Proposal for East Midlands Clinical Commissioning Groups Affiliated Commissioning

Executive Summary

1. There are a number of Clinical Commissioning Group (CCG) policies that are common across the East Midlands. Up until 2012 some of these policies used to be reviewed and updated by the former East Midlands Specialised Commissioning Group (EMSCG), supported by a Clinical Priorities Advisory Group (CPAG). Both these groups were established by the former Primary Care Trusts and disbanded as a result of the 2012 Health and Social Care Act. As a result of the Act a number of policies transferred to NHS England with others transferring to the CCGs.

2. With the demise of the above several CCG policies are now out of date and new policies are coming on line. At the current time every CCG needs to commit resource to update and/or produce policies. This is against a backdrop of competing priorities and limited resources both in manpower and finances.

3. Individual CCGs revising policies in isolation could result in a knock on effect to other CCGs in terms of quality, increased cost or equity of access. For example the In Vitro Fertilisation (IVF) policy limits the number of attempts a patient can have to access IVF. If a CCG agrees more or less than this number it could cause negative patient experience, a cost pressure, post code inequity and the potential for media and political interest.

4. The East Midlands CCG Accountable Officers are supportive of reinstating a revised structure to replicate the activities formerly undertaken by these groups with their powers. Therefore Governing Bodies (GB) are required to consider and ratify the establishment of the East Midlands Affiliated Commissioning Committee (EMACC) and a supporting Clinical Priorities Steering Group (CPSG).

5. The vision for EMACC is to: ‘Maximise resources, reduce duplication and ensure clinical and cost effective policies that improve the quality of care for patients’.

6. EMACC will have ways of working that will add value to CCG business. EMACC will approve policies that are worked up by CPSG described in the following scenario:
   a. If the In Vitro Fertilisation (IVF) policy didn’t exist and one was required, CPSG would invite all CCGs to take part in the development. A workshop would be held with representatives from all the East Midlands CCGs. This would include CCG non-executives, patients/public, clinical and non-clinical experts and managers for example public health, health economists, finance and contracting. This workshop would agree the final draft IVF policy for EMACC to ratify.

7. This scenario above demonstrates that these groups will reduce the need for 20 CCG teams and five public health departments to all do the same policy and reduces the need for 20 GBs to ratify the policy. However it assures GBs that full involvement and inclusion of CCG members has taken place.

8. CCG GBs are asked to consider the attached cover paper and appendices which include a number of recommendations requiring review and ratification.
East Midlands
NHS Clinical Commissioning Groups

Proposal for establishing
East Midlands Affiliated Commissioning Committee
### Amendment History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
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<tr>
<td>0.1</td>
<td>23-09-15</td>
<td>Shared with Lynn Sharp (LS), NHS Rushcliffe CCG Head of Governance</td>
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<td>1.1</td>
<td>23-09-15</td>
<td>Amended and issued to Vicky Bailey (VB) and LS for further comment and to discuss early legal advice</td>
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<td>1.2</td>
<td>05-11-15</td>
<td>Amended following workshop and issued to Craig Sharples (Governance), IFR leads - Jane Urquhart (JU), Andy Roylance (AR), Rose-Marie Usher (RM) Public Health (PH) - Jonathan Gribbin and legal - Browne Jacobson (BJ) for amend by 10-11-15</td>
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<td>1.3</td>
<td>10-11-15</td>
<td>Amended following Browne Jacobson and Jonathan Gribbin comments. For Vicky Bailey to review 11-11-15</td>
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<td>1.4</td>
<td>11-11-15</td>
<td>Amended and issued to BJ for final review before issue to Congress</td>
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<tr>
<td>1.5</td>
<td>10-12-15</td>
<td>Amended following Congress, final IFR and PH review. BJ review and amends added. Issued by VB to CCG AOs for CCG Governing Body consideration</td>
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### Approval

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<thead>
<tr>
<th>The following NHS Clinical Commissioning Group (CCG) Governing Bodies</th>
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<tbody>
<tr>
<td>Leicester City CCG</td>
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<td>West Leicestershire CCG</td>
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<td>East Leicestershire &amp; Rutland CCG</td>
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<td>South West Lincolnshire CCG</td>
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<td>Lincolnshire East CCG</td>
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<td>Lincolnshire West CCG</td>
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<td>Southern Derbyshire CCG</td>
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<td>Nottingham North &amp; East CCG</td>
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<td>Rushcliffe CCG</td>
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<td>Newark &amp; Sherwood CCG</td>
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<td>Mansfield &amp; Ashfield CCG</td>
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<td>Nene CCG</td>
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<td>Corby CCG</td>
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<td>Milton Keynes CCG</td>
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### Executive Summary

This paper proposes the establishment of a number of processes to implement affiliated commissioning for 20 East Midlands (EM) Clinical Commissioning Groups (CCGs) and makes a number of recommendations for CCG Governing Body members to consider, note or agree.

In the summer of 2015 CCG Chief Officers who are members of the Congress (referred to collectively as the “Congress”) supported the development of affiliated commissioning arrangements. The rationale is that for a number of policy areas there are reduced people resources available to undertake policy development and review existing, and often out of date, policies (Annex 1); CCGs are facing significant financial challenges and need to prioritise available resource on transformative change and the “postcode lottery” discourse and perceived risks of legal challenge.

Congress agreed that NHS Rushcliffe CCG should develop a proposal for affiliated commissioning for consideration.

This paper presents the draft terms of reference and accompanying papers as part of establishing the arrangements.

### Background

Since the NHS Reforms of 2012 the 20 East Midlands CCGs have not had a formal way of agreeing joint commissioning policies. The establishment of the Congress enabled CCGs to debate how commissioning can be strengthened collectively.

#### External and Legal Support

Recent changes to legislation allow for the establishment of joint committees between CCGs. The Congress has subsequently proposed that a joint committee could be established to develop common commissioning policies across the East Midlands.

NHS Rushcliffe CCG commissioned legal support and external consultancy to assist in the development of the proposal and terms of reference.

### Scope

This proposal only covers the CCG areas of commissioning and excludes all NHS England commissioning responsibilities.

### Proposal

Following a period of consultation with East Midlands CCG
Establishment of a formal decision making joint committee to be known as the East Midlands Affiliated Commissioning Committee (EMACC), operational from 1st April 2016. Draft Terms of Reference attached at Appendix 1.

- EMACC’s vision is to ‘Maximise resources, reduce duplication and agree clinical and cost effective policies that improve the quality of care for patients’;
- EMACC should be a formal joint committee with delegated responsibilities with managerial and clinical representatives from the 20 EM CCGs or their nominated geographical lead i.e. one managerial and one nominated clinical representative for each of Nottinghamshire, Derbyshire, Northamptonshire, Lincolnshire and Leicestershire;
- Once CCGs have agreed to be part of EMACC and it has been formally established with delegated authority from each CCG they will be bound by EMACC’s decisions;
- EMACC should have the authority to secure CCG resources from across the 20 CCGs on a fair shares basis;
- Decisions will be made by simple consensus, or where consensus cannot be reached, by simple majority vote of CCGs sitting on EMACC;
- EMACC and its supporting infrastructures will need to be hosted by one of the 20 CCGs;
- EMACCs Annual Work Programme should be ratified by all CCG Governing Bodies at the start of each financial year;
- Each CCG will need to review and amend their constitution to ensure that it appropriately references the new committee;
- The proposed start date for EMACC is 1st April 2016;
- It is proposed that EMACC has a review by internal audit after year one of it becoming operational.

**EMACC will need to establish a Clinical Priorities Steering Group (CPSG) who will be responsible for developing, reviewing and scrutinising policies for ratification by EMACC, CPSG:**

- Will not have any delegated powers and is an advisory and delivery group;
- Should have a standing membership which advises EMACC with the same Public Health and contract/commissioning managers and lay representation, linking to finance but it should also have the flexibility to engage additional individuals according to the policies being developed;
- Will prepare the Annual Work Programme for EMACC undertaking the detailed technical and clinical work required to develop the clinical policies within the programme;
- Should ensure that risks and mitigation, cost and clinical benefits of policies have been considered for every CCG member before recommending approval by EMACC;
- Should ensure that CCGs consult and communicate widely on changes and new policies;
- Will be proactive in calling on resources from all CCGs as required, allocating responsibilities, sharing out the Annual
Work Programme across the 20 CCGs to reduce duplication and draw on relevant expertise;
- Should be measured by approval of a policy by EMACC on first presentation;
- Will submit new and amended policies to CCGs for publication on their websites.
- Will support any other duties that EMACC require in order to discharge its responsibilities.

Changes to constitutions
It is anticipated that most of the CCGs will have amended their constitutions following the introduction of the power to create joint committees at the start of this year using the (non-mandatory) model wording released by NHS England (Appendix 4). However, each CCG will be required to review their constitution and confirm that it allows them to create joint committees before EMACC can be formally established.

If CCG Governing Bodies ratify the terms of reference for EMACC they will also be giving delegated authority to EMACC to establish CPSG. The draft terms of reference have been through legal review and are compliant with legislation

Hosting arrangements
To agree the final arrangements it is proposed that Congress agrees to one CCG hosting the development of EMACC and that CCG appoints an interim, independent, lay chair from 1st January 2016 to 31st March 2016. This chair will be responsible for engaging all CCG Chairs and Clinical Leads to agree the final terms of reference and changes to constitutions by CCG Governing Bodies before 1st April 2016. The draft job description for the chair is attached at Appendix 2.

Costs
The estimated costs in developing this proposal are in Appendix 3. It is recommended that costs are shared across the 20 CCGs which are expected to be off-set by the impact of EMACC in the increased efficiency of policy review and development.

Consultation
Local consultation
A workshop was held to develop the proposal on the 4 November 2015, with attendees from all EM CCGs, Individual Funding Request (IFR) leads, public health leads, patient representative, commissioning GPs and legal experts.

The case for change debated the policies covering non-specialised treatments which were originally developed by the former East Midlands Specialised Commissioning Group (EMSCG), which was disbanded following the reforms.

Attendees agreed the need to secure consistency of thresholds across the whole region, using a ‘do-once’ approach, for example in relation to policies such as cosmetic procedures, surrogacy and Gamete cryopreservation. These policies and others (Annex 2) are now out of date, beyond their review date or require amendment.
due to new evidence. The former EMSCG was successful in undertaking this function on behalf of East Midlands former Primary Care Trusts and with its demise the process in now undertaken by individual CCGs with the resulting risks highlighted below.

| Risks and benefits | The benefits of establishing formal arrangements for affiliated commissioning include maximising efficiencies, reducing duplication, removing the postcode allocation and maximising the commissioning of quality services. It was also agreed that EMACC would provide a collective, region wide voice that supports the evidence to change policies that may be subject to high profile challenge. All public health departments have confirmed their full support and input into this development and see it as fundamental to the review and development of robust policies.

The risks to establishing these arrangements include the negative financial impact a decision may have on a local CCG and the alignment with current hosted arrangements for other areas, such as IFR. The workshop attendees felt that these risks could be mitigated by ensuring that the governance arrangements include no responsibility for financial limits and clear roles and responsibilities outlined in the voting arrangements.

Subject to the above mitigation the recommendation from those who attended the workshop was that EMACC should be established.

| Recommendations | The Congress is asked to: CONSIDER the draft terms of reference (Appendix 1) and if supported;
- **AGREE** to recommend to each participating CCG that EMACC be established as a formal joint committee with delegated powers under section 14Z3 of the NHS Act 2006;
- **AGREE** to recommend which CCG will host EMACC;
- **AGREE** to recommend the appointment of an interim chair by the host CCG set out in Appendix 2;
- **AGREE** to recommend that each CCG approves the terms of reference by 1\textsuperscript{st} April 2016, set out at Appendix 1;
- **AGREE** to recommend that each CCG approves the funding of EMACC as set out in Appendix 3;
- **NOTE** the establishment of EMACC may require amendments to each CCG’s Constitution by 1\textsuperscript{st} April 2016;
- **NOTE** the commencement date of EMACC of 1\textsuperscript{st} April 2016;
- **NOTE** that EMACC will be subject to an internal audit review after one year.

If the above recommendations are agreed each Chief Accountable Officer of the Congress is asked to:
- **NOTIFY** the Host accountable CCG when their CCG GB has:
  a) Approved the establishment of EMACC, including the host arrangements and appointment of the interim chair;
  b) Approved the terms of reference set out in Appendix 1 and funding in Appendix 3;
  c) Confirmed that any necessary amendments have been made to their constitution in order for EMACC to be
established as a joint committee with delegated powers with effect from 1st April 2016.

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<td>2016/17 Recurrent £72,232</td>
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<td>Expected to be recovered and deliver efficiencies</td>
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<tr>
<th>Appendices</th>
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<tr>
<td>Appendix 1: EMACC Draft Terms of Reference</td>
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<tr>
<td>Appendix 2: Draft Chair Job Description</td>
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<td>Appendix 3: Funding</td>
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<td>Appendix 4: NHS England Guidance on Constitution Changes</td>
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East Midlands Affiliated Commissioning Committee

Draft Terms of Reference

1. Introduction

20 East Midlands Clinical Commissioning Groups (CCG) wish to establish a joint committee which enables the CCGs to work collaboratively on the development and maintenance of:

- Policies for services which CCGs have responsibility for commissioning; and
- New policies identified as being appropriate for identical implementation on a regional scale.

Accordingly the East Midlands Affiliated Commissioning Committee ("EMACC") has been established as a joint committee of the 20 East Midlands CCGs in accordance with section 14Z3 of the NHS Act 2006 and the constitutions of each of the CCGs listed in Annex 1 (the "Participating CCGs").

The terms of reference set out the membership, remit, responsibilities and reporting arrangements of EMACC.

2. Vision

The vision for EMACC is to:
Maximise resources, reduce duplication and ensure clinical and cost effective policies that improve the quality of care for patients.

3. Principles

The EMACC decisions will be based on the following principles:

- **Optimise Health Outcomes:** To agree policies that aim to achieve the greatest possible improvement in health outcomes for the East Midlands population within the resources that are available;
- **Clinical Effectiveness:** Ensure that the decisions are based on sound evidence of clinical effectiveness;
- **Cost Effectiveness.** Take into account cost-effectiveness analyses of healthcare interventions (where available) to assess which interventions yield the greatest benefits relative to the cost of providing them as part of agreeing policies;
- **Equity.** Operate within the context of each individual within the East Midlands population being of equal value;
- **Access.** Ensure that policy decisions reflect the need for care to be delivered as close to where patients live as possible;
- **Patient Choice.** Respect the right of individuals to determine the course of their own lives, including the right to be fully involved in decisions concerning their health care. However, this has to be balanced against the responsibility to ensure equitable and consistent access to appropriate quality healthcare for all the population;
- **Affordability.** Not agree policies that may not be able to afford all interventions supported by evidence of clinical and cost-effectiveness within the available resources. Where this is the case, advise CCGs to undertake further prioritisation based on criteria including national and local policies and strategies, local assessment of the health needs of the population, to ensure that the CCGs do not exceed their available resources;
4. **Host arrangements and funding**

The Participating CCGs have agreed that [INSERT NAME] CCG will be the initial CCG Host of EMACC and that it will employ the chair and supply any other staff required to provide managerial and administrative support for EMACC (the “Host CCG”). Hosting arrangements will be agreed annually as part of the Annual Work Programme (as defined below).

The costs of the above employees, administrative support and audit and governance arrangements are funded by all of the Participating CCGs.

The budget is agreed annually by the Participating CCGs as part of the Annual Work Programme and the agreed budget is then apportioned amongst the participating CCGs on a capitated basis.

5. **Membership**

The members of EMACC shall be as follows:

**Voting members:**
- Independent Chair.
- 1 x CCG clinical representative from each Participating CCG nominated by their respective Governing Bodies (“CCG Representative”).
- 1 x CCG non-clinical representative from each Participating CCG nominated by their respective Governing Bodies (“CCG Representative”).

The CCG Representatives may appoint a deputy to attend on their behalf (“Nominated deputy”).

The CCG Representatives may also agree to appoint 1 regional representative for each geographical area to attend and vote on behalf of all of the Participating CCGs provided that any such appointing CCG Representative is entitled to revoke this appointment and attend and vote at meetings themselves at any time should he or she wish to do so.

**Non-voting members**
- Senior Officer of the Clinical Priorities Steering Group (as defined below).
- Public and Patient CCG representative.

**Co-optees**

The Chair may co-opt such other individuals as may be required from time to time including, for example, but not limited to:
- EMACC Commissioning Manager.
- Topic experts, clinical and non-clinical.
- Director of Commissioning.
- Director of Finance.
- Directors of Nursing/Quality.

- **Disinvestment.** As well as agreeing new policies on the basis of the criteria above, EMACC will keep policies under constant review to ensure that they continue to deliver clinical and cost-effective services at affordable cost;
- **Quality:** EMACC will aim to agree policies that offer high quality services as evidenced against national and international best practice.
<table>
<thead>
<tr>
<th><strong>6. Chair and Vice Chair</strong></th>
<th>The Chair of EMACC will be an independent lay member and the Vice Chair will be a CCG Representative. They will be appointed by the Host CCG. In the event of the Chair being unable to attend all or part of the meeting the Vice Chair will deputise.</th>
</tr>
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<tbody>
<tr>
<td><strong>7. Quorum</strong></td>
<td>No business shall be transacted at any meeting unless a quorum is present. A quorum will be the Chair or Vice Chair and one clinical or non-clinical CCG Representative from each of the five geographical regions of Nottinghamshire, Derbyshire, Leicestershire, Lincolnshire and Northamptonshire</td>
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<tr>
<td><strong>8. Attendees</strong></td>
<td>The Chair may invite representatives from the following areas to attend as may be required from time to time including (but not limited to):  • CCG Chief Accountable Officers/Chief Operating Officers.  • Patient/public leader/expert representatives.  • Directors of Public Health (local authority and/or Public Health England).  • Communications and Engagement.  • Representatives for an area of business under review or with experience or expertise pertinent to a particular topic.</td>
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<tr>
<td><strong>9. Frequency and conduct of business</strong></td>
<td>EMACC will meet at least three times a year and meetings will be held in April, September and January. Meetings (including extraordinary meetings) shall be convened at the discretion of the Chair. Meetings will be organised and supported by the Host CCG. An agenda and supporting papers will be issued to Members not less than five working days before the meeting dates.</td>
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<tr>
<td><strong>10. Authority</strong></td>
<td>The EMACC has delegated authority from each of the Participating CCGs in accordance with section 14Z3 of the NHS Act 2006 to:  • Undertake the responsibilities listed in paragraph 11 (below)  • Seek any information it requires in order to discharge its duties from any source;  • Seek information from any of the CCG’s employees;  • Secure support from each Participating CCG to ensure they commit officers who are competent, available, authorised to represent and negotiate the CCG’s position to input fully to the delivery of the Annual Work Programme;  • Call on the obligation of Local Authority Public Health to support delivery of the Annual Work Programme under the CCG Memorandum of Understanding with Public Health in Local Authorities;  • Establish and oversee a Clinical Priorities Steering Group (CPSG) which will support delivery of any EMACC’s duties and responsibilities;  • Direct CPSG to adopt task and finish processes to deliver the Annual Work Programme calling on subject matter experts to develop, review and amend policies. For further details regarding CPSG please refer to paragraph 13</td>
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11. Responsibilities

The principal duties of the EMACC are to:

- Recommend the Annual Work Programme (Annex 2) which will set out the policies to be developed by EMACC for approval by the governing bodies of the Participating CCGs by 31st March every year (“Annual Work Programme”);
- Make binding decisions on clinical policies delegated by the Participating CCGs in the Annual Work Programme (which may include (without limitation) some or all of the policies listed in Annex 2 which were in place prior to the 2012 NHS reforms);
- Make binding decisions on clinical policies that are outside the Annual Work Programme in year where the EM CCGs determine that they fall within EMACC’s remit (in the future these may include, but are not limited to, the policies set out in Parts 2 and 3 of Annex 2);
- Receive and/ consider recommendations from the CPSG;
- Agree decisions using a recognised and validated process for assessment based on evidence, quality, value for money, equality and inequality with due regard to the need to act transparently and ensure a robust decision making process;
- Take or arrange for all necessary steps to be taken to enable CCGs to comply with their statutory duties including (but not limited to) the quality and choice of health care provision, working to the NHS Constitution;
- Manage and update risk and conflict of interest registers;
- Ensure a shared commitment to improving quality, reducing inequalities and ensuring that collective resources secure a sustainable NHS that does not disadvantage or destabilise the resources required to discharge the functions;
- Promote partner organisations contribution to the production of robust policies;
- Engage patients and the public in the development and maintenance of the policies;
- Provide opportunity for shared learning and development across the local system that result in improved practice and better outcomes for the population;
- Provide the mechanism through which consensus can be built between the CCGs;
- Agree communications and ways of working as part the implementation of the decisions made;
- Establish and annually review the terms of reference for the CPSG;
- Publish meetings and minutes and an annual overview for inclusion in the Host CCG’s public annual report; and
- Deliver the Annual Work Programme on time and within the annual budget set by the Participating CCG’s as part of the Annual Work Programme.

12. Voting and decision making

Decisions will normally be made by consensus of the CCG Representatives. Where this is not possible a vote of the CCGs Representatives will take place. The process is:

- One CCG Representative one vote;
- A simple majority vote of CCG Representatives present and eligible to vote;
- Nominated Deputies shall have the same voting rights as the full CCG Representative;
- The presiding Chair will have the casting vote;
- CCG Representative’s voting against a decision or abstaining but in the minority may request the minutes reflect their position. Other attendees are not entitled to vote.

13. Sub groups

EMACC has established a delivery group to assist EMACC’s delivery of the responsibilities listed in paragraph 11: The Clinical Priorities Steering Group (“CPSG”) will not have any delegated powers and is an advisory and delivery group. CPSG:
- Should have a standing membership which advises EMACC with the same Public Health and contract/commissioning managers and lay representation, linking to finance but it should also have the flexibility to engage additional individuals according to the policies being developed;
- Will prepare the Annual Work Programme for EMACC undertaking the detailed technical and clinical work required to develop the clinical policies within the programme;
- Should ensure that risks and mitigation, cost and clinical benefits of policies have been considered for every CCG member before recommending approval by EMACC;
- Should ensure that CCGs consult and communicate widely on changes and new policies;
- Will be proactive in calling on resources from all CCGs as required, allocating responsibilities, sharing out the work programme across the 20 CCGs to reduce duplication and draw on relevant expertise;
- Will submit new and amended policies to CCGs for publication on their websites
- Should be measured by approval of a policy by EMACC on first presentation;
- Will advise CCGs on publication of amended and new policies for their websites;
- Will support any other duties that EMACC require in order to discharge its responsibilities.

14. Reporting

The EMACC will report to each CCG Governing Body following each meeting. Such reports will be prepared and circulated to all Participating CCGs by the Host CCG (following approval by the Chair) and will compromise the minutes of the meeting, summary of action taken since the last report, up to date risk register and an up to date conflicts of interest register. Minutes of the meeting will be available as requested and published publicly on the Host CCG website.

The work of EMACC will be subject to regular monitoring by the Host CCG Audit Committee, which will undertake at least one formal review in the first year as part of its assurance function.

15. Declaration of Interest and Register of Procurement Decisions

The Host CCG will maintain and keep up to date a conflicts of interest register on behalf of EMACC.

Members are required to declare any interests which relate to a particular issue under consideration as soon as they become aware of it and at the start of each meeting. Any such declaration will be formally recorded in the minutes (along
with details of the action taken to address the conflict) and declaration of interest forms completed for the Register of Interests. The Chair’s decision regarding a Member’s participation, or that of any attendee, in any meeting will be final. The Chair’s decision regarding a Member’s participation in a meeting (or part of a meeting) and, in the case of a CCG Representative, their entitlement to vote in a meeting will be final.

If the Chair has a conflict of interest the Vice Chair shall make a decision regarding their participation and that decision shall be final.

16. Conduct

Members and attendees will act in accordance with all applicable laws and guidance and relevant codes of conduct/good governance practice, and shall comply with the Host CCG’s Conflict of Interest Policy.

17. Review of the Terms of Reference

The EMACC Terms of Reference will be reviewed annually by the EM CCG Congress.

Any changes to these Terms of Reference which are proposed by the EM CCG Congress must be approved by the Governing Bodies of the Participating CCGs before they are deemed to take effect.

Final EM CCG Governing Body Approval Date: TBC
Review Date:
Ref: TM\ToR\EMACC v1.5: 25-11-15
Annex 1

Participating CCGs

1. NHS Leicester City CCG
2. NHS West Leicestershire CCG
3. NHS East Leicestershire & Rutland CCG
4. NHS South West Lincolnshire CCG
5. NHS Lincolnshire East CCG
6. NHS South Lincolnshire CCG
7. NHS Lincolnshire West CCG
8. NHS Southern Derbyshire CCG
9. NHS North Derbyshire CCG
10. NHS Erewash CCG
11. NHS Hardwick CCG
12. NHS Nottingham City CCG
13. NHS Nottingham West CCG
14. NHS Nottingham North & East CCG
15. NHS Rushcliffe CCG
16. NHS Newark & Sherwood CCG
17. NHS Mansfield & Ashfield CCG
18. NHS Nene CCG
19. NHS Corby CCG
20. NHS Milton Keynes CCG
### Affiliated Policies – Potential Areas for the Annual Work Programme

#### Clinical Policies

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<tr>
<td>Sacral Nerve Stimulation (for CCG commissioned elements)</td>
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<tr>
<td>Orthotic functional electrical stimulation for foot drop of neurological origin</td>
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<tr>
<td>Hip Arthroscopy all pathologies</td>
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<tr>
<td>East Midlands Regional Adult Cosmetics policy</td>
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<td>Individual Funding Requests</td>
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<td>Surrogacy</td>
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<td>Gastric Electrical Stimulation</td>
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<td>Gamete Cryopreservation</td>
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<td>Use of Bone Morphogenetic proteins</td>
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<tr>
<td>In Vitro Fertilisation (IVF)/Intracytoplasmic Sperm Injection (ICSI) within Tertiary Infertility Services</td>
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#### Non-Clinical Policies

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<td>Frameworks for reviewing and agreeing policies at CPWG</td>
</tr>
<tr>
<td>Orphan Drugs</td>
</tr>
<tr>
<td>Experimental and Unproven treatments</td>
</tr>
<tr>
<td>Defining the Boundaries between NHS and private treatments</td>
</tr>
<tr>
<td>Patients changing responsible commissioner</td>
</tr>
<tr>
<td>Ongoing access to treatment following a ‘trial of treatment’ which has not been sanctioned by the responsible CCG for a treatment not routinely funded or which has not been formally assessed and prioritised.</td>
</tr>
<tr>
<td>Ongoing access to treatment following completion of non commercially funded trials, third party funded treatment</td>
</tr>
<tr>
<td>Use of cost effectiveness, value for money and cost effectiveness thresholds</td>
</tr>
<tr>
<td>Commissioning policy for guidance produced by the National Institute of Clinical Excellence.</td>
</tr>
<tr>
<td>The role of commissioners in the evaluation of individual treatments and the funding of clinical research.</td>
</tr>
<tr>
<td>Priority setting and decision making</td>
</tr>
<tr>
<td>NHS pick-up of Drug Company sponsored treatments</td>
</tr>
<tr>
<td>In year service developments and the CCG approach to treatments not yet assessed and prioritised</td>
</tr>
<tr>
<td>Prior Approval</td>
</tr>
<tr>
<td>Policy for Policies</td>
</tr>
</tbody>
</table>
DRAFT JOB DESCRIPTION

JOB TITLE: Independent Chair, East Midlands Affiliated Commissioning Committee.


Salary Grade: Starting from £500/day, negotiable depending on experience, excluding travel and sundry expenses.

Accountable to: Accountable Officer, NHS [insert name] CCG.

Hours of Duty: 10 days per annum (with a commitment to be flexible if significant tasks arise), to be appraised and reviewed on an annual basis.

MAIN PURPOSE:

1. To provide independent leadership and strategic vision to the East Midlands CCGs on agreed affiliated policies.
2. To chair the East Midlands Affiliated Commissioning Committee (EMACC).
3. To deliver the vision for EMACC that is to ‘maximise resources, reduce duplication and ensure clinical and cost effective policies that improve the quality of care for patients’.

KEY RESPONSIBILITIES:

1. Recommend the Annual Work Programme which will set out the policies to be developed by EMACC for approval by the governing bodies of the Participating CCGs by 31st March every year (“Annual Work Programme”);
2. Make binding decisions on clinical policies delegated by the Participating CCGs in the Annual Work Programme;
3. Make binding decisions on clinical policies that are outside the Annual Work Programme in year where the EM CCGs determine that they fall within EMACC’s remit;
4. Establish and oversee a Clinical Priorities Steering Group (CPSG) which will support delivery of any EMACC’s duties and responsibilities;
5. Annually review the terms of reference for the CPSG;
6. Direct CPSG to adopt task and finish processes to deliver the Annual Work Programme calling on subject matter experts to develop, review and amend policies.
7. Receive and/ consider recommendations from the CPSG;
8. Agree decisions using a recognised and validated process for assessment based on evidence, quality, value for money, equality and inequality with due regard to the need to act transparently and ensure a robust decision making process;
9. Take or arrange for all necessary steps to be taken to enable CCGs to comply with their statutory duties including (but not limited to) the quality and choice of health care provision, working to the NHS Constitution;
10. Manage and update risk and conflict of interest registers;
11. Ensure a shared commitment to improving quality, reducing inequalities and ensuring that collective resources secure a sustainable NHS that does not disadvantage or destabilise the resources required to discharge the functions;
12. Promote partner organisations contribution to the production of robust policies;
13. Engage patients and the public in the development and maintenance of the policies;
14. Provide opportunity for shared learning and development across the local system that result in improved practice and better outcomes for the population;
15. Provide the mechanism through which consensus can be built between the CCGs;
16. Agree communications and ways of working as part the implementation of the decisions made;
17. Publish meetings and minutes and an annual overview for inclusion in the Host CCG’s public annual report;
18. Deliver the Annual Work Programme on time and within the annual budget set by the Participating CCG’s as part of the Annual Work Programme.
19. Seek any information required in order to discharge duties from any source;
20. Seek information from any of the CCG’s employees;
21. Secure support from each Participating CCG to ensure they commit officers who are competent, available, authorised to represent and negotiate the CCG’s position to input fully to the delivery of the Annual Work Programme;
22. Call on the obligation of Local Authority Public Health to support delivery of the Annual Work Programme under the CCG Memorandum of Understanding with Public Health in Local Authorities;
23. Ensure the committee works collaboratively and effectively by encouraging and supporting the development of partnership working between the partner members its sub-groups.
24. Liaise with the appropriate managers to ensure the timely and effective management of committee business within agreed budgets.
25. Link nationally and regionally to ensure that the activities are aligned with national policy expectations and other developing practice.
26. To continually review membership and sub groups to ensure it is effective and representative.
27. To ensure that the work of the committee is managed in line with the principles of promoting equality and respecting diversity for all.
28. To comply with any other duties as may be jointly agreed from time to time as necessary and appropriate to the role.

**Job Description prepared by:** Vicky Bailey, Accountable Officer, NHS Rushcliffe CCG

**Date:** 25 November 2015

**Agreed by Post holder:**

**Date:**
# Job Specification: Independent Chair

**Note to Applicants:**

The Essential Criteria are the qualifications, experience, skills or knowledge you MUST SHOW YOU HAVE to be considered for the job.

The How Identified column shows how the CCG will obtain the necessary information about you. If the How Identified column says the Application Form next to an Essential Criteria you MUST include in your application enough information to show how you meet this criteria. You should include examples from your paid or voluntary work.

<table>
<thead>
<tr>
<th>Experience</th>
<th>Essential (E) or Desirable (D)</th>
<th>A How Identified: A: Application Form; I: Interview, R: Reference, P: Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leading and managing in a large public or independent or voluntary organisation at a senior level to command respect within a multi-partner committee of agency senior representatives.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Sufficient experience of the operational context of commissioning work to enable well-rounded contributions to policies</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Experience of chairing complex professional meetings at a senior level and ability to chair in an efficient manner.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Experience of working across organisations and professional boundaries and collaborative and partnership working.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Experience of working with members of the public in order to improve services.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Experience of managing strategic and operational change.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Experience of developing performance management across a complex organisational structure</td>
<td>E</td>
<td>A, I, R</td>
</tr>
</tbody>
</table>

**b) Training and Qualifications**

<table>
<thead>
<tr>
<th>Training and Qualifications</th>
<th>Essential (E) or Desirable (D)</th>
<th>A How Identified: A: Application Form; I: Interview, R: Reference, P: Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant professional qualification of sufficient standing to command professional respect</td>
<td>E</td>
<td>A, R</td>
</tr>
<tr>
<td>Clinical qualification</td>
<td>D</td>
<td>A</td>
</tr>
</tbody>
</table>

**c) Knowledge and Understanding**

Applicants should be able to demonstrate knowledge and understanding of the following areas relevant to the post

<table>
<thead>
<tr>
<th>Knowledge and understanding of developments in CCGs and their commissioning responsibilities</th>
<th>Essential (E) or Desirable (D)</th>
<th>A How Identified: A: Application Form; I: Interview, R: Reference, P: Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of appropriate corporate governance frameworks</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Knowledge of structure and functioning of large organisations</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>An understanding of funding and accountability in the public sector</td>
<td>E</td>
<td>A, I, R, P</td>
</tr>
<tr>
<td>Knowledge of performance management and quality assurance systems and operational environment</td>
<td>E</td>
<td>A</td>
</tr>
<tr>
<td>Knowledge of the key drivers and influences on public services and partners</td>
<td>E</td>
<td>A, I, R, P</td>
</tr>
<tr>
<td>Knowledge and understanding of administrative processes supporting CCG organisations.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
</tbody>
</table>

**d) Personal Skills, Abilities and Competencies**

Applicants should be able to provide evidence that they have the necessary skills and abilities
<table>
<thead>
<tr>
<th>Required</th>
<th>E</th>
<th>A, I, R, P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairing skills: ability to organise, coordinate and follow through on key decisions; manage competing or differing views and positively challenge to achieve the desired outcome.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to influence key stakeholders and decision makers</td>
<td>E</td>
<td>A, I, R, P</td>
</tr>
<tr>
<td>Effective communication skills: interpersonal, presenting, media relations, maintaining a positive public and professional profile, sufficient to represent the CCGs effectively to the media &amp; other forums as required.</td>
<td>E</td>
<td>A, I, R, P</td>
</tr>
<tr>
<td>Effective problem solving skills: Able to identify issues and areas of risk and lead partners to effective resolution and decision.</td>
<td>E</td>
<td>A, I, R, P</td>
</tr>
<tr>
<td>Skills in negotiating to assist in managing and resolving conflict</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Ability to generate and develop good working relations across member organisations</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Ability to influence senior personnel and liaise with political representatives</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Ability to recognise discrimination in its many forms and promote Equal Opportunities policies within the operation of the committee</td>
<td>E</td>
<td>A</td>
</tr>
<tr>
<td>Ability to ensure high standards of confidentiality in terms of sensitive cross-organisational matters.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>The ability to be self-motivating and able to operate outside of single agency hierarchal structure.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Assertive, clear thinking and able to negotiate.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Conversant with and able to use information technology systems.</td>
<td>E</td>
<td>A</td>
</tr>
<tr>
<td>e. Attitude/Motivation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enthusiasm, commitment and a determination to carry forward a complex agenda.</td>
<td>E</td>
<td>A, I, R, P</td>
</tr>
<tr>
<td>Commitment to improving outcomes for patients</td>
<td>E</td>
<td>A, I, R, P</td>
</tr>
<tr>
<td>Ability to enthuse and gain the commitment of others.</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>Commitment to principles of promoting equality and respecting diversity</td>
<td>E</td>
<td>A, R</td>
</tr>
<tr>
<td>f. Availability:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have the flexibility to carry out the required tasks and duties.</td>
<td>E</td>
<td>A, R</td>
</tr>
<tr>
<td>Be accessible to Members outside of committee meetings</td>
<td>E</td>
<td>A, I, R</td>
</tr>
<tr>
<td>g. Physical Requirements:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where the applicant/post holder has a disability every effort will be made to make reasonable adjustments to enable them to carry out the duties of the post.</td>
<td>E</td>
<td>A, I</td>
</tr>
<tr>
<td>It may be necessary to travel within and outside the region in order to attend meetings, conferences, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Funding

Forecast costing for developing affiliated commissioning across the East Midlands

<table>
<thead>
<tr>
<th>Item</th>
<th>Costs</th>
<th>Non Recurrent 2015-16</th>
<th>Recurrent 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Support</td>
<td>x8 days @ £650</td>
<td>5,200</td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td>not inc. VAT</td>
<td>5,000</td>
<td>1,000</td>
</tr>
<tr>
<td>Interim Chair</td>
<td>10 days up to March 2016, £1,000/day</td>
<td>10,000</td>
<td></td>
</tr>
<tr>
<td>Chair</td>
<td>10 days/year, £1000/day</td>
<td>10,000</td>
<td></td>
</tr>
<tr>
<td>Management support B7</td>
<td>WTE 0.5</td>
<td></td>
<td>21,197</td>
</tr>
<tr>
<td>A&amp;C B4</td>
<td>WTE 0.5</td>
<td></td>
<td>12,035</td>
</tr>
<tr>
<td>Topic experts</td>
<td>20 days/year @ £500</td>
<td></td>
<td>10,000</td>
</tr>
<tr>
<td>Communication</td>
<td>10 days @ £300</td>
<td></td>
<td>3,000</td>
</tr>
<tr>
<td>Non Pay and overheads</td>
<td></td>
<td></td>
<td>15,000</td>
</tr>
<tr>
<td><strong>Total 2015/16 N/R</strong></td>
<td><strong>20,200</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total 2016/17 Recurrent</strong></td>
<td><strong>72,232</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To support communication if policy changes are challenged

Assumes benefits realised offsets costs
Model wording for amendments to Clinical Commissioning Groups’ constitutions

November 2014

Publications Gateway ref no. 02422
Model wording for amendments to clinical commissioning groups’ constitutions

Note to accompany template document
1. The template documents have been developed to help minimise the work involved for CCGs.

2. When the nature of the co-commissioning required has been determined the use of the template documents will be considered. That could mean they are adapted or amended in light of your specific governance arrangements.

Template constitution amendment

3. The template constitution amendment sets out three clauses that CCGs may wish to adopt. The clauses cover the following:
   • Joint commissioning arrangements with other CCGs
   • Joint commissioning arrangements with NHS England in relation to CCG functions
   • Joint commissioning arrangements with NHS England in relation to NHS England functions

4. Some CCGs may already have a clause similar to the first template clause (joint commissioning arrangements with other CCGs). However, what is new is the provision for the establishment of a joint committee between CCGs.

5. The other two clauses provide for joint working with NHS England in two instances, as follows:
   a. The first is where the CCG wants NHS England to be involved in relation to the exercise of its (i.e. the CCG’s) functions.
   b. The second is where NHS England and a CCG either jointly exercise NHS England functions or where a CCG is given delegated authority to exercise NHS England functions.

6. Where a CCG is working collaboratively, it is recommended that the detailed arrangements for that joint working are set out in a terms of reference document (see below). Where a delegation has been made by NHS England, there will also be a formal delegation document and a detailed agreement between the parties setting out the terms and conditions of the delegation.

Template terms of reference

7. A template terms of reference document for joint commissioning arrangements has been developed for CCGs to use. This establishes a joint committee and sets out the things that would need to be considered and addressed when establishing such a committee.

8. We have also developed a template terms of reference document for the establishment of a CCG committee in the context of delegated commissioning.

9. As with the constitution amendment, these templates do not have to be adopted in their entirety and can be altered as appropriate to fit the specific requirements of the CCG(s) in question.

10. The template terms of reference and delegation documents will be included as annexes to Next Steps when it is published on 10 November 2014.
[1.1] the clinical commissioning group (CCG) may wish to work together with other CCGs in the exercise of its commissioning functions.

[1.2] The CCG may make arrangements with one or more CCG in respect of: [1.2.1] delegating any of the CCG’s commissioning functions to another CCG; [1.2.2] exercising any of the commissioning functions of another CCG; or [1.2.3] exercising jointly the commissioning functions of the CCG and another CCG

[1.3] for the purposes of the arrangements described at paragraph [1.2], the CCG may:
[1.3.1] make payments to another CCG;
[1.3.2] receive payments from another CCG;
[1.3.3] make the services of its employees or any other resources available to another CCG; or
[1.3.4] receive the services of the employees or the resources available to another CCG.

[1.4] Where the CCG makes arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.

[1.5] for the purposes of the arrangements described at paragraph [1.2] above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 1.2.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

[1.6] Where the CCG makes arrangements with another CCG as described at paragraph [1.2] above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:
• How the parties will work together to carry out their commissioning functions;
• the duties and responsibilities of the parties;
• How risk will be managed and apportioned between the parties;
• Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
• Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

[1.7] The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph [1.2] above.

[1.8] The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

[1.9] Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

[1.10] The governing body of the CCG shall require, in all joint commissioning arrangements, that the lead clinician and lead manager of the lead CCG make a quarterly written report to the governing body and hold at least annual engagement events to
review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

[1.11] Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year.


[2.1] The CCG may wish to work together with NHS England in the exercise of its commissioning functions.

[2.2] The CCG and NHS England may make arrangements to exercise any of the CCG’s commissioning functions jointly.

[2.3] The arrangements referred to in paragraph [2.2] above may include other CCGs.

[2.4] Where joint commissioning arrangements pursuant to [2.2] above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

[2.5] Arrangements made pursuant to [2.2] above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

[2.6] Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph [2.2] above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements; and

[2.7] The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph [2.2] above.

[2.8] The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

[2.9] Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

[2.10] The governing body of the CCG shall require, in all joint commissioning arrangements that [insert who] of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.
[2.11] Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.


[3.1] The CCG may wish to work with NHS England and, where applicable, other CCGs, to exercise specified NHS England functions.

[3.2] The CCG may enter into arrangements with NHS England and, where applicable, other CCGs to:
- Exercise such functions as specified by NHS England under delegated arrangements;
- Jointly exercise such functions as specified with NHS England.

[3.3] Where arrangements are made for the CCG and, where applicable, other CCGs to exercise functions jointly with NHS England a joint committee may be established to exercise the functions in question.

[3.4] Arrangements made between NHS England and the CCG may be on such terms and conditions (including terms as to payment) as may be agreed between the parties.

[3.5] For the purposes of the arrangements described at paragraph [3.2] above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

[3.6] Where the CCG enters into arrangements with NHS England as described at paragraph [3.2] above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:
- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

[3.7] The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph [3.2] above.

[3.8] The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

[3.9] Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

[3.10] The governing body of the CCG shall require, in all joint commissioning arrangements that the [insert who] of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.
[3.11] Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.

---ENDS---