template variation agreement is set out at Schedule 6 – NHS England and the CCG should use this template

Clause	Clause Name	Description
	Variation Agreement	when agreeing variations to the Delegation Agreement. This is intended to be used for variations that may be required in future years once the delegation has occurred.
7	Local Terms	Schedule 7 is where NHS England and the CCG will set out any locally agreed terms. Local Terms may only be agreed between the CCG and NHS England on an exceptional basis, must be approved prior to the signing of the agreement and must not derogate from the terms and conditions of the Delegation Agreement. NHS England does not intend that there should be any locally agreed terms, other than in relation to: • details of any pooled funds of NHS England and the CCG; • resourcing arrangements between NHS England and the CCG; and • details of any particular services that the Assigned Staff will provide to the CCG under Schedule 8. •
8	Assignment of NHS England Staff to the CCG	Schedule 8 sets out the terms that apply between NHS England and the CCG in relation to staffing until NHS England and the CCG agree which Staffing Model will be adopted for the co-commissioning arrangements. NHS England agrees to make NHS England staff available to the CCG to perform administrative and management support services, to assist the CCG to exercise the Delegated Functions (paragraph 3.1). NHS England will continue to employ and be responsible for the Assigned Staff (paragraph 4.1) and will continue to pay salaries and benefits (paragraph 4.2). The Assigned Staff will carry out their work from NHS England's places of work (although may be required to attend the offices of the CCG from time to time) (paragraph 4.3). NHS England will have day-to-day control of the Assigned Staff and the CCG will provide reasonable assistance and co-operation (paragraph 5).

Clause	Clause Name	Description
		The CCG must let NHS England know if it becomes aware of any claim by or against a member of the Assigned Staff and the CCG will not settle a claim without NHS England's consent (paragraph 6).

Richmond CCG Primary Care Financial Risk

The 2015/16 primary care budget for Richmond which is held by NHS England is forecasting an overspend of £0.2m on a budget of £22.5m. Next year the budget benefits from 3.6% growth, with a funding allocation of £23.5m coming to Richmond from NHSE.

While this provides an extra £1m for primary care in Richmond, NHSE is imposing Business Rules which offset the amount which can be spent on patients:

- 1% headroom must be retained locally as uncommitted - £235k for Richmond
- CCGs must also hold 0.5% contingency - £118k for Richmond
- Budgets will equate to the published allocation for all CCGs

In order to manage the requirement for 1% headroom, which was not funded in the allocation, we understand that NHSE London is making available 1% funding on a non-recurring basis, which will bring the funding available up to £23.8m. This £0.2m has been included in the deficit calculation below, but it should be noted that it is not yet confirmed and without it, the potential deficit would increase to £0.45m.

As well as funding the business rules, the primary care team has budgeted for demographic growth at 1.33% and inflation at 1%, with 1% inflation only on premises costs. NI/pension increases are funded at a 1.1% increase. This gives the following budget which has been included in SWL planning:

	£'000s
Additional and Essential Services	15,952
Enhanced Services	1,343
Quality and Outcomes Framework (QOF)	1,847
Premises Payment	3,796
Seniority	465
Other Administered Funds (eg Maternity)	121
Personally Administered Drugs	117
Other Medical Services	20
Business Rules, 0.5% contingency + 1% headroom	357
Primary Care Investment Pot	0
Total	24,017
Funding NHSE Allocation of £23,536k + additional 1%	(23,771)
Forecast deficit	246

QIPP and Investment

There are no QIPP savings and no investments provided for in the budget above. Any investments, therefore, would need to be funded from QIPP savings which have not yet been identified. QIPP savings of £246k need to be delivered for expenditure to match funding as per the Business Rules listed above.

Transformation

CCGs are being asked to demonstrate in their plans, on the basis of the growth funding provided, how they are accelerating plans for transformation, with the following priorities:

- Delivery of the London Offer (or equivalent) for PMS practices (including transition)
- Delivery of the London Offer for GMS and APMS practices (eg equalisation)

- Delivery of the wider transformation in primary care (ie the remainder of the Strategic Commissioning Framework)

It is possible that NHSE London will be able to provide additional one-off funding from its surplus drawdown from 2015/16 for pump priming investment, but this is not guaranteed and has not been included in these figures.

Additional risk

- The contingency in the budget, at 0.5% equates to just over £100k which is minimal
- Rent costs are budgeted to increase by 1.1%. This makes no allowance for the revenue impact of any capital invested in either new or existing premises
- No funding for new investment is included in the budget

Financial Risks Identified by due diligence:

- Rent reviews – the biggest risk is the impact of retrospective rent reviews which could leave practice budgets with significantly higher premises costs when these are completed. The CCG does not have the data to quantify this risk and alongside the other four SWL CCGs going for delegated commissioning, is seeking an indemnity from NHS England to counteract any adverse impact. We believe that an indemnity was provided for London CCGs which took on delegated commissioning for 2015/16 and one which will cover Richmond is being drafted with NHSE
- Non-delivery of 15/16 QIPP – Richmond is showing a £0.2m shortfall in 15/16, because of under-delivery of QIPP savings. This carries through into the £246k deficit shown above. As in any forecast, the year-end outturn could be different, so there is some risk that the underlying deficit could turn out to be higher (or lower). The CCG will be expecting to carry this risk into 16/17 but will not be mandated to deliver a primary QIPP but an increased placed based QIPP.
- Prior year accruals – NHSE has not been able to break down primary care 14/15 accruals by CCG. There is, therefore, a risk that run rates are not fully understood which could have impacted on 15/16 budgets, with any adverse impacts running into 16/17
- Unresolved issues – a survey of contact between of GP practices on their contact with NHSE has shown that several have unresolved issues which have not been identified by NHSE and therefore not been provided for in the accounts or budget
- Management costs – NHSE has not yet given the CCG details of the share of the support budget which it would transfer to Richmond to fund increased finance and management costs which the CCG will incur in managing primary care.

Mitigation: As noted above, The SWL CCGs are working with NHSE on securing a letter of support on financial risks incurred up to 31st March 2016. The CCG should not formally take on delegated commissioning until a satisfactory side letter is in place agreed with all CCGs across SWL. Negotiation of such is to be delegated by GB to CFO and CO.

NHS
Richmond
Clinical Commissioning Group

APPENDIX 2

RICHMOND CCG PRIMARY CARE COMMISSIONING COMMITTEE

TERMS OF REFERENCE

Introduction

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

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

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

4. It is a committee comprising representatives of the following organisations:
   - Richmond CCG
   - Richmond Healthwatch
   - Richmond Health & Wellbeing Board
   - Surrey / Sussex Local Medical Committee

Statutory Framework

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

7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its

functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

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

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

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

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

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

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

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

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

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

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

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

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

9. The Committee is established as a committee of the Richmond CCG Governing Body in accordance with Schedule 1A of the “NHS Act”.

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

Role of the Committee

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

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

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

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

15. This includes the following:

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

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

- Plan, including needs assessment, primary medical care services in Richmond
- Undertake reviews of primary medical care services in Richmond
- Co-ordinate a common approach to the commissioning of primary care services generally
- Manage the budget for commissioning of primary medical care services in Richmond
- Oversee the CCG's transforming primary care agenda including the CCG's annual commissioning intentions; a key element of its out of hospital strategy
- Oversee arrangements for the commissioning of locally commissioned services (LCS)
- Work with Richmond GP practices to address issues relating to GP IT

- Manage the primary care element of the CCG's local estates' strategy

Geographical Coverage

17. The Committee will comprise the Richmond CCG area.

Membership

18. The Committee shall consist of:

a. Core voting members:

- Lay Member for Governance (Chair)
- Lay Member for Patient and Public Involvement (PPI) (Vice Chair)
- Chief Officer
- Chief Finance Officer
- CCG Chair
- CCG Vice Clinical Chair (VCC)
- Independent GP
- Chief Nurse
- Director of Commissioning
- Director of Corporate Affairs
- Chief Pharmacist

b. Non-voting attendees:

- Richmond Healthwatch representative
- Richmond Health & Wellbeing Board representative – Director of Adult & Community Services, London Borough of Richmond upon Thames (LBRuT)
- Local Medical Committee (LMC) representative

c. In attendance (as required):

- Head of Finance
- Head of Commissioning, primary care and QIPP
- Relationship Manager(s)
- Public health representative

19. The Chair of the Committee shall be the governing body lay member for governance

20. The Vice Chair of the Committee shall be the governing body lay member for patient and public involvement.

Meetings and Voting

21. The Committee will operate in accordance with the CCG's Standing Orders. The agenda will be set by the Chief Officer in conjunction with the Committee Chair and the CCG Chair. The agenda will be accompanied by supporting papers and sent to each member representative no later than five working days before the date of the meeting. Secretarial support to the Committee will be provided via the Corporate Office. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

22. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Quorum

23. One third of committee members are required for the meeting to be quorate, including:

- the committee chair or the vice chair
- two of the following: chief officer, chief finance officer, director of commissioning

Frequency of meetings

24. Meetings of the primary care commissioning committee will normally be held on a bi-monthly basis. Members will be expected to attend each meeting.

25. Meetings of the Committee shall:

    a) be held in public, subject to the application of 25(b);

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

26. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective

expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

27. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

Sub-Groups reporting to the Committee

28. The primary care commissioning committee will agree the terms of reference of and receive regular reports from its sub-groups, including:
    - Local Commissioned Services (LCS) Contract Monitoring Sub-Group
    - Primary Care Premises Sub-Group
    - Primary Care IT Sub-Group
    - Patient Participation Group (PPG)

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

30. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Standing Orders and Standards of Business Conduct Policy.

31. The Committee will present its minutes to NHS England (London Region) and the governing body of Richmond CCG on each occasion for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 27 above.

32. The CCG will also comply with any reporting requirements set out in its constitution.

33. These Terms of Reference will be reviewed by the CCG at least annually, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time, in which case the CCG will review these terms of reference and revise as appropriate.

Accountability of the Committee

34. The budget and resource accountability arrangements and the decision-making scope of the Committee will be agreed pursuant to the delegation and delegation agreement with NHS England.

35. For the avoidance of doubt, in the event of any conflict between the terms of this Scheme of Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the latter will prevail.

36. The Committee will make allowance for consultation with members of the public and other CCGs.

Procurement of Agreed Services

37. The detailed arrangements regarding procurement will be set out in the delegation agreement entered into between the CCG and NHS England.

Decisions

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

39. The decisions of the Committee shall be binding on NHS England and Richmond CCG.

40. The Committee will produce an executive summary report which will be presented to NHS England (London Region) and the governing body of Richmond CCG on each occasion for information.

NHS
Richmond
Clinical Commissioning Group

Richmond Clinical Commissioning Group Report Summary

Meeting Title:	Governing Body in public			**Date:**	23 February 2016
Report Title:	Recommendation for 12 month contract extension for AQP Services for MSK neck and back and podiatry				
Agenda Item:	7			**Attachment:**	C
Purpose: ***(please indicate with X)***	Approval/ Ratification	**X**	Discussion / Comment		Information
Author: ***(name & job title)*:**	Jackie Clare Project Manager j.clare@richmond.gov.uk		**Executive Leads (Clinical and Officer)** ***(name & job title)*:**		Victoria Otley-Groom Director of Commissioning
Presented by: ***(name & job title)*:**	Victoria Otley-Groom Director of Commissioning		**Further Information contact** ***(email address)*:**		**Victoria.Otley-Groom@richmond.gov.uk**
Executive Summary:	Decision being sought: • Governing body approve AQP contract extension for a further 12 months from 1 April 2016 – 31 March 2017 with a 3 month notice clause and 5% tariff reduction to support the transition of these services to the OBC contract, projected value £772k. <u>Context and Rationale</u> In January 2015, CET approved the recommendation to extend the AQP services contracts for MSK (neck and back) and Podiatry for one year (this was an optional extension allowed under the term of the original contract) pending transition to Outcome Based Commissioning (OBC) contract for 2016-17. Richmond CCG's commissioning intention is for the OBC Coordinating Provider (CP) to have a single outcomes based commissioning contract for the integrated provision of all out of hospital health and social care for adults in Richmond from 2016-17. AQP services for MSK (neck and back) and podiatry have been included within the scope of the OBC contract. The current providers are: • The Forge Clinic • Healthshare Ltd • Hounslow and Richmond Community Health Care NHS Trust • Body Logic Physiotherapy • Premier Therapy • St George's NHS Trust				

- Ravenscroft Healthcare
- The Integrated Care Clinics

In order to ensure services in scope of OBC are maintained during the transition to the OBC contract in 2016 -17 it is recommended that the contracts are extended for an additional 12 months at a 5% reduction to current tariffs. This will allow for the OBC CP to continue with the existing arrangements from 1 April 2016 for transition 2016-17.

To date there has been no change to the tariff rate since the introduction of the AQP contracts in 2013. There have however been tariff efficiencies required of acute and community care over the last few years and the net impact on tariffs is approximately -5%.

The impact of 5% efficiency reduction on AQP tariffs would be:

	Current Tariff £	Proposed Tariff wit reduction £
AQP MSK (Back and Neck) Package	162	153.90
AQP MSK (Back and Neck) Assessment only	38	36.10
Podiatry Package A Wound Treatment	118.56	112.63
Podiatry Package B Nail Surgery	212	201.40
Podiatry Package C Routine consultation & treatment	121.35	115.28
Podiatry Package D Non specialized biomechanical assessment & intervention	104.62	99.39
Additional to package prices • Additional toes nail surgery • Orthotics band 1 • Orthotics band 2	 49.49 19.54 52.30	 47.02 18.56 49.69

A desktop quality review of AQP services was conducted during the autumn of 2015, and a summary report was submitted to CET in January 2016 and is attached in appendix 2.

To extend the contracts for 12 months requires a single tender waiver as this is effectively a direct award without following RCCG's tender and procurement procedures. The single tender waiver will need to be approved by chief officer, chief financial officer and reported to the

	audit committee. Please see appendix 1 for options and risks which have been considered.
Financial/Resource Implications:	**Budget and forecast expenditure for 2015-16 and 2016-17 with 5% tariff reduction** Budget 2015-16 / FOT (Month 9) 2015-16 / FOT 2016-17 MSK £511k / £521k / £495k Podiatry £323k / £292k / £277k Total £834k / £813k / £772k This is a cost and volume based contract based on patient usage of the service.
Communication plan and stakeholder involvement:	All AQP providers will be offered contract extension at the new price. GPs will be notified of any changes to the provider list for 2016-17.
Committees that have previously discussed/agreed the report and outcomes:	Finance and Performance November 2015 Report on Quality Review submitted to CET January 2016
Equalities Analysis	
Report Recommendation:	Governing body approve AQP contract extension for a further 12 months from 1 April 2016 – 31 March 2017 with a 3 month notice clause and 5% tariff reduction to support the transition of these services to the OBC contract, projected value £772k.
Next Steps:	1. Approve single tender waiver for AQP Services (CO and CFO) 2. Contract Variation for AQP services issued to providers

STRATEGIC OBJECTIVE(S) ***(please indicate with X against relevant strategic objective)***	**Clinical Leadership**:	
	Use the experience of GPs and other healthcare professionals to commission safe, efficient, sustainable secondary, tertiary and community health services	**X**
	Commissioning:	
	Work closely with our local health providers in primary, social and community care, the local authority, and community and voluntary sectors to secure the best services delivered in the best setting for local people	**X**
	Quality:	
	Engage and involve the local population in the decisions we make in the planning, design, procurement and quality monitoring of services and ensure sustained focus on	**X**

	improving quality and safety of services	
	Governance:	
	Ensure appropriate constitutional and governance arrangements are in place to enable the CCG to become a highly effective membership organisation	**X**
	Finance:	
	Ensure the most efficient use of resources to get the best value for patients	**X**

BOARD ASSURANCE FRAMEWORK (BAF)	**Area(s):**	*(eg 3)*	*(eg Governance)*					
	Priority Area(s):	*(eg 3c)*	*(eg Governance & assurance framework)*					
Current Risk Status: ***(please indicate with X)***	**Extreme**		**High**	**X**	**Moderate**		**Low**	
Movement since last month: ***(please indicate with X)***	↑		↔		↓	**X**		
Current position including action required:								

Appendix 1 Options and Risks

Future Contracting Options

Option 1 – Extend Current AQP Contracts for MSK (back and neck) and podiatry services for one year (with a 3 month notice clause) pending the transition of these services to the outcomes based commissioning contract which is planned to start from April 2016. This will allow for the OBC CP to continue with the existing arrangements from 1 April 2016 for transition during 2016-17.	
Benefits	**Disadvantages and Risks**
Continuation and consistency of provision of MSK back and neck and podiatry services	Other providers may wish to become an AQP provider, however it is felt that RCCG can justify retaining only the current providers during the contract extension period based on the plan to align with OBC CP in 2016-17.
Maintain patient choice of provider	
These services can be aligned with transition of community services to OBC from April 2016	
Option 2 – Allow contracts to end and re-procure for MSK and podiatry services	
Benefits	**Disadvantages**
Potential for better value for money	Lack of time and resource available for full re-procurement plus costs associated with a re-procurement exercise
	Does not align with proposed OBC plans which are due to incorporate all community services from April 2016
Option 3 – Return MSK and Podiatry to HRCH block contract and do not extend AQP contracts with other providers.	
Benefits	**Disadvantages**
Amount of resource needed for monitoring and inspection would be	Not consistent with NHSE strategy to introduce AQP providers to enable

reduced.	patient choice
	Potential for large increase in waiting times – some current providers able to see patients within 24 hours.
	HRCH may not be able to resource at an adequate level at short notice
	Removal of patient choice of provider

3.6 **Recommendation is to choose Option 1**

3.6.1 Option 1 provides the best solution. This would allow current providers who choose to do so, to continue to provide services under these contracts. This would maintain patient choice of provider which was one of the key reasons for NHS England setting up the AQP programme.

3.6.2 Due to the expected transition to Outcomes Based Commissioning during 2016-2017, it would not be appropriate to embark on a full procurement exercise for these services in the short term. This will allow for the OBC CP to continue with the existing arrangements from 1 April 2016 for transition during 2016-17.

3.6.3 The contract extension should include a 3 month termination clause in case the OBC CP is ready to proceed with different arrangements for these services during 2016-17.

Appendix 2

AQP Quality Review (July 2015) **23 October 2015**

Period under Review: Jan to March 2015 (4Q 2014-15) and April to June 2015 (1Q 2015-16)

As of 23/10/15: Responses received from all providers except St George's (MSK and Podiatry)

MSK Summary

Providers: Premier, Body Logic, HRCH, Forge Clinic, TICCS, St George's, Ravenscroft, Healthshare

(Note: TICCS is changing name from The Injury Care Clinics to The Integrated Care Clinics Ltd)

1. Timeliness of Appointments – urgent referrals seen within 72 hours, except for HRCH who see 90% within this timescale.
2. Timeliness of Appointments – most routine patients (approx 90%) generally offered appointments within timescale (10 days) but not necessarily seen within specified timescale due to patient choice.
3. Average wait for first appointment varies from 6 to 31 days (Jan to March 2015) and 6 to 15 (April to June 2015). Delays attributed to patient choice.
4. Between 96% to 100% of patients sampled (minimum 20%) had an individual care management plan.
5. Informal carers have not been identified.
6. Evidence of ethnic recording is variable.
7. All patients completed PROM (Patient Reported Outcome Measures) before treatment except for Healthshare who state all patients asked to complete PROM, but 89% completed in Q4 and only 59% in Q1.
8. Most patients completed PROM after treatment though HRCH percentages of completed PROMS were 75% and 79%. Healthshare had low percentage of patients who completed PROM after treatment, 23% and 42%, although they state that all patients asked to complete this as part of discharge process. Poor response is due to patients not attending follow up or final discharge appointments.
9. Patient Surveys – issued when patients discharged. Response rates vary from 40% to 100%. Some providers (HRCH) are taking extra measures to encourage patients to complete.

10. Overall satisfaction from patient survey is good, 95% to 100%.

11. Most providers have received a number of 'compliments' and submitted anonymised positive comments from surveys

12. 2 complaints – Healthshare and Forge Clinic – about process (eg appointment, discharge), not treatment. Both resolved.

Podiatry Summary

Providers: HRCH, Healthshare, Ravenscroft, St George's (not responded as at 23/10/2015)

1. HRCH have majority of referrals (over 1200 compared to next highest Healthshare (approx. 300)

2. Timeliness of appointments – patients seen within timescales for Ravenscroft and Healthshare but HRCH do not meet timescales: 50% urgent referrals offered appointment within 5 working days in 4Q, (though 100% in Q1) and 47% routine patients were offered an appointment within 10 working days.

3. Overall responses to improvement in mobility, foot pain and foot health average around 50% but all providers explain reasons for this – see HRCH comments below.

4. Informal carers generally not identified, except for HRCH.

5. Response rate to patient surveys is low.

6. Of those who responded to patient survey, overall satisfaction varies between 73% and 100%.

7. Compliments received by Healthshare and Ravenscroft

8. No complaints recorded.

General Comments were received from most Providers – particular issues shown below:

Body Logic (MSK)

It is a pity that with such high patient satisfaction levels, the NHS referrals are still such a small percentage of our patient caseload. Even after several years of AQP existence. It is my opinion that there are real problems with the referral process from GPs. Some GPs deny the existence of AQP for neck and back pain to their patients and I have highlighted this previously. Some GP's favour the provider who is renting a room from their GP practice and I have highlighted this previously.

Healthshare (MSK and Podiatry)

We have decided to undertake the majority of our patient surveys via phone interview as this has helped in increasing response rates in our other services and should do the same for this service. Hopefully this will be reflected in the next quality update that we send across to yourself.

Of the cohort surveys there were 2 patients who reported a 'highly dissatisfied' view with reference to the fact that they were unable to receive treated for a peripheral problem (knee's on both occasions) due in part that the service specification stipulating that treatment on peripheral joint problems is outside scope. On explaining the difference between AQP Neck and Back and All Body Parts AQP the patients understood the reasoning for our inability to treat a peripheral joint problem unrelated to their spinal problem and have decided to make representation to their GP's on the service scope.

HRCH

All patients had heard about AQP with 98% from their GP. Of this 70% reported they were **not** given a choice of provider.

Ref Podiatry survey questions: … However, it should be noted many podiatry patients have existing long-term conditions, which can be painful despite podiatry intervention. Patients often report their general pain levels in answer to this question, not necessarily in relation to the foot or our intervention. The majority of our patients (95%) report no change in their mobility. It should be noted that many patients report no mobility problems at the start of treatment, so it would be difficult to improve on this. Reporting of worsening pain or mobility could be due to health problems unrelated to the podiatry issue.

HRCH have queried why the contractual requirements of AQP MSK and podiatry services have much more demanding timescale requirements than the general MSK and podiatry services contracted with RCCG, potentially for more serious MSk and podiatry problems eg AQP referrals: urgent referrals to be seen within 3 days, routine referrals within 10 days for MSK and within 5 days for urgent and 10 days routine for podiatry; whereas general MSK and podiatry: urgent referrals to be seen within 5 days maximum (MSK), 3 days (podiatry), routine referrals within 8 weeks maximum for MSK and 4 weeks for podiatry.

HRCH state that issuing appointments within 10 days is an inefficient and costly process as most patients do not choose to make themselves available for appointments within this timescale and then need to rearrange. **HRCH recommend that patients be advised to phone to book an appointment at a date and time convenient to themselves, 48 hours after the referral has been made.**