Developing a great clinical commissioning group – your views on the domains

TECHNICAL APPENDIX 3

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Developing a great clinical commissioning group – your views on the domains

This section draws together the material developed to date through joint workshops with pathfinders and other key stakeholders, about the kinds of areas that might be looked at through the authorisation process. We are grateful for the many contributions made to date, and have sought, in summarising the very rich material, to do justice to them all.

It must be emphasised that this material does not represent guidance on what emerging clinical commissioning groups (CCGs) need to do to be authorised, but is a summary of the views represented so far to us. These views put the flesh on the bones of the domains and could be a useful development tool for CCGs. We will continue to refine this content to ensure that any proposed requirements meet the key principles set out in the draft Authorisation Framework i.e. 'adding value', 'minimising administrative demands', 'consistent approach', 'evidence should be a by product of core business'.

Once the shadow NHS Commissioning Board is formed, it will need to establish the final details on which specific aspects will be assessed, and ensure that the expectations are appropriately set for the authorisation process. The authorisation process will also need to reflect the final composition of legislative requirements (see technical appendix 1).

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1. A strong clinical and multi-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.

Using clinical insights to have a tangible impact and add value

- A clear focus on quality as a driving principle, within a shared vision;
- Clinical outcomes and quality are integral to commissioning plans and decisions;
- Clinical leadership and engagement enables both transformational change and the focus on continual quality improvement (across all commissioned services, and within primary care);
- Priorities for clinical improvement are clearly identified with a rationale that builds from the Joint Strategic Needs Assessment and patients' and carers' experiences, objectives that reflect best evidence and an emphasis on benefits realisation and outcomes;
- A comprehensive range of systems and processes to ensure increasingly timely information and relevant incentives to drive continual improvement in clinical quality – both within constituent practices and the services which are commissioned;
- Clinicians are involved in and understand their local service and economic context – and use clinical knowledge of local care pathways to increase the appropriateness of care, make best use of available resources and improve population health;
- Systematic approach to monitoring delivery of commissioning plans, including quality, outcomes and reducing inequalities; and
- Mechanisms are in place for recording, reviewing and acting on concerns and complaints (and actively drawing on the daily interactions of local clinicians with patients).

Clinical engagement with constituent practices

- The emerging CCG has a clear mandate from constituent practices and participatory mechanisms for enabling practice engagement in decision-making and delivery;
- Clinicians in constituent practices are engaged in shaping and delivering locally agreed priorities, and have timely information and relevant incentives to play their full part in improving clinical quality; and
- There is a process for local clinicians working together across the system to bring innovative proposals forward for consideration.

Clinical engagement among wider clinical and professional stakeholders

- Appropriate clinical and professional engagement in service improvement and pathway redesign, with decisions based on both evidence and patients' experience. Depending on the care pathway or service area (e.g. diagnostics) being considered, appropriate input would include speciality consultants, allied health professionals, healthcare scientists and nurses, other community practitioners and social care professionals;
- Processes in place to secure appropriate specialist clinical and professional expertise for each stage in the commissioning cycle; and
- Arrangements for full engagement with public health professionals, particularly securing public health advice.

In summary, emerging clinical commissioning groups should be able to describe:

- ✓ How they will improve the understanding of their local population needs by bringing their knowledge of their patients' needs and experiences of services;
- ✓ How they will effectively lead service redesign, taking their fellow clinicians and local stakeholders with them, based on their shared knowledge of clinical effectiveness and risk; and
- ✓ How they will improve the quality of all services, including primary care, and align their clinical and financial decisions within the resources available.

Examples of evidence CCGs might wish to use to demonstrate their competence:

- ➢ A description of how the emerging CCG has assessed local needs and responded to them – are they making a real difference in terms of clinical focus, not only in the way they engage constituent practices, but also in the involvement of other clinical and social care colleagues;
- ➢ The Joint Strategic Needs Assessment (JSNA) and evidence of how they will play their part in this;
- ➢ Their constitution, which would include details of the key work with all clinical groups and the arrangements for involving constituent practices;
- ➢ Their commissioning plan;
- ➢ Plans to ensure effective leadership of service redesign taking their fellow clinicians and local stakeholders with them, based on their knowledge of clinical effectiveness and risk;
- ➢ Plans to improve the understanding of their local population needs by bringing their knowledge of patient needs and experiences of services;
- ➢ Plans to improve the quality of all services including primary care, and align their clinical and financial decisions within the resources available; and
- ➢ A document that describes the style and way of working, with mutual accountability between the practices and the CCG's overall leadership team.

Examples of how the NHS Commissioning Board could gain additional insight include:

- o 360 degree review seeking views of all relevant stakeholders; and
- o Assessment of their plans for service improvement.

2. Meaningful engagement with patients, carers and their communities

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.

Understanding the local population

- CCGs have completed a profile of the population that looks at communities of interest as well as geographic communities;
- CCGs are establishing links in localities in order to ensure user views are represented;
- CCGs are using existing engagement resources for example, community nurses, health visitors, receptionists, community development workers and the local voluntary sector – where possible, making use of joint engagement activities with local partners, such as local authorities;
- Meaningful engagement with local (shadow) health and wellbeing boards and with LINks or local HealthWatch (from October 2012) is taking place, and there is evidence of how this influences their actions, including how the local health and wellbeing strategy will be delivered; and
- CCGs have a strategy for how they will promote choice, including shared decision making.

Engaging with patients and the public, including disadvantaged groups

- Plans are in place to ensure that emerging CCGs can effectively engage with and gather insight from patients and the public, including disadvantaged groups;
- An increasingly comprehensive range of mechanisms are in place to secure this engagement, and respond to the views raised – working in partnership with other agencies (e.g. local authority or voluntary/charitable sector groups);
- Patient experience and feedback from patients, carers and other stakeholders is measured and analysed effectively, and is used to influence decision making;
- Mechanisms are in place for involving patients and their representatives in the redesign of pathways;
- Systems and processes are in place to promote patients' recruitment to and participation in research; and

- Commissioning arrangements ensure that providers involve patients in decisions about their own care, and support them in making choices about where, when and how they are treated.

Using engagement in commissioning decisions

- Plans describe how emerging CCGs will engage patients and the public throughout the commissioning cycle and in the major commissioning decisions they will make;
- Communication processes are in place to describe how the views of the local population and patients have been responded to;
- There is a clear approach to engaging patients and the public in prioritisation, service change and strategy and as appropriate, an integrated approach to engagement in the management of any major service or multi-organisational change; and
- CCGs' governance arrangements set out how they will deliver local accountability.

Collecting and sharing information with patients and the public

- CCGs have a systematic approach to information – including:
  - how they organise and use information from other organisations to feed into commissioning;
  - how they publish outcomes data (including outcomes of engagement); and
  - how they process feedback and create intelligence that can be used to inform commissioning decisions.
- Patients and the public understand how to contact and engage with the CCG, including how to complain where appropriate and raise issues of concern; and
- Patients and the public have access to appropriate information on conditions, treatment, available services, safety, access, effectiveness and experience, and that information is available in a range of appropriate formats.

In summary, emerging clinical commissioning groups should be able to describe the arrangements they are putting in place to ensure:

- ✓ They can effectively engage with and gather insight from patients, carers and the public, including disadvantaged groups;
- ✓ The results of their engagement and insight are reflected in their decision-making processes;
- ✓ CCG plans set out how they intend to engage patients, carers and the public throughout the commissioning cycle and in the major commissioning decisions they anticipate they will need to make; and

- ✓ The CCG plans set out how they intend to involve patients in decisions about their health and care, and support them to make choices about where, how and when they will be treated.

Examples of evidence CCGs might wish to use to demonstrate their competence

- ➢ A comprehensive range of mechanisms for engaging with their local population and patients, and responding to their views;
- ➢ Transparent governance arrangements that deliver local accountability;
- ➢ Mechanisms for involving patients, carers and their representatives in service improvement and the redesign of pathways;
- ➢ Meaningful engagement with local health and wellbeing boards and LINks or local HealthWatch (from October 2012), and evidence of how this influences their actions – including how the joint health and wellbeing strategy will be delivered;
- ➢ Demonstration of engagement activity in partnership with other agencies (e.g. local authority or third sector groups), particularly to reach groups with specific needs; and
- ➢ Demonstration of how CCGs will promote choice, including access to information and shared decision making.

Examples of how the NHS Commissioning Board could gain additional insight:

- o 360 degree review of relevant stakeholders;
- o Assessment of CCG's patient and public engagement strategy; and
- o Review of their governance arrangements, including reports of meetings or engagement sessions.

Other evidence has also been suggested:

- o Evidence that CCGs understand their role around leadership of change and building public support and mandate for change; and
- o Evidence that CCGs understand what local information and insight about patient and public voices is available, what methods work best for different circumstances, and has commissioning support arrangements in place to draw on this continuously.

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

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.

A credible commissioning plan which:

- Outlines the CCG's clear vision owned by patients, constituent practices and stakeholders;
- Demonstrates how the CCG has understood and quantified the health needs of the population (including disadvantaged groups and those not registered with a GP practice);
- Identifies the health inequalities and unwarranted variations that exist and sets out how they will be addressed;
- Sets out how the CCG will deliver continuously improving services, ensure that the NHS contributes fully to improving the public's health and secure value for money. Contains well described initiatives linked to the vision and focused on the outcomes to be achieved;
- Describes intentions to promote choice, and to commission more integrated forms of provision where this will benefit patients;
- Demonstrates an understanding of, and plan to improve and embed continual quality improvement across primary care;
- Demonstrates how the CCG will deliver financial balance, all quality outcomes and a reduction in inequalities;
- Demonstrates how the CCG has worked with the whole health system and community to agree the way in which QIPP will continue to be delivered in the relevant parts of the health system;
- Demonstrates an understanding of the impact on the provider landscape, and how they are working and will work productively with providers to deliver the local QIPP challenge;

- Gives confidence that the CCG has robust plans to manage demand of acute services, triangulated with quality requirements, workforce capacity and financial allocations; and detail around their capacity and capability to deliver; and
- Has a set of key performance indicators that will enable the CCG to demonstrate delivery against plan for the QIPP challenge, including demonstrating improved quality and outcomes for patients, and robust arrangements for performance management.

Underpinned by:

- Planning assumptions derived from the Joint Strategic Needs Assessment and draft joint health and wellbeing strategy;
- Rigorous financial management arrangements;
- Information about explicit investment and disinvestment plans and their impact on quality and outcomes;
- Appropriate risk-sharing and risk-pooling arrangements; and
- Robust arrangements to test and measure achievement against their plan, including a set of key performance indicators collected and used by the CCG to demonstrate improved quality and outcomes for patients.

Examples of evidence CCGs might wish to use to demonstrate their competence

- Their commissioning plan(s), which shows alignment of financial activity, demand management and workforce assumptions;
- A track record of successful implementation and delivery towards planned objectives within a delegated budget;
- A track record of improvements in outcomes and value for money since they became a pathfinder, for example a track record in reducing unwarranted variation;
- Evidence of influence, active participation, whole systems working and impact during previous planning round(s); and
- Evidence of active implementation of sustainable transformational change objectives within QIPP plans for previous planning round(s) as partners within whole health system working.

Examples of how the NHS Commissioning Board could gain additional insight

- Technical assessment of the commissioning plan(s), and associated documents; and
- Assessment of performance during preparatory phase, including their contribution to delivering the 2011/12 components of the SHA/PCT cluster QIPP plans.

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.

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.

Corporate

- A clinically led infrastructure, with highly competent management support;
- A clear organisational form, with effective business systems and processes, and a sound financial footing;
- Governance arrangements that show clear and effective bonds across member practices and demonstrate clear and transparent processes for discharge of functions;
- Robust systems and processes in place for effective decision-making and to manage conflicts of interest;
- Systems in place to manage external communications, briefings and correspondence;
- Decision-making structures clearly set out in the constitution, to include an independently chaired audit committee;
- A constitution that is appropriate and complies with requirements of the Health and Social Care Bill including setting out the procedures to be followed and arrangements made to secure transparency in decision-making and provision for the governing body to meet in public; and
- Appropriate arrangements described that would secure at least two lay members, a secondary care clinician and a nurse on their governing body.

Systems and processes

- A scheme of delegation with underpinning processes to delegate decision-making to an appropriate level;
- Information and quality systems in place that focus on delivering high quality outcomes with adequate arrangements for information and data management;
- Systems in place to manage knowledge and undertake robust and regular Joint Strategic Needs Assessments (with health and wellbeing boards), that establish a full understanding of current and future local health needs and requirements;
- Full range of systems and processes to ensure practices have timely information and relevant incentives to improve clinical quality – both within constituent practices and the services which are commissioned; and
- Systems and processes that ensure that in the exercise of the CCG's functions, it has regard to the need to promote research including funding the treatment costs of patients taking part in research funded by Government and Research Charity partner organisations, through normal arrangements for commissioning patient care.

Financial

- Financial and business leadership with robust systems for the management of financial control, performance and risk, ensuring value for money;
- Evidence of wider economic understanding, along with appropriate processes and finance controls in place, scheme of delegation, standing financial instructions (SFIs), financial management and risk management;
- Prioritised investment/disinvestment of all spend in line with local needs, service requirements and the values of the NHS;
- Secured the right expertise to ensure compliance with best procurement practice;
- Ownership of the budget through to practice level;
- Ensuring efficiency and effectiveness of spend; and
- Mechanisms in place to ensure the delivery of NHS Operating Framework financial directions.

Equality

- The CCG considers equality and human rights when designing, delivering and reviewing its business priorities e.g. business planning, commissioning and decommissioning; and
- The CCG has plans to deliver on the duties in the Equality Act 2010.

Quality

- The CCG can clearly demonstrate that they have the competence and capability to secure quality (effectiveness, safety and experience) in everything it does.

Safeguarding

- The CCG has arrangements to work with safeguarding partners e.g. through shadow health and wellbeing boards, the Local Safeguarding Adults and Children's Board(s) and multi-agency public protection arrangements.

Commissioning

CCG commissioning responsibilities encompass the full range of the above sub domains. The NHS Commissioning Board is likely to need to be reassured that a CCG is applying these to all its arrangements (through the complete commissioning cycle of planning and agreeing services and monitoring services) for taking its commissioning responsibilities forward.

The Board is likely to seek evidence that demonstrates how a CCG has applied these in practice, both in terms of its generic commissioning responsibilities as well as the commissioning of particular services.

- ✓ The capability to carry out its commissioning duties, including the access to quality assured commissioning support and expertise;
- ✓ Evidence that commissioning facilitates integration across the care pathways;
- ✓ Robust arrangements can be demonstrated for delivery of the commissioning cycle; and
- ✓ Evidence that all decision-making processes reflect sound governance.

Examples of evidence CCGs might wish to use to demonstrate their competence

- ➢ Constitution and governance arrangements;
- ➢ Commissioning plan(s);
- ➢ Scheme of delegation;
- ➢ Committee structures and terms of reference;
- ➢ A full set of signed contracts; with examples of how the levers in the contracts and payment reforms are being used to drive up quality and increase flexibility in range of provision; and
- ➢ Service level agreements with commissioning support providers.

Examples of how the NHS Commissioning Board could gain additional insight

- o Assessment of the governance arrangements;
- o Assessment of capability;
- o Assessment of contracts with providers and service level agreements for commissioning support arrangements;
- o Technical analysis of commissioning plan(s), and associated documents; and
- o Review of the track record of delivery.

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

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 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.

Commissioning support

- A documented approach that sets out how they intend to secure commissioning support (in-house, shared or bought-in), how they will be assured of quality and value for money and what governance arrangements are in place to ensure delivery;
- A clear description of how all back office functions will be delivered giving economies of scale; and
- Capacity and capability to deliver, including being an intelligent customer of commissioning support services.

Collaborative commissioning with neighbouring CCGs

- Collaborative/federated arrangements in place to commission specific services, including links with clinical networks, with appropriate and proportionate governance arrangements in place;
- Sharing best practice with other CCGs to support innovation in commissioning; and
- Clarity about how they will work with the NHS Commissioning Board where overlaps of primary care commissioning and specialised commissioning are inevitable.

Joint commissioning with local authorities

- Clear agreement with relevant local authority/ies to deliver integrated health and social care commissioning, that ensures service continuity and maximum benefit for patients and carers;

- Partners committed to improving understanding of working arrangements and procedures and processes in different sectors: cross cultural understanding;
- CCG's plans and strategies (including QIPP) aligned to those of local stakeholders, and developed in partnership; and
- Joint health and wellbeing strategy developed with communities, tackling local needs and harnessing local energy.

In summary, emerging clinical commissioning groups should be able to describe:

- ✓ How, alongside their arrangements for effective and efficient commissioning support, they intend to secure back office functions, to access technical expertise and benefit from economies of scale; and
- ✓ How they have determined arrangements for collaborative commissioning with neighbouring CCGs.

Examples of evidence CCGs might wish to use to demonstrate their competence

- ➢ Contracts for commissioning support including how they will be assured of quality and value for money and what governance arrangements are in place to ensure delivery;
- ➢ Specified arrangements for joint commissioning including shared governance and pooled budgets; and
- ➢ Specified arrangements for lead commissioning with other CCGs.

Examples of how the NHS Commissioning Board could gain additional insight

- o Assessment of commissioning plan(s), and associated documents;
- o Assurance of commissioning support capability; and
- o Oversight of collaborative arrangements.

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

Together, CCGs 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.

Overall capability – to ensure both resilience and transformational energy

- The collective energy, clarity and focus to secure a vision and strategic direction, developed and agreed with patients and carers, constituent members and stakeholders – absolutely aligned with the draft joint health and wellbeing strategy;
- A visibly clinically-led infrastructure, with highly competent management support and a fit for purpose leadership team – alongside a distributed leadership model (involving constituent practices and other stakeholders, particularly wider clinical colleagues);
- Leadership that ensures the CCG is well placed to implement best practice in discharging all its statutory duties, particularly in safeguarding, emergency planning, equality and diversity and securing quality, with documented roles and responsibilities where these duties need to be aligned with other statutory bodies;
- Leadership which understands and values partnership working;
- Leaders committed to core NHS values;
- Leadership shared and developed across all levels and professions of the clinical commissioning group;
- Leadership driving improvement in patient experience and outcomes; and
- Evidence that the leadership team can successfully change behaviours and positively influence change in others.

Individual senior leadership capacity and capability

- An Accountable Officer in place, with the appointment confirmed by the NHS Commissioning Board;
- Strong strategic financial and business leadership (to include an appropriately qualified Chief

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Finance Officer) with robust systems for the management of financial performance and risk, ensuring value for money;

- Evidence of succession planning for senior leadership roles and good processes for developing people;
- Clinical leaders who can deliver; and
- Capable leaders of all kinds on the governing body.

Leadership culture and behaviours

- Evidence of an open, transparent culture, committed to learning and continual quality improvement;
- Leaders who are building strong relationships with other individuals in senior roles, especially senior clinical leads in providers, and partners in the local authority and on shadow health and wellbeing boards;
- Evidence that the CCG can successfully change behaviours, and positively influence change in others; and
- Robust and transparent recruitment and selection processes for all senior lead roles.

Distributed leadership across constituent practices

- Mandate to lead from constituent practices alongside demonstrable clinical leadership at locality level.

Examples of evidence CCGs might wish to use to demonstrate their competence

- A prospectus which would include the CCG's vision and strategy;
- Constitution and governance arrangements;
- Organisation and leadership development plan;
- Information about individual leaders' competence and development;
- Dynamic communications and engagement strategies delivered through visible leadership supported by local expertise and other support arrangements; and
- Evidence of succession planning for senior leadership roles, a commitment to reflecting the diversity of member practices and local communities and good processes for developing people.

Examples of how the NHS Commissioning Board could gain additional insight

- Assessment of the CCG's team's strengths;
- Assessment of individual leaders; and
- 360 degree review of stakeholders' perspectives.

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