Developing clinical commissioning groups

Towards authorisation

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1. Foreword

The Government's ambition to create the NHS as the best healthcare system in the world is rooted in the three principles of giving patients more power, focusing on healthcare outcomes and quality standards, and giving frontline professionals much greater freedoms and a strong leadership role.

At the heart of these proposals are clinical commissioning groups (CCGs). Based on the membership of constituent practices, but involving and empowering the full range of clinical professionals, these organisations are designed to unleash the potential for clinical leadership. The NHS has made huge strides over the past decade and everyone who works in it should be justifiably proud. But the challenges of the next few years should not be underestimated and will only be met through changing clinical practice in a way which not only improves the quality of care for patients but also makes the most efficient use of taxpayers' money.

CCGs are dependent on the unique role of general practice in connecting and acting as the intermediary for all the care patients receive. General practice connects patients with specialists; it connects clinical professionals who care for the same patients with one another; and it connects patients, carers and their families with the broad range of support they need from both within the NHS and social care. Most importantly, as trusted local community leaders, general practitioners have the ability to give a voice to the population of patients and communities they serve.

But this is not about general practice alone. CCGs, as groups of practices, will have responsibility for bringing together a range of health and care professionals, together with patients and the public. The requirement to have a nurse, a hospital doctor and lay people on the CCG governing body will ensure that there is a broader perspective on health and care issues to underpin the work of the CCGs. CCGs will need the full range of skills and clinical advice from many different professional groups if they are to truly harness the full potential of clinical leadership and stakeholder engagement to design integrated services that provide both the best quality of care and health outcomes, and also maximise the impact of improving population health. And to achieve the best outcomes for patients, the latest clinical research and innovation must drive and influence the design and provision of local services. CCGs will need to recognise the vital roles innovation and the promotion and support of research have to play.

I am publishing this document for those of you interested in becoming a clinical commissioning group in the new system. My ambition is to support you in becoming the very best you can be, so that as a clinical commissioning group you can face these challenges with confidence and ambition to improve health and health services for the communities you serve. This document sets out the early thinking on the authorisation process – the process by which you would be assessed as ready to take on responsibility for health care budgets for your local communities. And I want to set that process within the context of the long-term journey of development of the new commissioning architecture, so that the NHS Commissioning Board and CCGs can develop together to drive the improvements in outcomes, which we all – across the NHS and local government – want to see.

Over the past few months we have sought ideas and views from a comprehensive programme of engagement, working with pathfinders, Department of Health (DH) and NHS leaders and a

range of stakeholders including other clinical professionals, colleagues from local authorities and, of course, representatives of patients and the public. We have also learnt from the experience and expertise of other organisations and quasi-regulatory processes.

This document brings together the results of that work, alongside the views expressed in the listening exercise and the Government's response. It sets out the scale of the ambition to create excellent CCGs at the heart of the transformational changes we need to deliver for patients in the NHS in the current economic circumstances, and at the heart of delivering value to the taxpayer. It outlines the practical ways in which CCGs can take up development opportunities, and the ways in which it is anticipated that CCGs might become authorised over the next two years. These include areas such as the importance of building relationships with local partners ready for the 360 degree assessment which will feature as a key element in authorisation, so that CCGs can take their place with other leaders in their system to drive improvements in health and care. It sets out some of the support that you can expect from your PCT clusters and SHA clusters.

Authorisation should not be seen as an end point, but as a journey which can begin adding value to the communities we serve right from the start. And I am committed to making sure that, in that journey, we do not lose sight of our deep commitments to equality and diversity and to making sure that the most vulnerable people in our society are protected.

Over the coming months, we will refine our approach and continue to work with pathfinders and key stakeholders on taking these proposals forward. This document needs to be read with recognition that all these proposals will be subject to change and refinement as the Health and Social Care Bill passes through Parliament. But I hope that this will encourage you as emerging CCGs to continue your local work to develop, taking on delegated responsibilities with the support of your PCT clusters, so that the benefits of clinical leadership – systematically embedded across the country – can be realised for the communities we all serve.

Sir David Nicholson

Chief Executive Designate
NHS Commissioning Board

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2. Development of clinical commissioning groups: authorisation in context

The Government's ambition for the best healthcare service in the world will be dependent on the development of highly effective CCGs covering the whole of England and fully authorised. This reflects confidence in your ability to take up the reins of securing the majority of healthcare safely, and to discharge responsibly your stewardship of most of the NHS budget.

We want to see CCGs that can do this in a way which is truly transformational, with a clear clinical focus and added clinical value – and when we talk about clinicians, we mean the full range of healthcare professionals that patients, carers and families deal with, not only doctors. To do this, our work with stakeholders has identified the key characteristics of the new CCGs. You will need to be clinically led and focused, open and transparent, lean, capable and efficient, inclusive and demonstrably able to work well with others.

The authorisation process will be an important point in the development journey to achieve these ambitions. Authorisation represents the way in which we can all assure ourselves that we have moved from the current position of a vibrant network of pathfinders to a position where we have achieved comprehensive coverage of established CCGs across England. It should be viewed as part of the ongoing development of CCGs to drive improvements in health and health care, and as part of delivery of today's QIPP (quality, innovation, productivity and prevention) challenge. It should also be seen in the context of the relationship between the NHS Commissioning Board and CCGs, and the annual assessment of CCGs, and accountability for improving performance. For the NHS Commissioning Board, reaching a system of fully authorised CCGs as quickly as possible will be an important measure of the success of the NHS Commissioning Board itself.

Many CCGs have already begun their development journey and are keen to understand the process by which their capability to be an authorised clinical commissioning group will be judged. Whilst we cannot prejudge the thinking of the NHS Commissioning Board, which we expect will be created in shadow form in October 2011, this document provides an outline of the work already undertaken, and sets out some areas where we anticipate the NHS Commissioning Board will wish to focus in authorisation. This section sets out the principles that are guiding the development of the approach to authorisation, and explains the context for the process.

Principles for authorisation

Working with a broad range of stakeholders, especially pathfinders themselves, we have developed a set of principles which should guide the development and implementation of this process:

- A process 'fit for purpose' – **sufficiently robust** to enable a thorough and cost effective assessment of the CCG's capacity and capability to carry out its functions;
- A process viewed by both the NHS Commissioning Board and CCGs as developmental and as **adding value** and helping improve quality and overall patient experience and outcomes;
- **Setting the tone** for the future positive relationship between CCGs and the NHS Commissioning Board;

- **Minimising administrative demands** for both emerging CCGs and the review team/s, and delivering a process which is both rigorous and efficient;
- **Evidence required should be a by-product of core business**, as far as is possible;
- Recognising that this is a unique process – as 'start-up' bodies, CCGs will be building a track record of performance, therefore **authorisation will focus on confidence in their potential to deliver**, drawing on their participation in, for example, improving long term conditions care, clinical care in general and other aspects of QIPP, but will also draw on their **track record to date** as sub-committees of PCTs to whom certain commissioning responsibilities have been delegated; and
- **A nationally consistent approach** – so that all emerging CCGs can have confidence that the same standards are being applied.

Authorisation in context

By April 2013, subject to the approval of the Health and Social Care Bill, the whole of England will need to be covered by established CCGs. Each one will have been authorised to take on some or all of the commissioning responsibilities for the populations it serves; or if it is not yet ready or willing to do so, established as a 'shadow' CCG – a CCG that is legally established but operating only in shadow form, with the NHS Commissioning Board taking on responsibility for ensuring that its functions could be discharged. This is in line with the Government's commitment to allow CCGs to come forward "when they are good and ready".

The proposed detailed content and process for authorisation are shaped by the likely legislative requirements. These are currently under scrutiny by Parliament. As emerging CCGs, you will want to be aware of the specific requirements, particularly around the need to have a defined geographic area, so that you can take responsibility for a clear population. Details on both the likely legislative requirements and the commitments given in response to the NHS Future Forum are set out in the technical appendices.

Subject to parliamentary approval, once the NHS Commissioning Board is formally established as a non-departmental body (likely to be between July and October 2012), the Board can begin to consider applications for the establishment and authorisation of CCGs. This process needs to be closely aligned to the development support which CCGs have undertaken supported by the PCT clusters and subsequently the Board itself. The authorisation process should be seen as a stage on a journey of continuous improvement:

- **Initial development phase:** already well underway in many aspiring CCGs, with increasing responsibility for service redesign and delegated budgets from your local PCTs. Investing time and effort in understanding what you will need in terms of **commissioning support** and beginning to build long-term relationships will be an important ingredient of the development phase;
- **Application:** in submitting applications to become established, emerging CCGs will need to set out their application for the NHS Commissioning Board to become established and authorised. The Board may, at the request of the CCG, exercise functions on the CCG's behalf although the aspiration is for all CCGs to become fully authorised;

- **Authorisation process:** the NHS Commissioning Board will consider the application. Details of what would be considered by the NHS Commissioning Board, including the views of stakeholders, and how it would be considered, are covered in the next section. The Board will determine the level of commissioning responsibility and agree with each emerging CCG the nature of the development support needed, or conditions to be placed upon the CCG, in becoming established; and

- **Annual assessment:** once authorised (with or without conditions), the CCG is subject to an annual assessment. This will determine the nature of support or conditions going forward, based on its performance and other aspects of its organisational capabilities and relationships, and will enable the continued development of CCGs.

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3. The focus of authorisation

All those we have involved to date have reinforced the message that the authorisation process itself should support and reinforce the work needed to create truly excellent CCGs, delivering the transformation needed to improve outcomes and the quality and productivity improvements required. The journey itself should also be able to make a significant contribution to the delivery of today's challenges, enabling emerging CCGs to build their track record. The proposed content of the authorisation process is therefore built around six domains – six areas which are most likely to act as pre-conditions of success for a CCG. It will also need to reflect the final composition of legislative requirements.

During the listening exercise we were able to test early proposals for these six key domains. There has been significant support, particularly in that they create a simple framework which is easily understood. They address the key issues which emerged, namely: the need to give reassurance that CCGs could safely take on the responsibility for securing healthcare services and the drive for CCGs to be truly different organisations through the clinical engagement and leadership you can bring and your ability to be much closer to communities and patients given your foundations in local GP practices.

Stakeholders and pathfinders have told us they want to see organisations with:

- **A strong clinical and professional focus which brings real added value;**
- **Meaningful engagement with patients, carers and their communities;**
- **Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national outcome standards and local joint health and wellbeing strategies;**
- **Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control as well as effectively commission all the services for which they are responsible;**
- **Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support; and**
- **Great leaders who individually and collectively can make a real difference.**

We therefore propose that to be authorised, CCGs should be able to demonstrate an adequate level of competence across all these areas and the potential to achieve excellence in future. Working with many stakeholders, particularly pathfinders, we have gathered a wealth of material around descriptions for each domain. This is set out in the technical appendices and will be used as a backdrop to the next phase of work finalising proposals for the NHS Commissioning Board to consider, and tested against the principles set out earlier in the document. This appendix represents the full range of areas which stakeholders have told us are important in delivering health services for patients. As such they should be seen as a useful developmental tool for emerging CCGs and not as a list of tests for authorisation.

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Domain	Description
A strong clinical and professional focus which brings real added value	A great CCG will have a clinical focus perspective threaded through everything it does, resulting in having quality at its heart, and a real focus on outcomes. It will have significant engagement from its constituent practices as well as widespread involvement of all other clinical colleagues; clinicians providing health services locally including secondary care, community and mental health, those providing services to people with learning disabilities, public health experts, as well as social care colleagues. It will communicate a clear vision of the improvements it is seeking to make in the health of the locality, including population health.
Meaningful engagement with patients, carers and their communities	CCGs need to be able to show how they will ensure inclusion of patients, public, communities of interest and geography, health and wellbeing boards and local authorities in everything they do, especially their commissioning decisions. They should include mechanisms for gaining a broad range of views then analysing and acting on these. It should be evident how the views of individual patients from the consulting room are translated into commissioning decisions and how the voice of each practice population will be sought and acted on.
Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources in line with national outcome standards and local joint health and wellbeing strategies	CCGs should have a credible plan for how they will continue to deliver the local QIPP challenge for their health system, and meet the NHS Constitution requirements. These plans will set out how the CCG will take responsibility for service transformation that will improve outcomes, quality and productivity, whilst reducing unwarranted variation and tackling inequalities, within their financial allocation. They need a track record of delivery and progress against these plans, within whole system working, and contracts in place to ensure future delivery. CCGs will need to demonstrate how they will exercise important functions, such as the need to promote research.
Proper constitutional and governance arrangements with the capacity and capability to deliver all their duties and responsibilities, including financial control, as well as effectively commission all the services for which they are responsible	CCGs need the capacity and capability to carry out their corporate and commissioning responsibilities. This means they must be properly constituted with all the right governance arrangements. They must be able to deliver all their statutory functions, strategic oversight, financial control and probity, as well as driving quality, encouraging innovation and managing risk. They must be committed to and capable of delivering on important agendas included in the NHS Constitution such as equality and diversity and safeguarding. They must have appropriate arrangements for day to day business, e.g. communications. They must also have all the processes in place to commission effectively each and every one of those services for which they are responsible, from the early health needs assessment through service design, planning and reconfiguration to procurement, contract monitoring and quality control.
Collaborative arrangements for commissioning with other clinical commissioning groups, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support	CCGs need robust arrangements for working with other CCGs in order to commission key services across wider geographies and play their part in major service reconfiguration. They also need strong shared leadership to develop joint health and wellbeing strategies, and strong arrangements for joint commissioning with local authorities to commission services where integration of health and social care is vital and the ability to secure expert public health advice when this is needed. They also need to have credible commissioning support arrangements in place to ensure robust commissioning and economies of scale. They need to be able to support the NHS Commissioning Board in its role of commissioner of primary care and work with the Board as a partner to integrate commissioning where appropriate.
Great leaders who individually and collectively can make a real difference	Together, CCG leaders must be able to lead health commissioning for their population and drive transformational change. These leaders need to demonstrate their commitment to, and understanding of, partnership working in line with such senior public roles, as well as the necessary skill set to take an oversight of public services. They need individual clinical leaders who can drive change, and a culture which distributes leadership throughout the organisation. The accountable officer needs to be capable of steering such a significant organisation and the chief finance officer must be both fully qualified and have sufficient experience. All those on the governing body will need to have the right skills.

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4. The steps to authorisation and beyond

Road map to authorisation

We have developed thinking about the development journey for emerging CCGs through authorisation, and set out proposals to develop a clear 'road map', with some widely understood milestones. This is important given the scale of the change, and the serious nature of the responsibilities which are being transferred and transformed to create the new commissioning architecture.

The whole of England will need to be covered by established CCGs by April 2013. To be established, CCGs will need to comply with some minimum legal requirements, concerning geography and governance (see technical appendices). But we also expect, judging by the swift growth in pathfinder numbers, the vast majority of CCGs will want to become authorised to take on some or all of their potential commissioning responsibilities. It is against this context that the road map has been developed.

The road map to authorisation is based on a phased approach.

It is proposed that the first phase is a risk assessment of the proposed '**configuration**' of a CCG. We would like to invite each emerging CCG to participate in an initial risk assessment of your configuration as soon as possible from October 2011, and ideally no later than December 2011. SHA clusters will undertake this with you. This is specifically designed to help CCGs understand whether your current proposed arrangements are likely to meet the criteria defined in the Health and Social Care Bill, understand any risks associated with your proposed arrangements and give you time to consider how to manage these risks. We will be looking to ensure that you can demonstrate a boundary which broadly encompasses most patients registered with your constituent practices. This should delineate a clear geographical population for which the CCG will be responsible. These boundaries should not cross upper tier boundaries unless there is good reason for them to do so, in patients' interests.

All emerging CCGs are encouraged to work with your SHA clusters to achieve this milestone. There will be four areas for consideration in the risk rating (see technical appendices): sign-up from member practices; appropriate geographical coverage that allows you to take on responsibility for commissioning for a population; where CCGs straddle upper-tier local authority boundaries, to ensure this is for patient interest reasons; and finally, a risk assessment of the impact of your proposed configuration on your organisational viability and the degree of sharing of role and functions or use of commissioning support you will need to consider. This will need to consider the risks of both very small and very large CCGs. From our current understanding, many emerging CCGs are already likely to score green against most aspects of such an assessment.

This early risk assessment is important for several reasons:

- It enables emerging CCGs to be in the best possible position to take on the full range of functions in April 2013, as it gives you time to develop as organisations and establish a track record;
- It enables any fundamental concerns about the geography (e.g. your size, shape or boundaries)

to be aired and resolved well before 2013, so that local plans can be revisited if necessary or appropriate support and measures put in place;

- It will allow emerging CCGs to more easily lead the planning round for 2012/13 supported by PCT clusters;
- It will allow for enduring relationships with local authorities to take shape;
- It enables work on indicative allocations of budgets to begin, as these can only be calculated when the proposed configuration is known; and
- It allows data collections to be mapped from PCTs to CCGs.

At the point of authorisation, it is for the NHS Commissioning Board to take the final decision on configuration (taking into account the views of stakeholders through the 360 degree assessment part of the process). This earlier stage is primarily designed to act as an enabler so that as emerging CCGs you are able to continue organisational development in the knowledge that you are creating a viable organisation which is likely to meet the geographical requirements, and be locally sensitive, or understand what measures you might need to put in place to do so.

This risk assessment will be led by the four SHA clusters working to a single operating model and supported by the Commissioning Development team in the Department of Health. They will ensure a move towards comprehensive coverage and that there are no communities for whom commissioning development is not underway in time for comprehensive establishment by April 2013, even if in shadow form.

Emerging CCGs will need a considerable period of stability to become ready for authorisation, ideally a full twelve months. Subject to the passage of the Health and Social Care Bill, we expect that the NHS Commissioning Board would be able to receive the earliest applications for establishment and authorisation from summer 2012. All CCGs would be established by April 2013. So the first CCGs to identify and have their risk assessment of their configuration confirmed will be those most likely to be able to apply for establishment and authorisation at the earliest opportunity.

Stage two of the process is the '**development path**' which is the period during which emerging CCGs can gain experience and continue to build up a track record, that will serve you both in the authorisation process and in the responsibilities you wish to take on.

Again, many emerging CCGs are already well down this path. PCT clusters will support emerging CCGs to take on delegated responsibilities within the existing legislative framework, so that you can increasingly lead various key elements of work such as the delivery of the QIPP (quality, innovation, productivity and prevention) challenge for the local health system, the planning round for 2012/13, begin to build up relationships with local authorities and patient and public groups, and play an active role in developing the new health and wellbeing boards. We will begin to track the level of delegation underway so that it is possible to build a picture of the extent to which this is all taking place.

It will also be important to work through locally how emerging CCGs might make best use of the public health expertise that will be based in local government.

Alongside this, PCT clusters and emerging CCGs should not underestimate how critical the development of commissioning support models and understanding CCG requirements will be during this period, as a prerequisite for CCG success.

The final stage of the process is the full '**authorisation process**' where CCGs will need to apply to the NHS Commissioning Board to be established and authorised. The authorisation process, looking across the six domains, will result in a judgement being made by the NHS Commissioning Board.

In order to demonstrate capability across these six domains, there will be a range of ways in which emerging CCGs can pull together evidence for the authorisation process. This will include the development path that you as an emerging CCG can be following now, ahead of the conclusion of the legislative process. This is how you can begin to build up your **track record of delivery** and begin to design your **organisational arrangements.**

Another critical element, in line with the Government's response to the NHS Future Forum, will be gaining insight about the relationship between the CCG and its partners and its ability to secure patient, public and professional involvement. We believe that **360 degree assessment** will be a vital tool in ensuring that the views of all partners can shape the development of this new architecture.

From the outset of the establishment of the NHS Commissioning Board, it will be working closely with emerging CCGs and developing an understanding of their strengths and weaknesses and support needs, and the judgement that the Board makes on this basis will be a key factor in the authorisation process.

Evidence for authorisation

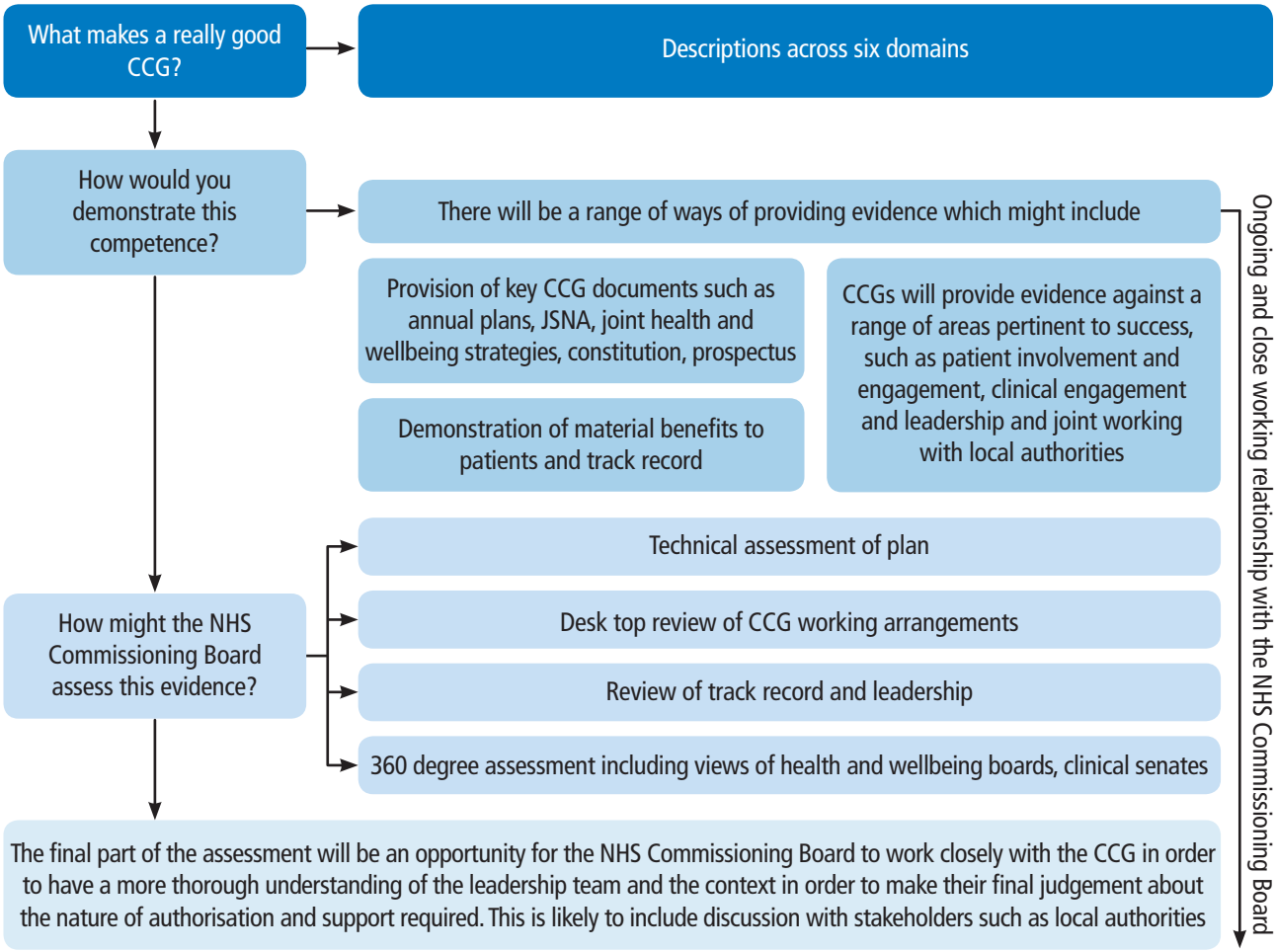
The formal application to grant establishment of a CCG will have three aspects. The first will be your submission of evidence to demonstrate capability across each of the domains. In line with the principles developed with pathfinders, there will be a particular emphasis on using what a CCG will want to have in place if it is to operate as a highly performing organisation so that the additional work for authorisation is minimal.

We would expect internal documents such as the commissioning plan, the constitution, the prospectus and an organisational development plan to form a major part of this evidence, but CCGs may also wish to complement this with case studies or other information that demonstrates they have already begun to operate in this way. In particular, examples that demonstrate the contribution of the emerging CCG to the delivery of their local QIPP challenge are likely to provide good evidence of impact, or examples that demonstrate how the CCG will have regard to the need to promote research and other such functions. Personal development plans and other evidence of competence for key leaders would be another source.

The second aspect will be where the Board satisfies itself about the validity of the evidence submitted and uses other information to understand how the emerging CCG has matured. In addition to the knowledge and understanding you have gained in the preceding year there would be a technical analysis of the plans submitted. It will also include a 360 degree review of how you are working with partners, including through the shadow health and wellbeing board to enable local views to be properly taken into account. In addition, the clinical senates will have a role in ensuring that the CCG has involved local professionals in clinical design and would feed this into the 360 degree assessments and constituent practices themselves would have an

opportunity to comment. Another important component would be the CCG's track record during the development phase.

The process would conclude with the NHS Commissioning Board drawing together all its background knowledge and information from all aspects of the process for discussion with the CCG and any local stakeholders the Board felt should be involved in further assessment, including the level of risk in that particular system. Following this the Board would be in a position to make a final judgement.



CCGs could be established from October 2012 (or potentially earlier, depending on the date at which the NHS Commissioning Board comes into being) if they were seen as having the potential to put in place a robust organisation and meeting the minimum requirements. This would allow CCGs to operate as a statutory body, sign contracts, and take on formal employment of staff. They would not however be able to take on commissioning responsibilities independent of their PCT cluster until 1 April 2013.

We have described below some examples of the potential outcomes of the authorisation process. We continue to work on the detail of how the NHS Commissioning Board might wish to determine these outcomes. But we know this is an area where emerging CCGs are eager for information, so can set out here some minimum expectations.

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The criteria for full authorisation would be that the Board judged the capability of the CCG to be such that it would be a competent commissioner of all services without additional support, and taking into account the local circumstances. This would be a risk-based assessment and CCGs would generally be authorised unless the Board felt that alternative arrangements would deliver better outcomes for patients.

Conversely, if a CCG was established but did not wish to undertake any commissioning or the Board deemed they were not yet competent to take on any commissioning, then the CCG would have to operate as a 'shadow CCG' with the Board taking on responsibility for ensuring that their functions could be discharged.

OUTCOMES

Shadow CCGs	Authorised with conditions	Fully authorised
Definition: These would be CCGs who were established but either did not wish to undertake any commissioning or were deemed not yet competent to take on any commissioning by the NHS Commissioning Board. The NHS Commissioning Board would ensure all functions were undertaken including fulfilling the role of accountable officer	Definition: These would be CCGs who were established but not fully authorised. There would be a range of circumstances in which this might apply, for example: Those who do not have a comprehensive competent infrastructure, i.e. are not yet organisationally ready Those who are not ready, willing or able to take on the full range of commissioning e.g. managing complex service change or commissioning complex services such as ambulance services	Definition: These would be CCGs who had completed the entire authorisation process and had been authorised by the NHS Commissioning Board to commission all relevant services on behalf of their population. They would have a development plan agreed with the NHS Commissioning Board and have an ongoing relationship and monitoring
Legal definition: Established with conditions	Legal definition: Established with conditions	Legal definition: Established without conditions

Roles in the authorisation process

There is more work to do to determine the way in which the authorisation process will work in practice, and this will take place over the autumn. There are some parameters however within which this will take place. These include:

- PCT clusters will have the role of preparing and supporting emerging CCGs within their area through to authorisation. Neither they nor any successor outpost of the Board covering the emerging CCG's area will be involved in the decision about authorisation of local CCGs;
- SHA clusters will have the role of overseeing and managing the flow of applications for authorisation ahead of the establishment of the sectors for the NHS Commissioning Board, as envisaged in the recent publication "Developing the NHS Commissioning Board". Authorisation and establishment can only be undertaken by the NHS Commissioning Board itself. Working with the central team and to a single operating model with consistent standards it is anticipated this function will then be overseen by the proposed four sectors of the NHS Commissioning Board;

- There will be a role for shadow health and wellbeing boards in the authorisation process. Health and wellbeing boards will be crucial in bringing together all of the key local leaders for health and wellbeing such as local councillors, commissioners of adult social care, children's services and public health, CCGs, and representatives of patients and public through local HealthWatch, to develop joint health and wellbeing strategies to inform both CCGs and councils' commissioning plans. Health and wellbeing partners will be key in the 360 degree review, providing views on the CCG's willingness and ability to be involved in partnership working and their relationship to the local population. This will influence the final judgement made by the NHS Commissioning Board;

- There will be a role for clinical senates in the authorisation process. Clinical senates will support both CCGs and the NHS Commissioning Board, providing expertise, advice and support which commissioners can draw on. Although senates are expected to provide advice predominantly on wide strategic areas covering many CCGs, they will also provide a link between local clinicians and national leadership to gauge the extent to which CCGs are including the full range of professionals in their local commissioning arrangements;

- The final decision can only be taken once the NHS Commissioning Board is established, and has the relevant legal powers (this is likely to be between July and October 2012, depending on the passage of the Health and Social Care Bill);

- The NHS Commissioning Board will ensure a single and consistent process across the country for the authorisation of all CCGs.

Commissioning support

Key to the authorisation of CCGs will be your plans to share or buy in commissioning support for the non-clinical aspects of commissioning. Even the largest CCGs will be unable to undertake the full range of commissioning functions in isolation. Commissioning support is probably the single biggest issue being raised by local pathfinders and PCT clusters in terms of the development of the new system.

In response to that, the Department of Health has been working with SHAs, PCTs and pathfinders to define the way in which these commissioning support functions can develop alongside CCGs to ensure that the overall commissioning architecture is effective and efficient. We have also been listening to the full range of current and potential providers of commissioning support, including local authorities and third sector as well as commercial organisations.

This work has included:

- Business reviews across all PCT clusters to assess the maturity of their approach;

- An analysis of the scale at which individual commissioning support functions are best undertaken to protect scarce expertise and deliver economies of scale;

- Modelling of potential CCG running costs and how they could most effectively be deployed; and

- Supporting CCGs to become intelligent purchasers of commissioning support.

In order to help manage the transition through until April 2013, as well as ensuring that CCGs will have access to high quality services, we will be publishing a range of information about our expectations for commissioning support, and sharing the results of work to date.

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5. Support for CCG development

The driving force behind the development of CCGs is to liberate and harness the strengths of clinical commissioning to transform the quality of services for the population of England. All CCGs across the country will be supported to be the best you possibly can be, through a programme of development – designed in partnership, described consistently and then tailored to local needs.

This support has thus far included a small number of national offers but has largely been driven by individual SHAs and PCTs to meet local circumstances. As we move towards the proposed establishment of the NHS Commissioning Board and a single operating model it will be essential to create a consistent approach and a core curriculum for your development. Whilst development will take place to a set of national standards it is envisaged that much of the support will continue to be delivered locally through PCT and SHA clusters in line with your CCG's needs and wishes. Emerging CCGs need to be able to choose your own support, but we also need to ensure that the full range of necessary options are available and that there is no unwarranted variation for different parts of the country. Working with pathfinders earlier in the year, we identified three areas where you considered you needed support.

Knowledge	Skills	Mindsets
• Governance • Finance • Understanding of local need • Range of care types • Contracts and commercial processes • Information management	• Selling strategy • How to lead change • Communication skills • Continuous quality improvement • Negotiating skills • Performance management • Relationship management • Planning skills • Tackling health inequalities and advancing equality	• Transformational not transactional • Quality at the heart of everything • Design around the patient • Accountability to the local population • Working across boundaries • Working in partnership • Commitment to equality • Clinical engagement • Financial responsibility
…the organisation and its leaders are equipped with the knowledge they need or an understanding of where they can find that knowledge	*…the organisation and its leaders have the full set of required healthcare and business skills or know how it will access these*	*…as a team and as individuals, everyone has the right mindsets to drive the changes which will deliver the highest quality and greatest productivity*

Many emerging CCGs are already working to increase their organisational capability, ready themselves for authorisation and are taking on increased commissioning responsibilities. Following your risk assessment of your configuration with your SHA cluster in the autumn, all CCGs will be invited to take responsibility for your own development plan to authorisation and beyond. PCT clusters will be expected to support you to do this and they will be held to account

for providing this support and for making available the resources to carry it out. This will be offered at a pace and scale commensurate with achieving authorisation by April 2013 (where CCGs want to take on commissioning responsibilities). A number of national tools are currently available to inform this process. These include:

- The national Pathfinder Learning Network;
- An interactive, self-assessment diagnostic tool to enable an understanding of immediate development needs;
- A national leadership development offer; and
- Support in preparing to take on your equality and diversity duties (through the use of the NHS Equality Delivery System).

National Pathfinder Learning Network

The national Pathfinder Learning Network is playing a key role in helping to test the different elements involved in clinical commissioning and enabling pathfinder CCGs to get more rapidly involved in current commissioning decisions, using powers and budgets delegated to them within the current statutory framework. By working alongside the national network of early implementers for health and wellbeing boards, there are opportunities to learn together in creating the new architecture.

The aim is to:

- Create learning networks across the country for support, debate and to share best practice between individual pathfinders;
- Provide access to a Pathfinder Learning Network online hub;
- Develop sample documents and governance models;
- Provide access to development support (for example on how to meet public sector equality duties) and provide speedy response to questions; and
- Enable active involvement, and genuine opportunities to shape national frameworks for implementation.

Self-assessment diagnostic tool

To help emerging CCGs assess capacity and capability, a diagnostic tool has been co-produced which enables you to identify your own development needs. The tool is hosted on the Pathfinder Learning Network online hub at **http://healthandcare.dh.gov.uk/category/context/pathfinder-learning-network/**. Your PCT cluster will also be able to give you access to the tool.

It includes some of the key areas which are likely to be required for authorisation and should provide you with insight into how you can create vibrant organisations that can continually improve beyond the point of authorisation.

This interactive self-assessment tool enables you to understand and reflect upon values, culture, behaviours and wider organisational health. It will encourage your leadership teams, with constituent practices, to have conversations about the roles and responsibilities which will be

expected of CCGs as statutory bodies and levels of readiness to take these on. The tool supports emerging CCGs to focus on delivering tangible benefits to patients, the wider community and the health system overall by:

- Stimulating discussion within CCG leadership teams about the skills and capabilities required of commissioners;
- Providing insight into areas where there may be gaps in knowledge or capability; and
- Helping you to identify priority development areas.

National Leadership Development Framework

To support CCGs in developing the leadership capability required, a national leadership development framework is being developed by the National Leadership Council, working with the GP stakeholder organisations, SHA Directors of Commissioning Development and others. Details of the framework will be available in due course at **http://www.nhsleadership.org.uk/** A high quality offer has been commissioned that will build clinical leadership capacity at pace and scale, to complement development support that is being offered at regional and local level. This includes:

- Access to personal coaching for all pathfinder clinical leaders, and also team coaching for emergent leadership teams. The offer is for up to four funded coaching sessions for each GP leader and/or one team coaching session; and
- A national leadership offer to clinical leaders and their management colleagues facilitated by the National Leadership Council. This will develop a national and coherent view of what good leadership for clinical commissioning looks like, including the competencies and behaviours that will be required.

The range of complementary programmes already on offer across the country include:

- Additional tailored development support for individuals who expect to take on key leadership roles, not only emerging accountable officers and chief finance officers, but also clinical leaders and other governing body members;
- Appropriate programmes to support organisational development including opportunities for senior teams to work together to develop their vision and strategy and operating model, and to help them achieve transformational change;
- Appropriate programmes of development with key local partners, supporting CCGs to work with their local authorities as well as provider organisations;
- Options for seminars, masterclasses, e-learning to help address the additional knowledge CCG leaders may need, such as a better understanding of governance, NHS finance systems, how to meet equality and diversity duties or the processes required to ensure safeguarding;
- Growing the already vibrant Pathfinder Learning Network into an enduring connection for all CCGs where they can share best practice, learn from one another and gain mutual support; and
- Support for how practices can work together.

Going forward, the next phase of the programme of delivery has been designed to expressly respond to the needs of the full breadth of clinical commissioners.

Next steps

We will continue to refine the core curriculum over the summer based on further working with all stakeholders. This will enable us to confirm that the range of development offers in place nationally and locally meets the articulated needs of emerging CCGs and will help us to ensure that investment is prioritised appropriately. We are also looking at how we ensure that in supporting the development of the leadership of the new system, we are meeting all the public sector equality duties.

The technical appendices set out some of the support material that will be provided at a national level in the coming months.

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6. What happens next?

At a national level, we will continue to work with stakeholders to develop further detail of the authorisation process. We would anticipate this being ready for publication in early 2012, subject to the deliberations of the NHS Commissioning Board and Parliament. This will need to include:

- The detail on the full range of requirements across each of the domains and evidence of how each will be assessed;
- The relevant roles and responsibilities of those undertaking the authorisation process and the governance arrangements around the process; and
- The annual assessment of CCGs once authorised.

Final guidance and regulations will be issued once the Health and Social Care Bill has received Royal Assent. But there is much we can be doing collectively now to prepare for the new system, ahead of the final detail of the authorisation process. This is set out below.

Emerging CCGs

- Are invited to discuss with your SHA clusters your proposed membership, geography and size and your arrangements for collaboration and securing commissioning support in order that the SHA can undertake the risk assessment with you;
- Are invited to undertake the self-assessment diagnostic tool (available at **http://healthandcare.dh.gov.uk/category/context/pathfinder-learning-network/**) or an equivalent and draw up a development plan;
- Are invited to increasingly take on a lead role in commissioning through delegated authority from your PCT especially in leading the planning round for your shadow year and QIPP delivery for your area;
- Are invited to begin to develop your own joint working arrangements with local government, to engage in the development of health and wellbeing boards and to explore how you will make best use of public health expertise from local authorities in the new system;
- Are invited to begin to build a track record of delivery (e.g. on QIPP, primary care, relationships with partners including participation in shadow health and wellbeing boards, patient and public involvement and engagement and leading planning for 2012/13) in preparation for authorisation;
- Are invited to begin to develop as 'intelligent commissioners' working to articulate commissioning support requirements, 'do/buy/share' options;
- Should expect the support of your PCT clusters and SHA clusters to understand the range and quality of support available to meet your development needs, both as a group and individual leaders; and
- Should expect a range of national products to be available to support the establishment of your arrangements and prepare for taking on full responsibilities.

PCT clusters

- Should maximise the responsibilities delegated to CCGs in 2011/12 and for 2012/13 within their delegated powers;
- Should support emerging CCGs to find a configuration that will meet the likely legislative requirements;
- Should work with SHA clusters in supporting emerging CCGs to find a configuration that will meet the likely legislative requirements;
- Should support all emerging CCGs to access a self-assessment diagnostic development tool, using the national tool or a recognised alternative;
- Should ensure that all emerging CCGs have the mandated £2 per head support in place as minimum;
- Should ensure that emerging CCGs have, in addition to the £2 per head cash resource, the appropriate management support either assigned directly to them or working across several groups to allow them to develop and take on delegated responsibility during the development phase;
- Should ensure that all GP practices are part of an emerging CCG by April 2012 and facilitate discussions where practices are having difficulty defining CCG boundaries;
- Should ensure that all emerging CCGs have a development plan in place, agreed with clusters, including access to individual leadership development;
- Should support all emerging CCGs to have appropriate earned autonomy/delegation of budgets, which can be reported and tracked through the Operating Framework indicators;
- Should facilitate discussions with HealthWatch (in its pre-establishment form), and local authorities to ascertain their support and contribution to supporting CCGs in delivering personal, fair and diverse commissioning services for individuals belonging to protected characteristics and those facing health inequalities. Clusters may need to support CCGs to understand and prepare for delivery on the Public Sector Equality Duty and the Equality Diversity System is a tool which is available for this;
- Should ensure emerging CCGs have the opportunity to build up a track record of delivery (e.g. on QIPP, primary care, tackling health inequalities, relationships with local partners including participation in emerging health and wellbeing boards, patient engagement and public involvement) in preparation for authorisation;
- Should support emerging CCGs in leading the planning round for 2012/13 as appropriate;
- Should support emerging CCGs to ensure they are engaged early in the development of their local health and wellbeing board in shadow form during 2011/12 and that they are able to play a lead role in shaping the Joint Strategic Needs Assessment and joint health and wellbeing strategy; and
- Should support emerging CCGs in engagement with critical aspects of provider development, and in particular the future for NHS trusts.

Local authorities

- Can expect emerging CCGs, supported by their PCT clusters, to develop their own joint working arrangements with local government and start working with them on the development of the Joint Strategic Needs Assessment, and the development of the joint health and wellbeing strategy;
- Can expect emerging CCGs, supported by their PCT clusters, to start establishing fruitful and positive relationships through the shadow health and wellbeing boards where appropriate;
- Can expect emerging CCGs to engage in existing, or work to accelerate, joint health and social care commissioning;
- Can expect emerging CCGs, and PCT clusters to respect pre-existing local joint working or joint appointments; and
- Are invited to support emerging CCGs in accessing public health expertise.

SHA clusters

- Should work with emerging CCGs to undertake a risk assessment of their proposed configuration October – December 2011 in line with a nationally consistent process, and support emerging CCGs in addressing any risks identified as a result;
- Should help resolve any issues of geography, size and practice membership; and any 'orphan' practices so that by April 2012 there is a configuration of CCGs across the country that is likely to meet legislative requirements; and
- Should ensure that the range of development offers is widely understood and is appropriately targeted.

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