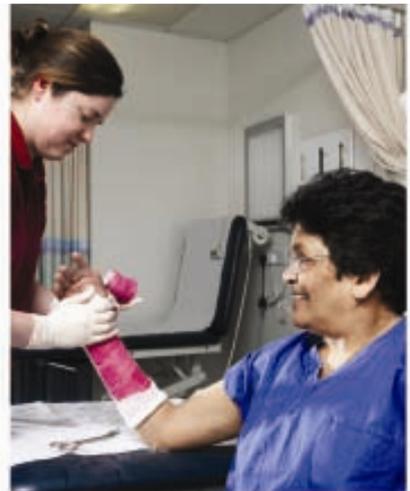




**Commissioning Board**  
*A special health authority*

# Clinical Commissioning Groups

## HR Guide



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**This guide will be supplemented by the HR expertise and advice already available, which we know CCGs are already accessing via PCTs and SHAs, as they will often be best placed to give the specific advice required on the ground. Initial questions should therefore be directed through these routes. This guide should be read in conjunction with the document “Clinical Commissioning group governing body members: Role outlines, attributes and skills”.**

**Further questions can also be posted to the NHS Commissioning Board Authority’s HR Lead for Clinical Commissioning Groups, Mike Walker – [mikewalker@nhs.net](mailto:mikewalker@nhs.net)**

## 1. Clinical Commissioning Groups – HR Guide

- 1.1 The Government's ambition for the NHS to deliver health outcomes among the best in the world is rooted in the three principles of giving patients more information and choice, focusing on healthcare outcomes and quality standards, and empowering frontline professionals with a strong leadership role. At the heart of these proposals are clinical commissioning groups (CCGs).
- 1.2 CCGs will be different from any predecessor NHS organisation. Whilst statutory NHS bodies, CCGs are also membership organisations accountable to constituent GP practices. These member practices must decide, through developing their constitution, and within the framework of legislation, how the CCG will operate. They must ensure that they are led and governed in an open and transparent way which allows them to serve their patients and population effectively.
- 1.3 CCGs are moving towards establishment at different rates, as they begin to design their organisational structure, begin to establish their operating forms, and develop their commissioning priorities. The decisions which individual CCGs are free to make on their structure, process and form will have significant implications for the way they operate, but also for the employment opportunities for existing staff within the NHS.
- 1.4 The complexity of the reforms and the workforce challenges cannot and should not be underestimated. Approximately 50,000 staff being reorganised across a large number of employers into new organisations, requires clear processes and systems and effective partnership working of all stakeholders. Structural changes to the NHS of the kind being outlined are generally covered by employment regulation – including redundancy and TUPE<sup>1</sup> transfer as well as government policy - including COSOP<sup>2</sup>.

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<sup>1</sup> TUPE – Transfer of Undertakings (Protection of Employment) Regulations

<sup>2</sup> COSOP – Cabinet Office 'Staff Transfers in the Public Sector' Statement of Practice Guidance

## 2. Purpose of this guide

- 2.1 This guide is designed to support CCGs as they move towards establishment and authorisation, whilst reflecting the high-level principles governing the changes affecting staff across the NHS. It provides practical advice about how CCGs can approach the main HR issues that they are likely to encounter as they become established, beginning with the senior appointments process, transfers of staff and remuneration.
- 2.2 The guide has been developed with input from CCG leaders and in partnership with staff side (recognised NHS Trade Unions) in order to protect and guide CCGs through complex HR issues and support their development to become good employers.
- 2.3 The NHS has established longstanding fora for working in partnership with trade unions (see Appendix 4). These fora have been supplemented and supported by the establishment of national HR working groups for this change process – including the national HR Transition Partnership Forum<sup>3</sup>. This Forum commends the guide to CCGs, which has been developed as part of a suite of tools and guidance, some of which will be relevant to CCGs during this process - these include the HR Transition Framework; the assignment guidance; regional HR Frameworks; and the HR Transition Guidance and Toolkit (see reference guide – section 10).
- 2.4 Finally, this guide recognises that CCGs will become statutory NHS employers who will be required to enact their duties in line with the Health and Social Care Act. It recognises that CCGs are moving forward at different rates, but they will all have to navigate through complex structural change covered by employment legislation and government policy. This guide therefore aims to provide a broad framework to keep CCGs safe, enable good practice and consistency; and recognise that an appropriate level of local flexibility will also be required. The guide therefore needs to be supplemented by local HR expertise and advice, which we know CCGs are already accessing via PCTs and SHAs, as they will often be best placed to give the specific advice required on the ground.
- 2.5 Fundamentally, this framework will enable CCGs to secure the best possible clinical commissioning arrangements, by helping them to:
- Secure the best available talent;
  - Enable clinicians to take on senior leadership roles;
  - Abide by the principles of the HR Transition Framework, including fair treatment of staff and minimising redundancies;
  - Establish suitable partnership arrangements;

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<sup>3</sup> HR Transition Partnership Forum is a partnership of Department of Health, Trade Unions, Employer and SHA Representatives; established to provide a single national forum for the discussion and development of HR policies and processes to support workforce transition across the NHS.

### 3. HR Transition Framework

3.1 With so many different organisations, functions and staff groups involved in making the NHS reforms a reality, it is vitally important from both a moral and legal perspective that staff are treated consistently and fairly as the organisational changes move forward. This document therefore holds true to the HR Transition Principles, which have been established to ensure fairness and consistency during these changes across the NHS. The HR Transition Principles have been developed and agreed in partnership with trade union colleagues.

3.2 The HR Transition Principles state that current and future employers should:

- consult and engage with employees and their representatives and make sure they are kept fully informed and supported during the change process;
- promote transparency, equitability and fairness in all transfer, selection and appointment processes;
- ensure professional and respectful behaviour towards all employees moving between organisations;
- work with pace to minimise disruption and uncertainty for employees affected by change;
- ensure the consistent treatment of employees at all levels;
- actively promote equality and diversity standards through all transfer, selection and appointment processes;
- highlight necessary compliance with relevant employment legislation;
- undertake early engagement with employees and unions to enable effective and sustainable change. There will be partnership working with trade unions at a national, regional and local level;
- ensure that there is an equality impact assessment of the proposed changes to determine whether there is a disparate impact on one gender, ethnic group, those with disabilities or those working part-time;
- ensure that all reasonable steps are taken to avoid redundancies;
- work to ensure that valuable skills and experience are retained;
- ensure that employees who leave the NHS are supported and treated with dignity and respect;

3.3 In developing the HR Transition Framework organisations have been categorised between those who will be receiving staff into new organisations (e.g. CCGs) and those who will be sending staff (e.g. PCTs and SHAs). Throughout this document these will be referred to as “senders”, (PCTs and SHAs) and “receivers” (CCGs).

#### **WHAT DOES THIS MEAN FOR CCGs?**

3.4 *CCGs should be supported by the local HR expertise available to them to ensure the transition is effectively managed on their patch, in line with the principles above. SHA Clusters have been asked to ensure that every CCG has a named HR lead to support them through the transition. The HR processes for appointing and transferring staff into CCGs will need to take account of the overall agreement of*

*which functions will be carried out where in future. We expect a number of staff will be transferred from PCTs to CCGs, continuing to deliver core functions, although the detail will need to be worked through locally. The HR Transition Principles above will support individual CCGs to manage this transition effectively together, with current employers, staff and trade unions, which is best achieved through local partnership mechanisms.*

## 4. Future structures - working with PCT Clusters and affected staff and trade unions

- 4.1 Decisions made by emerging CCGs in relation to their operating model and organisational structure create new opportunities for staff within clinically-led organisations. This will in turn impact on the employment of some of the staff currently employed by the NHS – particularly those in PCTs. PCTs are already engaged with staff and trade unions, and are re-organising staff to deliver existing operating plans, while positioning them to face the new world. They are using the national assignment guidance to facilitate this process. There is also national HR Transition Guidance and Toolkit (see section 10 Reference Guidance and Tools), which outlines some clear responsibilities for PCTs and SHAs in terms of managing the transfer of functions and staff to CCGs, once they have designed their structures. As receiving organisations, CCGs will have responsibilities for providing clear and timely information on organisational design, structures, roles and responsibilities.
- 4.2 PCTs will also have to share a great deal of information with CCGs about current staff roles. Current employers, potential new employers and trade unions will need to understand which staff are employed in each current function and how this current picture may or may not compare with CCG functional design. Role responsibilities are currently being clarified for existing staff, so that organisational design and roles in new organisations can be more easily matched against existing staff, as appropriate. This information is critical in terms of managing the movement of staff at April 2013.
- 4.3 A local joint working group of CCGs, PCTs and trade unions would be an effective way of co-ordinating and managing the workforce issues arising from the establishment of CCGs. The working group would support decision making, facilitate necessary consultation with staff and allow the CCG to address risks and problems locally.

### **WHAT DOES THIS MEAN FOR CCGs?**

- 4.4 *CCGs will find it helpful to work closely with PCT Clusters and trade unions in managing this process. We recommend setting up joint working groups through the PCT Cluster to support this process of working. CCGs will find it helpful to share their development plans at an early stage with the relevant local Partnership Forum, making use of current arrangements or establishing new ones, which will enable CCGs to resolve any workforce problems and issues arising from their establishment. As emerging CCGs determine their future arrangements, they will need to share information on:*
- 4.5 *The functions they intend to perform in-house - with an initial organisational structure and staffing arrangements – identifying roles and responsibilities. This staffing structure will need to include the projected number and range of roles in each function;*

- 4.6 *The functions they intend (or are considering) to share across CCGs – with any emerging model for how those functions might be shared and clarity as to whether their thinking includes a lead CCG employing staff; and*
- 4.7 *The functions they intend to buy in from alternative providers, including from commissioning support services.*
- 4.8 *The decisions CCGs make in how they will deliver their functional responsibilities will impact on the way staff may be transferred from one employer to the next and it may also impact on the number of staff who are employed in the future.*
- 4.9 *Recognised trade unions will have certain rights to information and collective bargaining (negotiations with employers about matters affected their members and other employees). It is also recommended therefore that CCGs establish and share with PCTs and trade unions the following additional information, at the earliest opportunity:*
- 4.10 *The process for determining the pay, terms and conditions to be used for new staff (transferring staff will be transferred on their existing NHS pay, terms and conditions package) with consideration given to equal pay legislation.*
- 4.11 *The system they will be using for managing staffing and workforce functions – e.g. payroll; employment advice; indemnity.*
- 4.12 *How they will work with PCTs and trade unions through the consultation process.*
- 4.13 *Not all this needs to be done straight away, but PCT clusters should ensure that CCGs have the support they need to enable them to do this over time, but some of this information will need to be clear before any pooling or recruitment process can begin.*

## 5. Transfer and appointments to CCGs

- 5.1 Establishing a CCG is a complex process, as it will bring together a range of functions that may be performed in different parts of the existing NHS system (resulting in potential staff transfers) and they will also carry out new functions (resulting in potential new appointments) and manage new relationships with partners in the reformed health and social care system. It will be important that CCGs understand the legal framework within which they need to operate to manage the transition to establishment.
- 5.2 Staff will be employed in the new organisations by either:
- a) transferring with their function (which may involve a competitive process– before or after transfer - if there are fewer jobs than people), or
  - b) a recruitment and selection process, if there is no basis for a transfer, in line with the HR Transition Framework.
- 5.3 CCGs will secure clinical and other expertise from a wide range of areas, including member practices. However this guide focuses on staff who the new organisations wish to employ directly.
- 5.4 Section 6 of this guide provides further detail on the senior appointments process and section 7 provides further detail on transfers.
- 5.5 The national policy on transfers of staff arising from the reforms is being kept under review.

### **WHAT DOES THIS MEAN FOR CCGs?**

- 5.6 *Throughout this process, current and future employers will be responsible for ensuring that all decisions comply with employment law and the public sector duty under equality legislation in order that decisions are fair, transparent, accountable and evidence based, and consider the needs and rights of their workforces. Establishing joint working groups would help future employers to manage this process.*

## 6. Senior appointments process

- 6.1 The aim of this section of the guide is to provide an overarching framework that will enable CCGs to secure the best talent for the new system, whilst treating staff fairly, maximising opportunities for all employees and minimising avoidable redundancies. This will enable us to retain talented and committed employees to ensure the future success of each CCG.
- 6.2 The immediate priorities for appointment will be the three specified leadership roles in clinical commissioning groups: chair of the governing body, accountable officer and chief finance officer. It is for CCGs to run the recruitment and selection process in association for each of these (working with the respective PCT, who will act as the employing organisation once appointments are made, until 31 March 2013, prior to transfer to the CCG).
- 6.3 The process will be very different for each of these three roles and will also take into account whether the background of those interested in the role is clinical or managerial. Much of this guide is focussed on the employment of accountable officers and CFOs
- 6.4 CCGs and PCTs should consider whether there are any TUPE implications arising from a senior appointment and take legal advice if necessary.

### Stage 1 – Assessment

- 6.5 A national level assessment centre and supporting development process has been procured for senior clinicians and managers who are interested in coming forward for one of the three specified leadership roles in clinical commissioning groups: Chair of the governing body, accountable officer or chief finance officer. The process is supported by bespoke development support, for the individuals delivered flexibly to suit different circumstances.
- 6.6 The assessment process is available from mid April 2012, and will be run by Haygroup, in partnership with the NHS Leadership Academy – and for Chief Finance Officers, by Penna - on behalf of the NHS Commissioning Board Authority. CCGs are invited to sponsor any clinician or manager who works in or for the NHS and who is likely to have an interest in applying for these roles, into this process. In addition, each SHA cluster has been asked to identify senior managers and employed clinicians (from SHAs and PCTs and who are on the VSM pay scale or equivalent) for the process.
- 6.7 Colleagues interested in applying for a CCG chief finance officer role will be subject to an initial accreditation process to ensure that they have the appropriate financial skills, qualifications and experience. This will provide a professional 'sign off' before the candidate moves through the next stage of the assessment centre for Chief Finance Officers.

- 6.8 The outcome of the assessment centre will be a short report outlining the participant's capability and potential for the role/s in which they are interested. It will identify whether the individual is ready now or likely to be ready with some further development. The outcome will initially be for the individual who will be expected to share it if they wish to progress to appointment.
- 6.9 This assessment process is separate from, but coordinated with, the actual recruitment and selection processes which individual CCGs will design and run. However, it will enable a pool of talent to be available to CCGs when they begin, or during, their recruitment processes. This is not an exclusive pool, but it is anticipated that the vast majority of leadership appointments will come from this tranche of individuals. This assessment process is also designed to give the NHS Commissioning Board assurance that individuals have the skills and competence to take on these roles, both when it comes to appointing the Accountable officer identified by each CCG, and in its role in assessing the leadership of CCGs in the authorisation process.

### **WHAT DOES THIS MEAN FOR CCGs?**

- 6.10.1 *SHA/PCT Clusters have already begun to liaise with CCGs to ensure individuals they wish to sponsor for any of the three specified leadership roles in clinical commissioning groups: chair of the governing body, accountable officer and chief finance officer are invited to undertake this assessment process. CCGs are not obliged to sponsor any individuals, however they are able to sponsor more than one individual for any of these roles, provided that they have a genuine interest and a realistic prospect in securing one of these key roles in the immediate future.*

## **Stage 2 – Recruitment and Selection of the accountable officer**

- 6.11 The key consideration for CCGs is how to identify and select candidates, by following a fair and transparent process. In agreeing the process to be followed, CCGs should consider how their process will identify the best talent for their particular circumstances, sustain confidence in the new system and minimise avoidable redundancy costs.
- 6.12 CCGs will run this process, which in following best practice; will typically consist of the following stages:
- CCGs will specify in writing the detailed role outline and attributes they are looking for, drawing on the model role outlines issued by the NHS Commissioning Board Authority. The key decision here is whether the CCG is looking for a clinician or a manager to take on the accountable officer role. The role specification should provide a clear indication of the essential criteria required to undertake the role.
  - CCGs determine the process they then wish to follow. There are likely to be four options:
    - To advertise for a clinician from a member practice
    - To advertise for a clinician

- To advertise for a manager, going through the initial ring fenced pool (likely to be at VSM level) in the first instance, and then to NHS staff affected by change more widely if unsuccessful initially.
  - If the preceding process is unsuccessful (or in exceptional circumstances see 6.14) an open recruitment process. The objective is to minimise the number of CCGs needing to access this stage by facilitating access to high quality candidates at the earlier stages.
- 6.12 The agreed selection arrangements should expressly recognise the right of any emerging CCG to secure a clinician from a member practice for the post of accountable officer, in the interests of securing clinical leadership for the group. Any CCG wishing to do so should draw up, in advance, a role specification for its accountable officer which specifies that a clinical background is a requirement for the role and if required a relationship with a member practice.
- 6.13 **Advertisement** – may take the form of a formal invitation to clinicians from member practices to come forward; an advert for a clinician in general; an advert for a manager giving prior consideration to staff affected by change; an open advert. The basis for this decision would need to abide by the principle of being fair, transparent and reasonable and so each CCG needs to be able to justify their approach.
- 6.14 **Pooling** – As receiving organisations, it is the responsibility of CCGs to establish the eligible pool of individuals. However, there is a clear expectation that this will be agreed with their respective sending organisations and local staff side representatives.

It is recommended that, where a non-clinician is being considered for the role, then the recruitment of Accountable Officers and other posts to emerging CCGs should proceed in accordance with ring-fenced pooling arrangements agreed with the recognised unions. This will help to minimise avoidable redundancy costs and potential challenge. If CCGs are unable to recruit from the ring-fenced pool, then the next step is to open the field to staff affected by change in the NHS, and then an open recruitment process. In exceptional circumstances, the CCG may propose to move straight to an open recruitment process. However, CCGs will need to be clear of the basis of this decision, have considered any potential challenge and be able to account for it publicly; particularly if this is likely to lead to an increase in redundancy costs. They should, therefore, take advice from their Cluster HR Lead and would need to discuss their intention to proceed on this basis (in advance) through the relevant local partnership forum.

It is likely that the two key pooling considerations will be banding and geography. In terms of banding, an initial pooling at VSM level / Band 9 (where Band 9 staff have previous experience of leading collective decision making groups, particularly Boards) will allow access to the level of staff (in terms of skills and experience) the NHS Commissioning Board will look for when confirming authorisation. In terms of geography, CCGs may want to consider mirroring the approach the NHS Commissioning Board follows for similar posts during their 'tranche 3' recruitment, which will allow access to the same talent pool as Local Offices and CSS; although in exceptional circumstances CCGs may wish to agree a wider pool.

- 6.15 **Shortlisting** – Guidance attached at appendix 1 (Good Shortlisting Guide)
- 6.16 **Interview** – Guidance attached at appendix 2 (Interview Panel Guide)
- 6.17 **NHS Commissioning Board (NHS CB) Approval for Accountable officer appointments** - The NHS CB has a distinctive role in relation to the appointment of the Accountable officer. The Health and Social Care Act stipulates that CCGs should put forward, as part of their application for establishment and authorisation, the person they wish the NHS CB to appoint as their accountable officer. If the board then considers that the nominee is appropriate, when the CCG is established the board will formally appoint that person as accountable officer. At this point, the NHS CB will need to be assured that the accountable officer is able to take on the specific responsibilities for stewardship of public funds. The assessment process for the accountable officer role is designed to give the NHS CB this assurance. If a candidate is put forward who has not been through this process, this could delay the application for authorisation as the NHS CB will then need to take steps to identify whether this is a suitable candidate.

#### **WHAT DOES THIS MEAN FOR CCGs?**

- 6.18 *In the first instance, the CCG needs to decide how it will approach the selection process. It is suggested that the emerging CCG, in the form of the delegated sub-committee, puts a proposal forward for how selection will take place, taking account of employment law and best practice. This proposal is for agreement by the member practices of the CCG. This needs to begin with an agreement on senior leadership structures.*

#### **For the Accountable officer role:**

- 6.19 - The CCG develops a role outline
- The CCG agrees the proposed remuneration/reimbursement level for the individual, through the appropriate governance arrangements e.g. remuneration committee
- The post is advertised or made available to relevant eligible people. This will vary depending on whether the CCG decides to specify that it would like a clinician who commands the support of its member practices, or a manager.
- 6.20 There are a range of options for selection. It is important that the CCG runs a selection process that protects the CCG from legal challenge (e.g. of discrimination); and enables it to satisfy the NHS CB at authorisation about the suitability of the person nominated as its preferred accountable officer.
- 6.21 Two options CCGs might consider are:
- interview panel, with an invited member of the NHS CB
- interview panel, with independent assessor, who has the confidence of the NHS CB and the CCG

- 6.22 In both situations, each candidate would be invited to share the outcome of their assessment centre report so that the CCG has external assurance of the suitability of the candidate.
- 6.23 There may be a limited number of situations where CCGs seek to recruit an accountable officer at a level below VSM (or equivalent) who have not had access to the assessment process in the very early stages. In these situations we would expect the CCG to shortlist candidates and then ask them to undertake the assessment centre prior to interview.

***For the Chief Finance Officer (CFO) role:***

- 6.24 It is the CCG who makes the appointment. The CFO is a crucial role on the Governing Body in ensuring financial liability, probity and effective use of resources; by its nature, the role will require a qualified accountant with a proven track record and expert financial competence. It is important that this is independently tested before CCGs undertake their local recruitment and thus an accreditation process has been established to test these elements and provide a professional 'sign off' before candidates enter the common leadership assessment centre for Chairs, CFOs, and AOs. It is intended that candidates nominated by the CCGs and SHA will undertake the accreditation from April 2012 onwards. Final recruitment into local roles will be undertaken by the CCGs.

***For the Chair of the governing body role:***

- 6.25 It is the CCG who makes the appointment, through either election, selection or a combination of both. They may wish to consider ensuring that all aspirant chairs of the governing body have taken up the opportunity of participating in the bespoke assessment centres, prior to confirming them as designate chair of the governing body. The NHS Commissioning Board will have responsibility to ensure the leadership of the CCG is appropriate through the process of authorisation. The assessment process would support the NHS Commissioning Board in this regard and would preclude the need for any other commitment.

## 7. Staff Transfers

### *The basis of transfers*

- 7.1 Transfers of staff are expected to take place as part of the transfer of functions from one organisation to another.
- 7.2 Transfers between organisations will be guided by the requirements of the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) and/or the Cabinet Office 'Staff Transfers in the Public Sector Statement of Practice' (COSOP) guidance. It should be noted that the Health and Social Care Act contains general powers to effect Transfer Orders, if appropriate to do so, and these powers support the use of COSOP (which protects the terms and conditions of staff involved in transfers).
- 7.3 CCGs and PCTs will have certain obligations to staff affected by the transition. These obligations will be best met, where they work closely with each other and in partnership with trade unions. The objective of the TUPE regulations are *"to ensure as far as possible the continuation without change of the contract of employment or the employment relationship with the transferee in order to avoid the workers concerned being placed in a less favourable position by reason of the transfer"* ECJ 1989.
- 7.4 The Cabinet Office Statement of Practice (COSOP) reinforces those principles of managing the change process without placing staff at a disadvantage. COSOP was developed by the Government as a mechanism to support effective transition and transfers between public sector bodies. It does this by applying the principles of TUPE, which are followed, even though TUPE does not apply in strict legal terms.
- 7.5 Any Transfer Order would not displace the appropriate application of the TUPE Regulations and both the current and future organisations would be involved in the development of any order.
- 7.6 CCGs should therefore take into account the best available advice on good practice in managing TUPE and TUPE-like COSOP based transfers.
- 7.7 Each transfer is different and decisions are taken depending on the particular circumstances of the transfer but when a transfer of a function takes place, employees who are substantially performing the duties and services in the function that are to be transferred in the undertaking or business before the transfer, would normally transfer to the new organisation, with their contractual terms, including continuity of service, protected, in line with TUPE/COSOP principles. Current and future employers should take legal advice as to the nature and scope of the possible application of TUPE and/or COSOP for each potential transfer that may occur.
- 7.8 There are technical aspects to the TUPE regulations and the definition of a transfer – legal advice should always be obtained throughout the process.

## **WHAT DOES THIS MEAN FOR CCGs?**

7.9 CCGs and PCTs need to confirm which functions are transferring and how those functions will be delivered in the CCG as these decisions will determine the scope for a TUPE or TUPE-related / COSOP transfer. These decisions will need to involve trade unions and will require PCT Clusters to fulfil their duties to inform and consult (highlighted in Appendix 3) to help build positive partnership arrangements (see Appendix 4).

- Consultation with staff and trade unions will assist in identifying which functions are transferring and how PCT staff will be affected by the transition
- Consultation with staff and trade unions must start once it is clear what functions are transferring and that PCT staff will be affected by the transfer (it can of course begin before this).
- CCGs and PCTs to commence consultation on service structure/roles as early as possible. Consultation needs to include trade union representatives.
- Need to consult on recruitment plans and sequencing of recruitment, as this will potentially result in redundancy selection, if staff do not secure suitable alternative employment.
- Consultations are the responsibility of the current employer, who will need to be supported by the new employer (CCG). Consultation needs to be a continuous process locally with use of trade unions / local Partnership Forum.
- As a result of the significant organisational change process, which extends beyond CCG establishment, PCTs will be consulting with staff and trade unions on a range of issues resulting from the establishment of new bodies, the closure of existing bodies, transfers and redundancies.
- There needs to be clear agreement between the partners on how any potential redundancies will be managed, for example any redundancies prior to transfer will be need to be enacted by senders (PCT), whereas after transfer by receivers (CCG).

*PCT Clusters and CCGs need to agree:*

- *Is this a transfer?*
- *Is this a TUPE transfer?*
- *Is this a COSOP transfer requiring a Transfer Order?*

7.10 *If in agreement, a Transfer Order can be used to affect the transfer and specify the terms and conditions of transferring staff.*

7.11 *There will be some functions where numbers currently working in those functions are greater than those needed in the new organisations, which may require a pre-transfer selection process. If TUPE applies to these functions, care will need to be exercised, as employees cannot be put at risk. The intention is likely to be to only transfer those staff who secure a job in the new organisation and any other staff who have a legal right to transfer. It is therefore imperative that PCT Clusters, emerging CCGs and trade unions begin consultation on these issues at the earliest opportunity.*

## 8. Remuneration for Senior Leaders and Executives in CCGs

- 8.1 Although CCGs have autonomy in setting pay within their organisation, pay for senior leaders and executives should be informed by and consistent with the principles set out in the Hutton Fair Pay Review (Hutton Review of Fair Pay in the Public Sector, March 2011):
- a) Remuneration should fairly reward each individual's contribution to their organisation's success and should be sufficient to recruit, retain and motivate executives of sufficient calibre. However, organisations should be mindful of the need to avoid paying more than is necessary in order to ensure value for money in the use of public resources;
  - b) Remuneration must be set through a process that is based on a consistent framework and independent decision-making based on accurate assessments of the weight of roles and individuals' performance in them;
  - c) Remuneration should be determined through a fair and transparent process via bodies that are independent of the executives whose pay is being set, and who are qualified or experienced in the field of remuneration. No individual should be involved in deciding his or her own pay;
  - d) there should be a coherent approach to senior pay across the organisation, which recognises the requirement to ensure value for money in the use of public resources;
- 8.2 CCG responsibilities on pay will be discharged through the governing body whose functions include, determining the remuneration, fees and allowances payable to the employees of the CCG (or other persons providing services to the group).
- 8.3 The NHS Commissioning Board Authority will issue further principles on remuneration in May 2012. This is likely to cover the accountable officer and chief finance officer roles only, rather than any other roles in the CCG.

### **WHAT DOES THIS MEAN FOR CCGs?**

- 8.4 *The governing body must have a remuneration committee that makes recommendations to the governing body about the above. Regulations or the CCG constitution may give remuneration committees additional functions in support of the governing body's functions. Regulations may also require governing bodies of CCGs to publish specified information about the determination of remuneration, fees and allowances.*

### **Impact of Redundancy costs**

- 8.5 Throughout this document, the principle of minimising redundancies has been highlighted as the costs of redundancies represent an opportunity cost to the local health system. It is important that CCGs recognise that there is no separate budget for redundancy costs, and therefore they will need to demonstrate that they have taken all steps to minimise these costs and secure talent from existing NHS staff in the first instance. CCGs will need to be able to justify this decision in public, particularly if it leads to an increase in redundancy costs, as these are funded from the overall budget for the NHS.

### **WHAT DOES THIS MEAN FOR CCGs?**

- 8.6 *Any CCG wishing to go to open recruitment in the first instance would be advised to discuss the basis for this with its SHA, as this may lead to an increase in redundancy costs to the NHS that cannot subsequently be justified. In such a situation, the funding for these redundancies would need to come from the local health system where the unjustified increase had happened. This is a situation that all parties will wish to avoid, and therefore CCGs will be protected from future challenge if they have discussed the basis for open recruitment in the first instance with the relevant SHA, and subsequently regional director for the NHS CB when appointed. There is nothing to stop CCGs using an open recruitment process once they have exhausted the NHS pool of talent.*

*This will ensure CCGs:*

- *Maximise retention of talent*
- *Minimise redundancies*
- *Treat staff fair and transparently*
- *Secure value for money*

## 9. Timeline / Checklist of activity for CCGs

9.1 Whilst recognising that CCGs are moving forward at different rates a suggested timeline has been developed to ensure CCGs are developing at a pace which will help secure the best available talent.

9.2 In order to maximise the opportunity to secure the best available talent, it is suggested that CCGs align to the NHS Commissioning Board Authority recruitment timeline, beginning in May 2012. This will enable staff to make a choice based on their first choice, rather than the first one available. In order to achieve this timescale, a range of activities will need to be underway over the next two months:

- Nominate individuals into the assessment centre and linked development process. This is without prejudice to the future selection process.
- Organisational structures and specified roles on the governing body, along with other senior clinical and managerial roles need to be determined with role outlines and/or job descriptions and person specifications, as appropriate.
- Recruitment plans need to be finalised and agreed
- Transfer plans need to be finalised and agreed
- CCGs and PCTs to commence consultations on senior roles and recruitment plans.
- Consultation to begin/continue locally using trade unions / local Partnership Forum.
- Expectation – when to start consulting on change and redundancy.
- Organisational Design:
  - Specified leadership roles to be confirmed in advance.
  - High level view of what will be provided in-house; shared; purchased from commissioning support organisations – by early May
  - High level structures finalised – by mid-May
  - Pools agreed – by mid-May
  - Matching staff in pools against new structures/jobs – by end of May
  - Pay systems devised, job descriptions written, job evaluation undertaken etc.
  - Assessment procedures for senior leaders to be progressed – June
- Recruitment process underway to senior posts – begin in May/June
- Interviews for accountable officer – begin in June

### **WHAT DOES THIS MEAN FOR CCGs?**

9.3 *CCGs will want to undertake their preparatory work by the end of May 2012 at the latest if they want to secure the best talent alongside the NHS Commissioning Board's recruitment timelines. It will also prepare them for authorisation. PCT Cluster HR teams will provide support to CCGs with this process.*

9.4 *By aligning with the NHS Commissioning Board's timeline, staff will be able to make clear decisions to apply for posts that they are most interested in, which will allow all organisations access to the available talent pool at the same time. Also, the majority of applicants will have been through the assessment and diagnostic process and therefore appointments can be made with confidence.*

9.5 *By following this checklist, CCGs will be well positioned to secure the talent they will need to set up successful organisations, which can drive improvements in outcomes for patients and the public.*

## 10. Reference guidance and tools:

HR Transition Framework -

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_128103.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128103.pdf)

HR Transition Guidance and Toolkit - [hrtransitionguidanceandtoolkit@dh.gsi.gov.uk](mailto:hrtransitionguidanceandtoolkit@dh.gsi.gov.uk)

Social Partnership Forum website - <http://www.socialpartnershipforum.org/Pages/home.aspx>

NHS Commissioning Board Authority -

<http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/>

## Appendix 1 - Shortlisting Guidance

In order to ensure that you identify the best possible talent to interview and potentially appoint, you must follow a robust and fair process of shortlisting. It is vital that once candidates have applied you are not only able to identify potential talent, but also ensure that they are treated fairly.

### What is shortlisting?

Shortlisting is a process used to identify from a set of applications or CVs, who you believe has demonstrated the right experience/skills that would potentially be right for the vacancy.

### Effective methods of shortlisting?

Whatever method of shortlisting is used by an interview panel it must be fair and applied consistently. If challenged the panel must be able to explain their decision for their chosen method and reasons behind their decisions.

Shortlisting involves using the job description/role outline for the post as a way of measuring applicants against the requirements of the role. It is therefore vital that this accurately reflects the job purpose and what requirements the candidate needs to undertake the role. If this does not accurately reflect the role then candidates will not have the best opportunity to demonstrate their abilities within their application form/CV.

Best practice guidance suggests that the interview panel undertake the process of shortlisting together to enable discussion around each applicant, and agree on the reasons for shortlisting or for rejecting each candidate. Panels should record their reasons for each decision to demonstrate the process they have used should they receive a request for feedback from a rejected applicant.

### How can the shortlisting process be made fair?

One way to minimise risk of any unfair discrimination is to ensure all applications/CVs are anonymised from any identifiable information such as age, sex, marital status etc. CCGs may wish to consider allowing an impartial person to anonymise the applications/CVs before they are sighted by the panel for shortlisting.

It is recommended that any agreed independent assessor also be involved in the shortlisting process.

### **What are the consequences for not shortlisting effectively?**

If you do not use an effective process of shortlisting you are likely to miss out on identifying the best talent for the role. The experience of candidates (both successful and unsuccessful) at each stage of the recruitment process will impact on their view of the organisation, therefore it is vital that every stage is handled appropriately.

You could also be challenged by applicants that your processes are unfair or discriminatory. It is important to note that applicants have a right to claim discrimination at an Employment Tribunal at the application stage.

It is also worth noting that if a complaint is made by an applicant, all recruitment documentation may be disclosed to an Employment Tribunal. Therefore, all language used on the forms must be appropriate and relate to the set criteria being measured.

## **Appendix 2 - Interview Panel – Guidance**

Part of the selection process for the accountable officer and chief finance officer roles on the governing body in the CCG is likely to be an interview.

In the case of the accountable officer, this should preferably take place after the candidates have undergone the national assessment process; though where this has not taken place it will be possible to undertake the assessment process after the interview. If a CCG eventually nominates an individual who has not undergone this process at any stage, the NHS CB will not have the external assurance it needs to appoint the individual as the Accountable officer and this could lead to a delay in establishment and authorisation.

Should the interview take place before, then the successful candidate cannot be appointed substantively until they have attended the assessment centre and received appropriate feedback

For Chairs of the Governing Body, CCGs may use election or selection, although most are using a combination of the two, since it is essential that these individuals can demonstrate both the confidence of their member practices as well as the right skills, competencies and attributes.

There are advantages with both election and selection. Election is more likely to maintain the ownership of the member practices and ensure the leaders are responsive to their members. Selection is more likely to ensure the leaders have the right skills competencies and attributes.

Individuals who are interested in the role of chair of the governing body are invited to attend a tailor made version of the assessment centre to access development support, and once completed a CCG could then confirm their designate chair of the governing body.

## **Who should sit on an interview panel for AOs and CFOs?**

CCGs may wish to consider constituting an interview panel with an independent assessor recognised by the NHS Commissioning Board and the CCG, which would help demonstrate a robust and fair recruitment process.

Ideally, the interview panel should consist of a minimum of three individuals from the CCG and one external individual as above. The external assessor should be capable of providing an expert opinion on the candidate's ability to undertake this role. If the external assessor is recognised by the NHS CB then this will facilitate both Accountable officer appointment and CCG authorisation. It is also good practice for at least one of the panel to have undertaken equality and diversity training.

For the chief finance officer post, the CCG should also consider inviting a finance expert on the panel, who could also be the independent assessor. CCGs may wish to contact their NHS CB sector office who will be pleased to facilitate this and in advance of these being established the SHA Director of Commissioning development.

## **Who is an appropriate independent assessor?**

An independent assessor is an individual that has total impartiality with the CCG and the post that is being interviewed for.

CCGs could invite a member of the NHS Commissioning Board to attend the interview. If they are unable to identify someone with the Board, they should seek to appoint an independent assessor whom the NHS Commissioning Board would have confidence in, particularly for the role of accountable officer or chief finance officer.

## **What is the role of the independent assessor on the interview panel?**

The Independent Assessor will be directly involved in:

- decisions on which candidates to shortlist for interview;
- reviewing the selection criteria to be applied at interview;
- assuring the fairness of the interview process itself;
- advising on the selection of those candidates recommended for appointment.

## **Why have an independent assessor?**

Independent scrutiny is at the heart of ensuring all appointments are fair, transparent and are made to the most talented individual for the post. The purpose therefore of an independent assessor is to provide an assurance that appointments have been made on merit after a fair, open and transparent process. This will help ensure not only that the process is fair, but is seen to be fair.

Fairness means that all candidates are treated equally and do not face any form of discrimination. A fair process allows candidates the best opportunity to demonstrate their skills and abilities during the interview process, therefore candidates must be assessed based on their skills, experience and knowledge they demonstrate and nothing else.

## Appendix 3 - Duty to inform and consult representatives

An employer is required to consult long enough before the transfer date (i.e. when there is a real prospect of transfer) to give reasonable time for the consultation. The consultation should include the fact of the transfer i.e. when it will occur; reasons for the transfers; the legal, social and economic implications of the transfer; and any measure, which the transferor (receiving CCG) will take and if no measure then that fact needs to be stated.

The legal, social and economic implications – include answers to what a transfer means; what legal rights are affected; what jobs will look like in the new world; and potential future scenarios in terms of managing the function and the impact on the workforce, whether staff are transferring or not, whether there is a redundancy or organisational change requirement as a result of functions transferring. There are legal rights for access to any affected employees and facilities for ‘appropriate representatives’.

If “measures” are envisaged, then these must be “with a view to seeking [representatives] agreement to the intended measure”. “Measures” are any material change in working practices or conditions of the affected employees.

All this information and detail will clearly be driven by decisions made by receiving organisations – in this situation – emerging CCGs.

The information and detail, which PCTs hold, which will need to be shared with CCGs and trade unions will include:

- The identity of employees who will transfer
- The age of those employees
- Statements of employment particulars
- Collective agreements, which apply to staff
- Any disciplinary action, which has been taken in the previous two years and where the statutory procedures apply
- Any grievances raised as above
- Any legal actions in the previous two years and any potential legal actions.

### Definitions of Consultation

Communication is concerned with the interchange of information and ideas within an organisation. Consultation – formally and informally – goes beyond this and involves managers actively seeking and taking account of the views of employees before making a final decision. There should be on-going and effective communication and consultation **with**, and engagement **of**, staff and their trade union representatives as part of best practice in local people management.

Engagement is not simply about selling or communicating a decision or solution that has already been agreed: it’s about listening and understanding the other party’s point of view in order to co-develop a solution that meets the proposer’s needs and is acceptable to the other party, wherever possible. In this context, the change can happen in a positive fashion rather than becoming an adversarial matter from the outset.

The point at which consultation starts is central to establishing the nature of the consultation and the ability of staff and their representatives to have a genuine impact. To be most

effective, consultation must happen before final decisions are taken and preferably should start as early as possible.

## Appendix 4 - Partnership working

In the NHS context, formal and informal partnership arrangements with trade unions have long been recognised as integral to effective operational management arrangements. The national Social Partnership Forum<sup>4</sup>, chaired by the Minister of State for Health, was created as part of the national commitment to establishing social partnership within the NHS. Successive policy documents have reinforced the importance of ensuring that effective social partnership arrangements underpin and are adhered to alongside established staff communication mechanisms:

*The importance of maintaining good communication and working effectively with trade union representatives cannot be underestimated. It is often the “softer” HR aspects such as effective communication, effective listening and timely engagement that provide for a positive outcome or otherwise. Often there is an underestimation at the start of the process about the time and effort that maintaining good communications might take. However, if handled well, many longer-term benefits can arise. Conversely, if workforce issues are not well handled then difficulties that could arise will take more time and effort to resolve.*<sup>5</sup>

As well as the specific national guidance on partnership and engagement set out above, there are more fundamental requirements set out in the NHS Constitution as follows:

*The (staff) rights are there to help ensure that staff can be involved and represented in the workplace. (Section 3a).*

*The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. (Formal Pledge).*

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<sup>4</sup> Social Partnership Forum: <http://www.socialpartnershipforum.org/AboutUs/Pages/Background-to-the-spf.aspx>

<sup>5</sup> Transforming Community Services, DH 2009:  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_093196.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093196.pdf)