NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group
Governing Body
Paper Summary Sheet
Date of Meeting: 28 March 2017

For: PUBLIC session ☒ **PRIVATE Session** ☐

For: Decision ☐ **Discussion** ☐ **Noting** ☒

Agenda Item and title:	GOV/17/03/18 Items as Approved at the Audit and Assurance Committee
Author:	David Noyes – Director of Planning, Performance and Corporate Services
Lead Director/GP from CCG:	David Noyes – Director of Planning, Performance and Corporate Services
Executive summary:	The Audit and Assurance Committee is a standing sub-committee of the Governing Body, with delegated authority to oversee all aspects of internal controls, satisfying itself that appropriate processes are in place to provide the required assurance. The following items were approved at the Audit and Assurance Committee meeting held on 14 March 2017 and are brought to the Governing Body for ratification: • Audit and Assurance Committee meeting minutes – January 2017 • Procurement Strategy • Records Management Strategy • Board Assurance Framework and Risk Register The meeting was quorate and at least 3 Governing Body Members were present.
Evidence in support of arguments:	
Who has been involved/contributed:	Audit and Assurance Committee Members.
Cross Reference to Strategic Objectives:	
Engagement and Involvement:	
Communications Issues:	These documents should be treated as public documents and would be available for release under the FOI Act.

Financial Implications:	
Review arrangements:	The Audit and Assurance Committee adheres to its annual work plan, which contains review details for all documents to be approved.
Risk Management:	
National Policy/ Legislation:	The CCG is required to show that these documents have been approved by the Audit and Assurance Committee and then ratified by the Governing Body.
Public Health Implications:	
Equality & Diversity:	
Other External Assessment:	
What specific action re. the paper do you wish the Governing Body to take at the meeting?	It is recommended that the Governing Body ratify the items as approved by the Audit and Assurance Committee.

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DRAFT MINUTES OF AUDIT AND ASSURANCE COMMITTEE MEETING
HELD ON TUESDAY 10 JANUARY 2017 AT 09:15hrs
AT SOUTHGATE HOUSE, DEVIZES

Present:

Peter Lucas	PL	Chair, Lay Member
Christine Reid	CR	Vice Chair, Lay Member
Mark Smithies	MS	Secondary Care Doctor
Dr Anna Collings	AC	GP Vice Chair, NEW
Steve Perkins	SP	Chief Financial Officer
Mark Harris	MH	Chief Operating Officer
David Noyes	DJN	Director of Planning, Performance and Corporate Services
Sujata McNab	SMcN	Deputy Chief Financial Officer

In Attendance:

Duncan Laird	DL	External Audit, KPMG
Jonathan Brown	JB	External Audit, KPMG
Natalie Tarr	NT	Internal Audit, PwC
Lorraine Bennett	LBe	Counter Fraud Manager, TIAA
Sharon Woolley	SW	Board Administrator

Apologies:

Susannah Long	SL	Governance and Risk Manager

Item Number	Item	Action
AAC/17/01/01	**Welcome and apologies for absence** PL welcomed everyone to the meeting, particularly Sujata McNab (who joined the WCCG as the new Deputy Chief Financial Officer) and Lorraine Bennett (from TIAA) to their first AAC meeting. The above apology was noted.	
AAC/17/01/02	**Declarations of Interest** Members were reminded of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of Wiltshire CCG. (This included any relevant interests previously declared on the Register of Interests). From the meeting held on 10 January 2017: • With reference to business to be discussed at this meeting, AC declared that she was a Governor at GWH. • MH declared an interest in item 11 as the Chief Operating Officer (Revised Scheme of Reservation and Scheme of Delegation) as the document referred to the COO role. • MS declared an interest in item 7 (Health and Safety Policy) as his son owned an internet start-up company providing a platform of online counselling and coaching for health and wellbeing.	
AAC/17/01/03	**Minutes from the Meeting held on 8 November 2016**	

	The minutes of the meeting held on 8 November 2016 were approved and signed.	
AAC/17/01/04	**Matters Arising** • **Position Paper on CHC and LD Eligibility** The Committee agreed that the update noted on the action tracker for this item (AAC/16/11/15.1) did not substantially cover the identified action from the November meeting. SP advised Members that the roundtable discussion between WCCG and Wiltshire Council was not due to take place until later in January, and would be considering general principles. The 3 outstanding disputes were to be presented to the Disputes Panel. Members requested that a position paper be brought to the Audit and Assurance Committee when appropriate.	
AAC/17/01/05	**Action Tracker** All actions were marked as completed, with the exception of the following action: **ACC/16/11/15.1 – Position paper on CHC and LD eligibility –** Following the roundtable discussion, Members requested that a position paper be brought to the Audit and Assurance Committee when appropriate.	**DMcA**
	ITEMS FOR DECISION	
AAC/17/01/06	**Salary and Expenses Overpayment Recovery Policy** DJN advised Members that this policy had undergone a fundamental review to ensure it was aligned to the latest guidance. Finance and HR colleagues had been involved in the review. The Policy had been discussed and agreed by the Staff Partnership Forum and the Executive Management Team. The Committee requested a minor amendment be made to 7.4 of the Policy – to incorporate “once all actions had been completed”. **The Audit and Assurance Committee approved the Salary and Expenses Overpayment Recovery Policy.** ACTION: AAC/17/01/06 – Amendment to be made to item 7.4 of the Policy.	**DJN**
AAC/17/01/07	**Health and Safety Policy** DJN reported that the Health and Safety Policy had undergone a routine review to ensure that it was fully up to date. The CCG’s health and safety framework was well established and regular meetings were held of the Representatives of Employee Safety group (ROES). HR and colleagues across the organisation had been involved in the review. The Policy had been discussed and agreed by the Staff Partnership Forum. MS requested the following amendment to 3.4 of the Policy – change ‘appropriate support is given’ to ‘appropriate support is offered’. Maintenance of staff wellbeing was not largely mentioned in the policy, which would confirm the organisations commitment. This would be considered for the next reiteration of the policy. **The Audit and Assurance Committee approved the Health and Safety Policy and recommended ratification by the Governing Body.** ACTION: AAC/17/01/07 – Amendment to be made to item 3.4 of the Policy.	**SL**
AAC/17/01/08	***Agenda item removed.***	
AAC/17/01/09	**Annual Governance Statement**	

	DJN tabled the Annual Governance Statement, which contained the M9 report of issues of controls. DJN advised there had been no major breakdowns. Items included were those where the CCG was recorded as below the constitutional targets. This M9 report was to be submitted by 20 January 2017. The Annual Report would record a full governance report. Two amendments were noted: • A&E – include the structures and frameworks in place that monitor A&E targets, including the Local Delivery Board. • RTT – additional outsourcing across the patch was being looked into. Due to the item being tabled, DJN requested that Members come back with any comments or amendments by 13 January 2017. ACTION: AAC/17/01/09 – Noted amendments to be made to the Annual Governance Statement before submission to NHSE.	**SL**
AAC/17/01/10	**EPRR Assurance** DJN reported that the CCG had a well tried and tested process in place for major and minor providers. At the Q3 Assessment meeting, NHSE had been in agreement with the CCG's assessment. The process was regularly tested by NHSE via the system and recall and cross-checking of information. A refresh of training and systems escalation for the on-call team was required. **The Audit and Assurance Committee approved the EPRR Assurance.**	
AAC/17/01/11	**Revised Scheme of Reservation and Scheme of Delegation** DJN reminded Members that this document had been discussed at the last Committee meeting. The document had been revised to now include the powers associated to the Chief Operating Officer role, when this position was appointed. MH confirmed that the delegated items reflected the role's job description. To support the management of Governing Body agendas, Committees were now delegated to approve items (if more than three Governing Body Members were present) and then recommend for ratification at the Governing Body. It was noted that the PCJCC reference should be changed to PCCC (Primary Care Commissioning Committee) from 1 April 2017. **The Audit and Assurance Committee approved the Revised Scheme of Reservation and Scheme of Delegation and recommended ratification by the Governing Body.**	
AAC/17/01/12	**Audit and Assurance Committee Terms of Reference** DJN advised Members that the Committee's Terms of Reference had undergone its annual review, and had been reformatted in line with all other Committee Terms of References. Two amendments were noted: • 2.1 – Add reference to GP attendance to reflect clinical engagement. • Under 2.5 – Counter Fraud and Security lines to be combined. **The Audit and Assurance Committee approved the AAC Terms of Reference and recommended ratification by the Governing Body.**	

AAC/17/01/13	**Local Government Pension Scheme Discretions Policy** SP explained that one employee was in the Wiltshire Pension Fund following the TUPE process to the CCG. As a Member of the Scheme, the CCG is required to have an Employer Discretions Policy. The paper included a standard policy template supplied by the Scheme. When joint appointments were made with Wiltshire Council, it was dependent upon the recruitment process and the payment arrangements as to whether they joined the Wiltshire Pension Fund. If the scenarios outlines in the Policy arose, the Remuneration Committee would be sufficiently supported to ensure they were appropriately briefed to attend to the matter. **The Audit and Assurance Committee approved the Local Government Pension Scheme Discretions Policy.**	
	ITEMS FOR DISCUSSION	
AAC/17/01/14	**Internal Audit Progress Report** NT presented the PwC internal audit progress report. The final reports shown on page 3 were on the meeting agenda for discussion. Page 5 indicated the summary of findings ratings.	
AAC/17/01/15	**Internal Audit Recommendation Tracker** NT presented the recommendation tracker, which indicated progress against recommendations made in all reports. Under 2015/16, Contract Performance items required comments from Managers to close them. Controls Around IT Expenditure required follow up. Risk Management would be followed up as part of the review. It was felt that the learning should be shared with Managers. CHC had four items closed and validated, with two in progress. NT assured the Committee that the CCG was in a good place and recommendations were making good progress. The format of the report would be reviewed to ensure that it was easier to read and print. ACTION: AAC/17/01/15 – Recommendation Tracker report format to be reviewed to ensure it was easier to read and print.	**PwC**
AAC/17/01/16	**Internal Audit Reports** • **Clinical Leadership** NT reported that meetings had been held with GPs, the Chief Financial Officer, the previous Accountable Officer and attended appropriate Committee meetings. NT highlighted the medium rated advisory findings. When speaking with Clinical Leaders it was found that sufficient induction training had not been in place and it had affected their introduction and understanding of how they contributed to the CCG. However, it was noted that the GP Mastermind had been very well received. Performance Management had also been raised, Clinical Leaders had felt that there was no formal process to enable personal objectives to be set. DJN advised Members that a process was in place for objective setting, but it was clear that it was not operating correctly. Members recognised the issue and proposed that the process was instigated better to ensure compliance and to alleviate any higher risks to the organisation this could bring. The Clinical Leadership report would be shared with the CCG Chair. Support would be put into place to ensure the WCCG Chair was able to ensure the process was implemented. It was both the Line Managers and	

	'employees' responsibility to ensure that objectives had been set (aligned to the CCG Operational Plan) and performance management was in place. A reminder could be given to all Clinical Leaders at a Clinical Exec meeting if required, and could be a topic for a future Governing Body Seminar. ACTION: AAC/17/01/16.0 – Clinical Leadership Internal Audit Report and feedback to be shared with the WCCG Chair. ACTION: AAC/17/01/16.1 – Consider appraisal and performance management as a possible Governing Body Seminar topic. The low rated findings indicated that more involvement of the Clinical Leaders should be encouraged. It was felt that this linked back to appropriate performance management and appraisal systems being in place. It was noted that Committee meeting papers should be more timely to enable preparation before meetings and wider engagement. ACTION: AAC/17/01/16.2 – Verbal update against Clinical Leadership involvement actions to be given the March Audit and Assurance Committee meeting. • **Community Contracts** NT highlighted the two medium points noted following the review. The CSU performance had been recognised by the CCG. Updates concerning the CSU contract would be brought to the Committee in due course. DJN had written to the CSU Manager outlining the CCG's concerns and would be meeting him next week. SP advised Members that through contract variations, changes could be instigated to the service received from CSU. 2017/18 contracts were being looked at to address the highlighted issues and to ensure the schedules were completed. A 'provider on a page' view was being prepared to indicate the requirements of the provider against all domains.	**DJN** **DJN / MH / Peter Jenkins** **DJN**
AAC/17/01/17	**External Audit Technical Update** JB presented the External Audit Technical Update, which indicated the actions undertaken since the November Committee meeting, and what would be looked at ahead of the March Committee meeting.	
AAC/17/01/18	**External Audit Annual Draft Plan 2016/17** JB presented the Annual Draft Plan, drawing Members attention to the Summary shown on page 2. There was no change in the proposed KPMG responsibilities in respect of the financial statements. The timetable is similar to that of last year. The draft accounts would be ready on 25 April 2017 for submission. One minor change would be seen in the guidance in the preparation of the accounts; previously provided by the Manual for Accounts; this was now to be provided by the Group Accounting Manual. DL went through the remainder of the report. Page 7 indicated that the materiality level worked to would be the same of that in previous years. A new risk identified for this year was co-commissioning and full delegation (page 8). SP advised that a full budget had not yet produced. MS suggested that the risks associated with Primary Care commissioning were quantified to identify the level of risk to the CCG and the resources and support required. This would be looked at during the audit process of Primary Care Commissioning. The Committee would review the outcome of the audit at the meeting in March. SP explained that the due diligence had been completed. The residual shortfall was to be addressed. The structure required wider discussion and would take into account the back office discussions had at the STP workstream. Jo Cullen would be invited to attend the March	

	meeting to brief the Committee. The delivery of QIPP had been identified as an initial risk. This would continue to be reviewed. SP corrected the QIPP amount reference to £13m. The 2017/18 QIPP target was £14.2m. Individual QIPP scheme were on track and being reviewed. ACTION: AAC/17/01/18.0 – Audit and Assurance Committee to review Primary Care Commissioning audit and associated risks at March meeting. ACTION: AAC/17/01/18.1 – Jo Cullen to be invited to March Audit and Assurance Committee meeting to brief the Committee about Primary Care Commissioning.	**KPMG** **SW**
AAC/17/01/19	**Local Counter Fraud Progress Report 2016/17** LB reported that there had been a change in submission date for the self-review tool. This had been moved forward to 1 April 2017, to be undertaken within the work plan for 2016/17. Page 3 and 4 of the report detailed the risk assessment; those highlighted by both CCGs and nationally. Page 6 listed the reactive work of the Local Counter Fraud Service (LCFS). All items had been reported to the Police, except for Enquiry 50 which had seen an alteration made to a fit note. This had not brought any fraud to the NHS, but LCFS were liaising with the surgery to issue a warning notice to the patient. Fraud Check was the quarterly summary produced by TIAA, which highlighted investigations undertaken across the patch. The Local Counter Fraud Service Annual Report would be brought to the March Committee meeting. ACTION: AAC/17/01/19 - The Local Counter Fraud Service Annual Report to be brought to the March Audit and Assurance Committee meeting.	**LB**
AAC/17/01/20	**Review Board Assurance Framework (BAF) and Risk Register (RR)** DJN advised Members that EMT had reviewed the BAF and RR before Christmas. The top ten risks listed in the RR were coherent with the performance concerns across the system. Discussions continued with Arriva Transport Solutions Ltd concerning the poor performance against the Patient Transport Service. This was now noted as a high risk as this was impacting upon other services. Additional funding had been provided to maintain the current service levels to ensure this did not deteriorate further. Workforce remained a prominent risk across all services, and particularly with AWP. A 20-30% vacancy rate had been reported by AWP, they had seen a real issue in recruiting staff. The Committee suggested that the RR be updated before being presented to the Governing Body to reflect the current Urgent Care system pressures. The format of the RR was to be revised to ensure content was as required and to list one risk per portrait page. There had been no major changes to the BAF. **The Audit and Assurance Committee approved the BAF and RR and recommended ratification by the Governing Body.** ACTION: AAC/17/01/20 – Risk Register be updated before being presented to the Governing Body to reflect the current Urgent Care system pressures.	**SL**

	ITEMS FOR NOTING	
AAC/17/01/21	**Information Governance Group Meeting Minutes (October 2016)** **The Committee received and noted the minutes.**	
AAC/17/01/22	**Aged Receivable and Payables Report** The report provided an update to the Committee on the current level of outstanding receivables and payables as at 31 December 2016 and the ongoing actions. Discussions continued with Wiltshire Council concerning their outstanding payables. **The Committee received and noted the report.**	
AAC/17/01/23	**Losses and Special Payments Report** – *None*	
AAC/17/01/24	**Competitive Tender Waives** SP reported that one tender waiver had been issued since November. A tender waiver form for Capita Healthcare Planning had been included in Appendix 1. The tender exercise, managed by the CSU, was to appoint Capita to undertake further Healthcare Planning work at Devizes, Bradford on Avon and Calne. Additional funding had been given to expand the work and contract. **The Committee received and noted the report.**	
AAC/17/01/25	**Any Other Business** **a) Review of Audit and Assurance Committee Performance** CR suggested that AAC performance feedback from external Committee attendees would be useful and would help inform the self-assessment. The self-assessment checklist would be circulated to all AAC Members for feedback. A verbal report would be given at the March meeting. ACTION: AAC/17/01/25 – Self-assessment checklist to be circulated to all Audit and Assurance Committee Members. The meeting concluded at 10.55hrs	**SW**

Date of next Audit and Assurance Committee Meeting: 14 March 2017 09:15 – 11:00hrs

NHS
Wiltshire
Clinical Commissioning Group

Procurement Strategy 2016/17-2017/18 for Clinical Healthcare Services

DOCUMENT INFORMATION	
Title / Version	**Procurement Strategy 2016/17 – 2017/18**
Version	1.4
Purpose	To ensure the Clinical Commissioning Group meets its legal obligations in relation to procurement and to act in the best interests of the organisation, in accordance with the Clinical Commissioning Group Constitution.
Status	For ratification by noting at the Governing Body
Lead Director	David Noyes, Director of Planning, Performance and Corporate Services
Approved / Ratified by (Date)	Audit and Assurance Committee (14 March 2017), Governing Body (xxx date)
Date Issued	
Author(s)	Based on a document written by Faye Robinson, Director of Procurement, South West Commissioning Support Unit
Superseded Documents	Procurement Strategy for the Purchase of Health Care Services V1 January 2014
Review	This document will be reviewed on a regular basis to ensure it remains up to date with all regulations, rules, best practice, and guidance and in accordance with the Wiltshire Clinical Commissioning Group Constitution and Strategic Plan
Equalities	Wiltshire Clinical Commissioning Group is committed to promoting equality of opportunity and avoiding discrimination, as required by the Health and Social Care Act 2012 and the Equality Act 2010. These duties are continuous and ongoing, and will apply to decisions about procurement.

VERSION CONTROL			
Version	**Date**	**Author**	**Amendment History**
1.4	March 2017	Assoc. Director of Procurement, SCWCSU	Complete replacement of Strategy with SCWCSU template

ASSOCIATED DOCUMENTS
Standards of Business Conduct Policy Counter Fraud Bribery and Corruption Policy Freedom of Information Act and Environmental Information Regulations Policy Communications and Engagement Strategy
Public Contracts Regulations 2015
NHS Act 2006
Health and Social Care Act 2012
Equality Act 2010
NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013
Public Services (Social Value) Act 2012
Local Government Act 1999 (where co-commissioning with a Local Authority)
The NHS (Clinical Commissioning Group) Regulations 2012
Procurement Guide for commissioners of NHS-funded services, 30 July 2010
Framework for Managing Choice, Cooperation and Competition, May 2008
NHS Procurement: Raising our game, May 2012
Securing best value for NHS Patients, August 2012
NHS Commissioning Board, Towards establishment: Creating responsive and accountable CCGs, February 2012
NHS Standards of Procurement, June 2013
Better Procurement, Better Value, Better Care :A Procurement Development Programme for the NHS August 2013
NHS Commissioning Board, Procurement of healthcare (clinical) services: Briefings for CCGs, September 2012
Monitor Substantive Guidance on the Procurement, Patient Choice and Competition Regulations, December 2013
Monitor Enforcement Guidance on the Procurement, Patient Choice and Competition Regulations, December 2013
NHS Commissioning Board, Transforming Participation in Health and Care, September 2013
Code of Conduct: Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services, July 2012
Government Procurement Policy Notes
NHS Standard Contract
Integrated Support and Assurance Process(ISAP)

Contents

PROCUREMENT STRATEGY

1. Introduction

1.1. Following the Health and Social Care Act 2012, NHS Wiltshire Clinical Commissioning Group (CCG) took over the commissioning of healthcare services for the residents of Wiltshire. The Act empowers Clinical Commissioning Groups to commission healthcare services for the local population, working in partnership with their Local Authorities, Health and Wellbeing Boards, the voluntary sector, local health providers and NHS England to deliver an improved quality of care in the context of the need to spend resources wisely.

1.2. Procurement is central to commissioning that drives quality and value. It describes a whole life-cycle process of acquisition of goods, works and services; it starts with identification of need and finishes with the end of a contract or the end of useful life of an asset, and includes performance management. Procurement encompasses everything from repeat, low-value orders through to complex healthcare service solutions developed through partnership arrangements. This strategy is limited to the procurement of clinical health and social care.

1.3. There are a range of procurement approaches available which include working with existing providers, non-competitive and competitive tender processes and multi-provider models such as Any Qualified Provider (AQP). These approaches are explained in this strategy document, and in relation to every commissioning decision, the CCG will need to consider carefully which approach is appropriate.

1.4. The CCG's approach to procurement is to operate within the relevant legal and policy frameworks and actively use procurement as one of the system management tools available to it to strengthen commissioning outcomes. It can do this through procurement by:

- Increasing general market capacity and meeting CCG demand requirements
- Using competition to facilitate improvements in choice, quality, efficiency, access and responsiveness for patients and people using services
- Stimulating innovation.

1.5. All procurement decisions made by the CCG will be to support the delivery of the Five Year Strategy and Sustainable Transformation Plan, and made in proportion to risk.

2. Scope of the Strategy

2.1. As far as it is relevant, this strategy applies to all purchasing decisions concerning health care and social care services for the CCG.

2.2. This strategy must be followed by all the CCG employees and staff on temporary or honorary contracts, representatives acting on behalf of the CCG including staff from member practices, and any external organisations acting on behalf of the CCG including other CCGs and the South West Commissioning Support Unit (SW CSU).

3. Guiding principles

3.1. When procuring health care services, the CCG is required to act with a view to:

- Meeting the needs of the people who use the services
- Improving the quality of the services, and
- Improving efficiency in the provision of the services

3.2. The CCG is required to and will:

- Engage with service users about its commissioning proposals and take their responses into account.
- Where appropriate, undertake formal engagement and consultation in accordance with the CCG Communications and Engagement Strategy
- Act in a transparent and proportionate way
- Treat providers equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership.

3.3. The CCG is required and committed to procuring services from one or more providers that are most capable of delivering the needs, quality and efficiency required, and provides the best value in doing so.

3.4. The CCG is required and committed to act with a view to improving quality and efficiency in the provision of services. The means of doing so may include:

- The services being provided in an integrated way (including with other healthcare services, health related services, or social care services)
- Enabling providers to compete to provide the services
- Allowing patients a choice of provider of the services

3.5. Actual and potential conflicts of interest will be managed appropriately to protect the integrity of the CCG's contract award decision making processes and the wider NHS commissioning system.

3.6. In relation to each purchasing decision for a major service area concerning health care and social care services, the CCG will test proposals and:

- Consider the extent to which any form of competition is required and consider the most appropriate process and procedure for awarding the relevant contract or contracts, taking account of the CCG's legal obligations.
- In that regard, give consideration to whether the use of a framework agreement, including the use of approved lists, is the most appropriate means of appointing providers. Of the providers on the approved list, the CCG will appoint the best provider, offering the best quality services that are affordable regardless of who the provider is as they will have passed the fit and responsible test in the first instance.
- When there is a joint procurement with Local Authorities, the CCG will ensure that the local authority complies with applicable NHS Guidance.

- Purchasing decisions will be led by priorities based on population needs and to address inequalities, clinical needs and measurable improvement in outcomes with clear clinical leadership informed by gathering information about patient needs from the outset to provide evidence based services.
- Will be open and transparent in its decision making relating to procurement, making arrangements to ensure that individuals to whom the services are being or may be provided are involved in the process and to take their views into account.
- Will give consideration as to how the service being procured might improve the economic, social and environmental well-being of the local area and how it might act with a view to securing that improvement in order to maximise value for money with reference to the Sustainable Transformation Plan.
- Will aim to procure and implement services that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

3.7 The CCG will, wherever possible and where it is consistent with legal requirements, ensure that contractual provisions, procurement procedures and selection and award criteria are designed to ensure that contractors and providers:

- Are good employers who comply with all relevant employment legislation, including the Public Interest Disclosure Act 1998;
- Maintain acceptable standards of health and safety and comply fully with all legal obligations in this regard;
- Meet all tax and national insurance obligations;
- Meet all equal opportunities legislation;
- Are reputable in their standards of business conduct;
- Respect the environment and take appropriate steps to ensure they minimise their environmental impact;
- Can evidence an appropriate record of involving patients in their services and providing high quality services;
- Can demonstrate an appropriate record of successful partnership working with commissioners and other providers in the best interests of patients and public;
- Are open and transparent with commissioners on all Patient Safety and Quality issues within their services with accurate information and reporting;
- Abide by and promote awareness of the NHS Constitution, including the rights and pledges set out in it.

3.8 The CCG will take decisions whether or not to exclude a particular provider from a procurement process, based on conviction of offences, fraud, bribery, insolvency/bankruptcy, non-payment of taxes, etc., in a proportionate way, having considered all relevant information.

3.9 The CCG will, for every procurement, and consistently within relevant EU and international law, ensure that contractual provisions, procurement procedures and selection and award criteria prohibit or restrict contractors' use of offshore jurisdictions and/or improper tax avoidance schemes or arrangements and /or exclude companies which use such jurisdictions and/or such schemes or arrangements

3.10 The CCG will only negotiate contracts on behalf of the CCG, and the CCG may only enter into contracts within the statutory framework set up by the 2006 Act, as amended by the 2012 Act and associated regulations.

4. Associated Policies and Procedures

4.1. This strategy should be applied in accordance with the following policies, procedures and guidance:

- Wiltshire Clinical Commissioning Group Constitution
- Sustainable Transformation Plan
- Standing Financial Instructions
- Standards of Business Conduct Policy
- Counter Fraud Bribery and Corruption Policy
- Freedom of Information Act and Environmental Information Regulations Policy
- Communications and Engagement Strategy

In each case, as amended from time to time.

4.2. Legislation affecting procurement includes:

- The Public Contracts Regulations 2015 set out procedural rules that must be following in the procurement of all contracts for goods and services above the relevant EU threshold.
- Section 14Z2 of the National Health Service Act 2006 provides that commissioners of healthcare services have, in relation to health services for which they are responsible, a legal duty to involve patients and the public in service planning, the development and consideration of services changes and decisions that affect service operation
- The NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, do not engage in anti-competitive behaviour and promote the right of patients to make choices about their healthcare
- Section 149 of the Equality Act 2010 sets out the Public Sector Equality Duty which means that public bodies must in the exercise of their functions have regard to the needs of individuals with protected characteristics.
- The Public Services (Social Value) Act 2012 requires that commissioners must consider how what is proposed might improve the economic, social and environmental well-being of the local area, and how it might act with a view to securing that improvement.
- Where the CCG is co-commissioning with the Local Authority, Section 3(1) of the Local Government Act 1999 sets out a duty of consultation.

4.3. All legislation is in force at the date of this Strategy. Further associated guidance is listed at the start of the strategy.

5. Aims and Objectives

5.1. To set out the approach for facilitating open and fair, robust and enforceable contracts that provide value for money and deliver required quality standards and outcomes, with effective performance measures and contractual levers.

5.2. To describe the transparent and proportionate process by which the CCG will determine whether health and social services are to be commissioned through existing contracts with providers, competitive tenders, via an AQP or framework approach or through a non-competitive process.

5.3. To enable early determination of whether, and how, services are to be opened to the market, to facilitate open and fair discussion with existing and potential providers and thereby to facilitate good working relationships.

5.4. To set out how the CCG will meet statutory procurement requirements primarily the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 and the Public Contracts Regulations 2006.

5.5. To set out how the CCG will ensure compliance with section 14Z2 of the NHS Act 2006 in respect of its duties of public and patient involvement in the conduct of a procurement process.

5.6. To enable the CCG to demonstrate compliance with the principles of good procurement practice

- Transparency
- Proportionality
- Non-discrimination
- Equal treatment.

6. Public Procurement Legislation

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

6.1 These apply to the CCG in the purchase of health care services only (i.e. they do not cover the procurement of non-clinical services). They provide that the CCG must:

6.1.1. act with a view to securing patients' needs and improving the quality and efficiency of the service;

6.1.2. in doing so, consider appropriate means of making such improvements, including through the services being provided in a more integrated way (including with other health care services, health-related services, or social care services), enabling providers to compete to provide the services, and allowing patients a choice of provider of the services;

6.1.3. act in a transparent and proportionate way and treat bidders equally and in a non-discriminatory way;
6.1.4. procure the services from one or more providers that are most capable of delivering the objectives of these Regulations and provide best value for money in doing so;
6.1.5. determine which providers should qualify for inclusion a tender process or within a list from which a patient is offered a choice of provider applying transparent, proportionate and non-discriminatory criteria;
6.1.6. maintain a record of each contract for the provision of health care services awarded, including details of how in awarding the contract the CCG complied with its duties as to effectiveness, efficiency, improvement in quality of services and promoting integration;
6.1.7. not engage in anti-competitive behaviour unless to do so is in the interests of people who use health care services, which may include by the services being provided in an integrated way or by co-operation between the persons who provide the services in order to improve their quality;
6.1.8. maintain a record of how any conflicts of interest between commissioners and providers are managed.

The Public Contracts Regulations 2015

6.2. These place legal requirements on public bodies procuring goods and services, and set out procedures which must be followed before awarding a contract when the value of the goods or services exceeds set thresholds.

6.3. Contracts for services are currently divided into two categories:
- Fully regulated – to which the entirety of the Regulations apply; and
- Light touch regulated – where only some of the Regulations apply

6.4. Health and social care services are categorised as light touch services (although some services in the health and social care sector, such as non-emergency patient transport, are classified as fully regulated services).

6.5. There is a statutory requirement to follow the Public Contracts Regulations 2015 (and Procurement Policy Note: New threshold Levels 2016), where contracts are to be awarded with an estimated full-life value above £589k (correct at time of writing) for health and social care services. The contract value is based on the total value expected to be paid over the life of the contract.

6.8 For any contract for health and social care services, the CCG will need to consider whether the opportunity may be of interest to providers based in other EU member states and should therefore be advertised.

6.9 The EU procurement regime, based on the EU Treaty principles of transparency, non-discrimination, equal treatment and proportionality and transposed into English law under the Public Contracts Regulations 2015 is not static. It is subject to change, driven by evolving European and domestic case law, European Commission communications and amendments to the existing UK Regulations.

6.10 The CCG's approach to fulfilling these requirements is described in Section 10.

The Public Services (Social Value) Act 2012

6.11 This Act, that came into force on 1st February 2013, requires commissioners at the pre-procurement stage to consider how what is to be procured may improve social, environmental, and economic well-being of the relevant area, how they might secure any such improvement and to consider the need to consult.

6.12 Although the Act applies only to certain public services contracts to which the Public Contracts Regulations 2006 apply, the CCG intends, as a matter of good practice, to consider how its procurement might improve economic, social and environmental well-being in order to maximise value for money. The considered application of the provisions of this Act will provide the CCG with the means to broaden evaluation criteria to include impact on the local area.

7 Patient, Carer and Public Engagement

7.1 CCGs are statutory organisations, responsible for public money and have a duty to demonstrate decisions are being made in partnership with their local population. The CCG will ensure that patients and the public are involved in the planning of commissioning arrangements, the development and consideration for proposals for changes in services and in decisions affecting the operation of commissioning arrangements. Working in partnership with patients, carers and the public is a key factor to the design, procurement and monitoring of services.

7.2 The duty to involve patients and the public applies from the very outset of a commissioning decision-making process, before procurement commences. The CCG will, where appropriate, take steps to obtain the views of the public at the earliest possible stage, while proposals are still being developed. The appropriate level of public involvement will depend on the specific circumstances of the service to be commissioned or changed.

7.3 In line with the CCG's Communications and Engagement Strategy, for major commissioning projects (for example, adult mental health services or children's community health services), a communications and engagement action plan will be drawn up to explain how the public and patients can put forward their views and be involved throughout the process.

7.4 The CCG is also subject to other legal duties which may require consultation with the public. These include the Public Sector Equality Duty and the obligations under the Public Services (Social Value) Act 2012.

7.5 In line with these requirements and the CCG vision, mission and values, the CCG will work in partnership with patients, carers and families, and partner organisations

across the public, voluntary and private sectors to develop high quality, safe and cost effective locality based services.

7.6 The CCG will hold providers of services to account for the quality, safety and performance of their services. The CCG expect local providers to aspire to be the best in their field and to involve and seek feedback on a regular basis from local patients and carers.

7.7 The CCG will determine the most appropriate method of engagement and consultation according to the service being procured (whether by being consulted or provided with information or in other ways).

8 Accountabilities & Responsibilities

8.1 Accountability for clinical procurement rests with the CCG Accountable Officer.

8.2 Where it is required and considered appropriate procurement support will be provided by the South West Commissioning Support Unit (SW CSU). The Director of Procurement, South West Commissioning Support will provide day to day procurement support to the CCG and be responsible for the procurement service provided and the application of current law and guidance. In the case of collaborative projects, procurement support may be provided by another CCG. The CCG will have systems in place to assure itself that the SW CSU's or relevant CCG's business processes are robust and enable the CCG to meet its duties in relation to procurement.

8.3 The CCG is the authority directly responsible for:

- Approving the procurement route
- Signing off specifications and evaluation criteria
- Signing off decisions on which providers to invite to tender
- Making final decisions on the selection of the provider.

8.4 Arrangements for delegation of authority to officers are set out in the relevant Standing Orders (SO), Standing Financial Instructions (SFI) and Scheme of Delegation. In the event of any discrepancy between this Procurement Strategy and the SO/SFI, the SO/SFI will take precedence.

9 Conflicts of interest

9.1 Managing potential conflicts of interest appropriately is needed to demonstrate the integrity of the wider NHS commissioning system and protect CCGs and GP practices from any perceptions of wrong-doing. The NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 prevent the CCG from awarding a contract for the provision of health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of that contract. This includes

interests of members of the CCG, its governing body, its committee and sub-committees or any CCG employee.

9.2 General arrangements for managing conflicts of interest are set out in the CCG Constitution and the Standards of Business Conduct Policy. This section describes additional safeguards that the CCG will put in place when commissioning services that could potentially be provided by General Practitioners (GPs) or GP practices.

9.3 The CCG will consider potential conflicts of interest at project inception and a fully documented audit trail in respect of each contract awarded will be kept to demonstrate the actions taken to mitigate risks.

9.4 For all procurement projects and decision making events, all members present must declare any interest or perceived conflict of interest in the topic being discussed.

9.5 Appendix 2 sets out the documents that must be used for all relevant procurement meetings.

10 Procurement approach for health and social care contracts

10.1 Taking all of the above factors into consideration, the CCG will, at the outset of a commissioning decision-making process for contracts for health and social care services, consider the appropriate procurement approach. In doing so, the CCG will take into account in particular the guidance published in December 2013 by Monitor Substantive guidance on the Procurement, Patient Choice and Competition Regulations .

10.2 The CCG will conduct health and social care procurements, as part of market management and development, according to priorities established in its Three Year Plan and the Sustainable Transformation Plan. Decisions of whether to tender will be driven by the need to commission services from providers who are best placed to deliver the needs of our patients and population, to improve the quality of services and to improve efficiency in the provision of services, and who will provide best value for money in doing so.

10.3 The decision-making process will vary depending on whether or not the service is an existing one, new or significantly changed.

Existing Services

10.4 For an existing service (i.e. one that is not new or significantly changed) that is not at the end of a fixed-term contract that was procured via competitive tender, where the service is fit for purpose, offers best value for money and continues to fit with the strategic direction of the CCG, the existing provider may be retained for as long as it is appropriate to do so.

10.5 Where the provider of an existing service was selected for a fixed period via a competitive tender exercise and the fixed period (including any options for contract extension) is due to end the CCG will determine whether the current provider is the only capable provider or whether integration or improvements to services could be attained from a competitive tender exercise. In determining whether the current provider is the only capable provider, the CCG will consider as a minimum factors such as the integration of the service with other services, the need for co-location due to clinical interdependencies, etc.

10.6 Where an increased number of providers are required to deliver a service, the CCG may seek to increase the provider base through the use of the AQP model (section 11). The practicability of implementation of the AQP model will take account of:

- Value of improving patient choice and contestability;
- Level of market interest and capability;
- Complexity of accreditation requirements and associated cost.

10.7 Where there is more than one capable provider and AQP is not appropriate, the CCG's expectation is that the service will normally be subject to competitive tender. However, all such cases will be subject to a review of whether a competitive tender process is appropriate on the grounds of demonstrating best value, market testing, maintaining competitive tension and complying with the EU procurement rules.

New or significantly changed services

10.8 The CCG will use a procurement decision support matrix to support consistent and thorough decision making. Appendix 3 provides a framework of questions the CCG will need to consider to support its decision making. Use of the template will ensure procurement implications are considered at the earliest stage of any review and take into account all appropriate procurement legislation and guidance. The CCG will also consider guidance from the Integrated Support and Assurance Process (ISAP) for the award of novel contracts.

10.9 In doing so it will:

- Determine whether the service can be accommodated through existing contracts with providers through future variations to those contracts, bearing in mind the potential for risk of material change.

- Determine whether there are demonstrable grounds to identify a most capable provider or group of providers without competition, taking into account Monitor's Substantive Guidance

- Where there is an opportunity or requirement to broaden the choice of provider available to patients, the CCG's approach where applicable and appropriate may be the AQP model. The AQP model will not always be appropriate, for example where:

- the number of providers needs to be constrained, e.g. where the level of activity can support only one provider or where clinical pathways dictate a restricted number of providers;
- value for money cannot be demonstrated without formal market testing (to determine the price the CCG will offer for provision of the services);
- innovation is required from the market and cannot be achieved collaboratively;
- there is no effective method of selecting from amongst qualified providers for delivery of specific units of activity;
- overall costs would be increased through multiple provider provision because of unavoidable duplication of resources.

If the AQP model is not appropriate, and the service is not of minimal value, the CCG's expectation is that the service will normally be subject to competitive tender. However, all such cases will be subject to a review of whether a competitive tender process is appropriate on the grounds of demonstrating best value, market testing, maintaining competitive tension and complying with the EU procurement rules.

10.7 Following a decision to procure, the SW CSU 'gateway' process will be implemented to provide a robust governance structure. The detail of this process is not covered within the strategy but gateway stages include:

- Develop full business case (if not already completed)
- Pre procurement
- Procurement stage 1 – Pre Qualifying Questionnaire
- Procurement stage 2 – Invitation to Tender
- Finalisation of Procurement Stage & Implementation

11 Approach to market

Once it has been determined that a competitive process should be undertaken, the CCG will consider the most appropriate approach to market.

11.1 Any Qualified Provider (AQP)

11.1.1 With the AQP model, for a prescribed range of services, any provider that meets the CCG's criteria can compete for business within that market without constraint by a commissioner organisation, unless specified. Under AQP there are no guarantees of volume or payment.

11.1.2 The CCG will set transparent, fair and non-discriminatory criteria which are intended to ensure that the choices include the providers best able to meet the needs of the CCG's population. Where appropriate, the CCG may limit the number of providers, other than in relation to services covered at paragraph 11.1.4 below.

11.1.3 The AQP model promotes choice and contestability, and sustained competition on the basis of quality rather than cost. Any service that is contracted through the AQP model is not usually tendered separately, although the opportunity will be advertised using the Contract Finder government procurement portal. Potential service providers will be assessed against the published criteria and if appropriate, 'qualified'.

11.1.4 Where the service concerned is a first consultant outpatient appointment, any provider who meets the CCG's criteria, including holding a licence (if required by law) and CQC registration, will be included on the list.

11.1.5 In all other cases, the CCG may only refuse to admit a provider to its list on the grounds that it has already reached the limit of the number of providers set for that service.

11.1.6 A standard NHS contract will be awarded to all providers that meet:

- A benchmark for standards of clinical care (implying qualification / accreditation requirement);
- The price the CCG will pay;
- Relevant regulatory standards.

11.1.7 The CCG will have due regard at all times to the EU Treaty principles of non-discrimination, equal treatment, transparency, mutual recognition and proportionality when applying the AQP procedure.

11.2 **Competitive Tendering**

11.2.1 Where there is more than one potential provider for a service and an AQP approach is not suitable, the CCG will seek to utilise a competitive tendering approach. The competitive tendering approach can demonstrate the application of the principles of transparency, openness, equal treatment of providers and obtaining and delivering value for money.

11.2.2 There are several types of competitive tendering options. These include:

- Open procedure where all bidders are invited to submit a tender for evaluation.
- Restricted procedure, used to 'restrict' the number of bidders by following a process that includes completion of a pre-qualification questionnaire, issuing of 'Invitation to Tender' and tender evaluation.
- Competitive Dialogue procedure where, following a selection process, bidders enter into dialogue with the commissioner to develop the service solution.
- Negotiated procedure where, following a selection process, bidders enter into negotiation with the commissioner.

11.3 **Non-Competitive process**

11.3.1 Competition may be waived in limited circumstances such as genuine urgency, or where there is demonstrably only one provider which can provide the service. In these circumstances the procedures set out within the CCG's Standing Orders and Standing Financial Instructions must be followed.

11.3.2 Where it is decided not to competitively tender for new or significantly changed services, a waiver must be documented and reported to the Finance Committee. Waivers must be approved by the Chief Financial Officer.

11.4 Grants

11.4.1 In certain circumstances the CCG may provide a grant payable to third sector organisations. However there should be no preferential treatment for third sector organisations. Use of grants can be considered where:

- Funding is provided for development or strategic purposes
- The services are innovative or experimental
- The recipient is the sole provider

11.4.2 Grants should not be used to avoid competition where it is appropriate for a formal procurement to be undertaken and will still be considered in conjunction with general procurement principles (transparency, proportionality, non-discrimination, equal treatment).

12 Decision Making Process

12.1 The CCG will use a procurement decision support matrix to support consistent and thorough decision making. Appendix 3 provides a framework of questions the CCG will need to consider to support its decision making. Use of the template will ensure procurement implications are considered at the earliest stage of any review.

12.2 Any service that is being considered, either as a new service or as a review of existing service, will be assessed in a consistent manner through the completion of the template.

12.3 The decision matrix will also be used as a stand-alone document to support consistent decision making when existing services are being considered for procurement due to performance concerns or the contract coming to an end.

12.4 The decision matrix can be completed as either a part of a service assessment or as a stand-alone procurement tool.

12.5 If a decision is taken to pursue a competitive tender process, there are a range of further issues that will be taken into account in the design of the process to be followed; these are not considered in detail in this strategy but include:

- Market analysis (e.g. structure, competition, capacity, interest)
- Engagement requirements in accordance with 14Z2 of the NHS Act 2006
- Tender routes
- Procurement timescales
- Affordability and Value for money
- Impact on service stability
- Procurement resource, including responsibilities and accountabilities

- Outcome-based specifications
- Existing related contractual arrangements
- Contract management
- Provider development
- Social value
- Public Sector Equality Duty

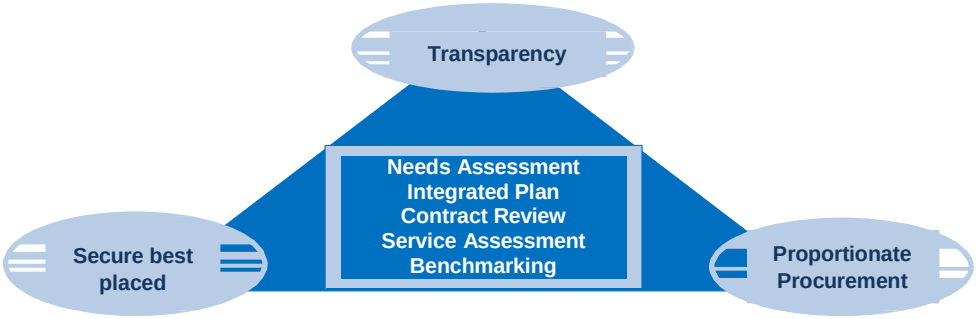
12.8 It is important that a record is kept of the decision making process, demonstrating that those responsible for taking formal decisions are fully briefed in relation to the factors to take into account.

13 Financial and quality assurance checks

13.1 The CCG will require assurance about potential providers. Where this is not achieved through a formal tender process, the following financial and quality assurance checks of the provider will be expected to be undertaken before entering into a contract:

- Financial viability
- Economic standing
- Corporate social responsibility
- Clinical capacity and capability
- Clinical governance
- Quality / Accreditation

14 Principles of good procurement



14.1 The key principles of good procurement are transparency, proportionality, non-discrimination and equal treatment. The CCG will ensure compliance with these principles in the following ways.

14.1.1 Transparency

- The CCG will commission services from the providers which are best placed to deliver the needs of our patients and population.
- The CCG will commission services from suppliers that offer best value for money.
- The CCG will determine as early as practicable whether and how services are to be opened to the market and will share this information with existing and potential providers.
- The CCG will retain an auditable documentation trail regarding all key decisions.

- The CCG will use the most appropriate media in which to advertise tenders or opportunities to provide services, including using the Contracts Finder procurement portal established by Government to advertise all appropriate tenders.
- The CCG will manage potential conflicts of interest and ensure these do not prejudice fair and transparent procurement processes.
- The CCG will provide feedback to all unsuccessful bidders.

14.1.2 Proportionality

- The CCG will ensure that procurement processes are proportionate to the value, complexity and risk of the services to be procured.
- The CCG will define and document procurement routes, including any streamlined processes for low value/local services, taking into account available guidance.

14.1.3 Non-discrimination

- The CCG will ensure that tender documents are written in a non-discriminatory fashion e.g. generic terms will be used rather than trade names for products.
- The CCG will inform all participants of the applicable rules in advance and ensure that the rules are applied equally to all. Reasonable timescales will be determined and applied across the whole process.
- The CCG will ensure that shortlist criteria are neither discriminatory nor particularly favourable to any one potential provider.

14.1.4 Equality of Treatment

- The CCG will ensure that no sector of the provider market is given any unfair advantage during a procurement process.
- The CCG will ensure that basic financial and quality assurance checks apply equally to all types of providers.
- The CCG will ensure that all pricing and payment regimes are transparent and fair (according to the DH Principles and Rules Document).
- The CCG will hold all providers to account, in a proportionate manner, through contractual agreements, for the quality of their services.

15 Procurement planning & monitoring

15.1 A procurement plan will be maintained that will list all current and future procurements. The procurement plan will be reviewed on a regular basis taking into account local and national priorities, the CCG's commissioning intentions, NHS England guidance and nationally mandated procurements. In addition it will take into account the impact of completed and on-going procurements.

15.2 The plan will highlight the priority, timescale, risk and resource requirement for each potential procurement. Not every priority on the procurement plan will result in procurement, but indicates the CCG's intention to review the service or activity.

15.3 The plan will be developed as a key element to provide communication between the CCG, its membership and potential providers. Through transparent and open processes the CCG will actively encourage provider communication.

15.4 The CCG will maintain a contracts database ("database") of all clinical service contracts held by providers. The database will be continuously updated in accordance with:

- Review of existing contracts
- Delivery of new services as identified through the Sustainable Transformation Plan
- Emerging priorities including nationally mandated procurements
- Completed, on-going or potential procurements

15.5 A summary of the database will be available to the Finance and Performance Committee, a committee of the Governing Body. Not every service within the database will result in a competitive procurement being undertaken.

15.6 A register of procurement decisions will be published on the CCG website in accordance with the Standards of Business Conduct Policy.

16. Sustainable Procurement

16.1 The NHS is a major employer and economic force both in the Wiltshire area and within the wider NHS South West region. The CCG recognises the impact of its purchasing and procurement decisions on the regional economy and the positive contribution it can make to economic and social regeneration.

16.2 The CCG is committed to the development of innovative local and regional solutions, and will deliver services in line with its Sustainable Transformation Plan.

16.3 Wherever it is possible, and does not contradict or contravene the CCG's legal obligations, the CCG will work to develop and support a sustainable local health economy.

17. Use of Information Technology

17.1. Wherever possible appropriate information technology systems i.e. e-procurement and e-evaluation methods will be used. These are intended to assist in streamlining procurement processes whilst at the same time providing a clear audit trail.

17.2. E-Tendering and e-evaluation solutions provide a secure and efficient means for managing tendering activity particularly for large complex procurements. They offer efficiencies to both purchasers and providers by reducing time and costs in issuing and completing tenders, and particularly to purchasers in respect of evaluating responses to tenders.

18. Decommissioning services

18.1. The need to decommission contracts can arise through:

- Termination of the contract due to performance not delivering the expected outcomes. This can be mitigated by appropriate contract monitoring and management and by involving the provider in this. The contract terms will allow for remedial action to be taken to resolve any problems. Should this not resolve the issues, then appropriate dispute resolution and termination provisions within the contract may be used.
- The contract expires.
- Services are no longer required as the need no longer exists.
- Services may be assessed as no longer being a priority or offering value for money.

18.2. Where services are decommissioned, the CCG will ensure where necessary that contingency plans are developed to maintain patient care and to ensure that patient data is held securely and transferred to any new provider. Where decommissioning involves Human Resources issues, such as TUPE, then providers (exiting and incoming) will be expected to cooperate and help all parties to discharge their obligations under current employment law.

19. Transfer of Undertakings and Protection of Employment Regulations (TUPE)

19.1. These Regulations arose as a consequence of the 1977 EU Acquired Rights Directive and were updated in 2006. They apply when there are transfers of staff from one legal entity to another as a consequence of a change in employer. This is a complex area of law which is continually evolving.

19.2. Commissioners need to be aware of these and the need to engage HR support, procurement and possibly legal advice if there is likely to be a TUPE issue. Additionally, NHS Bodies must follow Government guidance contained within the Cabinet Office Statement of Practice 2000/72 and associated Code of Practice 2004 when transferring staff to the Private Sector also known as “COSOP”.

19.3. The CCG will advise potential bidders of their obligations associated with TUPE and requirements in the preparation of any bids submitted to the CCG.

20. Public Sector Equality Duty

20.1. The CCG is subject to a duty under s.149 of the Equality Act 2010 to have due regard in the exercise of its functions to the need to:

(a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Act;
(b) Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it;

(c) Foster good relations between persons who share a relevant protected characteristic and those who do not share it.

20.2. The CCG will prepare an equality impact assessment, in line with its Equality, Diversity and Human Rights Strategy, at each key stage of the decision making process which explains the impact of the proposal on people within each group of protected characteristics, which will be considered by the decision makers. Where there is an adverse impact, the document will show how that impact will be mitigated.

20.3. The CCG aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

21 Contract Form

21.1 The CCG will ensure that the NHS Standard Contract or where appropriate a NHS Standard Deed of Variation will be used for all contracts for NHS funded health and social care services commissioned by the CCG. In exceptional circumstances, such as where a joint contracting arrangement is led by local authority, the CCG may agree to be party to a different form of contract.

21.2 The CCG will ensure that a standard Grant Agreement document will be used to record the provision of grants to third parties which will contain the provisions upon which the grant is made.

21.3 The contract will stipulate expectations with regard to Information Governance and in accordance with the Data Protection Act 1998 and the Freedom of Information Act 2000.

22 Procurement Training

22.1 All CCG staff and others working with the CCG will need to be aware of this strategy and its implications.

22.2 Staff need to know when and how to seek further support. All commissioning staff throughout the CCG should know enough about procurement to know to seek help when they encounter related issues; they must also be able to give clear and consistent messages to providers and potential providers about the CCG's procurement intentions in relation to individual service developments.

22.3 Awareness of procurement issues will be raised through organisational development and training sessions for clinical and non-clinical members of CCG.

22.4 A priority for the CCG will be to embed knowledge of the decision support matrix contained at Appendix 3.

23 Monitoring Compliance with this Strategy

23.1 This strategy will be reviewed at the end of 2017/18 but may be considered earlier in the light of emerging legislation, guidance and experience.

23.2 Effectiveness in ensuring that all procurements comply with this strategy will primarily be achieved through “business as usual” and the Finance and Performance Committee overseen by the Chief Financial Officer.

24 Complaints and Dispute Procedure

24.1 The CCG's approach to contestability means that it is likely to pursue a wide range of competitive procurements to secure new and existing services.

24.2 The CCG has developed the processes that will be followed within the CCG that enables any potential dispute relating to a procurement process or outcome from any procurement to be resolved in an open and transparent manner.

24.3 The CCG will utilise its dispute resolution processes to address and resolve any complaint received from either:

- Bidders/contractors,
- A member of the public.

Appendix 1

Commissioning, procurement and engagement cycles

Diagrams showing the tasks to be undertaken by CCG teams

IPC framework for joint commissioning and purchasing of public care services

Appendix 2

Conflict of Interest Disclosure Document

For use at meetings where procurement decisions are discussed

Re: Project name and/or including bidding Company names.

As part of any commissioning process, It is required that those individuals party to commissioning information have no actual or potential conflicts of interest. For these purposes, a ***conflict of interest*** means any fact or matter which might prevent (or might be seen by others as preventing) the commissioning process from being fair and impartial, either through your involvement in it or your knowledge of it.
Your attention is drawn to the Bribery Act 2010 and your obligations and responsibilities under this Act.
Examples of conflicts of interest include:

- Having a financial interest (e.g. holding shares or options) in a potential bidder except where this is a holding of less than 5% of the issued share capital in a public quoted company. Quoted will include the Stock exchange, equivalent overseas exchanges or the AIM.
- Having a financial or any other personal interest in the outcome of the Evaluation Process;
- Being substantively employed or engaged by any potential bidder, or having an expectation of so being, dependant on the outcome of the tender process; this includes a situation where you provide services under a contract for services, or expect to be asked to do so.
- Receiving any kind of monetary or non-monetary payment or incentive (including hospitality) from any potential bidder or its representatives;
- Canvassing or negotiating with any person with a view to entering into any of the arrangements outlined above;
- Having a close member of your family (which term includes unmarried partners) who falls into any of the categories outlined above; and
- Having any other close relationship (current or historical) with any potential bidder.
- a non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);
- a non-pecuniary personal benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

You also commit to immediately disclose any change in your status as it might pertain to conflicts of interest (i.e. you gain a financial interest in a potential bidder which is not currently reasonably foreseen).

The above is not an exhaustive list of examples, and it is your responsibility to ensure that any and all potential conflicts – whether or not of the type listed above – are disclosed now to the Director of Procurement.

On receipt of any notification of a potential conflict of interest, the Senior Responsible Officer will consider whether the interest is potentially prejudicial to the fairness and propriety of the procurement, and notify you of what restrictions on your involvement may be required as a result of the interest. The default assumption is that an actual or potential conflict of interest will result in your being excluded from the evaluation and decision making in relation to the procurement.

You acknowledge that as a result of your participation/knowledge of the commissioning process, you will receive confidential information. You agree at all times to keep this information and all other information you receive as part of the commissioning process confidential and agree not to disclose any details unless expressly told that you may do so.

You must also notify the senior Responsible officer of any approach you receive from any person seeking to obtain any confidential information from you. This would include being asked to advise bidders or related parties where you have relevant knowledge and that knowledge might be expected to affect your advice.

I confirm that I have no conflict of Interest arising from the above named Service and undertake to keep the CCG informed if this position changes.

Signature:		Name:	
Date:		Position:	

Appendix 3

Procurement decision support matrix – Template format

Question		Yes / No	Response	Notes	Status	Concern
1	What is the service being considered?				Not Started	
2	Why is the service being considered?				Not Started	
3	Are there concerns about quality, effectiveness or value for money?				Not Started	
4	What actions have been taken to address these concerns?				Not Started	
5	Will this be a change to an existing service?				Not Started	
6	Is the change material?				Not Started	
7	Is the service a materially significant part of an existing contract?				Not Started	
8	Has the service been previously procured?				Not Started	
9	Will this be a new service?				Not Started	
10	Has there been engagement with stakeholders and the public in the plans for the service?				Not Started	

Question		Yes / No	Response	Notes	Status	Concern
11	Is this a clinical or non-clinical service?				Not Started	
12	What is the total value of the service (annual service value x length of contract)?				Not Started	
13	Is this an elective service governed by the NHS Constitution?				Not Started	
14	Would extending choice to this service improve outcomes or drive required changes in line with commissioning priorities?				Not Started	
15	Is there a national framework covering this service?				Not Started	
16	What evidence is there of market interest/capability?				Not Started	

Question		Yes / No	Response	Notes	Status	Concern
17	Is there exceptional urgency?				Not Started	
18	Does the service have a strong interface with an existing service?				Not Started	

19	Is the cost of a contested approach justified in light of the contract service value?				Not Started	
20	Could this be a "reserved contract"?				Not Started	
21	Is there only one provider and can this be evidenced?				Not Started	
22	Are there concerns about destabilisation of existing services?				Not Started	
23	What are the consequences of making an unlawful decision?				Not Started	
Question		Yes / No	Response	Notes	Status	Concern
24	Evidence of how the procurement process might improve the social, economic or environmental well being of the geographical area.				Not Started	
25	Evidence that the Public Sector Equality Duty has been met in the procurement planning.				Not Started	
26	Evidence that the duty to consult has been met.				Not Started	
27	Evidence that the product of consultation been taken into account.				Not Started	

28	Evidence that any conflicts of interest have been managed.				Not Started	

At this point sufficient evidence should have been gathered to make an initial decision about whether you need to take a competitive procurement approach.

Reflecting on the answers to the questions so far, tap the button below to generate a report summarising your current evidence. This will depend upon the governance structure within your organisation and the meetings established to assess the service being considered for example, programme board arrangements should be in place for large complex services or 'task and finish' arrangement for smaller simpler services. You may wish to discuss the information report more widely within your organisation.

Question		Yes / No	Response	Notes	Status	Concern
29	What procurement process could be used?				Not Started	
30	Is the nature of this service complex?				Not Started	
31	How diverse is the supply market?				Not Started	
32	What is the pricing model?				Not Started	
33	What critical success factors are required for this service?				Not Started	
34	As part of the development of the service specification define the NHS outcomes.				Not Started	

NHS
Wiltshire
Clinical Commissioning Group

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Version Control (change record and reviewers/contributors)

Version	Date	Page	Reviewed By:	Detail of change:	Changes Approved By:	Approval Date:
1.0	27/01/16		RS, SCW CSU, IGG	Include CCG vision for records management; Addition of IAO/IAA role; Removal of records management Roadmap and Action Plan 14/15; Addition of 16/17 Strategy Plan.	Gov Body	22/3/16
Draft 2.2	22/02/17	All	SCW CSU Records Manager	Add: Classification: OFFICIAL	AAC	14/3/17
		3, 4		Update ref to Records Management Code of Practice for Health & Social Care 2016		
		4		Cross reference to TNA		
		6, 7		Section 7: Remove Strategy and replace with Workplan description		

Acknowledgements

The CCG would like to acknowledge the support of the CSU in preparation of the draft Records Management Strategy.

RECORDS MANAGEMENT STRATEGY

1.0 INTRODUCTION & PURPOSE

1.1 This Records Management Strategy broadly articulates the practical steps that NHS Wiltshire CCG will take to deliver compliance with our records management policy and wider NHS records management requirements.

The requirement for a records management strategy is noted in the Records Management Code of Practice for Health and Social Care 2016. It is also required evidence for the CCG's Information Governance Toolkit (requirement 13-420). The strategy provides a systematic and coordinated approach to records management working alongside the Information Governance programme.

The action plan includes a number of fundamental records management activities.

To deliver records management across the CCG we are working with South, Central and West Commissioning Support Unit's (SCW CSU) Records Management function.

2.0 SCOPE

2.1 Records are defined as any form of information which has been created or gathered as a result of any aspect of our work. Records can be manual (paper) and, most commonly, electronic. Common examples include invoices, email correspondence, faxes, contracts, datasets, spreadsheets, note pads and even 'post-it' notes can all qualify as records.

The records under this strategy include paper records held within Southgate House and in external archive storage which are the property of NHS Wiltshire CCG. The strategy also covers those records held electronically and managed by the South, Central & West CSU Information Technology Team (electronic archives, CCG folders), the CCG intranet and internet sites and any records held by SCW CSU while carrying out service lines for the CCG e.g. FOI.

3.0 DETAILED STRATEGY

NHS Wiltshire CCG's vision for records management is:

> *"Our information is consistently filed and managed over time including governed and regular disposal. We are able to find information we need quickly, and have assurance as to its quality, reliability and currency."*

NHS Wiltshire CCG has the following high level aims for the CCG records management programme:

1) Implement systematic approaches to records keeping throughout the records lifecycle.

   The CCG will implement a records framework that includes policy, procedure, guidance, taxonomy and governed file shares that, together, create a holistic and systematic approach to record keeping.

   The CCG will explore technology solutions and configuration which will help improve records management and bring user benefits and efficiencies, including the monitoring of paper storage contracts.

2) Be compliant with NHS and other national record keeping requirements.

   The CCG will design the framework and auditing programme so that it meets the Records Management Code of Practice for Health and Social Care 2016 and IG toolkit requirements.

3) Ensure that records governance, and roles and responsibilities are clear and effective.

   Governance, including what CCG staff will do is articulated in policy, Terms of Reference and through training modules. CCG Information Asset Owners and Information Asset Administrators have a key role to play in implementing the records management policy.

4) All staff and contractors shall receive records management training.

   Records management training is mandated and it is delivered through the Information Governance Training Tool modules, Intranet pages, classroom presentations and short guidance material. The training arrangements can be found in the CCG Training Needs Analysis (TNA).

5) Ensure the disposal of CCG records is legally defensible, scheduled and systematic.

   The CCG records framework will include agreed disposal schedules and a disposal procedure that must be implemented for all information assets.

6) Improve the quality and accessibility of CCG records whilst maintaining their security.

   The CCG's approach to filing and naming records will improve information accessibility and provide assurance as to its quality. The CCG will analyse permission rights and restrictions to ensure records cannot be tampered with, stand as effective evidence and remain restricted as necessary. The CCG will work with Information Governance colleagues in the SCW CSU to protect our information and use technology to provide solutions.

7) Monitor CCG performance against policy and seek to make improvements wherever possible.

   Regular records management audits will be carried out across the business encouraging continuous improvement and embedding best practice.

4.0 ROLES & RESPONSIBILITIES

4.1 All CCG staff have a role to play in delivering this strategy.

4.2 The Senior Information Risk Officer (SIRO) will deliver and be accountable for effective control of information assets.

4.3 The Lead Director for Information Governance will oversee the information governance arrangements for the CCG of which records management is a part.

4.4 The Caldicott Guardian will support, promote and critically assess the record keeping arrangements for Person Confidential Data (PCD).

4.5 The CCG Lead manager for Information Governance will work with the SCW CSU to implement the high level aims of this strategy.

4.6 Nominated Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) will promote good record keeping practice within their teams and ensure policy and procedure is being implemented.

4.7 The SCW CSU Records Manager will provide expert advice and knowledge to design, facilitate implementation and trouble shoot policies, procedures and arrangements to achieve the high level aims of this strategy.

5.0 EQUALITY, DIVERSITY AND MENTAL CAPACITY

5.1 An Equality Impact Assessment (EIA) has been completed for this strategy and no significant issues were identified.

6.0 REVIEW

6.1 The strategy will be reviewed after three years but may be reviewed before this time, where necessary.

7.0 WILTSHIRE CCG RECORDS MANAGEMENT WORK PLAN

7.1 A Records Management Work Plan will be maintained by the SCW CSU Records Manager and submitted to the Information Governance Group (IGG) each financial year for approval. The Work Plan will provide the Group with an update on key record keeping matters.

NHS Wiltshire Clinical Commissioning Group - Board Assurance Framework & Action Plan March 2017

Principal strategic objective	Issue impacting on achievement of strategic objective	Key controls and systems supporting issue management	Positive assurances of controls (the available evidence on the effectiveness of the controls / systems)	Gaps in controls and systems (or weak controls and systems)	Gaps in assurance (poor evidence of effectiveness of controls and systems)	Date of Last Review	Director Lead	Action Plan	By when	Status	Comments/Updates
A. To drive towards a clinically led model which delivers integrated high quality patient services within the community based upon neighbourhood teams to provide 'wrap around' care at or close to home.											
A.01	Achieving integrated commissioning to support the strategic objectives of CCG, the 5 Year Strategy and Better Care Fund.	Governing body reports; Joint Commissioning Board; Director of Integration; Integrated Performance Report; Engagement with Sustainable Transformation Plan (STP) Board; S75 agreement; Emergent Sustainable Transformation Plan (Dec'16); Joint working Group (agreed ToR).	Governing Body minutes; Positive relationships at Health & Wellbeing Board; Assessment of Integrated Team performance summer 2016.	Joint OD Plan	None	07/03/2017	**Interim Accountable Officer**	Joint Working Group with agreed Terms of Reference for developing work plan to progress integrated arrangements to be established by end April 2017.	Apr'17	Amber	
B. Commission appropriate services to meet the needs of the local population and national priorities, delivered in the right place (ideally in a primary and community care setting) and accessible at the right times identifying and addressing health inequalities.											
B.01	Key partner/contractors/providers may be unable to provide commissioned services.	Contracts for commissioned services with KPI; Contract performance arrangements (CSU support); Contract Managers; Integrated Performance Report; Systems Resilience Group; Provider licensing by Monitor.	Governing Body members receive Integrated Performance Report on a monthly basis.	None	None	27/02/2017	**Director of Planning, Performance and Corporate Services / Group Directors**	No action needed		Green	
B.02	Full delegated commissioning of Primary Care expected to come to the CCG wef April 2017.	Joint Primary Care Commissioning Committee; NHSE documented arrangements; Paper received by Governing Body July 2016; Application for Delegated Commissioning November 2016; External scrutiny of conflcts of interests arrangements (Feb'17).	Outcome of audit report for Conflicts of Interests management.	CCG staff resource	None	27/02/2017	**Director of Primary Care & Urgent Care**	Facilitate appropriate governance arrangements as roles and responsibilities become clear.	Mar-17	Amber	
C. Engage effectively with the local population to enable patients and practices to influence the services that we commission.											
C.01	Failure to fully engage with communities to influence service development	CCG Communication and Engagement Strategy; Lay Member role; Website; Governing Body meetings held in public at various locations around Wiltshire; Active involvement of Healthwatch; Acknowledgement of petitions; Equality & Diversity Strategy; Stakeholder Assembly June 2016; Action plan to implement Communication and Engagement Strategy approved at Governing Body November 2016; PPG development work.	Locality Stakeholder days; Public consultations on developments; Healthwatch feedback; Internal audit of stakeholder engagement presented to AAC Nov'16.	Engagement Plan for STP	None	27/02/2017	**Director of Planning, Performance and Corporate Services**	STP engagement Plan to be developed.	Mar'17	Amber	
D. Achieve a sustainable health economy optimising appropriate use of resources for the delivery of efficient and effective healthcare.											
D.01	The CCG is unable to deliver on all QIPP targets	Regular monitoring of QIPP delivery at Governing Body by means of Integrated Performance Report; Finance & Performance Committee (every two months); Directorate Dashboards; Detailed project workbooks; Internal FRP in place.	Governing Body members receive Integrated Performance Report on a monthly basis; Finance & Performance Committee monitoring (on a monthly basis from August 2016); Internal Audit of identification, implementation and management processes for QIPP in 2015/16.	None	None	27/02/2017	**Chief Finance Officer / Group Directors**	No action needed		Green	
D.02	CCG unable to meet the financial targets	Financial Strategy; 5-year Strategy/2yr Operational Plan: Financial management systems; Finance & Performance Committee; Audit & Assurance Committee; Integrated Performance Report; Internal Audit; External Audit; Organisational QIPP Plan; Contracts for commissioned services; Secondary Uses Service (SUS) data correctly attributed to CCG or NHSE; Signed Provider contracts 16/17; Internal FRP implemented; Financial Plans for 17/18.	Governing Body members receive Integrated Performance Report on a monthly basis; Finance & Performance Committee monitoring.	None	None	27/02/2017	**Chief Finance Officer / Group Directors**	No action needed		Green	

NHS Wiltshire Clinical Commissioning Group - Board Assurance Framework & Action Plan March 2017

Principal strategic objective	Issue impacting on achievement of strategic objective	Key controls and systems supporting issue management	Positive assurances of controls (the available evidence on the effectiveness of the controls / systems)	Gaps in controls and systems (or weak controls and systems)	Gaps in assurance (poor evidence of effectiveness of controls and systems)	Date of Last Review	Director Lead	Action Plan	By when	Status	Comments/Updates
D.03	CCG unable to deliver against NHS Constitution	5-year Strategy/2yr Operational Plan: Integrated Performance Report; Finance & Performance Committee; Quality Report at Q&CG Committee; Contract quality schedules to hold providers to account for performance; STP development; RTT delivery group/steering board.	Governing Body members receive Integrated Performance Report on a monthly basis; Finance & Performance Committee monitoring; CRM meetings reviewing providers performance data; Q&CG discussion of provider performance against targets; Reports from RTT delivery group/steering board.	None	None	27/02/2017	**Group Directors / Director of Quality**	No action needed		Green	Recovery action plan in place: RTT (RUH) A&E (SFT,RUH,GWH)
D.04	Lack of available workforce in the local health system to support transformation agenda.	Each organisation monitoring key workforce gaps and taking remedial action eg overseas recruitment; System wide workforce capacity audit undertaken Feb 15; Health Education England workforce planning; UWE courses for community and primary care staff in place; Wiltshire Institute of Health & Social Care; Workforce Action Group (system wide) commenced Sept'15 looking at operational collaborative solutions concentrating on efficiency, learning & development and recruitment ; Safer Staffing data part of IPR; Monitoring of provider vacancy rates at contract performance meetings; Workforce key work stream in STP and monitored at STP Leadership Group.	Gap analysis undertaken.	None	None	27/02/2017	**Director of Integration / Group Directors**	No action needed		Green	
E. Develop an effective and responsive clinically led commissioning organisation, working collaboratively with partner organisations.											
E.01	Failure of partner organisations in commissioning of services on behalf of CCG in regard to financial expenditure and patient safety.	Signed Memorandum of Understanding Service Specifications Monthly performance meetings between CCG Lead and Wiltshire Council Lead Joint Business Agreement agreed by JCB 24 October 2013 Better Care Plan governance arrangements; Outcome reports for commissioned services; Director of Integration post. Updated s75 agreement approved by Eiltshire Council and CCG at Health & Wellbeing Board; Internal audit of Better Care Plan Q4 16/17.	JCB as an assuring body; Performance risk assessed, detail included in JBA; Findings of follow-up audit of Better Care Plan.	None	None	27/02/2017	**Chief Finance Officer / Director of Quality / Director of Integration**	No action needed		Green	
E.02	Capacity and capability of CCG staff to deliver against the 5 year plan	Objective setting, PDP and appraisal system and timetable for 16/17; Learning & Development Policy (Jan'16); Project Governance Framework; Workforce report; Staff Survey issued 17/12/15; Central oversight of requests for staff development from April 2016.	Staff survey results; Workforce report (turnover, sickness absence and objective setting data) to Governing Body on six monthly basis.	None	None	27/02/2017	**Director of Planning, Performance and Corporate Services**	No action needed		Green	

NHS Wiltshire Clinical Commissioning Group - Board Assurance Framework & Action Plan March 2017

Principal strategic objective	Issue impacting on achievement of strategic objective	Key controls and systems supporting issue management	Positive assurances of controls (the available evidence on the effectiveness of the controls / systems)	Gaps in controls and systems (or weak controls and systems)	Gaps in assurance (poor evidence of effectiveness of controls and systems)	Date of Last Review	Director Lead	Action Plan	By when	Status	Comments/Updates
E.03	Accountable Officer and Chief Finance Officer leaving the organisation	Chief Finance Officer initially acting as Interim Accountable Officer for 3 months and Deputy Chief Finance Officer initially acting as Interim Chief Finance Officer; Interim Accountable Officer in place from September 2016 and Deputy Chief Finance Officer appointed to role of Chief Finance Officer. NHSE advice on AO post; Professional Recruitment organisation involved in recruitment arrangements for Interim Accountable Officer/Accountable Officer. Remuneration Committee; Staff briefings 11 May 2016, 21 June and 17 October 2016; 9 January 2017; 20 February 2017.	Approval of plans and confirmation of process at Remuneration Committee; Update to Governing Body in private session July 2016; NHSE approval of Interim Accountable Officer until March 2017; NHSE agreed arrangements; AO interview arrangements March 2017.	None	None	27/02/2017	**Chair/Interim Accountable Officer**	No action needed		Green	AO interviews arranged for March 2017 for minimum 12 months appointment
F. Enhance quality and safety of services by ensuring effective mechanisms are in place to set quality standards, assess performance, address concerns and drive continuous improvement.											
F.01	Range of risks associated with business continuity across local community and including the CCG as a separate organisation including: Severe weather; Disruption to transport infrastructure (incident/fuel supply); Disease pandemic; Telecommunications infrastructure failure.	Participation in Local Health Resilience Partnership at executive and working group level; Contributing through LHRP to risk management through LHR Forum; LRF Joint plans (e.g. Fuel, Telecommunications); Health Protection Unit; LRF Warning & Informing Strategy; LRF Major Incident & Recovery Plan; Business Continuity Plan and EPRR presented to and approved by AAC; EPRR annual self assessment (Aug 2016).	LHRP workplan and meetings; Community Risk Register; Involvement with EPRR exercise; Internal Audit and Business Continuity arrangements; 'Sahara' exercise and report to LHRP.	None	None	27/02/2017	**Director of Planning, Performance & Corporate Services**	No action needed		Green	Rolling cycle of readiness exercises.
F.02	Provider organisations failing to provide harm free care to Wiltshire residents.	Contracts for commissioned services with quality schedule (for NHS and non-NHS providers); Clinical Quality Review Meetings (for NHS and non-NHS providers); Incident reporting requirement and mechanisms; CQC registration and review; Safety thermometer; Quality & Clinical Governance Committee; Oversight by Q&CG of CQC reports and safety notices; Quality visits; Thematic review of Emergency Departments (January '17)	Monthly Integrated Performance Report to Governing Body including patient safety information; Monitoring of SIRI data at Q&CG; CCG participating in surveillance for highlighted providers.	None	None	27/02/2017	**Director of Quality**	No action needed		Green	Controls in place and assurances of controls working well.
F.03	Implementation of the General Data Protection Regulations by 2018.	Information Governance Group; Primary Care Information Governance Group; SCW CSU Information Governance support; Existing Information Governance Framework; Information Governance Toolkit.	Information Governance Toolkit annual compliance assessment.	National NHS Guidance GDPR compliance action plan. Assessment of current compliance against GDPR.	None	27/02/2017	**Director of Planning, Performance and Corporate Services**	SCW CSU to provide action plan to attain compliance with GDPR for agreement at IGG and approval at AAC.	May'17	Amber	
G. Encourage and support the Wiltshire population in managing and improving their health and wellbeing, wherever possible increasing the ability of people to manage their own care and to make their own choices.											
G.01	The greater involvement of the CCG in the health promotion agenda is contingent on engagement with Wiltshire Council Public Health.	Health & Wellbeing Board; Memorandum of Understanding (MoU) with Public Health - Refreshed 16/17; STP workstream.	Minutes of Health & Wellbeing Board.	None	None	27/02/2017	**Director of Planning, Performance and Corporate Services**	No action needed		Green	

NHS Wiltshire CCG
High Level Risk Register

Current Position	Previous Position	Risk Ref	Risk description including the effect of the risk	Existing controls	Original score: Likelihood	Original score: Consequence	Original score: Score	Actions required to mitigate risk	Due date	Progress against actions	Current score: Likelihood	Current score: Consequence	Current score: Score	Change in score	Status	Last Review Date	New Operational Lead	New Exec Lead	Overseeing Committee
1	1	C - 14/038	Lack of appropriately skilled staff across the health and social care system due to difficulties in recruitment, national staff shortages, transformation of model of care and competitive local market. Will result in the system being unable to cope with demand for services and provide safe high quality care both now and in the future.	Each organisation monitoring key workforce gaps and taking remedial action eg overseas recruitment. System wide workforce capacity audit undertaken Feb 15 and May 16. Patient outcomes in terms of quality and patient flow data collected and monitored by system, BCP dashboard; Health Education England workforce planning; Gap analysis; UWE courses for community and primary care staff in place; Workforce Action Group (WAG) commenced September 2015 (every month) looking at operational collaborative solutions concentrating on efficiency, learning & development and recruitment ; Strengthened links with HESW and HEW including attendence at their Membership Council; Workforce workstream one of key enablers in STP design; Community Education Provider Network developing . outline Wiltshire Workforce Strategy and draft 16/17 action plan presented to JCB.	4	4	16	7. Workforce Action Group determining deliverables and milestones for each workstream. Draft 2017 workforce action plan presented to JCB Jan/Feb 2017. STP action plan overseen by workfroce subgroup and STP leadership group	7. 31/12/17	Succesful bid to HESW for Primary Care Education Network (CEPN) , Steering Group established.CEPN meeting monthly since Aug 16. Project manager to commence March 17, workplan in place. Wiltshire WAG developed a shared coaching register. Now working on leadership development (common courses), promoting care certificate and passport pan-Wiltshire, shared recruitment/career fair resources and rotation and placements in different settings; More engagement with voluntary sector on training and development opportunities; All workforce actions described above are consistent with STP workforce strategy, which is being developed and planned at present. Principles of Homefirst project will be rolled out as part of integrated discharge, including testing a new role of rehab support worker. Programme of training for caring for people with dementia, rehabilitation skills and health coaching in place for delivery from October 2016 onwards. STP Workforce workstream meeting on a monthly basis. Jenny Hair has terms of employment secured with the CCG.	4	4	16	⇔	2 Action Required	13/02/17	Jenny Hair	James Roach / David Noyes	EMT
2	2	P - 16/044	Ongoing operational pressures and challenges, and regular periods of escalation across the Wiltshire Urgent Care whole system threatens to destabilise the health and social care system, leading to less timely treatment and poor outcomes for patients and non achievement of the constitutional targets for 4 hours (and knock on effect for RTT). Ongoing work focussed with RUH and GWH systems supporting A&E 4 hour Recovery and Improvement Plans. All systems undertook the national "Breaking the Cycle" exercise and SAFER patient bundle flow. sharing learning and actions, and monitoring the projects funded through ORCP - now managed through Local Delivery Boards.	Monthly Local A&EDelivery Boards (previously System Resilience Groups) (Wiltshire for SFT, Bath and North East Somerset for RUH and Swindon for GWH) examining strategic level actions and assurance against nationally mandated Rapid Improvement Guidance and : Tripartite meetings (NHSE and NHSI) with CCGs and acute on monthly basis for RUH monitoring submitted trajectories and action plans for delivery. Local weekly calls / meeting to review actions and understand pressures. ORCP funding targeted to manage patient flow through the hospital to assist A&E target delivery; Monthly contract performance review meetings and routine performance management arrangements. Daily and weekly reports and dashboards on acute performance. Group Urgent Care Networks. Quality and Safeguarding Reporting. Strategic conference calls as required. System wide escalation process in place - now reflecting new national guidance.	4	4	16	Monitoring delivery against RAP in place and whole sytem action plans - with clear actions and KPIs	31/12/2016	Since January all three provider systems been mostly at OPEL 3 or 4 Demand in has been high, acuity has been high, flow out has been constrained Average ED performance over last 28 days RUH 78.5% (lowest 66.1%) GWH 71.2% (lowest 52.1%) SFT 85.2% (lowest 67.3%) Actions: Daily sitrep reports (7 days a week) Support to silver and gold calls and on site meetings Escalation room / improved internal information flows and processes Additional triage of NHS111 calls to ED Additional capacity in Clinical Hub GPs visiting hospitals to review Green to Go Additional beds in Savernake Additional patient transport to support disharge	4	4	16	⇔	2 Action Required	21/02/2017	Patrick Mulcahy	Jo Cullen / James Roach	Local Delivery Boards
3	4	F - 16/012	Medium to long term financial position continues to be challenging which will put at risk the CCG's ability to deliver its statutory financial targets if the QIPP targets are not delivered and the out of hospital strategy is not delivered. Overall health and social care economy (both providers and commissioners) have a joint challenge to operate within available resources and to meet constiutional targets.	Financial Monitoring PMO methodology Robust contracting Financial and QIPP planning and service redesign Financial awareness across the membership of the CCG Ownership of the financial challenge acorss the healtheconomy - message through the finance sub group of the STP board.	3	5	15	Robust perfromance framework throughout the organisation. Engagement across the whole of the health economy through the STP	Ongoing	The impact of future demand predictions will put further pressure on the CCG's financial position in future years. As growth in funding to the NHS reduces in 2017/18 and 2018/19 the risk of expenditure outstripping funding will increase unless expenditure can be slowed in line with the transformation programme and the impact of the Sustainability and Transformation plan (STP) which is looking to develop and deliver a whole system approach to change. Commencement of Right Care approach in Q4 16/17.	2	5	10	⇔	2 Action Required	27/02/17	All Directors	Steve Perkins	Finance & Performance Committee and Governing Body
4	3	A-15/062	The deterioration in Patient Transport Service (PTS) performance during 16/17 has resulted in a continuing and significant failure of service. With Acute trust Strategic Transformation Fund (STF) income now impacted by 4hr etc. performance, and PTS failures contributing to pressure on acute trust flow, this issue is becoming more high profile and may require additional funding to resolve.	Monthly performance Data. Contract Key Performance Indicators	5	4	20	Improved system effectiveness between Arriva Transport Solutions Ltd (ATSL) and trusts. Additional funding required to at least maintain current performance and prevent deterioration.	31.03.2017	CCG committing aditional £369K p.a. from 13 Feb 17 to put ATSL into non-loss-making position. CCG has committed to funding additional discharge support vehicle at each trust initially from 6 Dec to 10 Feb, now extended to 31 Mar 17, total cost c.£110K Trusts continue to be engaged with, to improve pre-planning, and reduce some trust-generated inefficiencies. ATSL continue to be engaged with, to improve coordination with trusts. Additional actions were agreed between CCG AOs/DoFs and ATSL to enable further service improvements/efifciencies	3	5	15	⇩	2 Action Required	14/02/2017	Andy Jennings	Lucy Baker	

NHS Wiltshire CCG
High Level Risk Register

Current Position	Previous Position	Risk Ref	Risk description including the effect of the risk	Existing controls	Original score			Actions required to mitigate risk	Due date	Progress against actions	Current score			Change in score	Status	Last Review Date	New Operational Lead	New Exec Lead	Overseeing Committee
					Likelihood	Consequence	Score				Likelihood	Consequence	Score						
5	6	A - 14/025	There is a risk, that as a CCG we will not achieve the NHS Constitutional target for patients to be treated within 18 weeks of referral for elective care. The national target is 92% of incomplete pathways (patients not treated) to have been waiting for less than 18 weeks. This risk affects the CCGs assurance rating and may have financial implications if additional activity is commissioned or diverted from affected providers to improve performance overall.	• Monitoring arrangements: The Referral to Treatment (RTT) Assurance Group ensures increased scrutiny of provider actions to mitigate RTT delivery risk. The RTT Assurance Group monitors impact versus revised national targets and agrees next steps to ensure continued assurance of elective waiting times. • There is greater scrutiny of RTT assurance via contract performance meetings, which is reported collectively into the Wiltshire System Resilience Group (SRG). • Updates on demand and capacity modelling and risk areas ensures that a proactive, whole system approach to demand management. • Attendance of internal provider meetings by WCCG team members, as well as relevant tripartite discussions where issues remain. • Link between the CCG and Bristol where there is a separate agreed action plan to address 52 week waits for spinal surgery, and the CSU contacts any non local providers that report a 52 week wait to ensure a 'To Come In' (TCI) date has been agreed. • Remedial Action Plan in place with GWH. • Remedial Action Plan in place with RUH.	4	4	16	1. Creation and implementation of pan-Wiltshire winter elective sustainability plan working collaboratively with all acute and independent providers and BANES CCG and Swindon CCG. 2. Continued monitoring of remedial action plans in place for RUH and GWH via monthly dedicated assurance meetings with each provider. 3. Weekly dashboards with RUH and GWH to facilitate proactive review and remedial recovery actions. 4. Additional focus on SFT due to increasing w/list and delay in performance recovery due to NEL pressures. 5. Information deep dive at SFT to include shape and size of total w/list at speciality level, 18 week backlog with a focus on patients over 30 weeks and data trends. 6. Ongoing data quality issues at SFT.	31.3.17	1. Information deep dive at SFT completed with actions agreed to reduce tail. Focus on increasing validation team to expedite process and ensure reported performance is reflective of actual performance. 2. Monthly steering board at GWH continues. 3.. RTT Delivery Performance Group meeting monthly with RUH. 4. Agreement with all providers to increase cancellation reporting from 1 November to include all postponed patients for NEL pressures not just those cancelled on the day to capture likely performance impact and monitor patient experience 5. Agreement to review current Pan-Wiltshire RTT Assurance meeting and transition to STP wide meeting focusing on development of performance trajectories and strategic elective planning.	4	4	16	⇔	2 Action Required	23.2.17	Lucy Baker	Lucy Baker	RTT Assurance Group feeding into SRG
6	7	A - 14/043	Constitutional performance risk: there is a risk that 2ww cancer referrals will increase following the launch of the national cancer strategy particularly the focus on early diagnosis; and provider perfomance will suffer. Whilst the CCG is delivering the 2ww target (achieved for Q1 but failed for Aug), performance is tight and increasing risk has been flagged by acute providers via the RTT Assurance Group.	*KPI reports on performance *Contract Performance meetings to review achievement and trends alongside known operational issues and demand pressures. *Performance monitored against remedial action plans.	4	4	16	Review highest growth / poorest performance areas (RUH breast, GWH dermatology), engage with acute trusts to understand causes of growth in activity / referrals, causes of declining performance, constraints, recovery options, and continue to monitor delivery.	28.02.2017	* RUH improved breast performance for 3 months led to RAP and Contract Performance Notice being closed; however planned recruitment to enable sustained performance has failed and performance hasd again deteriorated. * GWH 2ww dermatology failure has been recovered. * NHS Wiltshire CCG breached 3 NHS Constitution standard indicators in Dec-16, Breast 2ww, 31 Day diagnosis to treatment and 62 Day RTT. This led to a quarterly breach in Breast 2WW and 62 Day RTT. SFT were the main contributor to all three CCG indicator breaches in Dec-16 * 2ww activity growth at 8% YTD (highest at 15% at RUH) - RUH pressure in upper GI & Gynae, SFT pressure in Lower GI, Breast & Lung, GWH pressure in Lower GI.	4	4	16	⇧	2 Action Required	14/02/2017	Andy Jennings	Lucy Baker	
7	9	CJ - 16/042	Within the AWP current contract there is 111 WTE vacancy rate across AWP Acute and Community services for Wiltshire population and within the next 5 years there is approximatley 40 MHO status that will be eligible for retirement. Taking all of this into account if AWP do not recruit to post and do not create a talent management pool to establish new clinical leadership across the Wiltshire services, the overall longevity of MH service for Wiltshire is at risk in the immediate medium term period (next 5 years). This will lead to sub-optimal care for Wiltshire patients and possible knock on effect in other services.	Wiltshire Focus Recruitment and Retention Strategy for 16/17; Workforce Strategy Group (agreed ToR); Local CQPM Contract Governance Structure; Recruitment and Retention Implementation Plan monitored through CQPM; AWP Wiltshire establishment monthly report.	5	4	20	AWP Talent Management Programme;	~~31/10/16~~ 30/06/17	The Workforce Strategy Group agreed to focus on 3 work streams: Workforce; Recruitment; Talent Management and a plan was developed to encompass these workstreams. Wiltshire CCG now receive a robust monthly Wiltshire AWP establishment report and an update of their recruitment and retention progress.It was decided during Oct AWP CQRM pre-meet that it would be more beneficial to have commissioning attendance of the Trustwide Workforce strategy meeting to ensure there is a direct forum to feedback or escalate workforce issues to AWP executive team, and promote the need to address Wiltshire workforce issues to the Trust. Dec' 16 vacancy rate 119.5 (21.2%) due to increasing rate, a recruitment and retention RAP was requested in Nov' 16. The RAP has not been signed off yet as it lacks tangible deliverables, outcomes or a trajectory. CSU will not support working with AWP to improve this. Recrutiment and retention continues to be monitored through monthly local and multi-lateral CQPM meetings. Jan'17 vacancy rate 116.59 (21.62%), RAP received but not focused or targeted enough. Revised RAP due 17/3/17.	5	4	20	⇔	2 Action Required	09/03/2017	Georgina Ruddle	Ted Wilson	?
8	Not on report	CJ-16/043	CTPLD service have raised ongoing capacity pressures and service need outside their commissioned remit. There is a potential patient safety risk owing to the service's reduced ability to deliver early interventions and manage escalations in presentation effectively, sometimes owing to not being informed of a service users placement in area until a crisis has occurred.	LD Service Development Group Review of LD services (Q4 16/17)	4	4	16	Briefing paper to highlight issues with complex cases Review LD Services	23/12/2016 31/03/2017	A review of LD services will be completed by Q4 16/17. The outcome of this review will inform future commissioning of services with a view to ensuring gaps in service need will be address, pathways improved to allow and accomodate effective and seamless escalation and step down of service users, and collaborative and effective service interface. Commissioners continue to work closely with CTPLD and LDWISS to support service delivery. An LD service development group has been established to facilitate practive working across the LD pathway. A briefing paper is being drafted to highlight issues with complex cases; paper due to completion 23/12/16	4	4	16	⇔	2 Action Required	09/03/2017	Georgina Ruddle	Ted Wilson	EMT

NHS Wiltshire CCG
High Level Risk Register

					Original score						Current score							
Current Position	Previous Position	Risk Ref	Risk description including the effect of the risk	Existing controls	Likelihood	Consequence	Score	Actions required to mitigate risk	Due date	Progress against actions	Likelihood	Consequence	Score	Change in score	Status	Last Review Date	New Operational Lead	New Exec Lead	Overseeing Committee
9	Not on report	Q - 16/035	GWH Emergency Department unable to provide assurance of patient safety. Actions agreed at the Single Item QSG such as SHINE checklist not embedded and NEWS audits sample small numbers of patients only. Quality risk profile tool completed with NHSE, NHSI & Swindon CCG. 12 hour trolley breaches occuring most weeks with additional patients outside of DTA waiting significant lengths of time in ED. Serious Incidents logged reflecting poor use of NEWS with deteriorating patients.GWH reliant on 50% tempoary staffing of Emergency Department. These issues reflect concern that patient experience and safety is not assurred which may lead to patient harm.	SHINE checklist NEWS audits Staffing profile NHSI involvement	2	4	8	GWH asked to provide further assurance, amending audit methodology to evidence SHINE.	31/03/17	Meeting being arranged by NHSE with Swindon CCG and Wiltshire CCG to complete quality risk profile. Review of all 12 hour trolley braech reports and traingulation with Serious Incidents data and NRLS.	4	4	16	new	2 Action Required	07/03/2017	Alison West	Dina McAlpine	Q&CG
10	Not on report	P - 16/045	Taking on delegated responsibility for primary care commissioning from April 2017 will impact on capacity of existing staff and require additional staffing with no transfer of resource from NHS England. Potential impacts include reduced support to practices and localities at a time of vulnerability; delayed practice payments, reporting, contract reviews or variations. Hosting services for other CCGs increases the risk that current or new staff are overwhelmed with issues in other areas and core support is impacted. Current trasition plans are not sufficiently detailed to plan impact.	Ongoing meetings and requests for information from NHS England. Alignment of NHS England staff during 2017-18 transition year will mitigate risk	4	3	12	Detailed transition plan to be agreed Staffing plan to be developed and agreed with other CCG(s)	15/03/2017	Ongoing NHS England meetings for primary care contracting and finance transition. Job description being finalised for first additional support staff member.	4	3	12	new	2 Action Required	21/02/2017	Tracey Strachan	Ju Cullen	PCJCC