
DEVELOPING CLINICAL COMMISSIONING GROUPS (CCGs) IN ESSEX

TOWARDS AUTHORISATION

A Guide for Practices and Emerging CCGs

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NORTH & SOUTH ESSEX LMCs LTD

CONTENTS	Page
Introduction	4
Principles for Authorisation	5
Authorisation in Context	6
Three Steps to Authorisation	6
Authorisation Process – Six Key Domains	8
Evidence for Authorisation	10
Who Has a Role in the Authorisation Process?	10
The Constitution of CCGs and Engagement with Member Practices	11
Model Constitutions: BMA Law and Lockharts	13
Outcomes of the Authorisation Process	14
Timescale for Authorisation	14
Commissioning Support	15
Support for CCG Development	15
What Next for Emerging CCGs?	15

INTRODUCTION

The final version of the Authorisation Framework for Clinical Commissioning Groups (CCGs) entitled “Developing Clinical Commissioning Groups – Towards Authorisation” has recently been published by the Department of Health. In addition, four technical appendices have also been produced which cover in more detail the likely legislative requirements, feedback received to date on the authorisation domains and a list of published and forthcoming supporting documentation. All these can be accessed on the LMCs’ website at www.essexlmc.org.uk

In his foreword to the DH document, Sir David Nicholson, the Chief Executive Designate of the National Health Service Commissioning Board (NHSCB) states: -

“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.”

The intention is that the shadow NHSCB will publish a further update of this Framework in Spring 2012 following further engagement with emerging CCGs and stakeholders. The current document needs to be read on the basis that all of these proposals will be subject to possible change and refinement as and when the Health and Social Care Bill passes through Parliament.

This guidance is the latest in a series produced by North & South Essex LMCs which aims to summarise and update practices on the latest proposals regarding the establishment and operation of emerging CCGs. Pages 11 and 12 of this Guide are of particular relevance to practices and emerging CCGs as they reinforce the LMCs’ view on the two-way accountability arrangements that need to be in place to reassure practices and facilitate their involvement in the commissioning process.

The Authorisation process will require all CCGs to produce a Constitution that will be publicly available. A key element of the Constitution will be the need for CCGs to detail their arrangements for securing the effective participation of its member practices.

North and South Essex LMCs are strongly of the view that the Constitution is the formal mechanism by which CCGs can ensure that fair and transparent rules of engagement with practices are agreed and documented.

BMA Law and Lockharts are both in the process of producing a Model Constitution for use by emerging CCGs. These models are being designed very much with the intention of fostering constructive relationships between practices and the CCG and will be a great help to CCGs in preparing evidence for approval by the NHSCB. Details can be found on Page 13.

PRINCIPLES FOR AUTHORISATION

The Government's ambition to put in place the "best healthcare service in the World" relies on the development of effective and fully authorised CCGs that cover the whole of England.¹

CCGs will be expected to have a clear clinical focus and added clinical value which require the involvement of a wide range of healthcare professionals who share in the care of patients.

Authorisation is the process by which the Government can be assured that the position has moved from a network of Pathfinders to one of established CCGs covering the whole of the country.

A set of principles that underpin and guide the development of the authorisation process has been developed and are detailed below: -

- 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;
- **Authorisation will focus on confidence in CCGs' potential to deliver**, drawing on their participation in, for example, improving long term conditions care, clinical care in general and other aspects of QIPP. It will also draw on CCGs' **track record to date** as sub-committees of PCTs to whom certain commissioning responsibilities have been delegated;
- **A nationally consistent approach** – so that all emerging CCGs can have confidence that the same standards are being applied.

¹ *DH Developing Clinical Commissioning – Towards Authorisation – September 2011*

AUTHORISATION IN CONTEXT

Subject to the approval of the Health and Social Care Bill, the whole of England will be covered by established CCGs by April 2013.

As soon as the NHSCB is fully established (likely to be between July and October 2012) it can begin to consider applications for the establishment and authorisation of CCGs.

The authorisation process will be closely aligned to the developmental support undertaken by CCGs. It is intended as a process of continuous improvement and will have four distinct phases as follows: -

Phase 1 – Initial Development

This is underway in many CCGs who have already assumed an increasing responsibility for service redesign and delegated budgets.

Phase 2 - Application

CCGs will need to formally apply to the NHSCB to become established and authorised.

Phase 3 – Authorisation Process

The NHSCB will consider the application and determine the conditions to be placed on the CCG on becoming established. The three outcomes of the authorisation process are detailed on Page 14.

Phase 4 – Annual Assessment

Once authorised each CCG will be subject to an annual assessment.

THREE STEPS TO AUTHORISATION FOR CCGS

Given the scale of the change and the serious nature of the responsibilities that are transferring to CCGs, a “Road Map” has been developed which will help CCGs prepare for the authorisation process.

The “Road Map” contains three important steps or milestones: -

Step One: Risk Assessment of the CCG’s Proposed Configuration

Between October and December 2011 each emerging CCG will be invited to participate in an initial risk assessment of its proposed configuration. This exercise will be undertaken by the SHA and is designed to help CCGs determine whether or not their proposed arrangements are likely to meet the criteria defined within the Health and Social Care Bill.

CCGs will need to demonstrate that their boundary broadly encompasses most patients that are registered with constituent practices. Boundaries should not cross local authority upper tier or unitary authority boundaries unless there is good reason to do so, which is in patients' best interests.

There will be four distinct areas as part of the risk rating: -

- Sign up from member practices.
- Appropriate geographical coverage that allows the CCG to commission responsibility for a defined population.
- In the case of a CCG that straddles either a local authority or unitary boundary, to ensure this is in the best interests of patients.
- Assessment of organisational viability and the sharing of roles and functions where appropriate.

The NHSCB will take the final decision on configuration at the point of authorisation. The view of the NHSCB will be informed by the views of stakeholders as part of a 360 degree assessment.

Step Two: The Development Path

This is the period during which emerging CCGs will be able to develop their internal structures, gain experience and build up a track record which will be crucial for the authorisation process and beyond.

CCGs will need to consider taking on increased delegated responsibility for budgets, the delivery of QIPP initiatives and have a role in the development of Health and Wellbeing Boards. How best to utilise public health expertise and develop effective commissioning support arrangements will also need to have been properly thought through.

Step Three: The Authorisation Process

The final stage of the process will require CCGs to apply to the NHSCB in order to become established and authorised. The authorisation process will be built on six key domains (See Pages 8 and 9).

CCGs will be expected to gather evidence to demonstrate compliance against the six domains. Relationships with stakeholders and the CCG's ability to secure patient, public and professional involvement will be crucial elements of the authorisation process.

THE AUTHORISATION PROCESS – SIX KEY DOMAINS

The proposed content of the authorisation process is built around six key domains. These six areas are considered to be the most likely indicators of success for CCGs.

The six key domains (see below) were tested and received significant support as part of the Government’s Listening Exercise. They are intended to create a simple framework that can be easily understood by all those involved.

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.

EVIDENCE FOR AUTHORISATION

There will be three aspects to the consideration of a CCG's application for formal establishment and authorisation.

Submission of Evidence

CCGs will be required to submit evidence that demonstrates capability across the six domains. A Commissioning Plan, the CCG's Constitution, the Prospectus and an Organisational Development Plan will form a major part of this evidence.

Validity of Evidence

The NHSCB will need to satisfy itself about the validity of the evidence. This process will include a 360 degree review of how the CCG is working with its partners. Constituent practices will have the opportunity to comment.

Drawing Together the Information

The third and final aspect will involve the NHSCB drawing together all the background knowledge and information for discussion with the prospective CCG and any local stakeholders that the Board feels need to be involved in the final assessment.

WHO HAS A ROLE IN THE AUTHORISATION PROCESS?

- 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 areas will be involved in decisions about authorisation of local CCGs.
- Shadow Health and Wellbeing Boards will have a role in the process. Health and Wellbeing partners will have a key role in the 360 degree review and providing views on the willingness and ability of CCGs to be involved in partnership working.
- There will be a role for Clinical Senates, although the detail is yet to be agreed.
- The NHSCB will ensure a single and consistent process across the country for the authorisation of all CCGs.
- The final decision can only be taken once the NHSCB is established and has the necessary legal powers.

THE CONSTITUTION OF CCGs AND ENGAGEMENT WITH MEMBER PRACTICES

An integral part of the authorisation process is the requirement on CCGs to demonstrate that they have in place a clear mandate from constituent practices and that practices are actively engaged in helping to shape and deliver locally agreed priorities.

Feedback from the Government's Listening Exercise reinforces the importance of arrangements being owned and supported by practices locally. On the subject of clinical engagement with practices, the documentation supporting the authorisation process recognises the importance of: -

- CCGs having a "clear mandate from constituent practices and participating mechanisms for enabling practice engagement in decision making and delivery".²
- Clinicians in constituent practices being "engaged in shaping and delivering locally agreed priorities" and having "timely information and relevant incentives to play their full part in improving clinical quality".²
- There being in place "a process for local clinicians working together across the system to bring innovative proposals forward for consideration".²

One of the key elements of the risk assessment of an emerging CCG's proposed configuration will be the need to have sign up from member practices who are "supportive of the proposed CCG configuration, especially to the consideration of shape, relationship with Local Authority boundaries and proposals for organisational viability".³

It remains clear that these radical proposals for NHS reform cannot work unless there is engagement with practices across the whole of the county. There needs to be an ownership of what is being proposed by the vast majority of the GP community in Essex, irrespective of their contractual status.

In July this year, North and South Essex LMCs adopted a policy document entitled "Accountability and Rules of Engagement with Practices". The document, which has been discussed with transitional CCG leads and circulated to all practices, highlights a number of guiding principles and rules which are intended to underpin the way in which CCGs engage with constituent practices. The document can be downloaded from the LMCs' website at www.essexlmc.org.uk

The authorisation process requires all CCGs to produce a Constitution which will be publicly available. The Constitution will be a crucial element of the portfolio of evidence that CCGs will be expected to produce to the NHSCB. It is the view of the LMCs in Essex that this Constitution is the formal mechanism by which CCGs can, and should, properly demonstrate their commitment to engaging practices in a way that allows practices to take responsibility for their own clinical behaviour and influence how best services can be configured to meet the needs of their patients. A model Constitution for use by CCGs is currently being produced by both BMA Law and Lockharts. Further details can be found on Page 13.

² *Technical Appendix 3: Developing an Agreed CCG – Your Views on the Domains*

³ *Technical Appendix 2: Risk Assessment of Configuration*

The Constitution must include as a minimum: -

- The geographical area for which the CCG will be responsible.
- Arrangements for discharging their statutory functions, including public and patient engagement and multi-disciplinary working.
- Procedures for decision making and managing conflicts of interest.
- Arrangements for securing the effective participation of the CCG's members.

North and South Essex LMCs' advice to practices and emerging CCG leaders is that CCG Constitutions must ensure that fair and transparent rules of engagement with practices are agreed and documented. These should be supported by sensible and transparent processes for dealing with conflicts of interest, performance management and dispute resolution, that properly protect practices and reassure patients that their treatment and care will not be in any way jeopardised by the establishment of CCGs.

Further details of the principles and rules being suggested by the LMCs can be found in the document "Accountability and Rules of Engagement with Practices – July 2011", referred to earlier. In summary these include: -

- Two-way Accountability between CCGs and Practices
 - Regular Meetings with Practices
 - Public Annual General Meeting
 - Annual Survey of Practices
 - Power of Recall available to members
 - Agreed Annual SLA/Accountability Agreement
- Clinical Leadership/Democratic Legitimacy
 - Clinical leaders must have the right competencies and skills and a mandate from the profession locally.
 - Appointment/election processes should be fair. All GPs working in an area must be eligible to stand for election and vote, irrespective of their contractual status.
- Performance Management
 - All GPs and practices will have an obligation to participate in a process that will be supportive in nature and based on the principles of peer review and shared learning.
 - Objectives will be agreed by both parties and documented in the annual SLA.
 - The LMC will act as a mediator in all cases where practices feel unable to engage in this process.
- Governance Arrangements
 - Each CCG must put in place effective clinical and corporate governance structures to underpin the commissioning process.
 - The LMCs have produced model policies which are intended to help CCGs put in place transparent processes for dealing with conflicts of interest and dispute resolution.

MODEL CONSTITUTION – BMA LAW

It is important to try and support GPs at an individual level in acquiring the knowledge and training to empower them to successfully operate under any form of a commissioning Constitution.

BMA Law is in the process of producing a Model Constitution and associated training workshops/seminars which will be aimed at enabling all GPs and CCGs to properly prepare for the new commissioning agenda.

The Constitution will deal with all the essential governance issues such as procurement, Any Willing Provider, elections to the Board, disqualification, conflict of interests, etc, and will shortly be available to Shadow CCGs. It will be flexible enough to be tailor made to the needs of each individual CCG and can be adapted to reflect any ongoing developments in legislation.

The training workshops/seminars will include: -

- Voting and election processes
- How to handle conflicts of interest
- Procurement procedures and the “Any Willing Provider” principle
- Fairness and equity
- Disqualification of members of CCGs
- Daily management and process
- The role of the LMC.

Further information is available from BMA Law.

MODEL CONSTITUTION - LOCKHARTS

The NHS Commissioning Board will be producing a model template constitution for CCGs and certainly parts of it, for example dealing with conflicts of interest and the required relationships with Local Authorities, are likely to be highly prescriptive.

There will however be considerable room for local adaptation in many areas. Lockharts will be able to spend time understanding the local and individual needs of practitioners and will help with moulding CCG arrangements so as to ensure that all those involved believe they are properly represented and can “buy into” the CCG’s operations and plans.

One particular area that needs attention is not just the CCG voting arrangements but a developed board member rotation system so that all feel they can be involved and can engage with the CCG work.

In addition, Lockharts will be able to provide tailored workshops to assist CCGs with the processes that they will be required to engage with, such as procurement and AWP working.

Further details are available through csd@lockharts.co.uk “

OUTCOMES OF THE AUTHORISATION PROCESS

There are three possible outcomes of the authorisation process. CCGs may be Fully Authorised, Authorised with Conditions and Established as "Shadow CCGs".

<p>Fully Authorised <i>Legal Definition: Established without Conditions</i></p>
<p>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.</p>
<p>Authorised with Conditions <i>Legal Definition: Established with Conditions</i></p>
<p>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:</p> <ul style="list-style-type: none"> o Those who do not have a comprehensive competent infrastructure, i.e. are not yet organisationally ready. o 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.
<p>Shadow CCGs <i>Legal Definition: Established with Conditions</i></p>
<p>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.</p>

TIMESCALE FOR AUTHORISATION

October – December 2011	Invitation to participate in risk assessment of the proposed configuration
October 2011 onwards	Preparation for authorisation
Summer 2012	Application to the NHSCB for establishment and authorisation
October 2012	Formal authorisation process
April 2013	All of England covered by established CCGs

COMMISSIONING SUPPORT

Even the largest CCGs may be unable to undertake the full range of commissioning functions in isolation. Key to the authorisation of CCGs will be their plans to share or buy in commissioning support for the non-clinical aspects of commissioning. In order to help manage the transition through until April 2013, as well as ensuring that CCGs will have access to high quality services, the DH will be publishing a range of information about commissioning support.

SUPPORT FOR CCG DEVELOPMENT

All CCGs across the country will be supported to achieve their full potential through a programme of development – designed in partnership and tailored to local needs. While much of this work is being driven by SHA and PCT clusters to meet local circumstances, a number of national tools are currently available to inform this process. These include: -

- National Pathfinder Learning Network
- Self-Assessment Diagnostic Tool
- National Leadership and Development Framework

WHAT NEXT FOR EMERGING CCGs?

- Establish strong relationships with and between constituent practices. Develop effective communication links to ensure the views of practices are properly considered by the CCG through the transition process.
- Secure the agreement of local GPs to a structure and management support arrangements that underpin clinically led commissioning in the locality.
- Consider and discuss with practices the use of the model Constitutions produced by BMA Law and Lockharts, which will act as the mechanism for ensuring two-way accountability between the CCG and its member practices.
- Discuss with your SHA cluster your proposed membership, geography and size in order that the SHA cluster can undertake the risk assessment with you.
- Consider undertaking the self-assessment diagnostic tool, available at <http://healthandcare.dh.gov.uk/category/context/pathfinder-learning-network/>
- Consider taking on a lead role in commissioning through delegated authority from your PCT especially in leading the planning around 2012/13 and QIPP delivery for your area.
- Begin to develop joint working arrangements with local government, to engage in the development of Health and Wellbeing Boards and to explore how to make best use of public health expertise from local authorities in the new system.
- Begin to build relationships, collaborative arrangements, and a track record of delivery (eg. 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.

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