

# The Authorisation Process

November 2011

NHS REFORM

## Introduction

This guidance document outlines the process by which clinical commissioning groups (CCGs) are deemed ready and able to take on responsibility for the commissioning process and budget (the “authorisation process”). The document:

- discusses the six domains of competence for CCGs that the Government has identified;
- highlights issues for general practitioners (GPs) and Local Medical Committees (LMCs) to consider and;
- provides examples of how a competent and successful CCG should operate.

## Contents

|  |         |
|--|---------|
| <b>Introduction</b>                                | Page 2  |
| <b>Background</b>                                  | Page 3  |
| <b>The Authorisation Process</b>                   | Page 3  |
| <b>The six domains</b>                             | Page 4  |
| <b>Timeline – Appendix 1</b>                       | Page 14 |
| <b>Summary grid – the six domains – Appendix 2</b> | Page 16 |

**Click the yellow boxes for further guidance**

N.B. The guidance documents linked to in the document have been produced by the BMA since the publication of the NHS White Paper 'Excellence and Equity: Liberating the NHS' in July 2010. Whilst all efforts are made to ensure these guidance documents are as up to date as possible, developments with relation to the NHS reforms are fast moving and events and terminology may have moved on since publication. The principles supported by the BMA in each document remain relevant however. Readers should bear in mind the date of publication of the guidance document whilst reading.

## Background

The Health and Social Care Bill<sup>1</sup> proposes radical changes to the way in which health care is commissioned in England. With the aim of placing clinicians at the heart of the commissioning process, the Bill mandates the setting up of CCGs led by general practitioners to take forward the planning and purchasing of healthcare.

The Bill is yet to complete its passage through parliament (as of November 2011), however, at the direction of the Department of Health, Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) are dismantling and clustering, and shadow CCGs are emerging. Subject to the passage of the Bill, the Government is aiming for all CCGs to be authorised – that is, judged ready and able to take full responsibility for commissioning processes and budget – by April 2013. Clearly, this timescale is incredibly tight. The British Medical Association (BMA) opposes the proposals in the Health and Social Care Bill, calling for the Bill to be withdrawn.

*Appendix 1 provides a timeline for change, identifying key dates for CCGs between now and April 2013.*

## The Authorisation Process

For the benefits of clinician-led commissioning to be realised, CCGs will need to be competent bodies able to promote integration and work collaboratively with other colleagues and patient representatives. As CCGs determine their constitution, elect board members and begin to commission in shadow mode, the coming months will be crucial in the development of financially robust and accountable bodies.

The authorisation process (as outlined in the Government document **“Developing Clinical Commissioning Groups: Towards Authorisation”**<sup>2</sup>) will be overseen by the NHS Commissioning Board (NHSCB). The NHSCB will ask CCGs to provide evidence of their competence in various areas and will seek the views of PCT and SHA Clusters, Health and Wellbeing Boards, LMCs and constituent practices. The Government has identified six key domains against which CCGs will be judged.

This document discusses each of the six domains in turn, highlighting issues for consideration by GPs and LMCs and gives examples of the sort of evidence CCGs could provide to the NHSCB.

*Appendix 2 provides a summary of the six domains and the GPC’s main concerns.*

1 The Health and Social Care Bill, 2010-11. Available at [http://www.publications.parliament.uk/pa/bills/cbill/2010-2012/0221/cbill\\_2010-20120221\\_en\\_1.htm](http://www.publications.parliament.uk/pa/bills/cbill/2010-2012/0221/cbill_2010-20120221_en_1.htm)

2 *Developing Clinical Commissioning Groups: Towards Authorisation*, September, 2011, Department of Health. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_130293](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293)

## The Six Domains

### Domain 1: A strong clinical and multi-professional focus which brings real added value.



#### **What the Department of Health says...**

*"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."*<sup>2</sup>

#### **The BMA view...**

The GPC supports increased clinician involvement in the commissioning process. The most effective way to limit the damaging consequences of the Bill (for example, fragmentation of care caused by the promotion of the internal market and the Any Qualified Provider policy) will be to ensure that the new structures work to encourage clinician-led commissioning.

**GPC GUIDANCE LINK: The principles of GP commissioning – a GPC statement in the context of 'Liberating the NHS'**

The engagement and support of constituent practices will be absolutely vital to a CCG's success. LMCs play a crucial role here; providing a channel of communication between practices and the CCG governance and decision-making bodies, facilitating elections to the CCG and acting as mediator to resolve conflict.

**GPC GUIDANCE LINK: The role of LMCs in supporting the development of CCGs**

More widely, the involvement of secondary care colleagues and public health doctors is also essential. The Government envisages that one avenue for this involvement will be via Clinical Networks and Clinical Senates but the BMA is concerned that without clarity of the roles and responsibilities of these bodies, they risk cultivating bureaucracy, hindering not helping the work of the CCG. We think these bodies should be linked to CCGs not the NHSCB, to ensure they can constructively contribute to the commissioning process and encourage integration.

**BMA GUIDANCE LINK: Consultant involvement in commissioning – implications of the Health and Social Care Bill.**

<sup>2</sup> *Developing Clinical Commissioning Groups: Towards Authorisation*, September, 2011, Department of Health. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_130293](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293)

***This domain should require CCGs to:***

- Develop a systematic approach to monitoring quality and outcomes;
- Demonstrate evidence-based decision making;
- Democratically engage with constituent practices;
- Involve a range of other health professionals, including public health doctors.

***To demonstrate competence in this domain CCGs could provide evidence of:***

- A commissioning plan and how this plan supports the Joint Health and Wellbeing Strategy;
- How constituent practices and other health professionals are consulted and involved;
- How the CCG will measure quality and outcomes, and how these will feed into the commissioning process;
- Active involvement in the CCG's shadow Health and Wellbeing Board.

## Domain 2: Meaningful engagement with patients, carers and their communities.



### **What the Department of Health says...**

*“CCGs need to be able to show how they will ensure inclusion of patients, carers, public, communities of interest and geography, health and wellbeing boards and local authorities. 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 are translated into commissioning decisions and how the voice of each practice population will be sought and acted on. CCGs need to promote shared decision-making with patients, about their care.”<sup>2</sup>*

### **The BMA view...**

The views of patients and the public are central to assessing population need, planning accordingly and evaluating the outcomes of commissioning decisions. This engagement should be meaningful, avoiding merely just “ticking boxes”, or, conversely, placing an unnecessary bureaucratic burden on CCGs. CCGs will need to seek the views of patients across the CCG population and balance this with engagement with single issue groups (although these expert views will be useful).

#### **BMA GUIDANCE LINK: Patient and public involvement: a toolkit for doctors.**

Shared decision making with patients involves not only consultation about an individual’s choices, but a population-wide discussion about the challenging decisions that need to be made. Advances in treatment, a growing population and huge financial constraints pose a considerable challenge to the NHS over the coming years. CCGs may well be better placed than PCTs to promote an honest and open (but difficult) debate with patients and the public about the challenges facing the health service. However to protect the doctor-patient relationship, CCGs will need to operate in a transparent manner with good scrutiny structures. Patients should have no reason to think that decisions taken by their GP are based on anything other than clinical need. In particular, the BMA has a strong objection in principle to the concept of financial incentives (such as the proposed ‘quality premium’ in the Bill) other than those already in place under the GP contract, particularly if those incentives are linked to any initiative designed to save money while reducing patient choice or care options.

#### **GPC GUIDANCE LINK: Ensuring Transparency and Probity The Governance of Consortia**

<sup>2</sup> *Developing Clinical Commissioning Groups: Towards Authorisation*, September, 2011, Department of Health. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_130293](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293)

Health and Wellbeing Boards will involve representatives from CCGs, local authorities, patient groups and public health. The Boards will provide strategic oversight, ensuring that a CCG's plan coheres with the Joint Health and Wellbeing Strategy and have potential to be a useful forum to promote a collaborative approach to commissioning. The GPC encourages CCGs and LMCs to get involved with their local Health and Wellbeing Board, as a good relationship between these bodies will help avoid conflict and ensure that the commissioning process is as streamlined as possible.

**GPC GUIDANCE LINK: Health and Wellbeing Boards.**

***This domain should require CCGs to:***

- Establish clear processes to gather patient views and to receive patient feedback;
- To construct mechanisms for gathering these views that are bureaucratically light and yield meaningful data;
- Demonstrate how these views are fed into the decision-making process;
- Seek public health expertise to aid understanding of patient populations and their need.

***To demonstrate competence in this domain CCGs could provide evidence of:***

- The mechanisms by which the CCG is able to engage with patients and the public;
- How this information is reflected on and used to inform the commissioning process;
- Liaison with public health colleagues to gain an understanding of local population need;
- Transparent and open processes with robust governance systems, to ensure local populations are able to hold their CCG to account.

## Domain 3: Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national requirements (including excellent outcomes) and local joint health and wellbeing strategies.



### **What the Department of Health says...**

*"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. Their 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."*<sup>2</sup>

### **The BMA view...**

CCGs will begin commissioning in the context of huge financial constraints and at a time of massive structural overhaul. Successful financial management will be essential. Good financial planning will depend, however, on a fair allocation of funding to CCGs and the Government needs to rapidly provide more detail of how this will be calculated, and how quickly CCGs will be expected to move to this from their current historical funding.

To achieve this domain, CCGs will need comprehensive support from PCT clusters whilst in shadow form, and from commissioning support units (CSUs) once authorised. We have serious concerns that PCT support to shadow CCGs is, at present, too variable, and the timetable for hand over of responsibilities far too swift. Demonstrating this domain, particularly gaining a 'track record of delivery', may prove especially challenging for CCGs who have been slow to form and who are yet to undertake the preparatory work (e.g. determining structures, processes and appointing members) required before they can focus on commissioning.

### **This domain should require CCGs to:**

- Develop robust financial management arrangements (including risk sharing and risk pooling);
- Develop comprehensive commissioning plans that include the QIPP objectives and how achievement of these will be measured;
- Ensure that all commissioning plans are backed by a coherent public health strategy.

### **To demonstrate competence in this domain CCGs could provide evidence of:**

- Retrospective evidence of achieving efficiencies (where showing evidence of deliverance of QIPP and operating in budget proves challenging for less developed CCGs);
- A comprehensive commissioning plan with reference to QIPP, the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy;
- Evidence of the financial support and governance systems.

<sup>2</sup> *Developing Clinical Commissioning Groups: Towards Authorisation*, September, 2011, Department of Health. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_130293](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293)

## Domain 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.



### **What the Department of Health says...**

*“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, safeguarding and choice. 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.”<sup>2</sup>*

### **The BMA view...**

It is vital that CCGs are of sufficient size to manage financial risk, enjoy a strong negotiating relationship with acute trusts, and take advantage of economies of scale in management and administrative costs; all areas that will pose significant challenges for CCGs serving populations under 100,000. Large CCGs will be able to benefit from these advantages and this does not need to be at the expense of local engagement, which GPs and practices value. We recommend that CCGs should be large, serving a population in the region of up to 750,000 (or even greater in some areas of the country where this makes geographical sense) but with strongly devolved locality groups of clinicians to lead the commissioning of appropriate services for their area. An alternative is the creation of a formal federation of smaller CCGs working together, although the governance arrangements would need to be robust to give confidence to all CCGs in the federation.

Properly constituted CCGs will hold open and democratic elections (with prior assessment of competency) to appoint their board members. LMCs will play an integral role in assisting with these processes and ensuring all constituent practices and the local profession are involved. Whilst practices are the constituents of CCGs, locum and other doctors who are not necessarily aligned to a practice will have a valuable contribution to the working of a CCG. CCGs should ensure that all doctors in their area have equal opportunity for involvement in their CCG.

**GPC GUIDANCE LINK: Sessional GPs: GP commissioning and impact of the NHS White Paper**

The establishment of the constitution of a CCG will be a good opportunity to consider the elements contained in this domain. The constitution should detail how the CCG will interact with the LMC and other bodies who will play a role in ensuring that the CCG remains accountable to its constituents and local population.

<sup>2</sup> *Developing Clinical Commissioning Groups: Towards Authorisation*, September, 2011, Department of Health. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_130293](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293)

Effective commissioning support will be essential to deliver this domain and PCT clusters and LMCs should be supporting shadow CCGs to ensure that, at this early stage, the emerging structures and processes of the CCG will be robust enough. The risk assessment undertaken by SHAs in autumn 2011 will be useful in highlighting likely support requirements, and particularly where a CCG will be too small to afford to buy in support.

Finally, robust governance structures will ensure that the benefits of clinician-led commissioning are realised, whilst promoting a transparent way of working to guarantee the probity of the decisions made. These accountability relationships, for example between CCGs and Health and Wellbeing Boards, should promote the central goal of clinician-led decision-making and not act to stifle local flexibility. The CCG should be able to demonstrate how these lines of accountability will operate in practice (e.g. how the CCG will seek the views of constituent practices and how often).

**GPC GUIDANCE LINK: Ensuring Transparency and Probity  
The Governance of Consortia**

***This domain should require CCGs to:***

- Engage with constituent practices, involving all GPs locally;
- Work with the LMC to construct democratic structures to ensure accountability to the local profession;
- Secure effective commissioning support to ensure good financial management;
- Demonstrate good governance arrangements.

***To demonstrate competence in this domain CCGs could provide evidence of:***

- A clear and comprehensive constitution outlining democratic processes, organisational structure and governance processes;
- Evidence of arrangements and contracts for commissioning support.

## Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support.



### **What the Department of Health says...**

*“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 with local authorities to develop joint health and well being 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.”<sup>2</sup>*

### **The BMA view...**

The Government needs to be clear where responsibility for commissioning of specific services will reside, for example ambulance services or services for rare and complex diseases. Collaboration between CCGs, local authorities, local hospitals and community providers is not only desirable, but will be necessary for the commissioning of such services. Collaboration between CCGs should not be viewed as anti-competitive, but as key to providing integrated and safe services.

Comprehensive commissioning support will be essential, and if, as seems likely, CSUs will provide support to more than one CCG, then the CSU will be able to facilitate joint working, potentially supporting both CCGs and the local authority. The CSU should act to support the work of the CCGs, however, and not dictate policy or procedure. CSUs will be best able to provide cohesive and patient-focussed support if they remain NHS bodies, and are not, as the Government has signalled, compelled to become social enterprises or partner with the private sector.

The GPC has serious concerns that the rushed timescale and lack of clarity on the ground means that many experienced and competent PCT staff are leaving their posts. CCGs will need the experience of these managers and efforts should be made to ensure that these skills are not lost in the transition. The GPC strongly urges the government to ensure that CSUs remain NHS bodies in order to provide cohesive support to CCGs, and a patient (not cost) focussed approach.

With respect to the commissioning of primary care, it is vital that, whilst CCGs may play some role in local standard setting in primary care, the NHSCB should have responsibility for holding the contract with practices. Whilst CCGs will encourage improved performance of their constituent practices they should have no role in performance management of the practice contract, to avoid conflict of interest and to ensure a consistent approach to contract management across primary care.

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<sup>2</sup> *Developing Clinical Commissioning Groups: Towards Authorisation*, September, 2011, Department of Health. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_130293](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293)

***This domain should require CCGs to:***

- Develop positive relationships with neighbouring CCGs, the Health and Wellbeing Board and local authorities;
- Adopt a proactive approach to joint commissioning, with a view to achieving economies of scale and commissioning services that pose particular challenges (e.g. complex or rare conditions, urgent care services);
- Ensure that they have access to comprehensive commissioning support.

***To demonstrate competence in this domain CCGs could provide evidence of:***

- A narrative explaining how the commissioning plan relates to and delivers the Joint Health and Wellbeing Strategy;
- Evidence of engagement with the Health and Wellbeing Board and NHSCB.

## Domain 6: Great leaders who individually and collectively can make a real difference.



### **What the Department of Health says...**

*“Together, CCG leaders must be able to lead health commissioning for their population and drive transformational change to deliver improved outcomes. 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.”<sup>2</sup>*

<sup>2</sup> Developing Clinical Commissioning Groups: Towards Authorisation, September, 2011, Department of Health. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_130293](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293)

### **The BMA view...**

Successful CCG leaders will have the support of the local profession, and this is where effective democratic structures, put in place in liaison with the LMC, will be central to ensuring the buy-in of the local profession and constituent practices. The GPC has concerns that the processes by which CCG leads are appointed vary greatly in terms of democratic legitimacy (as outlined in a letter from Dr Laurence Buckman, Chairman of GPC, to the profession on 7 October 2011).

Effective democratic structures will ensure that clinician-led commissioning is not reduced to a small group of enthusiasts making decisions on behalf of a largely disenfranchised and disengaged profession, but is led by individuals who command the respect of those whom they represent.

**BMA GPC Guidance:** Leadership in clinically-led Commissioning Consortia and Shadow consortia: developing and electing a transitional leadership.

LMCs, as statutory representatives of general practitioners, will need to help the local profession hold their CCG to account and may be able to mediate between individual GPs, practices and CCGs where problems arise.

### ***This domain should require CCGs to:***

- Set in place democratic structures and appointment processes designed to facilitate the appointment of skilled leaders with the support of their constituents;
- Ensure clear lines of accountability from the CCG leadership to constituent practices, including processes by which practices can access information about the decisions taken on their behalf, raise concerns, and ultimately, remove the CCG leadership if deemed necessary.

### ***To demonstrate competence in this domain CCGs could provide evidence of:***

- Robust democratic processes;
- Clear lines of communication between CCG leads and practices and vice versa;
- An open and transparent culture that allows CCG leads to be held accountable.

## Appendix 1

### NHS Reforms – Timetable\*

\*(subject to the passage of the Health and Social Care Bill)

#### November 2011

|                      | <b>NHS Commissioning Board, Health and Wellbeing Boards, SHAs, PCTs, Clinical Networks and Clinical Senates</b>   | <b>CCGs</b>  |
|----------------------|---|--|
| <b>October 2011</b>  | <p>Start date for Board in shadow form as a Special Health Authority. October 2011 – October 2012: Shadow running phase and further recruitment of staff.</p> <p>The 10 Strategic Health Authorities (SHAs) to cluster from October 2011.</p> <p>The 152 Primary Care Trusts have now been reduced to 51 PCT clusters.</p> <p>Over 130 local authorities have already established shadow Health and Wellbeing Boards.</p> | <p>SHAs to complete a risk assessment of the configuration of emerging CCGs to identify whether a CCG is likely to be viable in terms of size, geography, sign-up from members practices and the amount of support likely to be required. This is expected to be completed by December 2011.</p> <p>PCT Clusters expected to have delegated a clear percentage of budgets to CCGs with a trajectory for future delegation.</p> |
| <b>November 2011</b> |   | <p>PCTs should be supporting CCGs to take delegated responsibility within the existing legislative framework, with CCGs expected to lead on areas of work such as the planning round for 2012-13 and the delivery of QIPP. Evidence from these activities will form the basis of the application for authorisation.</p>  |
| <b>December 2011</b> |   | <p>PCT Clusters to be indentifying with CCGs their commissioning support requirements.</p>   |
| <b>April 2012</b>    | <p>All local authorities expected to have established a shadow Health and Wellbeing Board.</p>  |  |
| <b>May 2012</b>      |   | <p>The NHS Commissioning Board is expecting applications for authorisation and establishment from CCGs from Summer 2012.</p>   |

|                     | <b>NHS Commissioning Board, Health and Wellbeing Boards, SHAs, PCTs, Clinical Networks and Clinical Senates</b>   | <b>CCGs</b>  |
|---------------------|---|--|
| <b>July 2012</b>    | Health and Wellbeing Boards and Clinical Senates to feed their views to the NHSCB on the readiness of CCGs for authorisation.   | Health and Wellbeing Boards and Clinical Senates to advise CCGs in their path towards authorisation.   |
| <b>October 2012</b> | The Board will be established as an independent statutory body and take on some formal statutory accountabilities from this date such as the authorisation of clinical commissioning groups and the planning for 2013/14. | The earliest possible date for establishment and authorisation of CCGs. The established CCG would then be a statutory body, but would still not take on responsibility for commissioning strategy independent from the PCT until April 2013. |
| <b>April 2013</b>   | The Board will take on its full formal statutory accountabilities. The Board will initially host commissioning support units until 2016.  | The whole of England to be covered by established CCGs.  |

- Shared Operating Model for PCT Clusters, July 2011. Department of Health.
- Government Response to the Future Forum Report, June 2011. Department of Health.
- Developing Clinical Commissioning Groups: Towards Authorisation DRAFT, August 2011, Department of Health.
- Developing the NHS Commissioning Board, July 2011. Department of Health.

## Appendix 2

### The six domains: summary

*“To be authorised, you should be able to demonstrate an adequate level of competence across all these areas and the potential to achieve excellence in future.”<sup>3</sup>*

| <b>Domain</b>   | <b>GPC view</b>   | <b>To demonstrate competence in this domain CCGs could provide evidence of:</b>   |
|---|---|---|
| <p><b>1. A strong clinical and multi-professional focus which brings real added value</b></p> | <p>Successful CCGs will have the support of constituent practices, involvement of secondary care colleagues and public health doctors and robust governance structures.</p> <p>The Government needs to clarify the roles and responsibilities of Clinical Networks and Senates to ensure they allow meaningful input from secondary care and other experts into the commissioning process.</p>  | <p>A commissioning plan and how this plan supports the Joint Health and Wellbeing Strategy.</p> <p>How constituent practices and other health professionals are consulted and involved.</p> <p>How the CCG will measure quality and outcomes, and how these will feed into the commissioning process;<br/>Active involvement with shadow Health and Wellbeing Board.</p>  |
| <p><b>2. Meaningful engagement with patients, carers and their communities</b></p>            | <p>Engagement with patients and the public should be meaningful, playing an important role in the planning and evaluating stages of the commissioning process.</p> <p>Given the financial constraints, CCGs may need to not only ensure consultation with patients about individual choices, but facilitate a population-wide discussion about the challenging decisions that need to be made.</p> <p>Health and Wellbeing Boards have potential to be useful forums to encourage integration across health and social care. CCGs and LMCs should get involved with their local Health and Wellbeing Boards, as they will play an important role in overseeing commissioning plans.</p> | <p>The mechanisms by which the CCG is able to engage with patients and the public.</p> <p>How this information is reflected on and used to inform the commissioning process.</p> <p>Liaison with public health colleagues to gain an understanding of local population need.</p> <p>Transparent and open processes with robust governance systems, to ensure local populations are able to hold their CCG to account.</p> |

| <b>Domain</b>   | <b>GPC view</b>  | <b>To demonstrate competence in this domain CCGs could provide evidence of:</b>  |
|---|--|--|
| <p><b>3. Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national requirements (including excellent outcomes) and local joint health and wellbeing strategies</b></p> | <p>CCGs will need good support from PCT clusters whilst in shadow form if they are to be able to demonstrate a good 'track record of delivery' against budgets and the QIPP challenge.</p> <p>The Government's needs to provide more information about a system of allocation of funding to CCGs that is fair and allows for good financial management.</p>  | <p>Retrospective evidence of achieving efficiencies (where showing evidence of deliverance of QIPP and operating in budget proves challenging for less developed CCGs).</p> <p>A comprehensive commissioning plan with reference to QIPP, the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.</p> <p>Good financial support and governance systems (including risk sharing and risk pooling).</p> <p>A coherent public health strategy that underpins commissioning plans.</p> |
| <p><b>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</b></p>                    | <p>The formation of the constitution of a CCG will be a good opportunity for CCGs to consider their relationship with the bodies they will be accountable to (e.g. constituent practices, the NHSCB and the Health and Wellbeing Board) and how to implement robust governance structures.</p> <p>Properly constituted CCGs will hold open and democratic elections (with prior assessment of competency) to appoint their board members.</p> <p>LMCs will play an integral role in assisting with these processes and ensuring all constituent practices and the local profession are involved.</p> <p>PCT clusters should be supporting shadow CCGs to ensure that, at this early stage, the emerging structures and processes of the CCG will be robust enough.</p> | <p>A clear and comprehensive constitution outlining democratic processes, organisational structure and governance processes.</p> <p>Arrangements and contracts for commissioning support.</p> <p>Joint working with the LMC, as statutory representatives of the profession, to ensure accountability to constituent practices and the local profession.</p>   |

| <b>Domain</b>  | <b>GPC view</b>  | <b>To demonstrate competence in this domain CCGs could provide evidence of:</b>   |
|--|--|---|
| <p><b>5. Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support</b></p> | <p>The Government needs to be clear where responsibility for commissioning of specific services will reside, for example ambulance services or services for rare and complex diseases.</p> <p>Collaboration between CCGs, local authorities and others is not only desirable, but will be necessary for the commissioning of some services.</p> <p>CSUs should be NHS bodies, where possible retaining the expertise and skills of existing NHS staff in order to provide cohesive and patient (not cost) focussed service to CCGs.</p> <p>Whilst CCGs may play some role in the setting of local standards in primary care, the responsibility for holding the contract with practices and performance management should reside with the NHSCB.</p> | <p>A narrative explaining how the commissioning plan relates to and delivers the Joint Health and Wellbeing Strategy.</p> <p>Engagement with the Health and Wellbeing Board and NHSCB.</p> <p>Joint working with local authorities or other CCGs to commission specific services (e.g. complex or rare conditions or urgent care).</p> <p>Arrangements and contracts for commissioning support.</p> |
| <p><b>6. Great leaders who individually and collectively can make a real difference</b></p>  | <p>Successful CCG leaders will have the support of the local profession, and this is where effective democratic structures, put in place in liaison with the LMC, will be central to ensuring the buy-in of constituent practices.</p> <p>The BMA has concerns that the processes by which CCG leads are appointed vary greatly in terms of democratic legitimacy and LMCs should work to ensure that CCGs are accountable to the local profession.</p>  | <p>Robust democratic processes.</p> <p>Clear lines of communication between CCG leads and practices and vice versa.</p> <p>An open and transparent culture that allows CCG leads to be held accountable (e.g. processes by which constituent practices can remove the CCG leadership if deemed necessary).</p>  |