NHS Commissioning Board
A special health authority

Clinical commissioning group authorisation: Draft guide for applicants

Frequently asked questions
April 2012

Contents

1 Background

1.1 How many CCGs do you think will apply for authorisation?

There are currently around 220 emerging CCGs. (Updated April 2012)

1.2 How have the requirements for authorisation been reached?

In determining the requirements for authorisation, we have sought to strike a balance between the legal and policy requirements on CCGs, and their ability to manage risk; with recognising that these are new organisations, and considering the viability of alternatives.

The content and process of authorisation has been widely tested and co-produced. (Updated April 2012)

2 Authorisation process

2.1 Who will be involved in the 360° process?

This will involve all relevant partners of CCGs, including member practices, local authorities, (shadow) health and wellbeing boards, NHS providers, LINks/ (shadow) HealthWatch and other patient groups. A full list is set out in Annex C of the document. (Updated April 2012)

2.2 Will 360° feedback be split at locality level so that CCGs can understand where problems are?

The 360° stakeholder survey will comment on and analyse relationships formed by the aspiring CCG with its stakeholders up to the point of authorisation. As the majority of these stakeholders would have been building relationships with the overall CCG in general and the CCG leadership in particular, it would not be possible or indeed appropriate to feed back at a CCG practice member or locality level. (Updated April 2012)

2.3 Will the views of clinical senates be taken into account within the authorisation process?

Clinical senates will not be established until autumn this year, and therefore they will not have had the opportunity to form a view about CCGs. If they are ready to do so, they will be able to participate, but in general it will be clinical networks' views that will be sought as part of the 360° stakeholder survey instead. (Updated April 2012)

2.4 How will the desktop review work?

There will be a mix of assessors from within and outside the NHS. Each domain will be assessed consistently both within and between waves. Key assessors will also provide moderation across the overall assessment process. (Updated April 2012)

2.5 Who will the assessors be?

We expect to recruit the majority of assessors from the NHS, supplemented by external contractors. We will shortly be conducting a procurement exercise to select our external contractors. The main role of the external assessors will be to carry out the desktop review and provide support to the panels. They will also meet any specific functional gaps that we identify once we have sourced NHS internal support for the process. (Updated April 2012)

2.6 How will the site visits work?

There will be a one-day visit to each applicant CCG. The purpose will be for the NHS Commissioning Board (NHSCB) to meet the applicant CCG leaders and assess their capability to deliver, as well as probing further any issues emanating from the desk-top review and identifying areas for further development. (Updated April 2012)

2.7 Who will be on the site visits?

A senior representative from the NHSCB, a member of the authorisation team, a clinical leader from an aspiring or established CCG, a lay assessor and finance and commissioning experts. Depending on the conclusions of the desk top review there may also be local authority or public health representation. (Updated April 2012)

2.8 Will the site visit include visits / sessions with key stakeholders e.g. patient groups?

No. The stakeholder survey will be the opportunity for stakeholders to make their views about the applicant CCG known. (Updated April 2012)

3 Authorisation timetable

3.1 What are the application deadlines for authorisation?

The CCG authorisation process will take place in four waves. Applications must be submitted by 1 July 2012 for wave 1, 1 September 2012 for wave 2, 1 October 2012 for wave 3, and 1 November 2012 for wave 4.

The 360° stakeholder survey process will commence approximately six weeks prior to the deadline for each wave, and we expect the authorisation process to take around three months from submission of the application to a decision being returned by the NHSCB. (Updated April 2012)

3.2 Will all CCGs in a geographical location have to be authorised at the same time?

We believe that this is a local matter for CCGs to determine. If CCGs have so much in common around shared management, governance or support arrangements that it makes sense to move forward together then they should do so. However, CCGs applying at the same time will be considered for authorisation separately and may have different outcomes. (Updated April 2012)

3.3 Do CCGs sharing a CSS or a LA need to apply together or in the same 'batch'?

We are not going to dictate the principles about how or when batching may apply as we believe this is a local matter for CCGs to determine. CCGs will determine whether they have so much in common around shared management arrangements, commissioning support or provider flows for example that it makes sense to move forward together. Similarly, they will want to assess the readiness of all CCGs in the potential batch to move at the same speed and be ready for application at the same time.

However, even if they apply as a batch they will be considered for authorisation separately and batch members may have different outcomes in terms of being fully authorised or authorised with different conditions. We are considering whether there are some parts of the assessment process that may run slightly differently in the case of batched CCGs – for example sharing part of the site visit. (Updated April 2012)

3.4 What would the advantages be in going in Wave 1?

A CCG going through the process early may need to be able to manage the complexities of parallel processes underway (e.g. around commissioning support and leadership assessment centres). If authorised with conditions a wave 1 CCG may have time in the remaining part of the year to address any conditions they may have had placed upon them by 1 April 2013. They may also be able to take on more delegated responsibilities from their PCT. There are advantages and disadvantages to every wave. A CCG needs to make the right decision given its need to manage risk and comfort with being authorised with conditions, readiness to apply etc. (Updated April 2012)

3.5 What are the practicalities of going in an early wave?

The thresholds for authorisation are the same for every wave. However we recognise that as the year progresses CCGs will have more time to plan for their application. The inclusion of draft documents within the submission list explicitly recognises that at the point of submission a CCG may not have finalised or signed off a document. However, at the point of submission you must have developed your documents and structures sufficiently to meet the thresholds for authorisation. (Updated April 2012)

3.6 How will the flow of applications across the four waves be managed?

CCGs will be asked to nominate themselves into an application wave by 30 April 2012. SHAs will also provide a report on each CCGs progress by this date and indicate which wave they would support. In most cases this will be the same as the CCG view. The NHSCBA will need to consider the national picture and ensure that each wave has an appropriate number of applicants. (Updated April 2012)

4 Authorisation outcomes

4.1 What are the possible outcomes of the authorisation process?

There are three possible outcomes for each CCG: Fully authorised; authorised with conditions; and established but not authorised (shadow CCG). All CCGs will have a development plan agreed with the NHSCB that reflects the outcome. (Updated April 2012)

4.2 How will authorisation decisions be made?

The NHSCB will review all the documentary evidence as well as the conclusions drawn from the site visit. It will moderate recommendations across applications for consistency, and will then put recommendations to the Board of the NHSCB. (Updated April 2012)

4.3 How many CCGs do you expect to be fully or partially authorised?

We have not set targets for authorisation. Our goal is for all CCGs to be authorised by April 2013, with or without conditions. (Updated April 2012)

4.4 What will happen to CCGs who do not meet all the thresholds for authorisation?

CCGs who are authorised with conditions will agree with the NHSCB a time-limited rectification plan for the removal of conditions. All CCGs, regardless of the outcome of authorisation, will be invited to agree a development plan with the NHSCB. This will reflect the local challenges and context faced by each CCG and will focus on development beyond the thresholds set for authorisation. (Updated April 2012)

4.5 Is there any clarity about 'conditions' and how they will work?

Where a CCG does not meet all the thresholds for authorisation, the NHSCB may restrict what functions are undertaken by CCGs and/ or how, until all thresholds are met. It will do this through the use of legal directions and conditions. Where they are used, the NHSCB will agree a rectification plan setting out the conditions/ directions and what the CCG needs to do, by when, to remove the conditions/ directions. (Updated April 2012)

4.6 What will constitute 'failure' in authorisation?

CCG unable to be established – the NHSCB has a duty to ensure that the whole country is covered by CCGs by the time PCTs are abolished. If it were not possible to establish a particular CCG even on a shadow basis, the NHSCB would be obliged to assign the relevant practices to another CCG in order to meet that duty. (Updated April 2012)

4.7 Why is there no appeals procedure built into the authorisation process?

There will be opportunities throughout the process for each applicant to comment and challenge assessments made. Therefore, when the Board makes its final decision, it will be based on a set of assessments which have been discussed and clarified, and the reason for that decision should therefore be apparent and understood. (Updated April 2012)

4.8 There are still some practices who are not members of a CCG. What will happen to them?

SHAs and PCT clusters are working with emerging CCGs and GP practices on this issue.

The Government and the BMA have agreed that it will be a contractual requirement for all holders of primary care medical care contracts to be a member of a CCG.

The NHS Commissioning Board will have a statutory duty to ensure that all GP practices are members of a CCG and that CCGs' geographic areas together cover the whole of England and do not coincide or overlap. If absolutely necessary, the Board would be able to change the geographic area and/or membership of a CCG, by making a variation to a CCG's constitution. Before doing so, the Board would be required to consult the CCG (or any other CCG) affected. (Updated April 2012)

5 CCG governance

For all questions regarding CCG Governance, please refer to *Towards establishment: Creating responsive and accountable CCGs,* which has been published on the NHSCBA website along with supporting products (including the model constitution) and frequently asked questions. An *HR Guide for CCGs* document will also be published on the NHSCBA website, along with its own frequently asked questions:

http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/
(Updated April 2012)

6 Commissioning support

For all questions regarding commissioning support, please refer to *Developing commissioning support: Towards service excellence,* which has been published on the NHSCBA website along with frequently asked questions and key facts:

http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/
(Updated April 2012)

7 Evidence for authorisation

7.1 Does a green in the configuration risk assessment mean the NHSCB will support their membership and area?

Yes, unless triangulation of evidence as part of the desk-top review process means that further consideration is needed. (Updated April 2012)

7.2 What degree of variation of engagement by member practices is acceptable for authorisation purposes?

We don't expect every GP in every practice to be actively involved in the work of the CCG. However, we do expect effective engagement mechanisms to allow participation. (Updated April 2012)

7.3 Can "letter of support from members for chair" include a paper to governing body on election results?

Yes. (Updated April 2012)

7.4 Case studies - Is there anything that we can do to give examples of "good"?

We are considering how support can best be made available to CCGs. (Updated April 2012)

7.5 Can CCGs upload documents more than once before the application deadline (e.g. if versions change)?

We intend to introduce a system that allows CCGs to store documents online, and to alter their evidence before submission so they can ensure that they have collected the correct information for authorisation. Once a CCG submits its application, this information will not be changeable without special permission from the site administrator. (Updated April 2012)

7.6 Do CCGs have to submit everything on the submission list?

Yes. You are able to submit additional documents in the constitution and other governance documents heading. We will ask you to reference the criteria that is evidenced by each additional document you submit. (Updated April 2012)

8 Other

8.1 What is the difference between a commissioning plan and an integrated plan – and which will be used in authorisation?

The Health and Social Care Act 2012 places a legal obligation on CCGs to have a commissioning plan. The Board may issue guidance on the planning requirements of CCGs to which CCGs should have regard. For the purposes of authorisation the Board will use relevant information from the relevant PCT cluster integrated plan for 2012-13, and the applicant CCG's draft commissioning intentions for 2013-14. (Updated April 2012)

8.2 What resource information is available to CCGs to best develop plans for domain 3?

The Department of Health published 2010-11 baseline spending estimates for many CCGs on 7 February 2011 (http://www.dh.gov.uk/health/2012/02/baseline-allocations/).

Although subject to change, these provide an indication of the possible scale of resources to support initial planning. A further exercise is being developed to look at subsequent years to give as accurate a picture as possible before CCGs become operational, and so the published baselines will need to be used in the light of local knowledge and planning, such as shifts in local populations and QIPP plans. (Updated April 2012)

8.3 How will clinical commissioning groups assist and support the Board in securing continuous improvements in the quality of primary medical services

Working with the NHSCB, clinical commissioning groups will play a systematic role in helping to monitor, benchmark and improve the quality of primary medical services, including the use of clinical governance and clinical audit. Clinical commissioning groups will be well placed as local peer groups to spot potential issues of poor performance at an early stage, to identify the root causes of these problems, and to work with the Board and other agencies to support practices and practitioners in improving performance. This could include:

- sharing data and benchmarking primary medical care outcome indicators across member practices;
- working collaboratively with the NHSCB to address variability, service improvements, engage patients and the public and to develop any shared models of commissioning support.
- a clear approach to peer review and conversations about improvement across member practices, which include assessment of development needs, intended actions and anticipated impact.

CCGs will have a critical role in providing clinical leadership to deliver high quality, responsive and safe services for patients and that includes primary medical services. (Updated April 2012)

8.4 How will we ensure performance and population health profile packs are accurate?

Once the content of the profile is agreed and packs are ready to release, the CCG will get a short period of time to review the pack and comment on any factual inaccuracies. The packs will give the CCG an indication of the questions the site visit panel may wish to explore. However, the panel will be looking more at direction of travel and trends not specific numbers. (Updated April 2012)

8.5 Can local data be used so information is recognised by GPs and GPs not distracted by quibbling figures

We will be using national data sets not local data, to ensure a consistent approach across the country. CCGs will have a short period of time to review the pack and comment on any factual inaccuracies. However, CCGs are asked to note that the panel will be more interested in trends and key issues, not specific numbers. (Updated April 2012)