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To: Health and Wellbeing Board – 28th September 2011

Subject: CCG Authorisation process

Classification: Unrestricted

Summary: The consultation publication '*Developing clinical commissioning groups – Towards authorisation'* sets out the draft process for Clinical Commissioning Group (CCG) authorisation. There are three phases leading up to full authorisation which will commence from October 2012:

- Development phase
- Application
- Authorisation process

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1. Development Phase

1.1 Configuration of CCG

The initial development phase will commence in October 2011 with a risk assessment of the proposed configuration of a CCG. There are four element of the risk assessment which is designed to help CCGs understand whether their current proposed arrangements are likely to meet the criteria defined in the Health and Social Care Bill, the first three are:

- **Member Practices** – that member practices are supportive of the proposed CCG configuration especially in relation to the consideration of shape, local authority boundaries and proposals for organisational viability.
- **Geography – boundary/population** – that a CCG will have responsibility for persons who are provided with primary medical services by a CCG practice including people who are not registered with a practice.
- **Geography – relationship with local authority boundaries -** that the boundaries of local CCGs should not normally cross those of upper tier local authorities, with any departure needing to be clearly justified and in the interests of patients.

The fourth aspect is intended to help CCGs understand the likely impact of their proposed size both on their organisational viability, and the degree of sharing of roles and functions or use of commissioning support they will need to consider, and their ability to secure local practice engagement in the case of very large CCGs. A national Ready Reckoner Calculation tool is in development – it provides an opportunity for CCG to calculate running costs which gives examples of costs associated with corporate responsibilities as well as potential for bought in commissioning a back office functions.

1.2 **Self Assessment Development Diagnostic**

In addition to understanding their configuration, each CCG will be undertaking a self assessment of development needs. Strategic Health Authorities are being asked to consider and rate (red amber green') ratings, each CCG within their area by the end of October 2011 from the self assessment. This risk assessment is only looking at size and geography as a pre-requisite to achieving a track record through shadow running in 2012/13. Upper tier and Unitary authorities will be asked their views of size and geography through this process. No stakeholder, including the SHA has a veto on the ambition of a CCG to continue development to authorization.

Completion of the self assessment is fully supported by the SHA and will provide CCG with a detailed understanding of their development needs.

In addition to the risk assessment CCGs are being supported to follow through a 'pipeline' development process and identifying a development plan for the new organizations agreed with the PCT Cluster and SHA's. The PCT Cluster and SHA will work with each CCG to ensure that a tailored development plan is in place that will be worked on throughout the shadow period.

The PCT Cluster will support CCG through the development period ensuring CCG have opportunity for increasing responsibility for service redesign and delegated budgets. Further support will be available as the Cluster develops an understanding what CCG will need in terms of commissioning support.

1.3 **Commissioning Support**

Key to authorisation will be CCG plans to build, share or buy commissioning support for non clinical aspects of commissioning. Even the largest CCG's will be unable to undertake the full range of commissioning functions in isolation.

Work is ongoing to define the way commissioning support functions can develop alongside CCG's. This includes listening to the full range of current and potential providers of CS including local authorities, third sector and commercial organisations

Work includes:

- Business reviews across all PCT clusters to assess maturity of approach
- Analysis of the scale at which individual CS functions are best undertaken
- Modelling potential CCG running costs and how they could most effectively be deployed
- Supporting CCG to become intelligent purchasers of commissioning support

The DH will be publishing a range of information on the expectations for commissioning support in the autumn

2. Application

CCG's will need to apply to the NHSCB to be authorised. The process will look at six domains covered by the self assessment pipeline:

1. A strong clinical and professional focus which brings real added value
2. Meaningful engagement with patients, carers and their communities
3. 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
4. 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
5. Collaborative arrangements for commissioning with other clinical commissioning groups, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support
6. Great leaders who individually and collectively can make a real difference

It will focus on confidence in a CCG potential to deliver - and the ability of the CCG to build up a track record. Understanding the configuration of each CCG by December 2011 will provide a period of stability (the shadow term) whereby CCG can gain experience. The Development Path/Plan will be used to describe the experience gained.

Earliest applications for authorisation can be received in Summer 2012. The PCT Cluster will support CCG to take on delegated responsibilities within legislative framework and the DH will be tracking the level of delegation to build a picture of the extent to which this is taking place. The development of commissioning support models is a prerequisite to the success of building a track record.

3. Authorisation

There are three aspects to grant authorisation:

- Submission of evidence - CCG's will be required to pull together a range of evidence to demonstrate capability. The evidence should include a 360° assessment of views from all partners including the public, HWB Boards and clinical networks
- NHSCB satisfaction of the validity of the evidence including the 360° review, reviewing how the CCG is working with partners, and involvement of local professionals
- NHSCB will finally draw together all its background knowledge and information for a discussion with CCG and any local stakeholders, it would include assessing the level of risk in the particular system

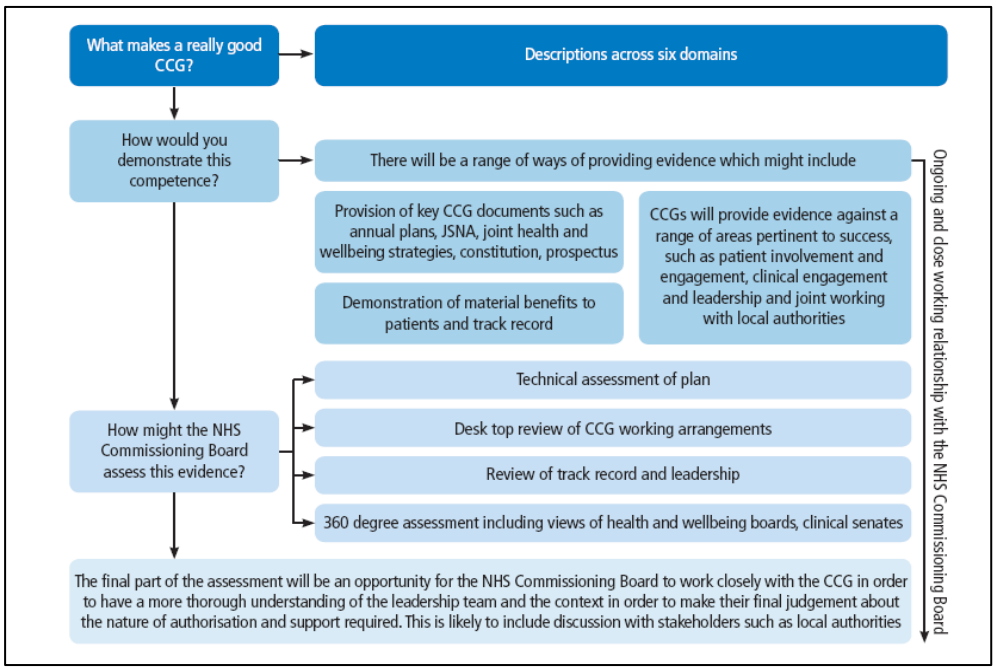
CCG's could be established from October 2012, this would allow CCG's to operate as a statutory body, sign contracts and take on formal employment of staff. However, they would not be able to take on commissioning

responsibilities of their PCT cluster until 1st April 2013. Consultation is ongoing to determine the potential outcomes for the authorisation process and how the NHSCB might wish to determine these outcomes.

There will be two levels of authorisation and an opportunity for CCG to remain in shadow form:

- Shadow CCG's: If CCG did not wish to undertake any commissioning, or the NHSCB deemed they were not yet competent – the CCG would operate as a shadow CCG with the NHSCB taking responsibility for ensuring the functions are discharged
- Authorised with conditions – CCG's who were established but not fully authorised, who did not have a comprehensive infrastructure or who were not ready, willing or able to take on the full range of commissioning responsibilities
- Full Authorisation - where the NHSCB judged the CCG to be a competent commissioner of all services without additional support

Process for authorisation



4. Roles and responsibilities

4.1 PCT Clusters - will have a role preparing and supporting CCG's. They will <u>not</u> be involved in the decision about authorisations of local CCG's. The final decision for authorisation will rest with the NHSCB and relevant legal powers for this will commence July – October 2012**.**

4.2 The SHA Cluster – will be responsible for supporting the CCG configuration exercise by providing a RAG rating in review of each CCG risk assessment. They will also have the role of overseeing and managing the flow of applications for authorisation ahead of the establishment of sectors of the NHSCB

4.3 The Health and Wellbeing Board (HWB) – The County Council Chief Executives will be invited to give a view on the efficacy of CCG configuration arrangements in their area to promote health and wellbeing and support integration through the 2011 risk assessment process.

There will be a role for shadow HWB in the full authorisation process through bringing together local leaders and patient/ public representatives to develop joint strategies. The 360 ° review will provide views on the CCG willingness and ability to be involved in partnership working.

4.4 Clinical Senates - will be involved in authorisation by providing expertise, advice and support which commissioners will draw on. They will provide the link between local clinicians and national leadership to gauge the extent to which CCG's are including the full range of professional in commissioning. This will be confirmed through the 360 ° review.

4.5 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.

5. Timetable	Milestone date
PCT Cluster to support CCG to find a configuration that will meet legislative requirements (membership, geography, size and arrangements for collaboration and securing commissioning support)	OCT – DEC 2011
PCT Cluster to support CCG through the self assessment development tool	DEC 2011
CCG to undertake self assessment and draw up a Development Plan	DEC 2011
CCG to take a lead role in the planning round and QIPP delivery	DEC 2011
Facilitate discussion with Healthwatch and local authorities and engagement with HWB in shadow form during 2011/12	OCT 2012
CCG to articulate commissioning support requirements	OCT 2012
Ensure CCG have appropriate earned autonomy/delegation of budgets which can be reported and tracked through the Operating Framework Indicators	OCT 2012
Support CCG to build a track record	OCT 2012
PCT Cluster to maximise the responsibilities delegated to CCG's in 2011/12 and for 2012/13 within their delegated powers	OCT 2012
Ensure CCG have, in addition to the £2ph appropriate management support either directly assigned or working across several groups	OCT 2012
Ensure all practices are members of a CCG	APR 2012
Support CCG in engagement with critical aspects of provider development and in particular the future of NHS Trusts.	OCT 2012

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