From the Earl Howe
Parliamentary Under Secretary of State for Quality (Lords)

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Lord Hunt of Kings Heath
House of Lords
London
SW1A 0PW

1 NOV 2012

Dear Philip,

Following the debate on the National Health Service (Clinical Commissioning Groups) Regulations 2012 on 16 October, I thought it might be helpful to write to you in order to further clarify our intentions. I also promised to write to peers in response to specific questions and these are contained in the Annex. Please do contact me if we have not addressed any of the points you raised.

As you are aware, Clinical Commissioning Groups (CCGs) are at the heart of our NHS reforms. CCGs will be different from any predecessor NHS organisation. Whilst statutory NHS bodies, they will be built on the GP practices that together make up the membership of a CCG. It will be vitally important that CCGs are clinically led, with the full ownership and engagement of their member practices, so that they can bring together advice from the broadest range of health and care professionals to influence patterns of care and focus on patients' needs. At the same time they will need to demonstrate probity and governance commensurate with their considerable responsibilities for their patients' healthcare and their stewardship of NHS resources. Without doubt, both are important. However a clear distinction should be made, as the NHS Future Forum set out, between clinical involvement in CCGs through designing care pathways, shaping local services and other operational activities, and the actual governance of the CCG. I will set out in this letter how our proposals enable both the genuine engagement of health and care professionals, other than GPs, in the new commissioning arrangements, while also ensuring that CCGs have robust governance arrangements and operate in a fair and effective manner.

Let me turn first to the issue of local secondary care clinicians and registered nurses. A CCG in the daily course of its activity will be able to retain local healthcare professionals to advise them on the design of healthcare. Indeed, the Health and Social Care Act 2012 places on them

explicit duties to seek advice from a broad range of professionals in commissioning services. This could involve, for example, a CCG employing or otherwise retaining healthcare professionals to advise the CCG on commissioning decisions for certain services, or indeed appointing health or care professionals to any committee that the CCG may set up to support commissioning decisions or other operational activity. We are completely clear that clinical commissioning will be at its best when it is a collaboration of professionals, based on a shared drive for continuous quality improvement and greater integration of services.

This is already happening. As I mentioned during the debate, Wokingham CCG, secondary care and primary care clinicians have been working to redesign cellulitis care by consulting with patients and moving more care into the community, and the South Devon and Torbay CCG has been working with secondary care clinicians to provide safer follow up care for men with prostate specific antigen levels. This new service was designed by secondary care doctors and GPs working together in a clinical group for urology.

The governance arrangement of a CCG should be looked at as a separate issue. The secondary care doctor and registered nurse are there to provide a view beyond primary care into the governance of the CCG, in particular, insights into secondary care and nursing. The challenge and scrutiny the secondary care doctor and registered nurse could input into the decision-making of the governing body, including for example about the quality of services provided by a local hospital, would be more robust if it came from a secondary care doctor or registered nurse who had no service links with the CCG or its constituent practices.

During the debate, a number of concerns were raised in relation to the conflicts of interest for GPs commissioning services. Unlike primary care, which will be commissioned by the NHS Commissioning Board, most local secondary and community services will be commissioned by CCGs. Given that GPs will not ordinarily commission primary care the level of potential for conflict of interest is not as great for that of secondary doctors and nurses who could possibly commission services from where they are employed. Where GPs do wish to commission services when GP practices are potential providers, the NHS Commissioning Board has produced a code of conduct that provides specific, additional safeguards that CCGs are advised to have in place.

In addition, CCGs will be subject to rigorous safeguards to prevent conflicts of interest affecting their commissioning decisions. Each CCG must make arrangements, set out in their constitution, to manage conflicts and potential conflicts of interest to ensure that they do not, and do not appear to, affect the integrity of the group's decisions. Each CCG must also

maintain registers of interests of members, members of the governing body, employees and members of committees and sub-committees (including of the governing body).

In relation to local councillors being disqualified from being members of the governing body, we believe that this would go against the grain of the reforms and that the most appropriate and effective way for councillors to influence NHS commissioning will be through health and wellbeing boards, rather than through opening up the membership of CCG governing bodies.

Health and wellbeing boards will be the forum for local authorities, the NHS, local Healthwatch, communities and wider partners, to share system leadership of both health and care services and population health. They will develop a joint understanding of local needs through Joint Strategic Needs Assessments (JSNAs); a shared set of priorities and a strategy to address these in Joint Health and Wellbeing Strategies (JHWSs). As I mentioned during the debate, this approach gives councillors a significant opportunity to influence NHS decision making at a strategic level.

I hope this letter has gone some way to addressing concerns members have about these CCG regulations. In summary, the restrictions we have placed on CCG governing body membership are there to protect the integrity of commissioning decisions. Nevertheless, local secondary care clinicians and councillors will still have significant opportunities to contribute their expertise to commissioning through local engagement and health and wellbeing boards.

I am placing a copy of this letter in the Library and copying it to all Peers who spoke during the debate.

Yours ever,

Freddie

EARL HOWE

Annex – Response to specific concerns

Lord Hunt

Lord Hunt asked for clarification concerning the position of House of Lords members and elected police commissioners on CCG governing bodies. Regarding members, they are not excluded from the boards of PCTs and SHAs. In addition, many peers are non-political and can draw on areas of expertise that will be useful to CCGs. On the issue of elected police commissioners, they were not in existence during the drafting of these regulations. Once they are formally appointed, we will consider reviewing legislation to add them to the list of individuals excluded from CCG membership.

Concerning NHS foundation trust members, CCGs will be able to appoint an NHS foundation trust member to its governing body if it has made provision for this in its constitution. However, they will be excluded from performing either of the two mandatory lay roles. The intention behind the regulations is that lay members on a CCG governing body should have no significant link, beyond being a patient, to a provider of healthcare services. Given the important role members have in their respective foundation trusts, it would not be appropriate for them to perform lay roles on a CCG governing body.

Lord Harris

Lord Harris asked a question about why local authority employees will not be allowed to sit on CCG governing bodies. Local authority employees are excluded (by paragraph 1 of Schedule 4 to the Regulations) from being lay members of CCG governing bodies. They are not disqualified from membership altogether. The Health and Social Care Act provides that the persons who may be members of a CCG governing body are a member of a group who is an individual, an individual appointed by virtue of regulations, and an individual of a description specified in the CCG's constitution. These regulations require that a governing body must have at least six members, comprising the accountable officer, the chief finance officer, a registered nurse and a secondary care specialist, and two lay persons, one with expertise in financial management and audit matters, and one with knowledge of the CCG's area. "Lay persons" are persons who are not members of the CCG or other healthcare professionals, and who do not fall into the descriptions of persons set out at Schedule 4. Local authority employees are therefore excluded from taking on either of these two mandatory lay roles.

However, it is open to a CCG to appoint more than the six required members to its governing body by specifying a description of such a person in its constitution. The only persons who could not be appointed in this way are those who are disqualified from membership as they fall within one of the categories at Schedule 5 to the Regulations. Local authority members (i.e. councillors, as opposed to employees) are listed at paragraph 2 of this Schedule, and are therefore banned from being governing body members.

Nevertheless, a councillor may still serve as a member of a committee or sub-committee of a CCG governing body (with the exception of the remuneration committee, membership of which is limited to members of the governing body). The CCG may include individuals on governing body committees (other than the remuneration committee) who are not members of the CCG or governing body, provided they are within a description of persons specified in the constitution of the CCG.

Lord Warner

Lord Warner raised a number of concerns about the accountable officers of CCGs. The Health and Social Care Act provides that the accountable officer may be a GP from a member practice of the CCG (or, in cases of joint appointments, of one of the CCGs in question), or the accountable officer may be an employee of the CCG or of any member of the group (or, in cases of joint appointments, an employee of one of the CCGs in question or any of its member practices). It is a matter for the CCG to decide whether it wants to appoint a GP as its accountable officer or not. There are no restrictions placed on the number of GPs who can sit on a CCG governing body – this is left to the members of the CCG to determine. In addition, GPs can be appointed to any of the CCG's committees or sub-committees, as well as to the governing body's committees and sub-committees, and may have specific functions delegated to them as individuals.

The same Health Service Journal (HSJ) report that Lord Warner quoted also stated that 89 per cent of GPs were fulfilling the role of CCG governing body chair. It is important that there is a good mix of expertise with clinicians and managers in the broader leadership team to help a CCG discharge its responsibilities effectively.

There are wide variations across the CCGs surveyed in the number of GPs in governing body roles. This testifies to the fact that CCGs as organisations are being developed locally, rather than to a national template.

Lord Warner also asked about integration. Health and wellbeing boards will play a crucial role in facilitating the integration of health and social care in future. CCGs will work with elected councillors, local authority commissioners and representatives of patients and the public through health and wellbeing boards to develop a comprehensive analysis of health and social care needs in each local area, and translate these into action in joint health and wellbeing strategies and their own commissioning plans. Regulations made under section 75 of the National Health Service Act 2006 enables CCGs and local authorities to enter into partnership arrangements in relation to the exercise of prescribed functions, if that is likely to lead to an improvement in the way in which those functions are exercised. These arrangements can involve, for example, pooling funds and one body exercising functions on behalf of the other.

Lord Warner also stated that he felt there were too many CCGs and the regulations will make it difficult for CCGs to merge. The current configurations have been driven by GPs on the ground and the NHS Commissioning Board has worked with CCGs to ensure their proposed arrangements are viable. These regulations provide flexibility for CCGs to refine further their configurations.

Baroness Williams of Crosby

Baroness Williams asked about the transparency of CCGs. There is a range of measures to ensure transparency in decision making by CCGs. In particular, the CCG must set out in its constitution its decision making processes, both for the group as a whole and for the governing body. In addition, it must set out the arrangements it has in place to manage conflicts of interest, and to ensure transparency about the decisions both of the group and of the governing body, and the manner in which they are made. These arrangements will be scrutinised by the NHS Commissioning Board when considering an application for establishment.

The governing body requirement to meet in public is modelled on provisions in the Public Bodies (Admission to Meetings) Act 1960. That Act allows bodies to exclude the public from meetings or parts of meetings if it considers that it would not be in the public interest for the public to be admitted. Similarly, with CCGs, the presumption is that meetings of the governing body will be open to the public unless the CCG considers that it would not be in the public interest to permit members of the public to attend a meeting, or part of a meeting. Further, a CCG's governing body must publish papers considered at its meetings, and certain information relating to determinations on remuneration, fees and allowances payable, except where the governing body considers that it would not be in the public interest to do so in relation to a particular paper or part of a paper. An example of when openness would not be considered to be in the public

interest might include discussing a staff matter or issues of commercial sensitivity.