NHS

Protect

Standards for commissioners

Frequently asked questions

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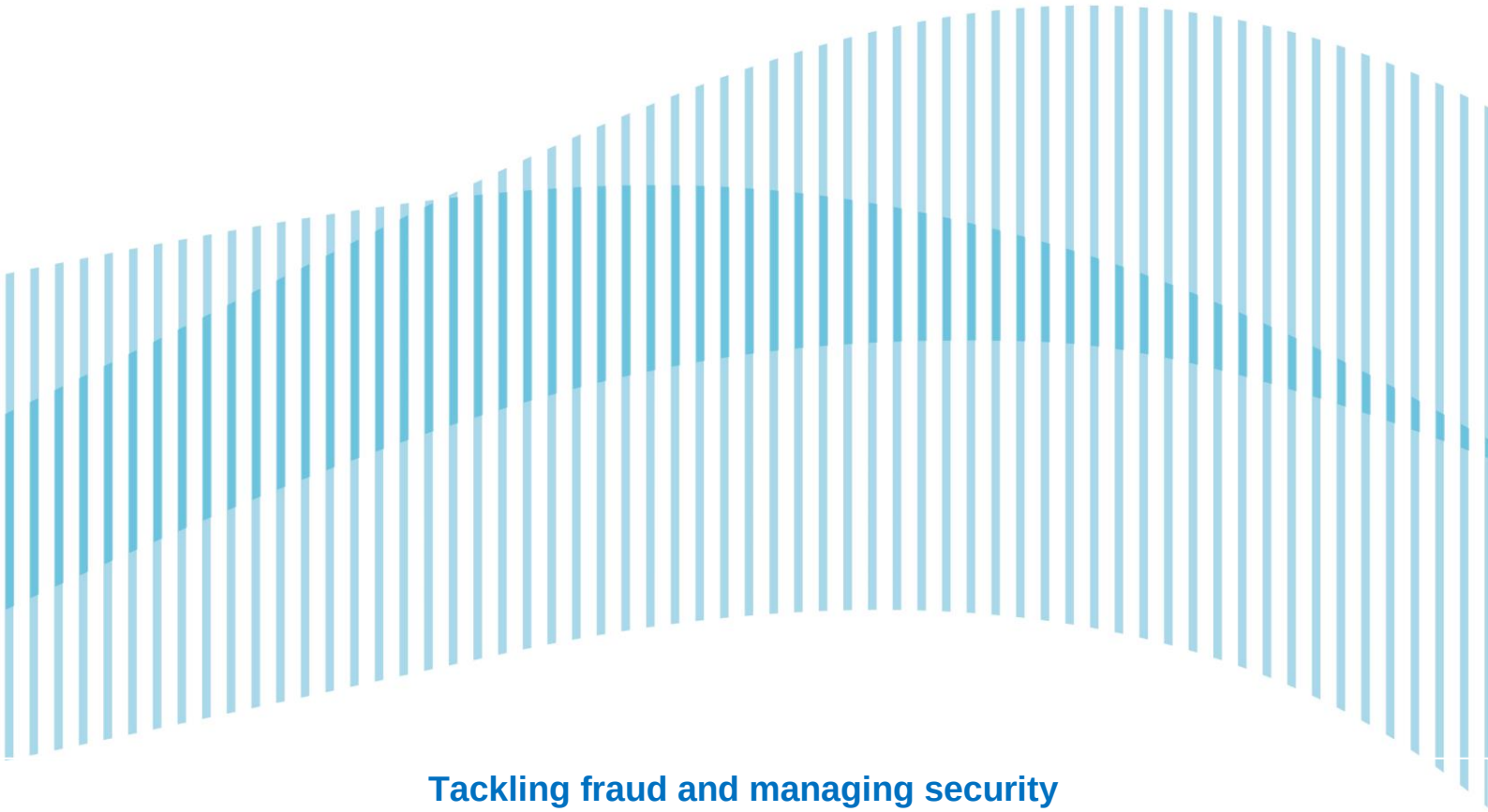

Tackling fraud and managing security

Contents

This is an updated version of the FAQs document produced in September 2015 following liaison meetings with commissioners on the NHS Standard Contract and on NHS Protect's anti-fraud, bribery and corruption standards.

It includes a number of new questions and answers, which have been added following a further round of liaison meetings with commissioners focusing on security management requirements under the NHS Standard Contract and NHS Protect's security management standards. These meetings were held in autumn 2015.

In this updated version questions and answers have been numbered. The new questions and answers are numbers 10-14, 22-24 and 48-49.

The NHS Standard Contract

1. What does Service Condition 24 of the NHS Standard Contract require of providers?

Service Condition 24 of the NHS Standard Contract sets out what providers need to do in respect of anti-crime arrangements (in this document the term 'anti-crime' will be used to refer to arrangements relating to fraud, bribery and corruption and security management). The clauses direct providers to NHS Protect's website, where further detailed information is available (on the Anti-crime standards page). The requirements are also set out and explained in the documents Standards for providers 2015-16: Fraud, bribery and corruption and Standards for providers 2015-16: Security management.

NHS Protect's Area Anti-Fraud Specialists and Area Security Management Specialists can also provide advice and guidance to commissioners and providers.

2. What is meant by anti-crime arrangements?

The standards outline what arrangements should be in place for an organisation to be effective in dealing with fraud, bribery and corruption risks and security management risks.

3. Should a different approach be taken for NHS and private providers?

No. The anti-crime clauses set out in Service Condition 24 are mandatory, and apply to all types of provider, regardless of their legal status.

The NHS Standard Contract exists so that commissioners and providers can operate under one clear and consistent set of rules which everyone understands, giving a level playing field for all types of providers. Section 5 of the NHS Standard Contract 2015/16 Technical Guidance, sets out how the contract should be used.

4. Can you confirm that non-NHS providers are covered by these arrangements?

Any provider commissioned to deliver services under the NHS Standard Contract is required to comply with the conditions set out in Service Condition 24, regardless of their legal status.

Further information on when the NHS Standard Contract should be used is available in the NHS Standard Contract 2015/16 Technical Guidance.

5. Are Local Enhanced Services commissioned under the NHS Standard Contract?

CCGs must use the NHS Standard Contract for all community-based services provided by GPs, pharmacies and optometrists that were previously commissioned as Local Enhanced Services. This will apply where the CCG is commissioning services which expand the scope of services beyond what is covered in core primary care contracts or LIS agreements.

Further details on how the contract should be used are available in section 5 of the NHS Standard Contract 2015/16 Technical Guidance.

6. How will the standards apply to GPs with or without enhanced services?

The NHS Standard Contract should be used by CCGs to commission Local Enhanced Services. If the value of these services is over £200,000, an organisation crime profile should be completed in respect of those services.

If the organisation is allocated to a category 1 or 2 following completion of the organisation crime profile, they will be required to follow the standards in respect of the Local Enhanced Services.

7. What is a small provider?

Small providers are defined in the NHS Standard Contract 2015/16 Technical Guidance as “providers whose aggregate annual income for the relevant Contract Year, in respect of services provided to any NHS commissioners commissioned under any contract based on the NHS Standard Contract is not expected to exceed £200,000”.

8. Why is the contract value for small providers set at £200,000?

This was set by NHS England. It applies to many elements of the NHS Standard Contract, not just Service Condition 24.

9. Can sanctions be implemented into the NHS Standard Contract for CCGs to apply?

There are no plans to introduce sanctions, such as fines, for failing to comply with Service Condition 24. If a provider fails to comply with the clauses set out in Service Condition 24, they may find themselves in breach of contract. It is for the CCGs to determine the level of action taken against a provider that fails to comply.

10. As of 1 April 2016, clinical commissioning groups (CCGs) are becoming responsible for managing GP practices' contracts. Do GP practices have to comply with NHS Protect's anti-crime standards for providers (for example have Local Security Management Specialist provision and a senior partner as a security management director etc.)?

Small providers don't need to complete an organisational crime profile, and are consequently not required to comply with NHS Protect's anti crime standards. A small provider is one whose 'aggregate income for the relevant contract year in respect of services provided to any NHS commissioner and commissioned under any contract based on the NHS Standard Contract is not expected to exceed £200k'.

11. CCGs and providers complete various data returns, such as self review tools and the reported physical assaults statistics. However NHS Property Services complete no returns, even though they may face significant crime risks with an impact on other organisations. Why is that?

The primary role of NHS Property Services is as landlord for commissioning health organisations: they are providing accommodation and associated services to the commissioner. This is outside of the standard contract and consequently the standards. However, they have voluntarily agreed to take part in NHS Protect's quality assurance process and they are voluntarily fully engaged with NHS Protect's anti crime standards and comply with them across all key areas of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account. This should contribute to minimising risk.

12. Where does accountability rest in the event of a significant security incident which leads to legal action? Is the provider or the commissioner accountable?

Primarily, accountability will rest with the organisation where the incident occurred. However, it may be possible that the commissioner has a shared liability in some circumstances, even if the incident took place at the provider.

13. How will CCGs get a clear understanding of how NHS Property Services deliver a safe working environment/comply with the standards?

Please see the answer to question 11 above.

14. Do CCGs need to get assurance from NHS Property Services about their anti-crime arrangements?

No. Please see the answer to question 11 above.

Implementing the standards: commissioners' own anti-crime arrangements

15. Why do I need to comply with the standards, and what happens if I don't?

Under their terms of authorisation, CCGs are required to have counter fraud and security management arrangements in place and access to accredited counter fraud and security management support.

CCGs should ensure that NHS resources are protected from fraud, bribery and corruption and from security management risks. Failure to do so has an impact on their ability to commission services and treatment, as NHS funds are wrongfully diverted from patient care.

The standards have been developed to support NHS commissioners in implementing appropriate measures to tackle fraud, bribery and corruption and appropriate security management arrangements. They were developed at the request of NHS England, and have been approved and adopted by their Audit Committee.

NHS England will be sent copies of quality assurance documents and kept informed of CCGs' compliance with the standards.

16. What happens where primary care co-commissioning is in place? Who will be responsible for fraud, bribery and corruption investigations when NHS England have contracted some elements of primary care work to the Clinical Commissioning Group (CCG)?

The exact arrangements in respect of primary care co-commissioning will depend on the nature of the agreement with NHS England. Broadly speaking, if the financial loss is to NHS England, their contractors will be responsible for anti-fraud work. If the CCG suffers the financial loss, their LCFS will be responsible for anti-fraud work.

17. How much is this going to cost us and who should complete the work to ensure that the CCG is compliant?

While an accredited counter fraud specialist is required to implement a number of the standards, it is the responsibility of the organisation as a whole to ensure it meets them. However, one or more departments or individuals may be responsible for implementing a specific standard. The key departments or individuals likely to be involved in helping the organisation meet the fraud, bribery and corruption standards are finance, internal and external audit, risk, communications and human resources.

There is no data available in relation to commissioning organisations to establish the estimated cost of compliance. The cost may vary depending on the size of the CCG and the operational risks identified. It is not the cost of the resource that is evidence of compliance, but rather the use of resource and the adoption of a risk based approach.

18. What happens if an assessment is completed on a CCG? Where does the report go?

NHS England will be sent copies of quality assurance documents and kept informed of CCGs' compliance with the standards.

19. Are commissioning support units commissioners or providers?

Commissioning support units exist to support CCGs by providing business intelligence, health and clinical procurement services, as well as back-office administrative functions, including contract management.

Commissioning support units are required to work towards some of NHS Protect's Standards for Commissioners.

20. Is there not a potential conflict of interest between a CCG and a provider if the same organisation (e.g an audit consortium) is contracted to carry out anti-fraud, bribery and corruption work for both of them? How do we manage this?

There is nothing that prohibits this arrangement. Commissioners should appropriately manage any potential conflicts of interest, and seek assurance from LCFSs where they provide a service to both a commissioner and a provider organisation.

CCGs should ensure they follow the NHS England guidance 'Managing Conflicts of Interest: Statutory Guidance for CCGs'.

The quality assurance process can provide assurance to commissioners on their anti-fraud arrangements where an assessment has taken place.

21. Does standard 1.13 apply only to NHS England?

Standard 1.13 applies to NHS England, CCGs and CSUs (if carrying out contract management on behalf of a CCG).

22. Will CCGs be responsible for ensuring they have access to Local Security Management Specialist services as with the PCTs under the old directions?

From April 2016 CCGs will be required to employ or contract a qualified, accredited, and nominated security specialist(s) to oversee and undertake the delivery of security management work within the organisation.

23. NHS Protect requirements for items to be included in the security policy are more onerous than the requirements for content in the health and safety policy (which is a legislative requirement) – why is this?

NHS Protect leads on anti-crime work for the health sector. It is important that our standards are exacting in order to reflect the specialised area that we cover, i.e. anti-crime work, whereas regulators have a more general role and standards as they cover more than one area.

24. NHS consortiums providing LSMS days to CCGs are having to pay £4,000 per trainee - is this correct?

The amount is correct and it is correct that unless the individual is directly employed by the organisation to fulfil the role, they have to pay the fee.

Implementing the standards: monitoring providers' anti-crime arrangements

25. How will the CCG get the appropriate organisation crime profile and self review tool?

The organisation crime profile is available from our website at http://www.nhsbsa.nhs.uk/4882.aspx.

The self review tool is an online reporting tool. Once a Local Counter Fraud Specialist (LCFS) is appropriately trained, accredited and nominated, they will be given access to the login and password required to complete the self review tool. The self review tool is completed on an annual basis with a deadline this year of 31 May for fraud, bribery and corruption and 30 November for security management submissions.

26. Should completion of the organisation crime profile be aggregated, or a separate one completed for each site?

One organisation crime profile per organisation is required under the terms of the contract, regardless of how many sites it operates from.

27. To what extent does an individual commissioner need to ensure that a provider's organisation crime profile is completed? For example, for non-contract activity, NHS Trusts may invoice a commissioner once or twice per year and well below the £200,000 threshold. Would non-contract activity need to be covered?

All providers commissioned to deliver services under the NHS Standard Contract are required to comply with Service Condition 24.1. This requires providers to put in place and maintain appropriate counter fraud and security management arrangements.

Service Condition 24.2 then goes on to state that all providers, with the exception of small providers, must complete an organisation crime profile. Small providers are defined in the NHS Standard Contract 2015/16 Technical Guidance as "providers whose aggregate annual income for the relevant Contract Year, in respect of services provided to any NHS commissioners commissioned under any contract based on the NHS Standard Contract is not expected to exceed £200,000".

These conditions only apply to providers commissioned under the NHS Standard Contract. If a provider is commissioned to deliver services under a different form of contract, they do not need to complete an organisation crime profile.

Further guidance on non-contract activity is available in section 20 of the NHS Standard Contract 2015/16 Technical Guidance and in the NHS England document Who Pays? Determining responsibility for payments to providers.

28. How do commissioners validate accuracy of the contents of organisation crime profiles?

Given the number of organisation crime profiles a CCG is likely to receive, we would recommend a simple check for reasonableness is carried out. If any concerns are raised, or the CCG wants to carry out additional checks on a sample of organisation crime profiles, several of the questions can be double checked for some providers against data that is publicly available; a few examples are listed below:

- Q8 on patient attendances can be checked on http://www.hscic.gov.uk/article/2021/Website-Search?productid=17195&q=title%3a+%22hospital+outpatient+activity%22&sort=Relevance&size=10&page=1#top. The spreadsheet titled 'Provider level analysis', can be checked by organisation code or name.

- Q9 on patient episodes can be checked on http://www.hscic.gov.uk/searchcatalogue?productid=17192&q=title%3a%22Hospital+Episode+Statistics%2c+Admitted+patient&sort=Relevance&size=10&page=1#top. Again, the spreadsheet titled 'Provider level analysis' can be checked by organisation code or name.

- Q12 on number of reported staff assaults. For many organisations this will be automatically populated on the organisation crime profile when they enter their NHS code. However, the data is also published on our website at http://www.nhsbsa.nhs.uk/3645.aspx

- Q30 on number of invoices processed. A number of NHS organisations publish this data in their annual reports under the 'Better Payment Practice Code'.

29. Do associate CCGs obtain assurance from co-ordinating commissioners on provider organisation crime profiles? Should it be only the co-ordinating commissioner that has responsibility to review the organisation crime profile?

For multilateral contracts, commissioners should decide amongst themselves who will take responsibility for reviewing the anti-fraud and security management measures within provider organisations, the same as they do for other aspects of the NHS Standard Contract. Service Condition 24.4 of the NHS Standard Contract allows the co-ordinating commissioner to nominate a person to review the arrangements in place on behalf of any of the commissioners.

Further information on collaborative commissioning is available in section 8 of the NHS Standard Contract 2015/16 Technical Guidance.

30. How will we ensure that all provider organisations complete the organisation crime profile and self review tool?

NHS Protect advises that in the first instance a copy of the organisation crime profile is sent to the contract manager within CCGs. The contract manager should be able to advise what providers are commissioned by the CCG, which will enable cross checks to be made.

For those organisations that have, on completion of the organisation crime profile, been allocated to a category 1 or 2, a self review tool should be completed. Once an LCFS is trained, nominated and accredited, access details for the self review tool will be provided by NHS Protect. It is advised that a copy of the provider self review tool is sent to the relevant co-ordinating commissioner.

31. Is it expected that the co-ordinating commissioner for a provider would have access to the provider's organisation crime profiles and self review tools?

Providers should send a copy of their organisation crime profile directly to their co-ordinating commissioner, as set out in the Standards for Providers document and NHS Protect guidance. The responsible person within commissioning bodies will differ, but in the first instance we would suggest the profile is forwarded to the contract manager.

The co-ordinating commissioner should also have access to the self review tool and NHS Protect are currently developing a means of efficiently sharing this information.

32. How can we possibly review all self review tools?

How organisations review self review tools is a matter for them to decide. However, the NHS Standard Contract Service Conditions state that the body responsible for leading on assurance of counter fraud and security management work for a provider is its co-ordinating commissioner. This should reduce duplication by other commissioners of the same provider.

33. Does the standard contract clause cover responsibilities in relation to the self review tool?

The requirements and responsibilities in relation to the self review tool are set out in standard 1.5.

34. Do you expect CCGs to only review counter fraud and security management arrangements for providers where they are the co-ordinating commissioner, or for all providers where they have a financial commitment?

For multilateral contracts, commissioners should decide amongst themselves who will take responsibility for reviewing the anti-fraud and security management measures within provider organisations, the same as they do for other aspects of the NHS Standard Contract. Service Condition 24.4 of the NHS Standard Contract allows the co-ordinating commissioner to nominate a person to review the arrangements in place or on behalf of any of the commissioners.

Further information on collaborative commissioning is available in section 8 of the NHS Standard Contract 2015/16 Technical Guidance.

35. Should the standards for providers include a requirement for the self review tool to be submitted to the co-ordinating commissioner?

Yes, the provider standards need to reflect that this action is completed, however we are currently advising providers that this needs to be completed (NHS Protect

guidance). We are currently developing an on-line solution to enable this for every case.

36. When reviewing the self review tool of a provider, it may show a lot of red. What are the co-ordinating commissioner's responsibilities when that happens? Are there "thresholds" below which providers or commissioners have to undertake specific actions?

If a provider's self review tool shows a number of red ratings, the co-ordinating commissioner should ensure that corrective actions are in place to address these. In these circumstances NHS Protect can also provide advice and guidance.

37. Would it be possible to provide guidance on the expected roles of associate and co-ordinating commissioners?

The NHS Standard Contract 2015/16 Technical Guidance, in section 8, provides further details on the role of commissioners in respect of multi-lateral contracts.

38. What happens when there are multiple commissioners for one provider? Will each of the co-ordinating commissioners be seeking assurance from the same provider?

The NHS Standard Contract 2015/16 Technical Guidance, in section 8, provides further details on the role of commissioners in respect of multi-lateral contracts.

39. Do private providers need to comply with the standards?

All providers commissioned to deliver services under the NHS Standard Contract are required to comply with Service Condition 24, regardless of their legal status.

All providers, with the exception of small providers, are required to complete an organisation crime profile. Providers that are allocated to a category 1 or 2 following completion of the organisation crime profile are required to comply with the standards.

40. How can CCGs enforce compliance with non-NHS providers? How will this impact on the CCG?

All providers commissioned to deliver services under the NHS Standard Contract are required to comply with Service Condition 24, regardless of their legal status. These are mandatory clauses, and failing to comply may lead to a breach of contract.

41. What can we do if we are not happy that the provider is compliant?

The clauses set out in Service Condition 24 of the NHS Standard Contract are mandatory, and providers must comply with them.

Service Condition 24.4 of the NHS Standard Contract allows the co-ordinating commissioner or NHS Protect to nominate a person to review, in line with the standards, the anti-fraud and security management arrangements in place within providers.

Service Condition 24.5 then goes on to state that the provider must implement any reasonable modifications to its anti-fraud and security management arrangements, as recommended by the commissioner or NHS Protect, in order to meet the standards, within whatever period of time the commissioner or NHS Protect may reasonably require.

If a provider fails to comply with the clauses set out in Service Condition 24, they may find themselves in breach of contract.

42. Can I insist that NHS Protect complete an assessment if I am not happy with the provider?

If an assessment has not yet been conducted, please contact the relevant Area Anti Fraud Specialist or Area Security Management Specialist, who can engage with and monitor the provider. NHS Protect use a risk based approach to select the organisations that receive quality assessments and will take into account documented information provided by commissioners as part of a range of factors to determine where they will conduct their assessments.

43. Do CCGs get copied into provider reports?

The co-ordinating commissioner will be sent copies of quality assurance documents and kept informed of provider compliance with the standards.

44. Would a contract potentially be cancelled if standard 1.8 was not met?

If a provider fails to comply with the clauses set out in Service Condition 24, they may find themselves in breach of contract. It is for the CCGs to determine the level of action they take against a provider that fails to comply.

45. Does standard 1.9 apply to private organisations?

Yes. All providers commissioned under the NHS Standard Contract are required to comply with Service Condition 24, regardless of their legal status.

46. What resource requirements are envisaged and could this be delegated to CSUs?

Inevitably commissioners will differ in terms of size, responsibilities and challenges and there is no straightforward means of calculating the resources required because they will be so varied. Therefore, we recommend that commissioners take a risk-based approach by using the standards as a basis to measure their performance and put work plans into place to address any issues in order to meet

the standards. Elements of compliance could be delivered by CSUs however it is still the responsibility of the organisation to ensure that these arrangements are adequate and processes are followed to comply.

47. Could NHS Protect produce a template of the types of evidence a CCG could request from a provider to seek assurance.

Detailed lists of guidance, documentation and supporting evidence is given for each of the provider standards. They are available in the standards for providers documents at http://www.nhsbsa.nhs.uk/4882.aspx.

48. Where GPs are coming together to form large federations of practices, or practice mergers, what is the role of the CCG in determining appropriate security management is in place?

As the commissioner the CCG will still need to satisfy itself that providers are complying with NHS Protect's anti crime standards if the standards apply to them, which depends on the value of their commissioning contracts. Of particular interest will be standard 1.4 of the security management standards for commissioners, which reads: 'The organisation allocates resources to effectively monitor security management arrangements within its providers In line with identified risks'.

Where federations and/or mergers between GP practices mean that the resulting provider falls under NHS Protect's standards, the provider should allocate resources and investment to security management in line with its identified risks.

49. Where primary care co-commissioning is in place, what are CCG's responsibilities for ensuring GPs have appropriate security management arrangements?

Commissioners have an essential role in ensuring that the services they commission are safe and secure. They should therefore review providers' security management arrangements to ensure they meet the requirements of the standard commissioning contract. The NHS Protect anti crime standards set out in detail what commissioners should do in this area.

The quality assurance programme

50. What is a review process and what is classed as accurate?

The review process is an evaluation of anti-crime arrangements in place. This could be the checking of a self review tool or organisation crime profile for a provider. Accuracy refers to (among other things) budgets, headcounts and services which are detailed in the self review tool submitted to NHS Protect and the commissioner.

51. Who is responsible for assessing providers and what level of assessment is required?

Quality assurance assessments are the responsibly of and are conducted by NHS Protect's Quality and Compliance team. Final assessment reports of providers will be shared with the relevant co-ordinating commissioner.

52. What is the division between NHS Protect and CCG responsibilities?

The NHS Protect quality assurance assessment process is designed to evaluate an organisation's effectiveness in dealing with crime. There are independent and specialist Senior Quality and Compliance Inspectors who undertake the assessments. NHS Protect consider appropriate evidence and information sources held before the assessment. In addition, whilst on site they discuss compliance with staff and gather further evidence to inform ratings for standards. CCGs receive a final quality assurance assessment report which can be used along with the organisation crime profile and self review tool to gain assurance that the appropriate arrangements are in place to mitigate risks and comply with the standards.

53. Will the commissioners be informed of provider inspection visits?

Once NHS Protect are notified who the co-ordinating commissioner for an organisation is, they will ensure that ongoing liaison takes place.

54. The standards seem to suggest that NHS England should be reviewing the counter fraud arrangements in place at CCGs. Does this mean that, as well as NHS Protect inspections, CCGs can also expect to be routinely inspected by NHS England?

The exact arrangements will be up to NHS England but clearly CCGs have responsibilities to NHS England under their terms of authorisation. NHS England need to assure themselves that those responsibilities are being met.

55. If the action plan following an assessment is not adhered to, who should the CCG inform and what action can be taken?

If the CCG is aware that recommendations have not been implemented within a reasonable time and it is not a risk the organisation is prepared to accept, then the CCG should inform NHS Protect for advice and assistance.

56. What level of assurance (detail) is the commissioner expected to seek?

CCGs receive a final quality assurance assessment report which can be used along with the organisation crime profile and self review tool to gain assurance that the appropriate arrangements are in place to mitigate risks and comply with the standards.

57. What is proportionate when relating to a green rating?

Proportionality depends on the risk identified or the standards to be reviewed. A green rating is achieved when evaluation of work is conducted and outcomes achieved. Relatively speaking this means that the risk identified has been mitigated.

58. Should there be a neutral rating for standard 1.10?

This will be a consideration to be taken forward and discussed at NHS Protect's Quality Assurance Review Working Group.