NHS
Commissioning Board
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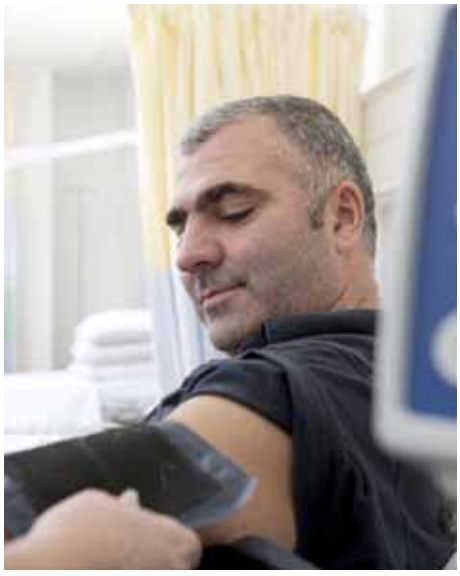
Clinical commissioning group authorisation:
Draft guide for applicants



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Contents

Section 1

Introduction

1.1 During 2012-13 general practices across England will be preparing to take on responsibility for commissioning the majority of healthcare for their local population by forming clinical commissioning groups (CCGs).

1.2 This draft guide for applicant CCGs, which builds on *Developing clinical commissioning groups: Towards authorisation* published in September 2011, is designed to enable aspiring CCGs to determine the timing of their application for authorisation and to prepare that application. It is intended to help aspiring CCGs develop clear plans to progress through the authorisation process and become authorised CCGs.

1.3 Based on the membership of constituent practices and involving a broad range of professional groups, CCGs are a cornerstone of the Government's reforms to give frontline professionals a strong leadership role in commissioning. By April 2013, subject to implementation of the Health and Social Care Act 2012 (the Act), the whole of England will be covered by established CCGs and the present system of commissioning organisations will be abolished.

1.4 The NHS Commissioning Board (NHSCB) must be satisfied as part of the process of CCG authorisation that CCGs are able (among other matters), to commission safely, to discharge responsibly their stewardship of the majority of the NHS budget and to exercise their functions in relation to improving quality, reducing inequality and delivering improved outcomes within the available resources. This assurance will be sought through the process of CCG authorisation.

1.5 CCG authorisation recognises that CCGs are new, clinically-led organisations coming into being for the first time. While aspiring CCGs are already showing commitment to being as good as they possibly can be, the full potential of clinical leadership of commissioning will emerge over time through learning from innovation and experience. At the same time, authorisation must ensure CCGs meet safe thresholds to assume their full statutory responsibilities. For this reason, authorisation of CCGs is designed as a maturity model in which the thresholds for authorisation are set in the context of a longer-term vision drawn from what aspiring CCGs are already striving to deliver. Therefore, authorisation should not be seen as an end in itself, but as a first step on a journey towards continuous improvement.

1.6 Within the six domains described in *Developing clinical commissioning groups: Towards authorisation*, which were intended to set out the characteristics of organisations likely to thrive as clinically-led commissioning organisations, this draft guidance provides a detailed description of the criteria, thresholds and evidence for authorisation. The sources of evidence for authorisation are also identified to assist applicants as they prepare their application.

1.7 The draft guidance then sets out the three phases of authorisation: pre-application, application and NHSCB-led assessment, and the timetable for applications in four waves commencing in July, September, October and November 2012. The outcomes of authorisation and the next steps for those NHS organisations involved in preparing for authorisation are also explained. Annexes to the draft guidance include the application form, key submissions and support available.

1.8 2012-13 is likely to see in the region of 220 CCGs moving through the authorisation process. This will necessitate focused and co-ordinated efforts of aspirant CCGs, those directly supporting them and those managing the wider transition; for authorisation and the transition to clinical commissioning groups to be a success. The draft guide for applicants offers a clear route map through the year ahead.

Section 2

Background

2.1 This draft guidance is aimed at those wishing to apply to become a clinical commissioning group. It is published by the NHSCBA to enable aspiring CCGs to determine the timing of their application for authorisation and to prepare that application. It is anticipated that final guidance will be published by the NHSCB, and that this would be issued at the same time as implementation by the Government of secondary legislation (regulations) on CCG establishment. This draft guidance reflects the current legal position. A decision to issue final guidance and its contents would be a matter for the NHSCB, but in the view of the NHSCBA other than updating this draft where legislative provision or policy change necessitates amendment, it is anticipated that any final guidance would otherwise be substantively the same as this draft guidance. As the NHSCB will not be established until October 2012, this draft guidance by the NHSCBA does not prejudge any decision the NHSCB may take about the establishment and authorisation of CCGs.

2.2 By April 2013, subject to the Act's implementation, the whole of England will be covered by established CCGs. Each one will have been established as a statutory body but where a CCG is not ready to undertake its full statutory functions the NHSCB may do some or all of the following:

- Impose conditions on the grant of its application; or
- Place restrictions on what functions it exercises or how it exercises them; or
- Some of its functions may be carried out by the NHSCB or other CCGs.

2.3 The Act refers to the establishment of CCGs and enables a CCG to be established with or without conditions or directions, depending on the extent to which the requirements for establishment have been met. Operationally establishment of CCGs means the formal establishment of the statutory body, and authorisation is the process of assessing the extent to which an established CCG should exercise statutory responsibilities itself.

2.4 The NHSCB will conduct a risk-based assessment of the application looking at the arrangements put in place and the potential of those arrangements to enable the applicant CCG, if established, to discharge its functions, to determine whether it meets the requirements for establishment and authorisation. The legal requirements are set out in Annex D. This draft guidance sets out the detail of how it is anticipated that the NHSCB will assess whether the legal requirements for establishment and authorisation have been met. This draft guidance also sets out the information that must accompany an application for authorisation[1]. This information is listed in section 5 and on the application form in Annex A. How it will be used is set out in section 4 and Annex B.

2.5 Authorisation will not assess every aspect of CCG responsibilities but will seek to enable the Board to understand whether a CCG has reached a safe threshold to take on its statutory responsibilities.

2.6 This document is designed for use as part of authorisation applications during 2012-13.

[1] *It is anticipated that this is the information that the NHSCB may specify in a document for the purpose of section 14B(3)(c) of the 2006 Act inserted by section 25 of the Health and Social Care Act 2012.*

Section 3

Context

The role of clinical commissioning groups in a modernised NHS

3.1 The NHS needs to change to satisfy the increasing healthcare needs and expectations of the people it serves, and to ensure that it remains sustainable as it continues to strive to achieve health outcomes that are among the best in the world in more restrained financial circumstances.

3.2 The Government has set out a clear vision of a modernised NHS to meet this challenge of delivering the best health outcomes within available resources. This vision is rooted in three principles: giving patients more power; focusing on healthcare outcomes, quality and reducing inequalities; and giving frontline professionals greater freedoms and a strong leadership role. Delivering commissioning is vital to delivering this vision.

3.3 Commissioning is the process of arranging continuously improving services which deliver the best possible quality and outcomes for patients, meet the population's health needs and reduce inequalities within the resources available.

3.4 It comprises:

- **Planning** the optimum services which meet national standards and local ambitions, ensuring that patients and the public are involved in the process alongside other key stakeholders and the range of health professionals who contribute to patient care;
- **Securing** services, using the contracting route that will deliver the best quality and outcomes and promote shared decision-making, patient choice and integration; and
- **Monitoring**, assessing and, where necessary, challenging the quality of services; and using this intelligence to design and plan continuously improving services for the future.

3.5 Based on the membership of constituent practices and seeking advice from a broad range of clinical professionals, CCGs are designed to unleash the potential of clinical leadership in commissioning to change clinical practice in ways that improve the quality of care and make the most effective use of resources.

The purpose of authorisation

3.6 Through the authorisation process, the NHSCB will be assured that CCGs are able to commission the majority of healthcare safely, to discharge responsibly their stewardship of the majority of the NHS budget and exercise their functions in relation to improving quality, reducing inequality and being efficient, and hence delivering better outcomes within their resources.

3.7 Authorisation recognises that CCGs are new, clinically-led organisations coming into being for the first time. Their full potential will emerge over time through learning from innovation and experience. At the same time, authorisation must ensure that CCGs meet safe thresholds to take up their full statutory responsibilities in 2013. For this reason, authorisation of CCGs is designed as a maturity model in which the thresholds for authorisation are set in the context of a longer-term vision drawn from what aspiring CCGs are already striving to deliver. The process should not be seen as an end in itself, but as a first step on a journey towards continuous improvement.

The focus of authorisation

3.8 CCGs securing the best possible outcomes for the patients and communities they serve within available resources, by securing improvement in local health services, are at the heart of the NHSCBA's approach to authorisation.

3.9 The NHS Outcomes Framework sets out the national indicators that the Secretary of State for Health will use to assess the progress of the NHS in improving patient outcomes in five domains:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

3.10 Based on this, the NHSCB will select the indicators for the Commissioning Outcomes Framework, which will provide transparency and accountability about the quality of services that CCGs commission and the outcomes achieved for their local populations. CCGs will be able to use information on baseline performance against these indicators to help identify local priorities and create commissioning plans that are meaningful at local level. Local redesign of services, where appropriate, will be key to achieving these improved outcomes, and authorisation takes into account CCGs' ability to achieve this. For example, in supporting communities to help themselves and each other, delivering early intervention and avoiding unnecessary late morbidity, supporting people to take control of their own care close to home, and in aligning services around the needs of patients from all backgrounds and communities.

3.11 The authorisation process supports and reinforces the work needed to create truly excellent CCGs capable of delivering these service transformations. The content of authorisation is built around six domains that were set out in *Developing clinical commissioning groups: Towards authorisation*, collectively describing the attributes of organisations that can best deliver for their communities. These domains and their underpinning criteria were developed with aspiring CCGs and other stakeholders and are set out in table 1. They bring together, within the legislative framework, the expectations of CCGs set out in the Act, the expectations for CCGs as statutory bodies in relation to existing national policy commitments, and the characteristics of effective clinical commissioning organisations capable of delivering the Government's vision for a modernised NHS.

3.12 Assessing CCGs through these six domains provides assurance that CCGs can safely discharge their statutory responsibilities for commissioning healthcare services, and is intended to encourage CCGs to be thriving organisations that are clinically-led and driven by clinical added value.

Supporting clinically-led organisations to thrive

3.13 Authorisation of CCGs is designed as a maturity model. The process recognises that CCGs are new, clinically-led organisations coming into being for the first time, and reflects the need to ensure CCGs meet safe thresholds to take up their statutory responsibilities in 2013. Along with these clear thresholds for authorisation in the short term, the longer-term potential beyond authorisation for the development of CCGs is also set out at the beginning of each domain to show how CCGs may mature and where innovation will be encouraged over time.

Table 1

Domain	Description
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.
Meaningful engagement with patients, carers and their communities	CCGs need to be able to show 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.
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.
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 process in place to commission effectively each and every one of those services for which they are responsible, from the early health needs assessment through service design, planning and reconfiguration to procurement, contract monitoring and quality control.
Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as 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.
Great leaders who individually and collectively can make a real difference	Together, CCG leaders must be able to lead health commissioning for their population and drive transformational change 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.

3.14 As envisaged by the Government in *Equity and Excellence: Liberating the NHS*, the added value that clinicians bring to commissioning based on their skills, knowledge and standing in local communities is a defining feature of the new commissioning system and underpins how CCGs will be successful in each domain. This added value includes:

- Strengthened knowledge of the needs of individuals and local communities and the variation in the quality of local services, by harnessing the unique role of general practice to be in everyday contact with patients, their families, and carers
- Increased capability to lead clinical redesign and engage other clinicians based on the understanding of clinical risk and evidence of best practice
- Better involvement and engagement of local people to adopt improved services and move from familiar but out-dated services based on the focus on quality and outcomes and the trusted positions held in communities
- Improved uptake of quality based referral options across practices based on greater involvement in priority setting and redesign
- Greater focus on improving the quality of primary medical care as a key part of clinically-led redesign of care systems.

3.15 Authorisation recognises that whilst CCGs are new organisations, there is an ambition for them to improve and excel over time. Authorisation tests whether CCGs have achieved a safe threshold of development to discharge their duties. It therefore reflects only the first step on a longer journey of continuous improvement. The evidence collected in authorisation will inform the NHSCB's understanding of CCG development and the system and support they will need to excel.

The guiding principles of authorisation

3.16 This draft authorisation guidance is based on the design principles developed with aspiring CCGs, patient and professional organisations that were set out in *Developing clinical commissioning groups: Towards authorisation*. Adherence to these principles (set out in the box below) will ensure that authorisation assures that CCGs safely discharge their statutory responsibilities for commissioning healthcare services as clinically-led organisations driven by clinical added value:

- A process 'fit for purpose' – sufficiently robust to enable a thorough and cost-effective assessment of the CCG's capacity and capability to carry out its functions
- A process viewed by both the NHSCB and aspiring CCGs as developmental and as adding value and helping improve quality and overall patient experience and outcomes
- Setting the tone for the future positive relationship between CCGs and the NHSCB
- Minimising administrative demands for both aspiring CCGs and the review team/s, and delivering a process which is both rigorous and efficient
- Evidence required should be a by-product of core business, as far as is possible
- Recognising that this is a unique process – as 'start-up' bodies, CCGs will be building a track record of performance, therefore authorisation will focus on confidence in potential to deliver, drawing on CCG participation in, for example, improving long-term conditions care, clinical care in general and other aspects of quality, innovation, productivity and prevention (QIPP), but will also draw on CCG track record to date for example as sub-committees of PCTs to whom certain commissioning responsibilities have been delegated
- A nationally consistent approach – so that all aspiring CCGs can have confidence that the same process is being applied.

CCGs, commissioning support and authorisation

3.17 Commissioning is a complex set of tasks and functions and CCGs may want to make use of commissioning staff who have developed invaluable skills and expertise as they strive to become excellent commissioning organisations. Some CCGs, especially those that cover larger populations, may choose to put in place significant internal capacity to support them in carrying out their commissioning functions. It is likely that all CCGs, to a greater or lesser extent, will harness capacity and capability from external support services. In line with the maturity model embodied by authorisation, this important relationship between CCGs and their commissioning support suppliers (where used) will focus at first on supporting CCGs through authorisation and, in the longer term, on delivering truly transformational clinical commissioning that transforms quality, outcomes and value from local services.

3.18 Authorisation will take account of the effectiveness of arrangements put in place for commissioning support, including NHS, local authority, private sector and significant internal capacity and capability in CCGs. The emerging commissioning support services being developed by the NHS will be assured through a national commissioning support business review process that is being led by the NHSCB. Where CCGs have their own significant internal capability (including where they share commissioning support services with other CCGs) these arrangements should be clearly identifiable with separate governance arrangements in place, so that the relevant assessments can be applied, details of which will be published shortly. Aspiring CCGs considering such arrangements were requested in NHS Operating Framework 2012-13 to inform their SHA by January 2012. During the period 2013-16, while the NHSCB is hosting commissioning support, as CCGs become clearer about their commissioning support requirements they will need to formalise their commissioning support arrangements through formal procurements. This means that CCGs should have a plan in place for this formal procurement which should include identifying and specifying their requirements and going through a procurement process that is legally compliant.

Authorisation and development

3.19 The authorisation process is designed to align with CCG development in order that timely and focused support is provided to CCGs during 2012-13, including where one national development offer or a model document is considered appropriate and helpful to CCGs. The national development support available to CCGs is set out in Annex E.

Section 4

Domains of authorisation

4.1 The legal requirements for establishing a CCG are set out in the Act and its secondary legislation. The secondary legislation is currently being developed, so Annex D sets out the primary legislation and gives an indication of the likely content of the secondary legislation. This section sets out the criteria and thresholds that the NHSCB will use to determine whether the requirements for establishment and authorisation have been met.

4.2 In setting proposed requirements for authorisation, the NHSCBA is committed wherever possible to focusing on the outcomes and impact of CCG action rather than prescribing how the CCG achieves those outcomes. Authorisation will provide opportunities for CCG applicants to demonstrate their emerging capability to deliver improvements in quality and outcomes. Through examples or case studies, applicants may be able to demonstrate an emerging track record of delivery on the basis of acting as a sub-committee of a PCT, but it is recognised that in most cases it will be too early to see more systematic evidence of delivery at this stage.

4.3 The tables in this section set out the detail of the requirements for authorisation. These requirements are divided into six domains:

1. A strong clinical and multi-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 challenge within financial resources, in line with national requirements (including excellent outcomes) 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 commissioning all the services for which they are responsible.
5. Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as the appropriate commissioning support.
6. Great leaders who individually and collectively can make a real difference.

4.4 Annex D explains the legal requirements for authorisation and explains how these domains relate to those legal requirements.

4.5 Each domain is introduced with a description of ‘potential beyond authorisation’. These descriptions do not form part of the authorisation assessment. Drawing on what aspiring CCGs are already striving to deliver, their purpose is to offer CCGs vision and support in their ambitions to lay the foundations of organisations fit to fulfil the potential of clinical commissioning as they mature over the longer term. They ensure that authorisation is not seen as an end in itself.

4.6 The authorisation process assesses whether CCGs meet safe thresholds to assume their full statutory duties as a first step on a journey towards continuous improvement.

4.7 In this section, guidance is given on the criteria, thresholds and evidence sources required for authorisation in each domain. The thresholds described are those that must be met for an applicant to be authorised without conditions (see section 7). Further detail on the phases of authorisation and the evidence requirements are given in section 5.

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

Potential beyond authorisation in this domain

Clinical perspective in everything that it does, with quality at its heart:
CCGs will bring a relentless focus on quality that clinically-led organisations naturally bring. Frontline contact with patients and with services will drive a clinical mindset that is singularly focused on inequalities, the quality and outcomes of services. This frontline contact with patients informs clinicians' views on how those services might be improved. Effective CCGs recognise that quality improvement through commissioning will depend on the involvement and support of a multi-professional community, and through clinical senates and networks; so that all those working with member practices understand their role in delivering change.

Gaining significant engagement from constituent practices:
GP practices are a key contact with the NHS for many people, and through their daily contact with patients, they have a unique insight into people's health needs and inequalities, the quality and outcomes of services, and how services might be more efficient. CCGs will harness these insights from their daily reality of general practice, together with insights from wider engagement with patients, carers and communities, into the commissioning of healthcare services. Strong relationships across member practices will be the driving force behind successful CCGs and the improved services and outcomes that CCGs deliver. At the heart of maturing CCGs, members will proactively support delivery of CCG objectives.

Widespread involvement of other clinical colleagues providing health services locally:
Through involvement of a range of clinicians in commissioning there will be an increase in the local focus and pace of service redesign in order to reduce inequalities, and to improve the quality and outcomes of local services. CCGs recognise that the redesign and integration of services is most effective when it involves co-operation between clinicians across primary, secondary and community care and CCGs will increasingly work with clinical senates and networks for this purpose. CCGs will ensure that those alternative, improved services and pathways are fully adopted and spread locally. Already in regular contact with clinician colleagues CCG clinicians value the ideas of other clinicians on how to improve services and outcomes for patients. They will encourage co-operation with colleagues in primary, community and secondary care to redesign and integrate pathways, and will ensure that those alternative improved services and pathways are fully adopted and spread locally.

Communicating a clear vision of the improvements it is seeking to make locally, including population health and reducing health inequalities:
CCGs will develop a compelling narrative for the improvements they are seeking to make. Based around local priorities for improvements in health outcomes, inequalities and quality and developed openly and transparently, this vision will demonstrate a relentless focus on what matters most to patients, families and carers. In doing so, CCGs will set out how they will work with local authorities and care providers to improve pathways, offer choice, and integrate services between health and social care. CCGs' vision and plans will be accessible to a diverse range of communities and groups to allow them to fulfil their role in making change happen locally, and to enable CCGs to be leaders in sustainable healthcare and accountable to the population they serve. Contributing to the wider vision for communities shared with partner commissioners in local government, CCGs will have a strong sense of place.

Criteria 1.1 Clinical perspective in everything it does, with quality at its heart.	
Threshold for authorisation 1.1 Ethos of the CCG is about improving quality and it is clearly an organisation driven by clinical perspectives.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. CCG has clearly articulated its shared mission, values and aims for improving quality.	Constitution and any other documents detailing governance arrangements **Pre-application**
B. Governance, decision-making and planning arrangements where quality is a priority and clinical views are foremost.	2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review** Relevant minutes of governing body and CCG committees **NHSCB-led assessment: Desk top review** Organisational structure **NHSCB-led assessment: Desk top review**
C. Examples of CCG delivering measurable improvements in quality and productivity under delegated arrangements.	Case study **NHSCB-led assessment: Desk top review**
D. CCG members recognise local quality priority areas identified in CCG plans.	Member practice views **NHSCB-led assessment: 360° stakeholder survey**

Criteria
1.2 Engagement from constituent practices.

Threshold for authorisation
1.2 Member practices supportive of proposed configuration, structure and governance arrangements.

Evidence for authorisation	Evidence source and phase for submissions
A. All members specified in the constitution will be providers of primary medical services on the date the CCG is established.	Constitution and any other documents detailing governance arrangements **Pre-application**
B. Configuration is appropriate.	Constitution and any other documents detailing governance arrangements **Pre-application**
C. CCG proposed constitution has been signed off by member practices.	Constitution and any other documents detailing governance arrangements **Pre-application**
D. Member practices are involved in decision-making processes and, where appropriate, there are clear arrangements for delegation of functions.	Constitution and any other documents detailing governance arrangements **Pre-application** Member practice views **NHSCB-led assessment: 360° stakeholder survey**
E. CCG has safeguards and agreed ways to manage potential conflicts of interest including register of interests.	Constitution and any other documents detailing governance arrangements **Pre-application**
F. Examples of member practice involvement in decision-making.	Case study **NHSCB-led assessment: Desk top review** Member practice views **NHSCB-led assessment: 360° stakeholder survey**

Criteria
1.3 Widespread involvement of other clinical colleagues providing health services locally.

Threshold for authorisation
1.3 Clear arrangements in place to enable a wider local multi-professional clinical community to inform the work of the CCG through the provision of advice.

Evidence for authorisation	Evidence source and phase for submissions
A. Arrangements in place for CCG to involve and seek advice from healthcare professionals from secondary, community, mental health, learning disabilities and social care.	Minutes of multi-professional meetings **NHSCB-led assessment: Desk top review** Multi-professional views **NHSCB-led assessment: 360° stakeholder survey**
B. CCG governing body includes nurse and secondary care doctor.	CCG organisational structure **Pre-application**
C. Arrangements in place between LA and CCG specifying how public health advice to CCGs will be delivered.	Draft JSNA **NHSCB-led assessment: Desk top review** Local authority views **NHSCB-led assessment: 360° stakeholder survey**

Criteria 1.4 Communicating a clear vision of the improvements it is seeking to make in the health of the locality including population health and health inequalities.	
Threshold for authorisation 1.4.1 A clear clinically-led and delivered vision and priorities for improving quality, access and health outcomes to the communities it serves.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. CCG can demonstrate that it has taken steps to communicate its vision and priorities to partners, via its clinical leadership, through the local health and wellbeing board[2].	Relevant shadow health and wellbeing board minutes and reports **NHSCB-led assessment: Desk top review** Health and wellbeing board members' views **NHSCB-led assessment: 360° stakeholder survey**
B. CCG can demonstrate it has taken steps to communicate its vision and priorities to stakeholders, patients and the public.	Communications and engagement strategy **NHSCB-led assessment: Desk top review** 2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review** All respondents **NHSCB-led assessment: 360° stakeholder survey**
Threshold for authorisation 1.4.2 CCG has credibility with patients and the public as a clinically-led organisation.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Clinicians have taken steps to engage with LINks/local HealthWatch and other patient groups.	LINks/local HealthWatch and other patient groups' views **NHSCB-led assessment: 360° stakeholder survey**
B. Positive feedback from LINks/local HealthWatch and other patient groups.	LINks/local HealthWatch and other patient groups' views **NHSCB-led assessment: 360° stakeholder survey**

[2]*The document refers to health and wellbeing boards in both shadow and statutory form.*

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

Potential beyond authorisation in this domain

Ensure inclusion of patients, carers, public, communities of interest and geography, health and wellbeing boards, local authorities and other stakeholders:
CCGs will recognise that communication and engagement drives transparency, accountability and ultimately better services and outcomes. They will recognise that their success in improving outcomes and the quality of services is significantly dependent on their ability to look outward and be inclusive of those they serve. CCGs will be transparent and open about the decisions they make, and therefore will include a wide range of individuals, groups and communities in their work so that the population feel involved in decision-making. They will adhere to the highest possible standards of probity and transparency to account regularly to the communities they serve about their allocation of public resources. As intelligence-led organisations, CCGs will have a clear understanding of who the communities of geography and interest are in their area, and CCG leaders will invest time in building strong relationships with diverse groups and communities to understand their needs, priorities and experiences. In partnership with local authorities through health and wellbeing boards and LINks/local HealthWatch, CCGs will play their part in driving local improvement in health and care, and reducing health inequalities, and will account to local communities for those improvements. CCGs proactively engage in the development of JSNAs and joint health and wellbeing strategies (JHWS) to integrate local services and work in shared governance and processes with local authorities where it makes sense to do so.

Analysing and acting on information from communication and engagement activities to translate into priorities for improvement in services, access and outcomes:
As the main contact with the NHS for the majority of patients, GPs and other CCG clinicians will engage with local communities to encourage adoption of improved services. CCGs will link patient feedback gleaned from practices with that from unregistered populations to develop a comprehensive understanding of patients' needs and experiences of health services. Patient and carer feedback to practices, and complaints and concerns raised with the CCG will be a significant way in which CCGs will detect at the earliest stage any potential deterioration in the quality of a service as well as evidence of excellence that should be adopted and spread. CCGs will work with LINks/ local HealthWatch and other partners to understand the experience of people using their services, to help local people to shape and understand the need for different services, and to encourage local people to use those services.

Voice of each practice population is sought and acted on and the views of individual patients are reflected in shared decision-making and commissioning decisions, including patients exercising choice:
The increasing ability of CCGs to commission services that are sensitive to the needs of all their local communities will be strengthened by proactively seeking feedback from each of their member practice populations, and in turn, CCGs provide on-going feedback about the changes that have been made because of their participation. CCGs will strengthen the use of the everyday contact member practices have with patients as an invaluable source of insight about the quality of local services for all their local communities. They will develop effective mechanisms to capture this insight so that it underpins and informs CCG decision-making processes, and so that it drives tangible improvements to local services. CCGs will explain how they have used clinical, patient and public insight to make effective commissioning decisions. CCGs enable patients to make choices and shared decisions about their care and treatment. They have clear plans to extend the potential for patients to exercise choice about their care and treatment.

Criteria
2.1 Ensure inclusion of patients, carers, public, communities of interest and geography, health and wellbeing boards, local authorities and other stakeholders.

Threshold for authorisation
2.1.1 Constituent communities and groups within the population served by the CCG identified.

Evidence for authorisation	Evidence source and phase for submissions
A. CCG has mapped and analysed constituent communities and groups.	2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**
B. Analysis of the health needs of constituent communities and groups is reflected in CCG integrated plan.	Draft JSNA **NHSCB-led assessment: Desk top review**
C. CCG has outline plans in place to communicate and engage with strategic partners and diverse groups and communities.	Communications and engagement strategy **NHSCB-led assessment: Desk top review** Draft JSNA **NHSCB-led assessment: Desk top review**

Threshold for authorisation
2.1.2 Engaged in health and wellbeing boards, the refresh of JSNAs and the development of the JHWS.

Evidence for authorisation	Evidence source and phase for submissions
A. CCG has engaged local authority/ties in establishing its geographic area.	Local authority views **NHSCB-led assessment: 360° stakeholder survey**
B. CCG is engaged in shadow health and wellbeing board, is participating in refresh of JSNAs and in development of the JHWS.	Relevant shadow health and wellbeing board meeting minutes and reports **NHSCB-led assessment: Desk top review**
C. CCG integrated plan aligns with JHWS and enables integrated commissioning, depending on local time frames.	Draft JSNA **NHSCB-led assessment: Desk top review** Draft JHWS **NHSCB-led assessment: Desk top review** 2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**

Criteria 2.2 Analysing and acting on information from engagement to translate into priorities for improvement.	
Threshold for authorisation 2.2 Plans, processes and resources are in place to measure and use insight from patients, carers, partners and stakeholders to improve services.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Arrangements in place to ensure appropriate on-going patient and public involvement in CCG decision-making. B. Systems and processes for monitoring and acting on patient feedback, and particularly in identifying quality including safety issues.	Communications and engagement strategy NHSCB-led assessment: **NHSCB-led assessment: Desk top review** Constitution and any other documents detailing governance arrangements **Pre-application** Case study **NHSCB-led assessment: Desk top review**

Criteria 2.3 Voice of each practice population to be sought and acted on.	
Threshold for authorisation 2.3 Arrangements in place for patient views to be sought at practice level to inform and receive feedback from CCG priority setting.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Accountability between CCG and member practices is reflected in its constitution and in any broader governance arrangements. B. Examples of CCG engaging different groups and communities through a range of communications channels in the development of its vision, plan, or in broader CCG decision-making processes.	Constitution and any other documents detailing governance arrangements **Pre-application** Communications and engagement strategy **NHSCB-led assessment: Desk top review** Case study **NHSCB-led assessment: Desk top review**

Criteria 2.4 Views of individual patients are reflected in shared decision making and translated into commissioning decisions.	
Threshold for authorisation 2.4.1 Arrangements in place to promote the involvement of patients and carers in decisions about their own care and treatment, including exercising choice.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. CCG understands its statutory duties in relation to enabling patients to make choices and to promote the involvement of patients, carers and relatives in decisions about their care and treatment.	Self-certification **Application**
B. Systems in place to convert insights about patient choice/s in practice consultations into plans and decision-making.	Communications and engagement strategy **NHSCB-led assessment: Desk top review** 2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**
Threshold for authorisation 2.4.2 Plans in place to manage and respond to concerns raised about its own operations or the services it commissions, to monitor patient/ public perceptions of its responsiveness as a NHS organisation, and to learn from concerns raised to improve its performance.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Arrangements for handling complaints raised with the CCG are compliant with the statutory framework for complaints handling. Arrangements for handling concerns raised with the CCG deliver equivalent outcomes.	Constitution and any other documents detailing governance arrangements **Pre-application**
B. Arrangements for handling concerns and complaints raised with the CCG, and actions taken as a result, are clearly communicated to the public.	Communications and engagement strategy **NHSCB-led assessment: Desk top review**
C. Clear line of accountability for patient safety including regular reporting to the National Reporting and Learning System.	Constitution and any other documents detailing governance arrangements **Pre-application**

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

Potential beyond authorisation in this domain

Credible plans for how CCGs will continue to deliver the local QIPP challenge for the local health system, and meet the NHS Constitution requirements:
In the context of the Secretary of State's annual mandate to the NHSCB, the NHS Outcomes Framework and the Commissioning Outcomes Framework, CCGs will integrate local planning with local authorities to use local resources to better effect. CCGs have in place robust processes for tracking and monitoring implementation and impact, and plans will be refreshed annually with more detail for the year to come. These plans will be live strategic tools to focus commissioning activity, and each CCG member practice will have been part of the planning process and committed to implementation in its day-to-day practice. Plans will be clear about what is to be improved and credible because stakeholders are committed to delivery. They will develop a shared vision and consensus with local authorities and local communities, through health and wellbeing boards, about the priorities for local services including where integrated services across health, social care and wider public services are the best approach.

Track record of delivering service transformation:
Whilst robust commissioning and financial planning are essential in this domain, delivery of improved health outcomes will be the ultimate measure of success. CCGs will use the national NHS Outcomes Framework and the Commissioning Outcomes Framework to determine local priorities. CCGs will be able to demonstrate a track record of delivering changes that improve quality and productivity. CCGs will drive improvement locally and help local people and partner organisations understand the need for change. CCGs will be guided in their service transformation by the NHS single model of change. They will ensure they have the resources to meet all their local priorities as well as national service performance requirements for people across the country. Confidence in delivery capability will be an important way for CCGs to account to their own members, and for CCGs to show their partners and local people that their leadership is making a tangible difference to health outcomes.

Contracts in place to secure future delivery:
Strategic and operational planning in CCG informs and is reflected in their contracts with providers. Delivery of these changes through contracts will be monitored rigorously by CCGs, including being assured of the quality of the care that providers deliver. CCGs recognise that mature relationships with providers drive and sustain improvement in the long term. They actively support present and potential service providers, and support education and training providers to derive the future size and skills base of the workforce. They will also support providers to derive the information technology and future use of estate in care settings. Increasingly, providers will be liberated by the clarity and certainty of quality and outcome-based plans and innovate, meet and surpass the clear expectations of their local clinical commissioners. This active dialogue with providers includes dialogue between CCGs' member practices about the quality of primary medical care, as CCGs work closely with the NHSCB to ensure all aspects of primary medical care are commissioned coherently with local plans in place for improvement. Over time, the NHSCB will consider CCG plans when carrying out its responsibility to lead the commissioning of both primary medical care and specialist services.

Criteria 3.1 Credible plans to deliver continuous improvement in quality, reductions in inequalities in access to healthcare and healthcare outcomes, financial balance, and QIPP across the local health system, which also meet NHS Constitution requirements.	
Threshold for authorisation 3.1.1 Clear and credible plans[3] that set out how CCGs will take responsibility for service transformation that will improve quality within available resources.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Commitment to have regard to and promote the NHS Constitution, including performance aspects.	Self-certification **Application**
B. CCG has a clear and credible integrated plan, which includes an operating plan for 2012-13, draft commissioning intentions for 2013-14 and a high-level strategic plan until 2014-15.	2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**
C. CCG has detailed financial plan that delivers financial balance, sets out how it will manage within its management allowance, and any other requirements set by the NHSCB and is integrated with the commissioning plan.	2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**
D. QIPP is integrated within all plans. Clear explanation of any changes to existing QIPP plans.	2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**
E. CCG plan supports delivery of JHWS and integrated commissioning, depending on local timeframe.	Draft JHWS **NHSCB-led assessment: Desk top review**
F. CCG plan sets out how it aligns with national frameworks and strategies, including the NHS Outcomes Framework.	2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**

[3]Initial criteria for a clear and credible plan. Detailed requirements for planning to be set out in planning framework that will be published by the NHSCB.

1. *Does the plan clearly identify how the health system will be transformed and improved in 2014-15 from that in 2011-12?*
2. *Is the plan clear on how the system will achieve the end-state?*
3. *Does the plan articulate how the CCG will quantify, measure and monitor delivery of their share of the QIPP challenge?*
4. *Are plans for delivery of QIPP appropriately financially phased and articulated for each year until 2014-15 (i.e. not too heavily front- or back- loaded) and do plans provide headroom (e.g. the savings for reinvestment are greater than the investment and challenge identified)?*
5. *Triangulation of activity, workforce and finance – is there a clear link between commissioner and provider activity changes and financial planning, and of workforce planning?*
6. *Do plans demonstrate clear stakeholder sign-up? Do they demonstrate where and how CCGs are working together where necessary to meet QIPP, and can demonstrate that plans are aligned with contractual requirements for providers?*
7. *When appropriate, does the plan cover the relevant 2013-14 national requirements flowing from the mandate and as identified by the NHSCB?*

Threshold for authorisation 3.1.2 Plan is understood by CCGs, members, and other key stakeholders.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. CCG can demonstrate that the process for developing its plans and priorities was inclusive and transparent.	2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**
B. Plans clearly demonstrate where and how the CCG is working with other CCGs to meet QIPP, and can demonstrate that stakeholders are aware of and understand CCG priorities.	All respondents **NHSCB-led assessment: 360° stakeholder survey** Constitution and any other documents detailing governance arrangements **Pre-application** All respondents **NHSCB-led assessment: 360° stakeholder survey** List of collaborative commissioning arrangements, draft agreements or plans, including pooled budgets, joint appointments, and Section 75 agreements where appropriate **NHSCB-led assessment: Desk top review**
C. Member practices understand at least at a high level their local plan and priorities.	Member practice views **NHSCB-led assessment: 360° stakeholder survey**
D. Member practices receive timely information to inform their involvement in CCG planning and monitoring delivery of those plans.	Member practice views **NHSCB-led assessment: 360° stakeholder survey**
Threshold for authorisation 3.1.3 Plan is evidence-based and rooted in the needs of its population.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Plans reflect JSNA, stakeholder engagement, and evidence/data analysis.	2012-13 plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review** Draft JSNA **NHSCB-led assessment: Desk top review**
Threshold for authorisation 3.1.4 The CCG can articulate the likely inherited issues, and operating environment within the local health economy and can set out a clear and credible plan for their resolution.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Declaration that likely inheritance from PCT is quantified, identified, understood and robust transition arrangements in place.	Self-certification **Application**
B. Where the area covered by the CCG is not on track to meet the plan for 2012-13, there is a clear and time-limited resolution path to recover.	2012-13 plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**

Criteria 3.2 Track record of delivering service transformation to improve outcomes, quality and productivity, whilst reducing unwarranted variation and tackling inequalities, within the financial allocation.	
Threshold for authorisation 3.2 Delivery of a local priority area for improvement of quality, productivity and prevention. Budget delegation and successful track record of managing devolved budget.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Examples of CCG successfully taking devolved responsibility for commissioning budgets and delivering improvements.	Case study **NHSCB-led assessment: Desk top review**

Criteria 3.3 Contracts in place to secure future delivery.	
Threshold for authorisation 3.3 Systems and processes established to translate commissioning plan into contracts and delivery. Aware of current procurement requirements, with systems in place to handle those requirements. Systems in place to track and manage performance and providers including taking action when required standards are not met, and responding to concerns raised about safety, quality or other risk issues.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. 2012-13 contracts with main providers agreed and signed off, via PCT clusters.	2012-13 contracts **Pre-application**
B. CCG involved, under delegated arrangements, in 2012-13 contracting round, including in monitoring delivery of 2012-13 contract through regular liaison with main providers, and benchmarking providers.	2012-13 contracts **Pre-application**
C. Examples of CCG involvement, under delegated arrangements, in 2012-13 contracting round.	Case study **NHSCB-led assessment: Desk top review**
D. Self-certification regarding understanding of requirements and legislation on procurement.	Self-certification **Application**
E. CCG has arrangements in place to manage all contracts that will be transferred from PCTs on/ by 31 March 2013, or new contracts from 1 April 2013.	2012-13 contracts **NHSCB-led assessment: Desk top review** Self-certification **Application**
F. CCG has systems in place to track performance of main providers.	2012-13 contracts **Pre-application**
G. CCG has arrangements in place to collaborate with neighbouring CCGs in areas such as lead commissioning where there is more than one CCG contracting with a provider.	Constitution and any other documents detailing governance arrangements **Pre-application** 2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**
H. On-going discussion between the CCG and provider organisations about long-term strategy and plans.	Constitution and any other documents detailing governance arrangements **Pre-application** Provider views **NHSCB-led assessment: 360° stakeholder survey**

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 commissioning all the services for which they are responsible

Potential beyond authorisation in this domain

Properly constituted with the right governance arrangements:
Good governance in CCGs means that they are clinically-led organisations that will operate with maximum transparency and accountability, and are rigorous enough to withstand challenge as statutory bodies and manage risk appropriately. The internal controls established in CCGs are sufficiently robust to deal with the scale and complexity of their responsibilities. This system of strong internal controls also means that clinicians will be able to focus their time and effort on driving real improvements in services and outcomes. CCGs embody the Nolan principles and the principles of good governance, setting the right policy and procedures for ensuring every aspect of CCGs' work is done in a systematic, transparent and publicly accountable way. They will adhere to the highest possible standards of probity and transparency in order to build their organisational reputation as fully accountable organisations.

Able to deliver all their statutory functions efficiently, effectively and economically; including strategic oversight, financial control and probity, public accountability, quality improvement, the public sector equality duty, reducing inequalities, promoting innovation and managing risk:
CCGs will be clear that they are discharging their statutory duties and responsibilities effectively, in terms of the specific functions required to fulfil each duty and how the elements of those duties can be fulfilled through the discharge of their other commissioning and organisational functions. CCGs will establish governance arrangements overseen by their governing body, to ensure effective commissioning of all the services for which they are responsible. CCGs will have effective and efficient ways to fulfil their statutory responsibilities, making use of excellent management expertise.

Committed to and capable of delivering on important principles included in the NHS Constitution such as equality and diversity, safeguarding and choice, CCGs will have processes in place for day-to-day business and to commission effectively each and every one of the services for which they are responsible:
CCGs will be clear about all their duties and responsibilities, and have worked through and learned how they can most effectively be delivered in a clinically-led commissioning organisation. CCGs will have determined where clinicians add most value to commissioning and those functions where they wish to retain skills within its organisation. They will have decided what external expert management and skills will best support their operating model and secured these from a quality-assured provider of commissioning support. CCGs will be assured that the support employed directly within their organisations meets or surpasses the same tests of quality and cost as the assured external providers.

Criteria 4.1 Properly constituted with the appropriate governance arrangements.	
Threshold for authorisation 4.1 Constitution is appropriate and complies with legislative requirements. CCG has a viable organisational size and has an appropriate geographical area.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Constitution complies with requirements of Part 1 of Schedule 1A of Health and Social Care Act.	Constitution and any other documents detailing governance arrangements **Pre-application**
B. Constitution is 'otherwise appropriate', i.e. complies with regulations and takes account of guidance and the model constitution.	Constitution and any other documents detailing governance arrangements **Pre-application**
C. CCG governance meets the requirements of legislation and takes account of guidance and the model constitution.	Constitution and any other documents detailing governance arrangements **NHS-led assessment: Desk top review**
D. CCG has an appropriate geographical area.	Constitution and any other documents detailing governance arrangements **NHS-led assessment: Desk top review**

Criteria 4.2 Able to deliver all their statutory functions, including strategic oversight, quality improvement, financial control and probity, innovation and managing risk.	
Threshold for authorisation 4.2.1 Effective system of internal controls to ensure CCG can maintain strategic oversight, including: Clinical risk management and patient safety.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Governance arrangements in place to identify and manage different types of risk, including key risks to delivery of QIPP.	Integrated risk management framework, including clinical, financial and corporate risk **NHSCB-led assessment: Desk top review** Constitution and any other documents detailing governance arrangements **Pre-application**
B. Systems and processes for monitoring and acting on patient feedback, and particularly identifying early quality issues including safety.	Constitution and any other documents detailing governance arrangements **Pre-application** Relevant minutes of governing body and CCG committees **NHSCB-led assessment: Desk top review**
C. Arrangements in place to monitor quality issues including safety in an on-going way.	Constitution and any other documents detailing governance arrangements **Pre-application** Relevant minutes of governing body and CCG committees **NHSCB-led assessment: Desk top review**
D. Quality issues are discussed regularly by CCG governing body.	Constitution and any other documents detailing governance arrangements **Pre-application** Relevant minutes of governing body and CCG committees **NHSCB-led assessment: Desk top review**
E. CCG has arrangements in place to proactively identify early warnings of a failing service.	Constitution and any other documents detailing governance arrangements **Pre-application** Relevant minutes of governing body and CCG committees **NHSCB-led assessment: Desk top review**
F. Arrangements in place to deal with and learn from serious untoward incidents and never events.	Constitution and any other documents detailing governance arrangements **Pre-application** Relevant minutes of governing body and CCG committees **NHSCB-led assessment: Desk top review**

Appropriate and effective financial reporting, management and governance in order to meet its statutory financial reporting duties and in year financial performance reporting requirements.	
Evidence for authorisation	**Evidence source and phase for submissions**
G. CCG has the following standard financial management arrangements in place: • Internal and external audit • Financial reporting through financial spine • Audit committee • Standing orders/standing financial instructions • Scheme/s of delegation • Arrangements for management of any charitable funds • Committee structure including management and audit • Counter fraud arrangements • Accounts payable and receivable, cash, fixed assets • Payroll and banking facilities • Appropriate risk-sharing arrangements with other CCGs in place and clearly understood by all parties.	Financial management arrangements compliant with national requirements **Pre-application**
H. Clear governance structures and programme management capacity and capabilities in place to support the delivery of QIPP.	Constitution and any other documents detailing governance arrangements **Pre-application** Integrated risk management framework including clinical, financial and corporate risk **NHSCB-led assessment: Desk top review**
Public sector Equality Duty (PSED).	
Evidence for authorisation	**Evidence source and phase for submissions**
I. CCG can demonstrate compliance with the public sector Equality Duty, and is using the EDS or an equivalent to help attain compliance and ensure good equality performance.	Self-certification **Application** Equality and Diversity plan **NHSCB-led assessment: Desk top review**
Promoting innovation.	
Evidence for authorisation	**Evidence source and phase for submissions**
J. CCG understands responsibility to champion innovation and adoption of innovation. K. Examples of CCG innovation.	Self-certification **Application** Case study **NHSCB-led assessment: Desk top review**

Threshold for authorisation 4.2.2 Systems and processes in place to ensure CCG complies with its statutory duties and other requirements, including: Commitment to promoting patients' recruitment to and participation in research. Commitment to promoting the education and training of the NHS workforce. Commitment to promoting environmental and social sustainability.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Commitment to promoting research and the use of research evidence.	Self-certification **Application**
B. Commitment to promoting education and training given.	Self-certification **Application**
C. CCG can demonstrate commitment to promoting environmental and social sustainability through their actions as a corporate body as well as a commissioner.	Self-certification **Application**
Threshold for authorisation 4.2.3 CCG has systems and processes in place to fulfil its specific duties of cooperation and partnership, including: Reducing inequalities in access and to outcomes from healthcare. CCG can demonstrate that it meets best practice in relation to safeguarding.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. At least one identified individual or committee is formally responsible for ensuring the CCG has regard to the need to reduce health inequalities in access to, and the outcomes from healthcare.	Constitution and any other documents detailing governance arrangements **Pre-application**
B. Through involvement in JSNA and in the development of the JHWS, the CCG has identified opportunities to reduce inequalities.	Draft JSNA **NHSCB-led assessment: Desk top review** Draft JHWS **NHSCB-led assessment: Desk top review**
C. Health inequalities issues identified and addressed in integrated plan.	2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review**
D. CCG has established appropriate systems for safeguarding.	Constitution and any other documents detailing governance arrangements **NHSCB-led assessment: Desk top review** Integrated risk management framework, including clinical, financial and corporate risk **NHSCB led assessment: Desk top review**
E. CCG plans to train staff in recognising and reporting safeguarding issues.	Organisational development plan **NHSCB-led assessment: Desk top review**

Criteria 4.3 Processes in place to commission effectively all services for which they are responsible.	
Threshold for authorisation 4.3.1 Capacity and capability to commission key areas of care for which they are responsible.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. To commission improvements in quality, as described in the NHS Outcomes Framework: • Preventing people from dying early • Enhancing quality of life for people with long-term conditions • Helping people recover from episodes of ill health or following injury • Ensuring that people have a positive experience of care; treating and caring for people in safe environments and protecting them from avoidable harm. The CCG has the capacity and capability to commission improved outcomes for the people it serves, including: • Mothers and newborns • People who need support for mental health • People with learning disabilities • People who need emergency and urgent care • People who need routine operations • People with long-term conditions • People with continuing healthcare needs • People at the end of life.	Self-certification **Application**
B. CCG choice of case studies illustrates their approach and the impact they have had to date in at least one of the above patient groups.	Case study **NHSCB-led assessment: Desk top review**
C. CCG can demonstrate how its proposed staff resource and any contracted commissioning support will provide capacity and capability to deliver its full range of responsibilities.	Organisational structure **Pre-application** Organisational development plan **NHSCB-led assessment: Desk top review**
D. CCG demonstrates clear understanding of lines of accountability between it and its support provider/s.	SLA with assured support provider **NHSCB-led assessment: Desk top review**
E. Agreement with support provider/s that has been assured through BDU business review process, or by the CCG through a procurement process.	SLA with assured support provider **NHSCB-led assessment: Desk top review** Organisational development plan **NHSCB-led assessment: Desk top review**
F. For CCGs developing significant internal capacity and/or shared services, these arrangements have been quality assured through an analogous process to BDU business review process.	SLA with assured support provider **NHSCB-led assessment: Desk top review** Constitution and any other documents detailing governance arrangements **Pre-application**

Threshold for authorisation 4.3.2 Appropriate and affordable plans to maintain communications support that enable CCG to discharge its statutory and operational functions and operate in a clear and transparent way.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. CCG has assessed its communications capacity/capability requirements. B. CCG has plans in place to build or secure appropriate capacity and capability for internal and external communications required to deliver its commissioning plan.	Organisational development plan **NHSCB-led assessment: Desk top review** SLA with assured support provider, if provider used for communications function **NHSCB-led assessment: Desk top review** Organisational structure **Pre-application**
Threshold for authorisation 4.3.3 Sufficient capacity and capability to develop the intelligence requirements to support commissioning.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. CCG has assessed its information requirements and planned capacity/ capability to deliver those requirements. CCG has used NHS Information Governance toolkit to assess its capability to meet information governance requirements.	Constitution and any other documents detailing governance arrangements **Pre-application**

Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as the appropriate commissioning support

Potential beyond authorisation in this domain

Robust arrangements for working with other CCGs in order to commission key services across wider geographies:
CCGs will work together in order to effectively commission all the categories of care for which they are responsible, but also to share risk safely, transfer skills and secure commissioning support. They will increasingly look beyond their own direct commissioning responsibilities to recognise where quality, access to and outcomes from local services depend on commissioning services on a larger geographical footprint. Collectively CCGs will prioritise those service areas where improvement is needed most to ensure collaborative arrangements, be that with other CCGs, local authorities or the NHSCB.

Strong partnerships with local authorities to develop JHWS and improve outcomes:
CCGs will recognise that health and wellbeing boards are the key planning forum for all local communities, and commit significant leadership resources to making them a success, promoting investment in health and wellbeing and acting as advocates for local people. With increasing freedom to innovate and generate solutions on behalf of the local communities they serve, CCGs will improve collaboration between practices and local patient and community representatives. In partnership with health and wellbeing boards, CCGs will build on the strong and common sense of place shared by patient and community representatives and local clinicians.

Strong arrangements for joint commissioning with local authorities to commission services where integration of health and social care are vital:
CCGs will recognise the important mutual relationship with local authorities to plan and commission improvements in health and care services for local populations. Working closely with the whole of local government to integrate the health agenda into all relevant areas (e.g. housing, leisure), CCGs will take much greater advantage of opportunities for aligning budgets, including commissioning budgets and integrating provision.
With both CCGs and local government devoting significant leadership resources to promoting integration locally, they will achieve better use of combined health and local government resources.

Effective commissioning support arrangements in place to ensure robust commissioning and economies of scale:
Based on a robust assessment of how the CCG effectively fulfils all its statutory duties and responsibilities whilst ensuring clinical added value, and in line with this assessment, high-performing CCGs may have established collaborative arrangements with suppliers of commissioning support that ensure they have high quality, locally responsive support that meets their requirements.

Support the NHSCB in its role as commissioner of primary medical care and specialised services. CCG clinicians have a vital role in supporting the NHSCB to improve the quality of primary medical care as well as specialised services:
Recognising that primary care is the gateway to the NHS for so many patients and because of the potential in primary care for the primary and secondary prevention of illness, CCGs will work in partnership with the NHSCB to improve the quality of and access to primary medical care services directly commissioned by the NHSCB. CCGs will work closely with the NHSCB to develop and implement integrated care pathways that ensure that the needs of patients for these services are identified and addressed in an appropriate and timely manner.

Criteria
5.1 Robust arrangements for working with other CCGs in order to commission key services across wider geographies and to play their part in major service reconfiguration where appropriate.

Threshold for authorisation
5.1 Collaborative arrangements in place with other CCGs, with clear lines of accountability.

Collaborative arrangements to ensure effective and efficient use of resources/running cost allowance.

Evidence for authorisation	Evidence source and phase for submissions
A. CCG has written agreements in place detailing the scope of the collaboration with other CCGs, with clear lines of accountability and decision-making processes.	Constitution and any other documents detailing governance arrangements **Pre-application**
B. Mechanisms in place for CCG to collaborate with others where patient flow or provider configuration necessitates this.	Constitution and any other documents detailing governance arrangements **Pre-application**
C. Examples of CCG collaboration with other CCGs and a multi-disciplinary range of clinicians.	Case study **NHSCB-led assessment: Desk top review**
D. CCG can demonstrate collaboration with other CCGs sharing employed staff/teams where appropriate.	Organisational structure **Pre-application**

Criteria
5.2 Strong leadership with local authorities to develop health and wellbeing boards.

Threshold for authorisation
5.2 CCG is fully engaged in the shadow health and wellbeing boards.

CCG plans reflect JSNAs and CCG aligns priorities with those identified by the health and wellbeing board, and in the JHWS.

Evidence for authorisation	Evidence source and phase for submissions
A. CCG has collaborated in the development of a shadow health and wellbeing board.	Relevant shadow health and wellbeing board meeting minutes and reports **NHSCB-led assessment: Desk top review**
B. CCG has collaborated in the refresh of JSNAs and in the development of the JHWS, depending on local timeframe.	Draft JSNA **NHSCB-led assessment: Desk top review** Draft JHWS **NHSCB-led assessment: Desk top review**
C. CCG can demonstrate understanding of accountability and decision-making processes in health and wellbeing board.	Relevant shadow health and wellbeing board meeting minutes and reports **NHSCB-led assessment: Desk top review**

Criteria 5.3 Strong arrangements for joint commissioning and cooperation with local authorities to enable integration, deliver shared outcomes and fulfil statutory responsibilities, drawing on public health advice.	
Threshold for authorisation 5.3 CCG collaborates with local partners to shape local commissioning plans to enable integration of services/ pathways.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Where the need for integrated commissioning has been identified by the health and wellbeing board and in the JHWS, CCGs are collaborating with the local authority to develop shared plans.	Relevant shadow health and wellbeing board meeting minutes and reports **NHSCB-led assessment: Desk top review** Local authority views **NHSCB-led assessment: 360° stakeholder survey** Draft JHWS **NHSCB-led assessment: Desk top review** 2012-13 integrated plan and draft commissioning intentions for 2013-14 **NHSCB-led assessment: Desk top review** List of collaborative commissioning arrangements, joint commissioning draft agreements or plans, including pooled budgets, joint appointments, Section 75 agreements where appropriate **NHSCB-led assessment: Desk top review**
Appropriate arrangements are in place to safeguard and promote welfare of children and vulnerable adults.	
Evidence for authorisation	**Evidence source and phase for submissions**
B. Clear line of accountability for safeguarding is reflected in CCG governance arrangements, and CCG has arrangements in place to co-operate with the local authority in the operation of the Local Safeguarding Children Board and the Safeguarding Adults Board.	Constitution and any other documents detailing governance arrangements **Pre-application** Integrated risk management framework, including clinical, financial and corporate risk **NHSCB led assessment: Desk top review** Local authority views **NHSCB-led assessment: 360° stakeholder survey**
C. CCG has secured the expertise of a designated doctor and nurse for safeguarding children and for looked after children, and a designated paediatrician for unexpected deaths in childhood.	Organisational structure **Pre-application**
D. CCG has a safeguarding adults lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.	Organisational structure **Pre-application**

Criteria 5.4 Effective commissioning support arrangements to ensure robust commissioning and economies of scale.	
Threshold for authorisation 5.4 CCG involvement as customers in BDU business planning process.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. CCG can demonstrate how they have identified their commissioning support intentions.	Constitution and any other documents detailing governance arrangements **NHSCB-led assessment: Desk top review** Commissioning support provider/s views **NHSCB-led assessment: 360° stakeholder survey**
Arrangements with commissioner support provider/s that have been quality assured through national commissioning support business review process, or through analogous process to that used by commissioning support business review.	
Evidence for authorisation	**Evidence source and phase for submissions**
B. SLA agreed with support provider assured through BDU business planning process. C. For CCGs developing significant internal capacity/capability or shared services, the CCG has ensured the quality of those services.	SLA with assured support provider **NHSCB-led assessment: Desk top review** Constitution and any other documents detailing governance arrangements **NHSCB-led assessment: Desk top review** SLA with assured support provider **NHSCB-led assessment: Desk top review**
CCG has arrangements in place to fulfil its commissioning support intentions post-April 2013.	
Evidence for authorisation	**Evidence source and phase for submissions**
D. CCG has plans in place for formally procuring any commissioning support services, to ensure that between 2013-16 it puts in place the arrangements to go through a compliant procurement process.	Organisational development plan **NHSCB-led assessment: Desk top review** Self-certification **Application**

Criteria 5.5 Support NHSCB in its role as commissioner of primary care and specialised services, and work as a partner with NHSCB to integrate commissioning where appropriate.	
Threshold for authorisation 5.5 Active discussions within the CCG relating to improving the quality of primary care and specialised services.	
Evidence for authorisation	**Evidence source and phase for submissions**
A. Mechanism for working in partnership with NHSCB to improve quality of primary medical care, and particularly to take account of need and unexpressed demand. B. Mechanism for working in partnership with NHSCB to improve quality of specialised services.	Constitution and any other documents detailing governance arrangements **Pre-application** Constitution and any other documents detailing governance arrangements **Pre-application**

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

Potential beyond authorisation in this domain

Individual clinical leaders who can demonstrate commitment to partnership working and have the necessary skill set to lead commissioning and drive transformational change: Leaders of CCGs will have a relentless focus on improving patient experience and health outcomes, and recognise that strong relationships with member practices, with local communities, with local government, other CCGs and the NHSCB are essential to delivering their purpose. CCGs will actively develop individual leaders to have the knowledge and skillset for the task and can effect change through working with others and by communicating effectively. In taking responsibility for decisions about how the majority of the health budget is allocated, CCG leaders will embrace the concepts of stewardship and responsible leadership. Individual leaders will recognise that strong interpersonal and communication skills and self-awareness are important, as clinical leadership has a powerful impact on clinical behaviour and decision-making in GP practices. CCG ability to manage in ambiguous and complex environments and across organisational boundaries will make collaboration a success.

Distributed leadership throughout the culture of the CCG organisation, with clinical leadership present beyond the governing body in every GP practice. CCGs will recognise that the scale and scope of the commissioning challenge requires distributed leadership at many different levels within the multi-professional clinical community: As CCGs mature as organisations, the relationships between leaders and members in CCGs will become more important than the behaviours, style or achievements of individual leaders themselves. In order to sustain improvement at the necessary pace and scale, CCG leaders will identify clinicians with the potential to provide leadership in taking commissioning forward, support these clinicians in developing the self-confidence, capabilities and vision to fulfil this role; and help them to develop the skills they will require as new leaders. Distributed leadership will lead to extensive and on-going communication and engagement across practices, as each individual engages more actively in commissioning. With full engagement from their member practices reflected in their governance arrangements, CCG leaders will have the legitimacy and mandate to make difficult decisions with the support of all their members. CCGs will have an operating model that encourages the involvement of clinicians other than GPs, with an appointment mechanism that is fair, transparent and inclusive.

Accountable Officers capable of steering clinical commissioning organisations, and Chief Financial Officers who are both fully qualified and have sufficient experience: Accountable Officers will have the leadership qualities, the judgement and the competency to discharge their responsibilities and have a clear personal development plan that reflects the CCG development priorities over time. All those on the governing body will have the right skills, whether clinicians, lay members or managers, and governing bodies will be central to CCGs being able to deliver their responsibilities today and to develop their organisational health for delivering over the longer term. CCG leaders will promote and embody the NHS values as set out in the NHS Constitution, and they will become leaders of the wider NHS system. As the ability of CCGs fully emerges, governing bodies will ensure that the organisation is aware of its performance and the root cause of that performance. Governing bodies will retain a focus on delivery today and the development of the health of the organisation to deliver tomorrow.

Criteria
6.1 Individual clinical leaders who can demonstrate commitment to partnership working and have the necessary skill set to lead commissioning and drive transformational change.

Threshold for authorisation
6.1 Assessment by CCG of organisational development challenges, and leadership development resulting from that assessment.

Evidence for authorisation	Evidence source and phase for submissions
A. CCG has completed OD diagnostic/ self-assessment tool or equivalent.	Organisational development plan **NHSCB-led assessment: Desk top review**
B. CCG has plans in place informed by the outcomes of a diagnostic self-assessment tool.	Organisational development plan **NHSCB-led assessment: Desk top review**
C. Assessment of leadership potential and competency was included in selection process for CCG clinical leads, and there are high-level arrangements for succession planning.	Organisational development plan **NHSCB-led assessment: Desk top review**
D. Examples of CCG leadership development.	Case study **NHSCB-led assessment: Desk top review**

Criteria
6.2 Distributed leadership throughout the culture of the CCG, and through the involvement of other clinicians via commissioning processes.

Threshold for authorisation
6.2 Two-way accountability between CCG and member practices.
CCG clinicians involved in commissioning.

Evidence for authorisation	Evidence source and phase for submissions
A. Systems in place to sustain two-way accountability between members.	Constitution and any other documents detailing governance arrangements **Pre-application** Member practice views **NHSCB-led assessment: 360° stakeholder survey**
B. Examples where the CCG has enhanced clinical involvement in service redesign and improvement.	Case study **NHSCB-led assessment: Desk top review**
C. Lead clinicians selected from member practices for CCG commissioning priority areas.	Organisational structure **Pre-application**

Criteria
6.3 Accountable Officer has capability in line with significant scale and scope of responsibilities.

Threshold for authorisation
6.3 Suitable proposed Accountable Officer who fits requirements for role.

Evidence for authorisation	Evidence source and phase for submissions
A. Proposed Accountable Officer selected in line with national role outline, attributes and competencies.	Positive assessment centre outcome for proposed Accountable Officer **NHSCB-led assessment: Desk top review**

Criteria
6.4 All those on the governing body have the right skills.

Threshold for authorisation
6.4 Governing body fulfils national requirements regarding composition and characteristics.

Lay members identified who would meet the statutory requirements.

CCG staffing structures give confidence it has sufficient in-house resource to maintain strategic oversight and ensure all statutory functions of the CCG are safely discharged.

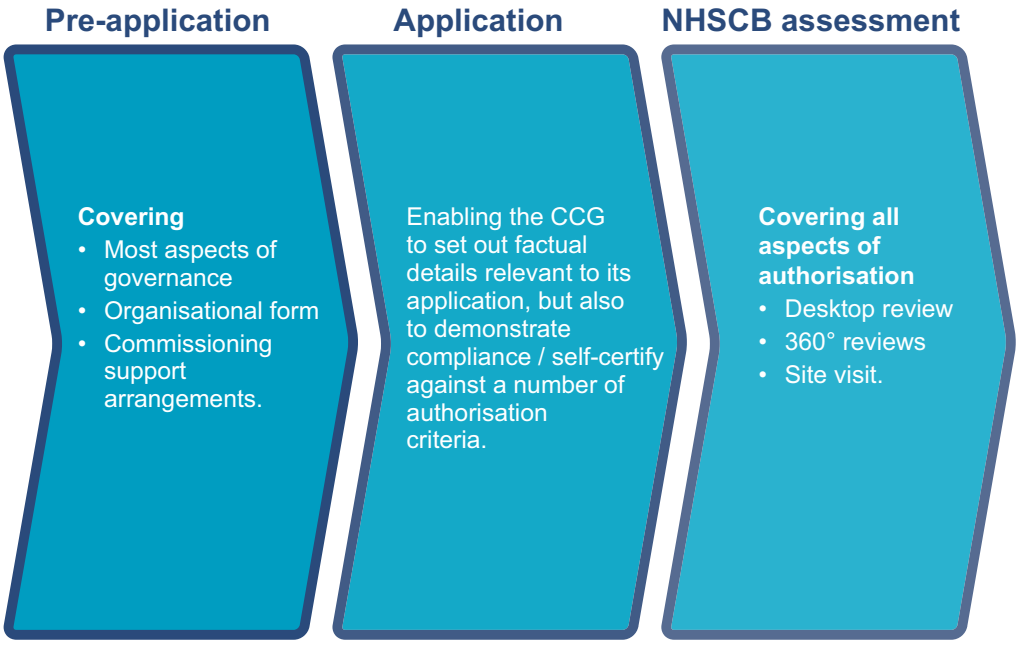
Evidence for authorisation	Evidence source and phase for submissions
A. CCG reflects Nolan principles of good governance.	Constitution and any other documents detailing governance arrangements **Pre-application**
B. Appointment process and composition of governing body reflects nationally determined role outlines, attributes and competencies and draws on good practice.	Organisational structure **Pre-application** Constitution and any other documents detailing governance arrangements **Pre-application**
C. Documented support of members for Chair of governing body.	Letter of support for Chair of governing body from members **NHSCB-led assessment: Desk top review** Member practice views **NHSCB-led assessment: 360° stakeholder survey**
D. CCG recommends appointment of governing body members.	Constitution and any other documents detailing governance arrangements **Pre-application**
E. CCG can demonstrate that it has assessed the skills possessed by governing body members and has a plan to build governing body competencies/skills where required.	Organisational structure **Pre-application** Organisational development plan **NHSCB-led assessment: Desk top review**
F. Chief Finance Officer and Chair of governing body secured in line with national role outlines, attributes and competencies.	Positive assessment centre outcome **NHSCB-led assessment: Desk top review** Organisational structure **Pre-application**
G. Senior in-house management roles in CCG provide adequate capacity and capability to maintain strategic oversight with available resources.	Organisational structure **NHSCB-led assessment: Desk top review**
H. CCG has sufficient in-house capability to manage its commissioning support arrangements well.	Organisational structure **Pre-application** SLA with assured support provider **NHSCB-led assessment: Desk top review** Organisational development plan **NHSCB-led assessment: Desk top review**

Section 5

The authorisation process

5.1 Applicants will move through three distinct phases of activity during the CCG authorisation process.

Fig. 1 Phases of authorisation



5.2 Aspiring CCGs are preparing to apply to be established as CCGs and subject to that application being granted, take on the full commissioning responsibilities of these new statutory bodies. These preparations began with a self-assessment diagnostic, have progressed to the assumption of delegated responsibility from PCTs under current legislation, and the focus is now on working towards establishment and authorisation.

5.3 CCG performance and population health profiles will be provided to all aspiring CCGs at least one month before the application date for their wave, giving time for aspiring CCGs to consider them and any factual errors to be corrected. Profiles will provide the following data configured at CCG level:

- Geography – including the relationship between the CCG and local authorities, and the relationship between a CCG's registered and resident population
- Demographic and socio-economic profile – e.g. age/ sex/ Index of Multiple Deprivation
- Population level outcomes data
- Activity and outcomes data (e.g. the latter from inpatient survey) split by main provider
- Performance data
- Financial data.

5.4 CCG profiles will be used by the assessor team to understand the challenges facing applicant CCGs and will form part of the data triangulation on track record, planning, prioritisation and financial management.

5.5 As part of their preparation, aspiring CCGs will begin to assemble the evidence required for submission. The timing for this will vary depending on local plans and aspiring CCG readiness. Annex B sets out the criteria where an aspiring CCG will be expected to make early progress. These criteria are fundamental to the establishment of a functioning

organisation with good governance. There are a range of national risk assessments and support tools available to support aspiring CCGs in this period. Details of these are set out in Annex E. Aspiring CCGs will also put in place the preparatory work to underpin the self-certification declarations to be made at the point of application.

5.6 All evidence will be assessed as part of the NHSCB desktop review. However SHA clusters will provide a report summarising their view of an aspiring CCG's progress during the pre-application phase, which will be submitted alongside the CCG's application. Aspiring CCGs will have an opportunity to review and comment on their SHA report ahead of its submission.

Application

5.7 The application phase includes a significant element of self-certification by CCGs. Here the proposed Chair of the governing body and proposed Accountable Officer sign on behalf of the applicant CCG to certify that the applicant CCG is ready, willing and has plans in place to discharge its duties and responsibilities in key areas. This level of self-certification reflects the wide-ranging responsibilities of the CCG and establishes the relationship between it and the NHSCB as one based on proportionality, transparency and trust.

5.8 Application forms should be received by the NHSCB upon or before the application date for each wave (see section 6 for dates). Forms should be signed by the proposed Chair of the governing body and the proposed Accountable Officer.

5.9 The forms will (see Annex A for template):

- Set out some factual detail about the applicant CCG
- Enable the CCG to declare compliance/ self-certify in a number of areas.

5.10 Additionally the application form lists the core documents CCGs must submit as part of their application:

- Authorisation application form
- Proposed CCG constitution and any other documents detailing governance arrangements
- CCG organisational structure
- Letter of support for proposed Chair of the CCG governing body
- Relevant minutes of multi-professional meetings, governing body and other committees
- Financial management arrangements compliant with national requirements
- Organisational development plan
- 360° stakeholder survey report and CCG comments
- Integrated risk management framework, including clinical, financial and corporate risk
- Draft joint strategic needs assessment
- Draft joint health and wellbeing strategy
- Relevant health and wellbeing board minutes and reports
- 2012-13 integrated plan and draft commissioning intentions for 2013-14
- List of 2012-13 contracts agreed and signed off, via PCT clusters
- List of joint commissioning draft agreements or plans, including pooled budgets and Section 75 agreements where appropriate
- SLA with assured support provider, where appropriate
- Case studies (please specify)
- Equality and diversity strategy
- Communications and engagement strategy.

5.11 A copy of the declaration of compliance and accompanying documentary evidence should be made available on the applicant CCG's website, or otherwise made available for public view if a website is not yet in place.

5.12 Declarations of compliance will be triangulated by the NHSCB with other evidence available, using one or more of the eight commissioning themes covered in the application form as themes for assessing the cohesiveness of the applicant CCG's arrangements across the domains and documentation. In the first instance the NHSCB will rely on the proposed governing body's certification. Where there is evidence to the contrary the NHSCB will explore the basis for certification further. This means that the onus is on the applicant CCG to assure itself that the certification reflects, to the best of its knowledge, the ability (or stated intention) of the applicant CCG to be compliant with the required duties. Should an applicant CCG be found to have knowingly misrepresented its position it will automatically fail its authorisation application. Once authorised, compliance will be monitored through on-going assurance. Should non-compliance be subsequently identified, this will be managed through on-going assurance of the CCG by the NHSCB.

NHSCB-led assessment

5.13 Once the application has been received, each document will be used to assess the applicant CCG against the criteria for authorisation. Evidence submitted will be triangulated for consistency with the SHA pre-application report, data from the CCG profile and the findings of the 360° stakeholder survey. Triangulation will use one or more of the patient groups set out in the application form to assess the cohesiveness of the applicant CCG's arrangements across the domains.

Desk top review

5.14 Desk top reviews will be undertaken by a team of assessors with expertise in finance, commissioning, governance and clinical quality. Assessors may contact the applicant CCG for clarification on particular points prior to the site visit. A record of any conversations or emails will be agreed with the applicant CCG and added to the applicant CCG's file. The findings of the desk top review will inform the focus of the site visit, and applicant CCGs will have an opportunity to comment on these findings before the site visit.

360° stakeholder survey

5.15 360° stakeholder surveys will be undertaken shortly before each wave. A range of stakeholders (see Annex C for list of stakeholders) will have been invited to complete a short web-based survey. A report analysing responses will be sent to the applicant CCG for them to submit to the NHSCB. The applicant CCG will be able to comment on and provide a response to any issues raised by the survey. Survey findings will inform both the desk top review and site visit.

Case studies

5.16 Case studies are an opportunity for each applicant CCG to demonstrate its ability to deliver improvements in access to services, health outcomes, service quality and productivity, and reduce health inequalities. They are also an invaluable opportunity for applicant CCGs to demonstrate their learning and development as individuals and as organisations. Applicant CCGs are invited to submit case studies not only as part of their application for authorisation but also to establish a national library of best practice emerging from clinical commissioning.

5.17 Case studies will be used as supplemental evidence across all six domains. However, case studies form part of the core evidence for authorisation in a number of areas. These are shown in Annex B. Evidence in these areas must be presented to illustrate a focus on one or more of the following patient groups:

- Mothers and newborns
- People with need for support with mental health
- People with learning disabilities
- People who need emergency and urgent care
- People who need routine operations
- People with long term conditions
- People at the end of life
- People with continuing healthcare needs.

5.18 Applicant CCGs are asked to submit a case study/ies indicating how they meet all the criteria set out above. Applicant CCGs may submit up to five different case studies but the total word limit across all case studies should not exceed 3000 words. Each case study should clearly indicate which policy objectives or characteristics it provides evidence for, and the main learning points from the actions or decisions described.

Site visit

5.19 Each applicant CCG will have a one-day site visit. The purpose of the site visit will be for the NHSCB to meet the applicant CCG leaders, assess their capability to deliver both individually and as a team, and test points arising from earlier phases of assessment. A report of the site visit will be shared with the applicant CCG for comment.

5.20 The site visit team will comprise a senior representative from the NHSCB, a member of the NHSCB authorisation team, a clinical leader from an aspiring or established CCG from a different geographical area, a lay assessor, finance and commissioning experts (these will be drawn from other parts of the country). Depending on the conclusions of the desk top review there may also be local authority or public health representation. The team will receive training and there will be a process of matching assessors to applicants to prevent conflicts of interest arising.

Decision

5.21 Only the NHSCB can legally make a decision on authorisation, although it is anticipated that under regulations it will be required to take into account the views of the NHSCBA and any other parties that may be specified, on certain matters.

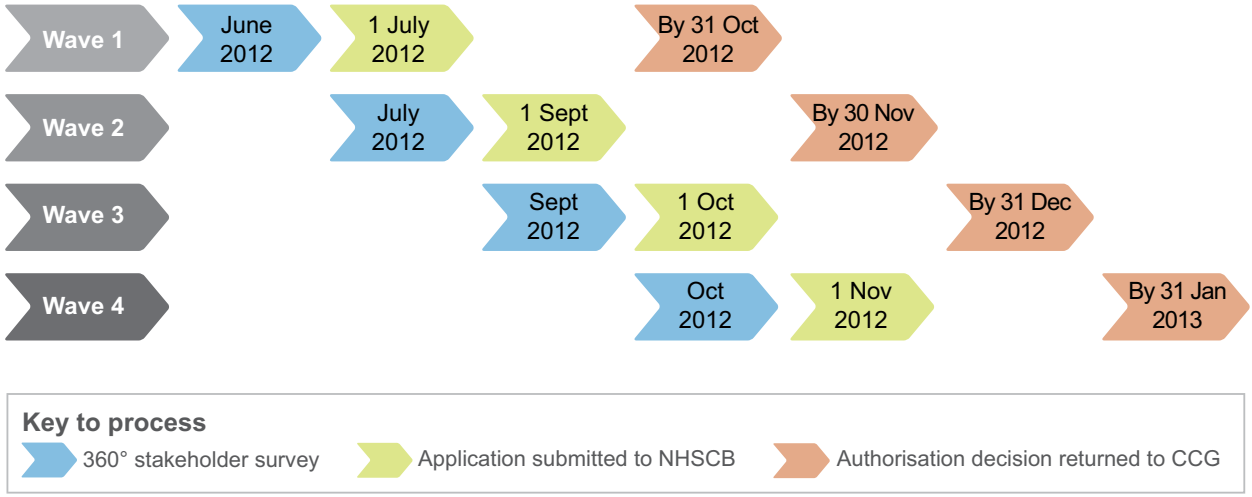
5.22 The decision of the NHSCB is final. There will be no appeals process. There will be opportunities throughout the process for each applicant to comment and challenge assessments made, such that when the Board makes its decision, it should be apparent from looking at the information submitted as to the reason for the Board's decision.

Section 6

Application timetable

6.1 There will be four opportunities to apply for authorisation in 2012:

Fig. 2 Authorisation application process per wave



6.2 In considering the timing of their application for authorisation, applicant CCGs should take into account their ability to meet the requirements set out in Section 4, and whether their operating model has a sufficient degree of interdependence that their application should be considered concurrently with other applicant CCGs. If this is the case, all applicant CCGs involved should go through authorisation together, although their applications will be considered separately. Aspiring CCGs should discuss the intended timing of their application with their SHA. Aspiring CCGs where possible should inform the NHSCBA authorisation team of their intentions by 30 April 2012. There may be some subsequent discussions to manage the flow of applications once all aspiring CCGs' intentions are known. Once the timing of the application has been agreed, applicant CCGs will be asked to identify the respondents to be invited to participate in a 360° stakeholder review, and site visit dates will be agreed.

6.3 Aspiring CCGs who are not ready or willing to apply for full authorisation in 2012-13 will still need to apply for establishment as a CCG. Doing so enables the NHSCB, should it consider it appropriate to grant an application for establishment, to make arrangements for another party to assume temporary responsibility for commissioning for the geographic area of that shadow CCG. Conditions imposed or directions given to a shadow CCG may be revised, or varied or removed or revoked (as the case may be), when the shadow CCG is ready to become fully authorised. Further details as to the procedure related to this will be published separately at a later date.

Section 7

Authorisation outcomes

7.1 All applicant CCGs will get a letter setting out findings from the authorisation assessment process, and the decision taken. Once the outcome of authorisation is known, the focus will be on ensuring a safe and managed transition from PCTs to CCGs on 1 April 2013.

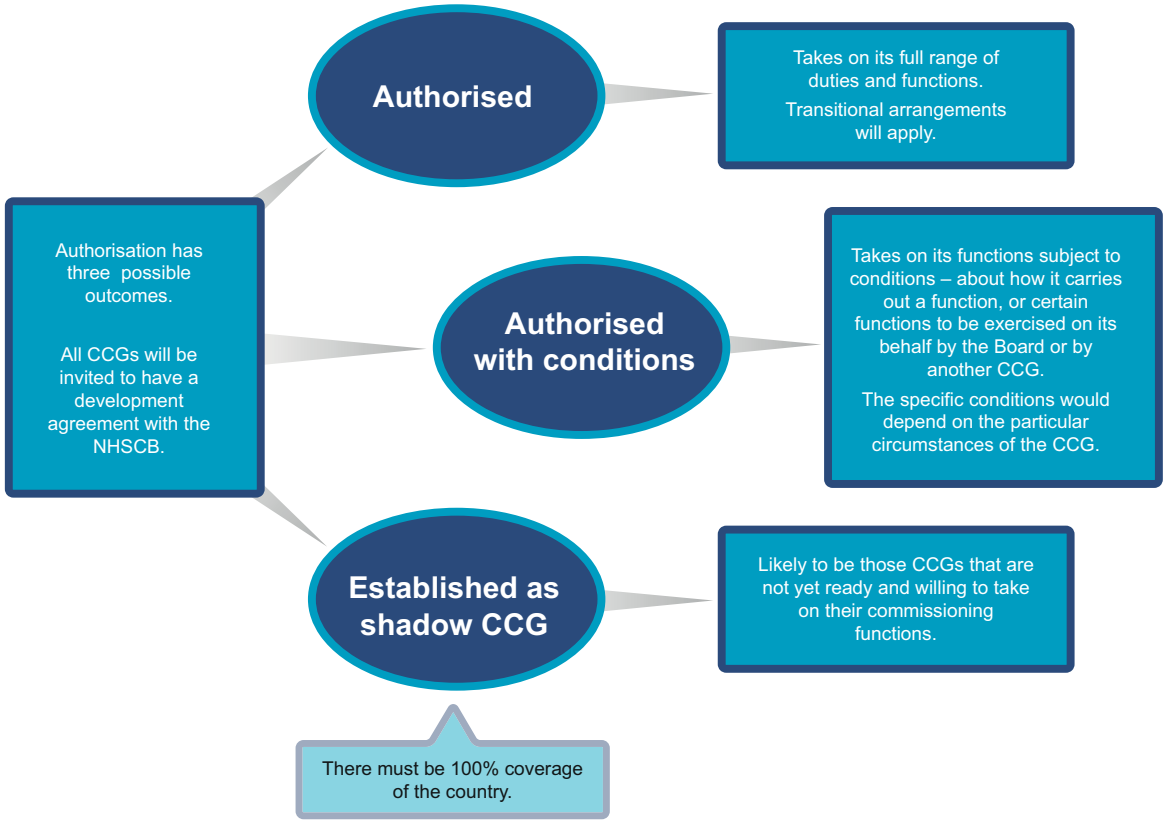
7.2 In practice, PCT clusters will ensure that relevant staff, premises, IM&T and other resources and assets are put at the disposal of CCGs, in preparation for full transfer to authorised CCGs on 1 April 2013.

7.3 At the time of authorisation, in order to promote and support the development of all CCGs wherever they are on their development journey, CCGs will be invited to agree a development agreement with the NHSCB. The agreement will reflect the local challenge and context in which the CCG operates (e.g. financial challenge or major reconfiguration plan for acute services).

7.4 Development agreements may take into account advice from clinical senates, where established, on how CCGs can develop their collaborative commissioning capability to deliver major change, or on how they can improve the extent and range of multi-professional input into commissioning decisions, or on local challenges and context.

7.5 The threshold for authorisation will be the same for all CCGs. However, the development agreement for those CCGs with a particularly challenging environment or inheritance will reflect the additional support they need. This reflects the NHSCB's intention to support all CCGs to improve continuously as organisations, and to support CCGs to innovate and spread the adoption of leading edge practice. All CCGs will have on-going monitoring and an annual review through an accountability framework. If a CCG is authorised with conditions, then it will also agree with the NHSCB a time-limited rectification plan for removal of those conditions.

Fig. 3 Possible outcomes of authorisation



Possible outcomes

Fully authorised

7.6 The CCG has demonstrated to the NHSCB that it satisfies all the requirements set out in legislation.

7.7 A list of the powers and duties that CCGs will have from April 2013 are set out in *The Functions of CCGs*. The CCG will be invited to agree a development plan with the NHSCB that is consistent with the potential beyond authorisation set out for each domain.

Authorised with conditions

7.8 If the CCG has not fully satisfied the NHSCB that it meets all the thresholds for authorisation, the Board may give it conditional authorisation by setting conditions or directing the CCG not to carry out certain functions or about how it carries out any of its functions. Further details will be set out in regulations. Conditions or directions will be specific to the particular requirements that have not been satisfied, and proportionate to the level of risk associated with the relevant function.

7.9 The NHSCB will set out how any condition or direction will be monitored and at what periods it will be reviewed. There will be a clear timetable for removal of all conditions and hence for full authorisation. The Act calls this 'a grant of initial application'.

7.10 There may be a wide variation within this category, as there is no upper or lower limit on the number of conditions. For example, if the CCG mainly meets the criteria for authorisation, and the NHSCB assesses that it is very close to meeting all of them, there may be very few minor conditions. It is possible that the CCG will fulfil these (and therefore be fully authorised) before April 2013.

7.11 At the other end of the spectrum, if a CCG has some significant areas where it does not meet the criteria, the NHSCB may assess that the CCG needs temporary additional support to develop and deliver. The NHSCB sector will determine the most effective source of support which might include putting specific management support in the CCG, the option of placing a representative on the CCG governing body for oversight, and assurance or temporarily 'junior partner' status in collaborative commissioning arrangements may be agreed where necessary. The NHSCB could make full alternative arrangements for the commissioning of some services. A time-limited rectification plan for removal of conditions will be agreed between the CCG and the NHSCB. The development agreement will be broader and reflect individual requirements and local challenges and circumstances. All conditions will be consistent with the thresholds in section 4.

Established but not authorised – shadow CCGs

7.12 Legally these CCGs have the same status as CCGs that are described here as established 'with conditions' but the term is used operationally where the conditions are significant and it cannot properly be described as authorised to take on its functions as a CCG, i.e. it is established but not authorised. The NHSCB will make alternative arrangements for commissioning for that population from April 2013 until the shadow CCG is ready to move forward to authorisation.

7.13 The NHSCB role is to ensure that the local population is protected and well served and it will make arrangements to this end. To do this, it may decide to make commissioning decisions itself on behalf of the shadow CCG, or make arrangements for another CCG to make those commissioning decisions. It is likely that, under these circumstances, the NHSCB would place a senior management team in the CCG to ensure delivery but also to support development.

7.14 In essence, a shadow CCG is a placeholder for a particular population, administered on its behalf by the NHSCB (or by another CCG) while the CCG gets itself ready and willing to take on its commissioning responsibilities. The shadow CCG and the NHSCB will agree a clear plan to get to the point of authorisation, with timescales and support in place to achieve this.

7.15 *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.

On-going assurance

7.16 The accountability framework will align with the criteria for authorisation and will flow directly on from the authorisation process. The development agreement that it is intended every CCG will be invited to agree with the NHSCB, regardless of its authorisation status, will form an important part of on-going assurance. Details of the accountability framework will be published later in the year.

Section 8

Next steps

Transition from PCTs to CCGs

8.1 This draft guidance is published by the NHSCBA to enable aspiring CCGs to determine the timing of their application for authorisation and to prepare that application. It is anticipated that final guidance will be published by NHSCB, at the same time as implementation by the Government of secondary legislation (regulations) on CCG establishment. This draft guidance reflects the current legal position. A decision to issue final guidance and its contents would be a matter for the NHSCB, but in the view of the NHSCBA other than updating this draft where legislative provision or policy change necessitates amendment, it is anticipated that any final guidance would otherwise be substantively the same as this draft guidance. As the NHSCB will not be established until October 2012, this draft guidance by the NHSCBA does not prejudge any decision the NHSCB may take about the establishment and authorisation of CCGs.

8.2 In the meantime, there is much to be done collectively to prepare for the new system. This is set out below.

Aspiring CCGs

- Should use this guide to assess their readiness for authorisation and determine their developmental path
- Should maximise the use of the risk assessment and development checklists to help tailor their development plans
- Should in partnership with SHA clusters decide when they wish to apply for authorisation, taking account of the thresholds for authorisation set out in this document
- Should discuss the timing of their application with their SHA and inform the NHSCBA of their intention by 30 April 2012. Aspiring CCGs that are not willing or ready to apply for full authorisation before April 2013 should notify their SHA of this by the same date.

PCT clusters

- Should maximise responsibilities delegated to aspiring and established CCGs in 2012-13 within their delegated powers
- Should ensure that aspiring CCGs have the appropriate management support either assigned directly to them or working across several groups
- Should ensure that all aspiring CCGs have a development plan in place, based on the self-assessment diagnostic tool and in line with their trajectory for authorisation
- Should continue to support aspiring CCGs to develop a track record of delivery in preparation for authorisation, with particular emphasis on the domains detailed in this document
- Should continue to support aspiring CCGs to ensure they are engaged appropriately in the development of the local health and wellbeing board, and have a leading role in the refresh of JSNAs and JHWS.

SHA clusters

- Should work with aspiring CCGs to agree their current state of preparedness and agree their trajectory towards authorisation, including the timing of applications
- Should ensure that PCT clusters continue to support CCG development, including the delegation of responsibilities and assignment of staff to ensure that CCGs are given the resources to maximise their development, and in line with the level of delegated responsibility they are taking on.

NHSCB guidance and support

8.3 A range of policy, guidance and toolkits to help aspiring CCGs in their progress towards authorisation are either already available or scheduled to appear over the coming months. See Annex E for a list of the support available to CCGs in producing the evidence required for authorisation. Details of further support materials are available on the pathfinder learning network website.

8.4 A final draft of this applicants guide will be published following the establishment of the NHSCB. The intention is that the final version of this guide will only differ from this version where legislative change necessitates amendment.

Annex A

Application form for authorisation as a clinical commissioning group

This annex sets out the proposed application form that CCGs will be required to complete and attach to their formal application for authorisation. It is indicative and will be finalised following the passage of regulations made under the Act.

Instructions on completing this form

This form should be completed electronically and be sent to the application email address CCGauthorisation@nhs.net

By the time of application it is intended that there will be an online secure portal where applications and supporting documentation can be uploaded. We will communicate the details of this to aspiring CCGs.

Contents **Page**

Statement on the Data Protection Act

You must sign the statement below. If you do not we will have to return your application.

I understand that the NHS Commissioning Board will use the information provided on this form (including personal data) and other relevant information that we obtain or receive, for the purposes of assessing this application for authorisation and to support its wider functions including CCG development and oversight.

Information (including personal data) may also be shared with other public bodies where necessary or expedient to assist in the exercise of public functions.

Personal data is processed in accordance with the Data Protection Act 1998.

If you are submitting this form electronically, we will accept a typed-in name as your signature.

*Name of CCG	
*Designate Chair's signature	
*Designate Chair's name	
*Nominated Accountable Officer's signature	
*Nominated Accountable Officer's name	
*Date (dd/mm/yy)	

*obligatory information

Application details

Details of the aspiring clinical commissioning group (CCG) applying for authorisation	
*Name	
*Main address line 1	
*Main address line 2	
*Town/city	
*County	
*Postcode	
*Email address	
Website	
*Main telephone	
Fax (if available)	

*obligatory information

This address will also be used for all correspondence during the authorisation process. If you want us to use a different address for correspondence regarding this application, please provide further details below. We will use this address to ask for more information, and to return incomplete applications and unnecessary documents.

Alternative correspondence address	
Name	
Organisation	
Address line 1	
Address line 2	
Town/city	
County	
Postcode	

Nominated Accountable Officer	
*Title	
*First name	
Middle name (if applicable)	
*Last name	
Previous name (if applicable)	
*Job title	
*Business address line 1	
*Business address line 2	
*Town/city	
*County	
*Postcode	
*Email	
*Main business telephone	
Fax	

*obligatory information

CCG practice membership For each GP practice who is a member of your CCG you should provide the practice name, code, address and confirmation that at the time of application each practice is a provider of primary medical services. Please give each GP practice a number so that we know you have sent us information about all your constituent practices.	
Number of constituent GP practices in CCG	
Total population size covered by CCG	

Practice name	Code	Address	Confirmation that at the time of application practice is a provider of primary medical services

Declarations of compliance

Applicants are asked to self-certify compliance with the following statements as part of this application. In undertaking this declaration applicant CCGs will be expected to be aware of the legal, regulatory and policy positions that exists at the point of application. A copy of the declaration of compliance should be made available on the CCG's website, or otherwise made available for public review together with key documents such as the CCG's constitution if a website is not yet in place.

Should an applicant CCG be found to have knowingly misrepresented its position it will automatically fail in its authorisation application. Once authorised, compliance will be monitored through on-going assurance. Should non-compliance be subsequently identified, this will be managed through on-going assurance of the CCG by the NHSCB.

Promotion of research and treatment costs of patient participation in research	
We declare that our CCG understands and will comply with our statutory responsibilities regarding promoting research; and that we are committed to following the policy of ensuring that the NHS meets the treatment costs for patients who are taking part in research funded by Government and research charity partner organisations.	

Commitment to have regard to, and promote the NHS Constitution	
We declare that our CCG will have regard to and promote the NHS Constitution.	

Procurement	
We declare that at the point of authorisation our CCG will be compliant with current procurement requirements, and will have systems in place to discharge these requirements.	

Choice and shared decision-making	
We declare at the point of authorisation our CCG is aware of its statutory duties to, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of their care and to promote the involvement of individual patients, and their carers and representatives, in decisions about their care and treatment.	

Inheritance from primary care trusts	
We declare that our CCG has quantified, identified and understood its likely inheritance from PCT(s) and has taken all steps to ensure that robust transition arrangements are in place.	

Public sector equality duty	
We declare that at the point of authorisation our CCG will be compliant with the public sector equality duty and can demonstrate the use of the EDS (or equivalent) to help attain compliance and ensure good equality performance.	

Education and training	
We declare that at the point of authorisation our CCG will demonstrate commitment to the education and training of the NHS workforce. We agree to work in partnership with the local education & training boards to ensure that the system for the planning, commissioning and delivery of education and training is able to respond to service commissioning priorities.	

Sustainability	
We declare that at the point of authorisation our CCG will demonstrate commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner.	

Innovation	
We declare that from 1 April 2013 our CCG will have robust arrangements in place to champion innovation and adoption of innovation.	

Commissioning support	
We are aware of our duties as a statutory body to conduct a formal procurement for any commissioning support we wish to use, within a reasonable timescale; and that we will need to begin preparing for that procurement from April 2013.	

Statutory responsibilities In line with the Health and Social Care Act 2012, CCGs will be required to comply with other related acts of Parliament and secondary legislation. These requirements are set out in the functions document[4].	
We declare that at the point of authorisation our CCG will be compliant with all its statutory responsibilities.	

[4] *The Functions of Clinical Commissioning Groups.*

Detailed commissioning arrangements

Capability and capacity to commission	
We declare that from 1 April 2013 our CCG will have the capability and the capacity to commission key areas of care for which we are responsible.	

In this section you should outline your CCG's commissioning arrangements for each of the eight areas below.

Mothers and newborns

People with need for support with mental health

People with learning disabilities

People who need emergency and urgent care

People who need routine operations

People with long-term conditions

People at the end of life

People with continuing healthcare needs

Application declaration

This declaration must be signed for the CCG by the nominated Accountable Officer and the designate Chair of the governing body.

We hereby declare that the information detailed in this application is true and accurate.

We understand that it is our responsibility to inform the NHS Commissioning Board of any information that is relevant to our application and which may not have been requested, and to update this information accordingly. We have kept a copy of all the information submitted in our application for our records.

In making this application for authorisation with the NHS Commissioning Board, we agree to comply with the Health and Social Care Act 2012 and associated regulations.

We understand that non-compliance with the relevant legislation could lead to the refusal of this application or intervention by the NHS Commissioning Board once authorised.

Please check or tick this box to confirm that the CCG's governing body members have seen and agreed the contents of this application	

If you are submitting this form electronically, we will accept a typed-in name as a signature.

*Nominated Accountable Officer's signature	
*Nominated Accountable Officer's name	
*Date (dd/mm/yy)	
*Email address	
*Job title	

*Designate Chair of the governing body's signature	
*Designate Chair of the governing body's name	
*Date (dd/mm/yy)	
*Email address	
*Job title	

*obligatory information

How to submit this application and accompanying documents

Please submit this application to the NHS Commissioning Board, making sure that all required additional forms and documents are included.

The checklist below lists the documents that you need to include with the application.

Form or document	Done
Authorisation application form	
Proposed CCG constitution and any other documents detailing governance arrangements (please specify)	
CCG organisational structure	
Letter of support for proposed Chair of CCG governing body	
Relevant minutes of multi-professional meetings, governing body and other committees	
Financial management arrangements compliant with national requirements	
Organisational development plan	
360° stakeholder survey report and CCG comment	
Draft Joint Strategic Needs Assessment	
Draft Joint Health and Wellbeing Strategy	
Relevant health and wellbeing board minutes and reports	
2012-13 Integrated Plan and draft commissioning intentions for 2013-14	
List of 2012-13 contracts agreed and signed off, via PCT clusters	
List of collaborative commissioning arrangements, joint commissioning draft agreements or plans, including pooled budgets, Section 75 agreements where appropriate	
SLA with assured support provider, where appropriate	
Case studies (please specify)	
Integrated risk management framework, including clinical, financial and corporate risk	
Communications and engagement strategy	
Equality and diversity strategy	
Other documents – list and state relevance to specific authorisation requirements	

Where to send the application

You should wherever possible email your completed form(s) and accompanying documents to CCGauthorisation@nhs.net

You must attach all forms and documents to the same email. By the time of application it is intended that there will be an online secure portal where applications and supporting documentation can be uploaded. We will communicate the details of this to aspiring CCGs.

If you do not submit all required forms and information, your application will be returned to you.

You can obtain further information on our website – www.commissioningboard.nhs.uk.

Annex B

Evidence required by source document

Evidence to be developed in pre-application phase

This evidence will be assessed either by self-certification or via the desk top review.

Evidence for authorisation	Domain reference
Constitution and any other documents detailing governance arrangements	
CCG has clearly articulated its shared mission, values and aims for improving quality.	1.1
All members specified in the constitution will be providers of primary medical services on the date the CCG is established. Configuration is appropriate. CCG proposed constitution has been signed off by member practices. Member practices are involved in decision-making processes and, where appropriate, there are clear arrangements for delegation of functions. CCG has safeguards and agreed ways to manage potential conflicts of interest including register of interests.	1.2
Systems and processes for monitoring and acting on patient feedback, and particularly in identifying quality including safety issues.	2.2
Accountability between CCG and member practices is reflected in its constitution and in any broader governance arrangements.	2.3
Arrangements for handling complaints raised with the CCG are compliant with the statutory framework for complaints handling. Arrangements for handling concerns raised with the CCG deliver equivalent outcomes. Clear line of accountability for patient safety including regular reporting to the National Reporting and Learning System.	2.4.2
Plans clearly demonstrate where and how the CCG is working with other CCGs to meet QIPP, and can demonstrate that stakeholders are aware of and understand CCG priorities.	3.1.2
CCG has arrangements in place to collaborate with neighbouring CCGs in areas such as lead commissioning where there is more than one CCG contracting with a provider. On-going discussions between the CCG and provider organisations about long-term strategy and plans.	3.3

Evidence for authorisation	Domain reference
Constitution and any other documents detailing governance arrangements	
Constitution complies with requirements of Part 1 of Schedule 1A of Health and Social Care Act. Constitution is 'otherwise appropriate', i.e. complies with regulations and takes account of guidance and the model constitution. CCG governance meets the requirements of legislation and takes account of guidance and the model constitution. CCG has an appropriate geographical area.	4.1
Governance arrangements in place to identify and manage different types of risk, including key risks to the delivery of QIPP. Systems and processes for monitoring and acting on patient feedback, and particularly identifying early quality issues, including safety. Arrangements in place to monitor quality issues, including safety in an on-going way. Quality issues are discussed regularly by CCG governing body. CCG has arrangements in place to proactively identify early warnings of a failing service. Arrangements in place to deal with and learn from serious untoward incidents and never events. Clear governance structures and programme management capacity and capabilities in place to support the delivery of QIPP.	4.2.1
At least one identified individual or committee is formally responsible for ensuring the CCG has regard for the need to reduce health inequalities in access to, and the outcomes from healthcare. CCG has established appropriate systems for safeguarding.	4.2.3
For CCGs developing significant internal capacity and/or shared services, these arrangements have been quality assured through an analogous process to BDU business review process.	4.3.1
CCG has assessed its information requirements and planned capacity/capability to deliver those requirements. CCG has used NHS Information Governance toolkit to assess its capability to meet information governance requirements.	4.3.3
CCG has written agreements in place detailing the scope of the collaboration with other CCGs, with clear lines of accountability and decision-making processes. Mechanisms in place for CCG to collaborate with others where patient flow or provider configuration necessitates this.	5.1
Clear line of accountability for safeguarding is reflected in CCG governance arrangements, and CCG has arrangements in place to co-operate with the local authority in the operation of the Local Safeguarding Children Board and the Safeguarding Adults Board.	5.3

Evidence for authorisation	Domain reference
Constitution and any other documents detailing governance arrangements	
CCG can demonstrate how they have identified their commissioning support intentions. For CCGs developing significant internal capacity/capability or shared services, the CCG has ensured the quality of those services.	5.4
Mechanism for working in partnership with NHSCB to improve quality of primary medical care, and particularly to take account of need and unexpressed demand. Mechanism for working in partnership with NHSCB to improve quality of specialised services.	5.5
Systems in place to sustain two-way accountability between members.	6.2
CCG reflects Nolan principles of good governance. Appointment process and composition of governing body reflects nationally determined role outlines, attributes and competencies and draws on good practice. CCG recommends appointment of governing body members.	6.4
Financial management arrangements compliant with national requirements	
CCG has the following standard financial management arrangements in place: • Internal and external audit • Financial reporting through financial spine • Audit committee • Standing orders/standing financial instructions • Scheme/s of delegation • Arrangements for management of any charitable funds • Committee structure including management and audit • Counter fraud arrangements • Accounts payable and receivable, cash, fixed assets • Payroll and banking facilities. • Appropriate risk-sharing arrangements with other CCGs in place and clearly understood by all parties.	4.2.1
2012-13 contracts	
2012-13 contracts with main providers agreed and signed off, via PCT clusters. CCG involved under delegated arrangements in 2012-13 contracting round, including in monitoring delivery of 2012-13 contract through regular liaison with main providers, and benchmarking providers. CCG has arrangements in place to manage all contracts that will be transferred from PCTs on/by 31 March 2013, or new contracts from 1 April 2013. CCG has systems in place to track performance of main providers.	3.3

Evidence for authorisation	Domain reference
CCG organisational structure	
Governance, decision-making and planning arrangements where quality is a priority and clinical views are foremost.	1.1
CCG governing body includes nurse and secondary care doctor.	1.3
CCG can demonstrate how its intended staff resource and any contracted commissioning support provide capacity and capability to deliver its full range of responsibilities.	4.3.1
CCG has plans in place to build or secure appropriate capacity and capability for internal and external communications required to deliver their commissioning plan.	4.3.2
CCG can demonstrate collaboration with other CCGs sharing employed staff/teams where appropriate.	5.1
CCG has secured the expertise of a designated doctor and nurse for safeguarding children and for looked after children, and a designated paediatrician for unexpected deaths in childhood. CCG has a safeguarding adults lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.	5.3
Lead clinicians selected from member practices for CCG commissioning priority areas.	6.2
Appointment process and composition of governing body reflects nationally determined role outlines, attributes and competencies and draws on good practice. CCG can demonstrate that it has assessed the skills possessed by governing body members and has a plan to build competencies/skills where required. Chief Finance Officer and Chair of governing body secured in line with national role outlines, attributes and competencies. Senior in-house management roles in CCG provide adequate capacity and capability to maintain strategic oversight with available resources. CCG has sufficient in-house capability to manage its commissioning support arrangements well.	6.4

Criteria to be assessed in application (self-certification) phase

Evidence for authorisation	Domain reference
CCG understands its statutory duties in relation to enabling patients to make choices and to promote the involvement of patients, carers and relatives in decisions about their care and treatment.	2.4.1
Commitment to have regard to and promote the NHS Constitution, including performance aspects.	3.1.1
Declaration that likely inheritance from PCT is quantified, identified, understood and robust transition arrangements in place.	3.1.4
Self-certification regarding understanding of requirements and legislation on procurement. CCG has arrangements in place to manage all contracts that will be transferred from PCTs on/by 31 March 2013, or new contracts from 1 April 2013.	3.3
CCG can demonstrate compliance with public sector Equality Duty, and is using the EDS or an equivalent to attain compliance and ensure good equality standards. CCG understands responsibility to champion innovation and adoption of innovation.	4.2.1
Commitment to promoting research and the use of research evidence. Commitment to promoting education and training given. CCG can demonstrate commitment to promoting environmental and social sustainability through their actions as a corporate body as well as a commissioner.	4.2.2
To commission improvements in quality, as described in the NHS Outcomes Framework: • Preventing people from dying early • Enhancing quality of life for people with long term conditions • Helping people recover from episodes of ill health or following injury • Ensuring that people have a positive experience of care; treating and caring for people in safe environments and protecting them from avoidable harm. The CCG has the capacity and capability to commission improved outcomes for the people it serves, including: • Mothers and newborns • People who need support for mental health • People with learning disabilities • People who need emergency and urgent care • People who need routine operations • People with long term conditions • People with continuing healthcare needs • People at the end of life.	4.3.1
CCG has plans in place for formally procuring any commissioning support services, to ensure that between 2013-16 it puts in place the arrangements to go through a compliant procurement process.	5.4

Criteria to be assessed during the desk top review

Evidence for authorisation	Domain reference
2012-13 integrated plan and draft commissioning intentions for 2013-14	
Governance, decision-making and planning arrangements where quality is a priority and clinical views are foremost.	1.1
CCG can demonstrate it has taken steps to communicate its vision and priorities to stakeholders, patients and the public.	1.4.1
CCG has mapped and analysed constituent communities and groups.	2.1.1
CCG integrated plan aligns with JHWS(s) and enables integrated commissioning, depending on local timeframes.	2.1.2
Systems in place to convert insights about patient choice/s in practice consultations into plans and decision-making.	2.4.1
CCG has a clear and credible integrated plan, which includes an operating plan for 2012-13, draft commissioning intentions for 2013-14 and a high-level strategic plan until 2014-15. CCG has detailed financial plan that delivers financial balance and any other requirements set by the NHSCB and is aligned with the commissioning plan. QIPP is integrated within all plans. Clear explanation of any changes to existing QIPP plans. CCG plan sets out how it aligns with national frameworks and strategies, including the NHS Outcomes Framework.	3.1.1
CCG can demonstrate that the process for developing its plans and priorities was inclusive and transparent.	3.1.2
Plans reflect JSNA, stakeholder engagement, and evidence/data analysis.	3.1.3
Where the area covered by the CCG is not on track to meet the plan for 2012-13, there is a clear and time-limited resolution path to recover.	3.1.4
CCG has arrangements in place to collaborate with neighbouring CCGs in areas such as lead commissioning where there is more than one CCG contracting with a provider.	3.3
Health inequalities issues identified and addressed in integrated plan.	4.2.3
Where the need for integrated commissioning has been identified by the health and wellbeing board and in the JHWS(s), CCGs are collaborating with the local authority(ties) to develop shared plans.	5.3
List of collaborative commissioning arrangements, joint commissioning draft agreements or plans, including pooled budgets, Section 75 agreements where appropriate	
Plans clearly demonstrate where and how the CCG is working with other CCGs to meet QIPP, and can demonstrate that stakeholders are aware of and understand CCG priorities.	3.1.2
Where the need for integrated commissioning and has been identified by the health and wellbeing board and in the JHWS(s), CCGs are collaborating with the local authority(ties) to develop shared plans.	5.3

Criteria to be assessed during the desk top review

Evidence for authorisation	Domain reference
SLA with assured support provider	
CCG demonstrates clear understanding of lines of accountability between it and its support provider/s. Agreement with support provider/s that has been assured through BDU business review process, or by the CCG through a procurement process. For CCGs developing significant internal capacity and/or shared services, these arrangements have been quality assured through an analogous process to BDU business review process.	4.3.1
CCG has plans in place to build or secure appropriate capacity and capability for internal and external communications required to deliver their commissioning plan.	4.3.2
SLA agreed with support provider assured through BDU business planning process. For CCGs developing significant internal capacity and/or shared services, the CCG has ensured the quality of those services.	5.4
CCG has sufficient in-house capability to manage its commissioning support arrangements well.	6.4
Minutes of multi-professional meetings	
Arrangements in place for CCG to involve and seek advice from healthcare professionals from secondary, community, mental health, learning disabilities and social care.	1.3
Relevant shadow health and wellbeing board minutes and reports	
CCG can demonstrate that it has taken steps to communicate its vision and priorities to partners, via its clinical leadership, through the local health and wellbeing board.	1.4.1
CCG is engaged in shadow health and wellbeing board, is participating in refresh of JSNAs and in development of the JHWS(s).	2.1.2
CCG has collaborated in the development of a shadow health and wellbeing board. CCG can demonstrate understanding of accountability and decision-making processes in health and wellbeing board.	5.2
Where the need for integrated commissioning has been identified by the health and wellbeing board and in the JHWS(s), CCGs are collaborating with the local authority(ties) to develop shared plans.	5.3

Evidence for authorisation	Domain reference
Relevant minutes of governing body and CCG committees	
Governance, decision-making and planning arrangements where quality is a priority and clinical views are foremost.	1.1
Systems and processes for monitoring and acting on patient feedback, and particularly identifying early quality issues, including safety. Arrangements in place to monitor quality and clinical care in an on-going way. Quality issues are discussed regularly by CCG governing body. CCG has arrangements in place to proactively identify early warnings of a failing service. Arrangements in place to deal with and learn from serious untoward incidents and never events.	4.2.1
Draft JSNA	
Arrangements in place between local authority(ties) and CCG specifying how public health advice to CCGs will be delivered.	1.3
Analysis of CCG constituent communities and groups' health needs is reflected in CCG integrated plan. CCG has outline plans in place to communicate and engage with strategic partners and diverse groups and communities	2.1.1
CCG integrated plan aligns with JHWS(s) and enables integrated commissioning, depending on local time frames.	2.1.2
Plans reflect JSNA, stakeholder engagement, and evidence/data analysis.	3.1.3
Through involvement in JSNAs and development of JHWS(s), CCG has identified opportunities to reduce inequalities.	4.2.3
CCG has collaborated in the refresh of the JSNAs and in the development of the JHWS(s), depending on local timeframe.	5.2
Draft JHWS	
CCG integrated plan aligns with JHWS(s) and enables integrated commissioning, depending on local timeframes.	2.1.2
CCG plan supports delivery of JHWS(s) and integrated commissioning, depending on local timeframe.	3.1.1
Through involvement in JSNAs and development of JHWS(s), CCG has identified opportunities to reduce inequalities.	4.2.3
CCG has collaborated in the refresh of JSNAs and in the development of the JHWS(s), depending on local timeframe.	5.2
Where the need for integrated commissioning has been identified by the health and wellbeing board and in the JHWS(s), the CCG is collaborating with the local authority(ties) to develop shared plans.	5.3

Evidence for authorisation	Domain reference
Organisational development plan	
CCG plans to train staff in recognising and reporting safeguarding issues.	4.2.3
CCG can demonstrate how its proposed staff resource and any contracted commissioning support will provide capacity and capability to deliver its full range of responsibilities.	4.3.1
Agreement with support provider/s that has been assured through BDU business review process, or by the CCG through a procurement process	4.3.1
CCG has assessed its communications capacity/capability requirements.	4.3.2
CCG has plans in place for formally procuring any commissioning support services, to ensure that between 2013-16 it puts in place the arrangements to go through a compliant procurement process.	5.4
CCG has completed OD diagnostic/self-assessment or equivalent. CCG has plans in place informed by the outcomes of a diagnostic self-assessment tool. Assessment of leadership potential and competency was included in selection process for CCG clinical leads, and there are high-level arrangements for succession planning.	6.1
CCG can demonstrate that it has assessed the skills possessed by governing body members and has a plan to build competencies/skills where required. CCG has sufficient in-house capability to manage its commissioning support arrangements well.	6.4
Positive assessment outcome for proposed Accountable Officer, Chief Finance Officer and Chair	
Accountable Officer selected in line with national role outline, attributes and competencies.	6.3
Chief Finance Officer and Chair of governing body secured in line with national role outlines, attributes and competencies.	6.4
Letter of support for Chair of Governing Body from members	
Documented support of members for Chair of governing body.	6.4

Evidence for authorisation	Domain reference
Integrated risk management framework, including clinical, financial and corporate risk	
Governance arrangements in place to identify and manage different types of risk, including key risks to delivery of QIPP. Clear governance structures and programme management capacity and capabilities in place to support the delivery of QIPP.	4.2.1
CCG has established appropriate systems for safeguarding.	4.2.3
Clear line of accountability for safeguarding is reflected in CCG governance arrangements, and CCG has arrangements in place to co-operate with the local authority in the operation of the Local Safeguarding Children Board and the Safeguarding Adults Board.	5.3
Communications and engagement strategy	
CCG can demonstrate it has taken steps to communicate its vision and priorities to stakeholders, patients and the public.	1.4.1
CCG has outline plans in place to communicate and engage with strategic partners and diverse groups and communities.	2.1.1
Arrangements in place to ensure appropriate on-going patient and public involvement in CCG decision-making.	2.2
Accountability between CCG and member practices is reflected in its constitution and any broader governance arrangements.	2.3
Systems in place to convert insights about patient choice/s in practice consultations into plans and decision-making.	2.4.1
Arrangements for handling concerns and complaints raised with the CCG, and actions taken as a result, are clearly communicated to the public.	2.4.2
Equality and diversity plan	
CCG can demonstrate compliance with the public sector Equality Duty and is using the EDS or equivalent to help attain compliance and ensure good quality performance.	4.2.1

Criteria to be assessed during the 360° stakeholder survey

Evidence for authorisation	Domain reference
Local authority views	
Arrangements in place between local authority(ties) and CCG specifying how public health advice to CCGs will be delivered.	1.3
CCG has engaged local authority/ties in establishing its geographic area.	2.1.2
Where the need for integrated commissioning has been identified by the health and wellbeing board and in the JHWS, CCGs are collaborating with the local authority to develop shared plans. Clear line of accountability for safeguarding is reflected in CCG governance arrangements, and CCG has arrangements in place to co-operate with the local authority in the operation of the Local Safeguarding Children Board and the Safeguarding Adults Board.	5.3
Health and wellbeing board members views	
CCG can demonstrate that it has taken steps to communicate its vision and priorities to partners, via its clinical leadership, through the local health and wellbeing board.	1.4.1
LINks/local HealthWatch and other patient groups' views	
Clinicians have taken steps to engage with LINks/local HealthWatch and other patient groups.	1.4.2
Positive feedback from LINks/ local HealthWatch and other patient groups.	1.4.2
Commissioning support provider/s views	
CCG can demonstrate how they have identified their commissioning support intentions.	5.4
Member practice views	
CCG members recognise local quality priority areas identified in CCG plans.	1.1
Member practices are involved in decision-making processes and, where appropriate, there are clear arrangements for delegation of functions. Examples of member practices involvement in decision-making.	1.2
Member practices understand at least at a high level their local plan and priorities. Member practices receive timely information to inform their involvement in CCG planning and monitoring delivery of those plans.	3.1.2
Systems in place to sustain two-way accountability between members.	6.2
Documented support of members for Chair of governing body.	6.4
Provider views	
On-going discussion between the CCG and provider organisations about long-term strategy and plans.	3.3
Multi-professional views	
Arrangements in place for CCG to involve and seek advice from healthcare professionals from secondary, community, mental health, learning disabilities and social care.	1.3

Evidence for authorisation	Domain reference
All respondents	
CCG can demonstrate it has taken steps to communicate its vision and priorities to stakeholders, patients and the public.	1.4.1
CCG can demonstrate that the process for developing its plans and priorities was inclusive and transparent. Plans clearly demonstrate where and how the CCG is working with other CCGs to meet QIPP, and can demonstrate that stakeholders are aware of and understand CCG priorities.	3.1.2

Criteria to be assessed from case studies

Evidence for authorisation	Domain reference
Examples of CCGs delivering measurable improvements in quality and productivity under delegated arrangements.	1.1
Examples of member practice involvement in decision-making.	1.2
Systems and processes for monitoring and acting on patient feedback, and particularly in identifying quality including safety issues.	2.2
Examples of CCG engaging different groups and communities through a range of communications channels in the development of its vision, plan, or in broader CCG decision-making processes.	2.3
Examples of CCGs successfully taking devolved responsibility for commissioning budgets and delivering improvements.	3.2
Examples of CCG involvement under delegated arrangements in 2012-13 contracting round.	3.3
Examples of CCG innovation.	4.2.1
CCG choice of case studies illustrates their approach and the impact they have had to date in at least one of the following patient groups: mothers and newborns; people with the need for support with mental health; people with learning disabilities; people who need planned interventions; people who need emergency and urgent care; people with long-term conditions; people with continuing healthcare needs; people at the end of life.	4.3.1
Examples of CCG collaboration with other CCGs and a multi-disciplinary range of clinicians.	5.1
Examples of CCG leadership development.	6.1
Examples where the CCG has enhanced clinical involvement in service redesign and improvement.	6.2

Annex C

360° stakeholder survey

This section sets out further detail on the 360° stakeholder survey that will form a central part of aspiring clinical commissioning groups' evidence for authorisation. It is designed to help CCGs understand how the survey will work, what role they will have and how they can respond to survey findings.

The survey itself will assess whether the foundations for key stakeholder relationships are present at the point of authorisation, and whether the relationships forged during transition are likely to provide sufficient basis for effective commissioning by CCGs.

Provider

Following an external invitation to tender, the NHSCBA has selected Ipsos MORI as the implementing agency for the 360° stakeholder survey. Ipsos MORI will contact participants and invite them to take part, synthesise participant responses and follow up non-responders. They will also provide a summary report for each CCG to submit to the NHSCB as part of the evidence base for authorisation. In addition, Ipsos MORI will provide email and telephone support for enquiries from both CCGs and survey participants.

Participants

For each CCG we will require input from the following stakeholder groups:

- All constituent GP member practices within your CCG
- Other CCGs (i.e. those involved in collaborative commissioning arrangements)
- (Shadow) health and wellbeing boards
- Local authorities
- LINks, (shadow) local HealthWatch and other patient groups
- NHS providers (including NHS Trusts and NHS Foundation Trusts)
- Clinical networks (and senates if established)
- Commissioning Support Services.

Format

Stakeholders will be asked to respond to a series of standard questions addressing how they perceive the aspiring CCG has fulfilled and will continue to fulfil the six domains of authorisation. In addition, as representatives from a specific stakeholder group, participants will be asked a number of bespoke questions linked to their specific relationship with the CCG in question.

Each nominated participant will receive an email invitation from Ipsos MORI to participate that will include a link to the survey website. Once connected to the website, the survey should take about 20 minutes to complete. Information materials explaining the process in more detail will be made available to participating stakeholders via a website to be launched shortly. Support to participants will also be made available through an email and phone enquiry service.

Role of the CCG

CCGs will be responsible for collecting and providing the contact details of all stakeholder participants for their area in a timely manner to Ipsos MORI using an online template. CCGs will need to obtain permission from the prospective participants to share their contact details with the third party agency for the purposes of the 360° stakeholder survey before these details are shared. CCG should also actively encourage stakeholders to participate in the survey, as their feedback will provide valuable input to the assessment of CCG applications for authorisation.

Survey timings

The 360° stakeholder survey will begin approximately six weeks before a CCG is scheduled to apply for formal authorisation. This timeframe allows surveys to be completed, the data analysed and the summary report finalised and commented in time for when the NHSCB will receive the authorisation application form and associated documents from a CCG. There will be four waves of surveys in line with the four application waves.

Survey results

A summary report will be written for each CCG summarising the feedback obtained from their list of stakeholder participants. This will be sent to the CCG for their comment prior to their application deadline. The CCG will then include the report and their comments within their formal application to the NHSCB.

Further details

Further guidance for CCGs and participants will be made available in due course.

Annex D

Legal requirements for establishment

This annex sets out in outline the legal basis for establishment and authorisation. The proposed content and process for authorisation is shaped by the legislative requirements under primary and secondary legislation. The secondary legislation is currently being prepared and will be subject to Parliamentary scrutiny. This section therefore seeks to highlight what is contained in the Health and Social Care Act 2012 on authorisation, as this may help aspiring clinical commissioning groups (CCGs), supported by PCT clusters and SHA clusters, prepare more effectively for the future. However, we cannot pre-judge the Parliamentary process around secondary legislation.

Once the relevant legislation comes into force, aspiring CCGs will be able to apply to the NHSCB to be established as statutory bodies. Our working assumption is that the NHSCB will come into being in October 2012, and at that point would be in a position to start making decisions on initial applications[5]. Before then, the NHSCBA will be able to carry out preparatory work and assessment for the NHSCB.

If the NHSCB is satisfied as to the full range of matters set out below, it must grant the application without any conditions[6]. However the NHSCB may direct that in the period before PCTs are abolished the CCG may only exercise those functions that are specified in the direction. This would not prevent the CCG from doing things that were necessary or expedient for the purpose of preparing it to exercise the function,[7] but reflects the fact that until PCTs are abolished, CCGs will carry out their commissioning functions under delegated authority as a result of arrangements made with PCTs[8].

This essentially means that from April 2013, when PCTs are due to be dissolved, the CCG in question could take on its full statutory responsibilities. We describe this as 'full authorisation'. Legally this is described as 'established without conditions'.

If the NHSCB is not fully satisfied as to the matters set out below, it may grant an 'initial application' placing conditions on the grant and/or making a direction that the CCG not exercise a specific function, or about how the CCG exercises any of its functions. The NHSCB may also itself carry out some function or functions on the group's behalf or arrange for another CCG to do so. We describe this as 'authorisation with conditions'. Legally this is described as 'established with conditions'.[9]

If necessary, the NHSCB could grant an 'initial application' but arrange for the NHSCB (or another CCG) to carry out ***all*** the commissioning functions of the group, until such time as the group was ready and willing to take on these functions. We describe this as a 'shadow' CCG. Legally this is described as 'established with conditions'.

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[5]An initial application is defined in the Health and Social Care Act 2012 as an application for establishment made under section 14B of the NHS Act 2006 made on a date between the date that section 25 of the Act is commenced and the date specified by the Secretary of State for the purposes of new section 14A of the NHS Act 2006, this is currently intended to be 1 April 2013. See paragraph 1 of Schedule 6 of the Act.

[6]See new section 14C of the NHS Act 2006 inserted by section 25 of the Health and Social Care Act 2012.

[7]See paragraphs 9 and 10 of Schedule 6 to the Act.

[8]Paragraph 11 of Schedule 6 to the Act.

[9]See paragraph 8 of Schedule 6 to the Act.

The specific areas that the NHSCB will be required to consider and be satisfied about in order to grant an application for establishment are that[10]:

- The constitution complies with the requirements of Part 1 of Schedule 1A to the NHS Act 2006 and is otherwise appropriate. These requirements include (but are not limited to) a requirement that the name of the CCG meets requirements that will be set out in regulations. Those requirements are likely to include that the name includes "NHS" and demonstrates a clear link to their locality
- The geographical area is appropriate – CCGs need to cover the whole of England without gaps and without overlapping
- The person proposed by the CCG to become the Accountable Officer is suitable
- Each of the members is or will be a primary medical services provider[11] on the date that the CCG would be established
- Appropriate arrangements are in place to ensure the CCG will be able to discharge its functions
- Arrangements are in place to ensure the CCG will have a governing body that satisfies the legislative requirements and is otherwise appropriate.

The table below sets out the relationship between the criteria given in this document and these matters:

	Criteria	Domain reference
14c(2)(a)	**Constitution** complies with the requirements of Part 1 of Schedule 1A and is otherwise appropriate	1.1, 1.2, 2.2, 2.3, 2.4.2, 3.1.2, 3.3, 4.1, 4.2.1, 4.2.3, 4.3.1, 4.3.3, 5.1, 5.3, 5.4, 5.5, 6.2, 6.4
14c(2)(b)	Each **member** specified in the constitution will be a provider of primary medical services on the date the CCG is established	1.2
14c(2)(c)	**Area** specified in the constitution is appropriate	1.2, 4.1
14c(2)(d)	Appropriate to appoint, as the **Accountable Officer** of the group, the person named in the application	6.3
14c(2)(e)	Applicants have made appropriate arrangements to ensure that the **CCG will be able to discharge its functions**	1.1, 1.3, 1.4, 2.1.1, 2.1.2, 2.2, 2.3, 2.4.1, 2.4.2, 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.2, 3.3, 4.2.1, 4.2.2, 4.2.3, 4.3, 5.1, 5.2, 5.3, 5.4, 5.5, 6.1, 6.2
14c(2)(f)	Applicants have made appropriate arrangements to ensure that the group will have a **governing body** which satisfies any requirements imposed by or under this Act and is otherwise appropriate	1.3, 4.1, 6.4

[10]See new section 14C of the 2006 Act inserted by section 25 of the 2012 Act. Secondary legislation may add other matters to this list.

[11]"primary medical services provider" will be defined by new section 14A(3) and (4) of the NHS Act 2006 and secondary legislation.

Each CCG will have a duty to arrange for the provision of the services and facilities listed in section 3(1) of the NHS Act 2006, to such extent as they consider necessary to meet the reasonable requirements of the persons for whom they have responsibility. In doing so, they must act consistently with the duty on the Secretary of State to promote a comprehensive health service, and the Secretary of State's mandate.

Each CCG will also have a power to commission such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement in the physical and mental health of the persons for whom it has responsibility or in the prevention, diagnosis and treatment of illness in these people (except where the NHSCB has a duty to arrange for the provision of a service or facility).

In addition, the Act places a range of further duties on each CCG. These are set out more fully in the document *The Functions of CCGs* and include but are not limited to duties in relation to:

- Exercising its functions effectively, efficiently and economically
- Ensuring that expenditure and use of resources do not exceed the limits set by the NHSCB
- Acting consistently with the duty on the Secretary of State, and the NHSCB, to promote a comprehensive health service, and with the mandate
- Exercising its functions with a view to seeking continuous improvement in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience
- Assisting and supporting the NHSCB in securing continuous improvement in the quality of primary medical services
- Having regard, in the exercise of its functions, to the need to reduce inequalities between patients with respect to their ability to access health services and with respect to the outcomes achieved for them
- In the exercise of its functions, promoting the involvement of patients, their carers and representatives in decisions about the provision of health services to patients
- In the exercise of its functions, acting with a view to enabling patients to make choices about their care
- Obtaining advice from individuals who taken together have a wide range of professional expertise in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health
- Involving the public in the planning of commissioning arrangements and in developing, considering and making decisions on any proposals for changes in commissioning arrangements that would have an impact on service delivery or the range of services available
- Co-operating with relevant local authorities, including participating in local health and wellbeing boards, and assisting with the preparation of Joint Strategic Needs Assessments and agreeing a JHWS
- Exercising its functions with a view to securing that health services are provided in an integrated way, or that the provision of health services is integrated with the provision of health-related or social care services, where the CCG considers that this would improve the quality of services, or reduce inequalities
- In the exercise of its functions, promoting innovation in the provision of health services
- In the exercise of its functions, promoting research on matters relevant to the health service, and the use of evidence obtained from research

- Having regard, in exercising its functions, to the need to promote education and training to persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England
- Having regard to the NHS Constitution and acting, in the exercise of its function, with a view to securing that health services are provided in a way which promotes the NHS Constitution, and to promote awareness of the NHS Constitution among patients, staff and the public
- Adhering to requirements when commissioning services in relation to good procurement practice, the promotion of patient choice and the prevention of anti-competitive behaviour that works against patients' interests
- Preparing an annual commissioning plan for each financial year and an annual report after the end of the financial year.

The Health and Social Care Act sets out that every CCG will have a defined geographic area and:

- Must cooperate with the relevant local authorities and be a member of and cooperate with health and wellbeing boards for that area
- Be responsible for people who are usually resident within the area and are not registered with a member of any CCG, in addition to being responsible for the registered patients of members of the CCG.

Regulations will provide that a CCG is responsible for commissioning emergency care for everyone present in that area.

Annex E

Support available

This annex reflects current available support materials and will updated as necessary on the NHS Commissioning Board Authority website at www.commissioningboard.nhs.uk/resources/resources-for-ccgs. CCGs are asked to self-certify their compliance in a number of areas as part of the assessment for authorisation. In undertaking this declaration, CCGs will be expected to be aware of the legal, regulatory and policy position that exists at the point of application.

Form or document to submit	Resources	Description	Further support
CCG constitution and any other documents detailing governance arrangements (please specify)	*Developing CCGs: Towards Establishment* http://www.commissioningboard.nhs.uk/files/2012/01/NHSCBA-02-2012-6-Guidance-Towards-establishment-Final.pdf	Sets out the arrangements a CCG needs to put in place to be established.	*National Leadership Council development tool for good governance,* July 2011 http://www.nhsleadership.org/workstreams-commissioning-governance.asp
	Clinical commissioning group governing members: role outlines, attributes and skills www.commissioningboard.nhs.uk/resources/resources-for-ccgs	Sets out suggested role outlines, attributes and skills for CCG governing body members.	
	Model Constitution Framework. This includes templates for: a. Standing orders b. Prime financial policies c. Scheme of reservation and delegation www.commissioningboard.nhs.uk/resources/resources-for-ccgs	Model constitution and supporting documents for CCGs to adopt and adapt as appropriate.	*NHS Audit Committee Handbook, May 2011* http://www.hfma.org.uk/download.ashx?type=infoservice&id=471
	Clinical commissioning group governing body committees: Terms of Reference Templates www.commissioningboard.nhs.uk/resources/resources-for-ccgs	Model templates to assist CCGs in the establishment and set-up of their governing body committees.	
	Quality including patient safety: *National Reporting and learning service* http://www.nrls.npsa.nhs.uk	Information about a national safety reporting system run by the National Patient Safety Agency. NPSA receive confidential reports of patient safety incidents from healthcare staff across England and Wales.	

Form or document to submit	Resources	Description	Further support
	Early Warning Systems in the NHS Review of early warning systems in the NHS, National Quality Board Feb 2010 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113021.pdf	National Quality Board review of the systems and processes in place for the NHS for safeguarding quality and preventing serious failures. The report sets out how the system should work in the future in order to prevent serious failures in quality.	
	Safeguarding and Mental Capacity Act *Working Together to Safeguard Children: A guide to inter-agency working,* Mar 2010 – revised version due autumn 2012 https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN.pdf *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act,* Mar 2007 (under revision with *Working Together to Safeguard Children*) https://www.education.gov.uk/publications/eOrderingDownload/DFES-0036-2007.pdf *Statutory Guidance on Promoting the Health and Well-being of Looked After Children*, Nov 2009 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108592.pdf *Accountability framework for safeguarding children in the reformed NHS,* due May 2012	Suite of statutory and non-statutory guidance documents on arrangements for safeguarding children.	

Form or document to submit	Resources	Description	Further support
	Statement of Government Policy on Adult Safeguarding, 2011 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126748 *Mental Capacity Act 2005: Code of Practice* http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf *Mental Capacity Act 2005: Deprivation of liberty safeguards* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476	This document sets out the Government's policy on safeguarding vulnerable adults. It includes a statement of principles for use by local authority Social Services and housing, health, the police and other agencies for both developing and assessing the effectiveness of their local safeguarding arrangements. The Code of Practice contains guidance on the deprivation of liberty safeguards. It is particularly intended to provide guidance for professionals involved in administering and delivering the safeguards, who are under a duty to have regard to the Code.	
CCG organisational structure	*The Functions of Clinical Commissioning Groups* www.commissioningboard.nhs.uk	Sets out the functions a CCG is responsible for exercising.	
Draft joint strategic needs assessments, draft joint health and wellbeing strategies	*JSNAs and joint health and wellbeing strategies, draft guidance,* January 2012 http://healthandcare.dh.gov.uk/files/2012/01/JSNAs-and-joint-health-and-wellbeing-strategies-draft-strats.pdf	Draft guidance on the roles for clinical commissioning groups and their partners in refreshing the JSNA and developing the joint health and wellbeing strategies.	National Learning Network for health and wellbeing boards http://www.communities.idea.gov.uk/comm/landing-home.do?id=10113659
Financial management arrangements compliant with national requirements	*Financial governance framework including templates,* spring 2012	A framework for CCGs to discharge their financial functions.	

Form or document to submit	Resources	Description	Further support
Organisational development plan	*Self-assessment diagnostic tool* http://healthandcare.dh.gov.uk/diagnostic-tool-for-emerging-clinical-commissioning-groups	A tool to help CCGs identify their development needs from which to build its OD plan.	Refresh of the self-assessment diagnostic tool, spring 2012
SLA with assured support supplier	*Developing commissioning support: towards service excellence,* February 2012 http://www.commissioningboard.nhs.uk/files/2012/01/NHSCBA-02-201208-Guidance-Towards-service-excellence-Appendix-A.pdf	Guidance for commissioning support organisations that can also be used by CCGs to inform their commissioning support requirements.	
2012-13 integrated plan and draft commissioning intentions for 2013-14	*NHS Operating Framework 2012-13 and integrated planning guidance* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360° *Guidance on delegation of commissioning responsibilities* http://healthandcare.dh.gov.uk/delegation	Guidance for PCT clusters and CCG on national priorities and process. Co-produced with the NHS, this guidance supports emerging CCGs to operate under delegated authority.	*NHS Atlases of variation, Health Investment Framework* http://www.rightcare.nhs.uk/index.php/nhs-atlas *Health Poverty Index* http://www.hpi.org.uk *National Support Team for Health Inequalities "How To" Guides,* available http://www.institute.nhs.uk/commissioning/general/health_inequalities_national_support_team_resources.html
List of collaborative and joint commissioning agreements, including section 75 agreements	*NHS and local government as partners in commissioning for health and wellbeing,* Department of Health http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs (Annex B, section 2 – Developing commissioning support: Towards service excellence)		

Form or document to submit	Resources	Description	Further support
Communications and engagement strategy	*Communications self-assessment tool,* Spring 2012 *'PPE resources on the Commissioning Zone and Pathfinder Learning Networks, including Better Health, Better Experience, Better Engagement* http://healthandcare.dh.gov.uk/better-health *Engagement Cycle* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098658	Set of resources that set out good practice on patient and public engagement.	*NHS Institute/ RCGP guides on patient and public involvement in clinical commissioning* http://www.rcgp.org.uk/pdf/Effective_PPI.pdf *Dr Foster tools for helping to make sense of patient feedback* http://www.drfosterhealth.co.uk/patient-experience Bringing Commissioning and community development approaches together http://www.healthempowermentgroup.org.uk
Equality and diversity strategy	*Essential guide to public sector Equality Duty,* Equality and Human Rights Commission http://www.equalityhumanrights.com/uploaded_files/EqualityAct/PSED/essential_guide_guidance.pdf *Equality delivery system* http://www.eastmidlands.nhs.uk/eds	The Equality Delivery System supports NHS organisations to meet the requirements of the public sector Equality Duty.	
Cross-cutting resources to support CCG self-certification areas Patient recruitment to and participation in research	*National Institute for Health Research* http://www.nihr.ac.uk	Information about health research.	

Form or document to submit	Resources	Description	Further support
Commitment to have regard to and promote the NHS Constitution	*NHS Constitution* http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/overview.aspx	The constitution brings together in one place details of what staff, patients and the public can expect from the NHS. It also explains what individuals can do to help support the NHS, help it work effectively, and help ensure that its resources are used responsibly.	
Public Sector Equality Duty	*Equality delivery system* http://www.eastmidlands.nhs.uk/eds	The Equality Delivery System supports NHS organisations to meet the requirements of the public sector Equality Duty.	
Intelligence and Information Governance	*Information governance training tool* https://www.igte-learning.connectingforhealth.nhs.uk/igte/index.cfm https://www.igt.connectingforhealth.nhs.uk	This tool is an online training resource that enables organisations to meet annual training requirements mandated for all of the public sector by government.	
	Commissioning Intelligence Self-Assessment Tool (CISAT), April 2012	The Commissioning Intelligence Self-Assessment Tool should enable CCGs to evidence their commissioning decisions more effectively and improve outcomes for patients.	
Procurement	*Principles and rules for co-operation and competition,* July 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118221	This document sets out revised principles and rules for co-operation and competition in commissioning and provision of NHS services.	

Form or document to submit	Resources	Description	Further support
Choice and shared decision-making	*White paper, Equity and excellence: Liberating the NHS* http://www.official-documents.gov.uk/document/cm78/7881/7881.pdf *Liberating the NHS: Greater choice and control* http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651	The Government's White Paper, Equity and Excellence: Liberating the NHS sets out proposals around shared-decision making and around choice. The consultation documents explain the proposals in more detail.	
Sustainability	*A guide to sustainable development for clinical commissioning groups* http://www.sdu.nhs.uk/documents/publications/SD_for_CCGs.pdf	Produced by the RCGP and the NHS Sustainable Development Unit, this document is designed to help CCGs establish commissioning structures and processes that will deliver business profitability, longevity and resilience.	
Innovation	*Innovation, Health and Wealth: Accelerating adoption and diffusion in the NHS* http://www.dh.gov.uk/health/2011/12/nhs-adopting-innovation	The report sets out a delivery agenda for spreading innovation at pace and scale throughout the NHS. This report requires all NHS organisations to build the actions set out into their planning processes for 2012-13.	
Statutory responsibilities of CCGs	*The Functions of Clinical Commissioning Groups* www.commissioningboard.nhs.uk		

Annex F

Glossary

Authorised: A CCG that is established and that has fully satisfied the NHSCB of the matters set out in the Act as is necessary in order for an application to be granted without conditions.

Authorised with conditions: If the CCG has not fully satisfied the NHSCB that it meets all the thresholds for authorisation, the NHSCB may give it conditional authorisation by setting conditions or directing the CCG not to carry out certain functions or about how it carries out any of its functions. Further details will be set out in regulations. Conditions or directions will be specific to the particular requirements that have not been satisfied, and proportionate to the level of risk associated with the relevant function.

BDU – Commissioning Support: The Business Development Unit (BDU) will sit within the NHS Commissioning Board and has two key roles. The first is to drive the overall development and transformation of commissioning support services (CSS) from their current PCT-hosted models and driving the necessary culture change. Secondly, to provide assurance to both the NHSCB and CCGs that the CSS models are capable and sufficiently commercially robust and are truly responsive to their customers' needs.

Commissioning Outcomes Framework (COF): A proposed framework of indicators. It will provide transparency and accountability about the quality of services that CCGs commission and the outcomes achieved for their local populations. The NHSCB will use it to:

- Drive quality improvement
- Allow the NHSCB to hold CCGs to account for the quality of services they commission
- Provide information for patients and the public.

CCGs will be able to use information on baseline performance against these indicators to help identify local priorities and create commissioning plans that are meaningful at local level.

Equality Delivery System (EDS): The EDS is designed to support NHS commissioners and providers to deliver better outcomes for patients and communities, and better working environments for staff. The EDS is designed to help NHS organisations meet the public sector Equality Duty; deliver on the NHS Outcomes Framework and the NHS Constitution, and if they are providers, to meet the Care Quality Commission's "Essential Standards of Quality and Safety".

Established: Legal term meaning a CCG is created as a statutory body under the Health & Social Care Act 2012. CCGs covering the whole of England must be established by April 2013, when PCTs are abolished. Established CCGs may be (fully) authorised, authorised with conditions, or established in shadow form (see over).

Index of Multiple Deprivation: The Index of Multiple Deprivation combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation.

Integrated plan: The NHS Operating Framework for 2012-13 requires each PCT cluster to have an integrated plan that brings together all of the key requirements across the areas of quality, resources and reform. Plans need to bring together the immediate operational requirements and the long-term strategy for services. It is expected that the integrated plan would be developed with aspiring CCGs and consist of a narrative supported by data trajectories.

Health and Wellbeing Board (HWB): Health and wellbeing boards are being established in every upper-tier local authority to improve health and care services, and the health and wellbeing of local people. They will bring together the key commissioners in an area, including representatives of CCGs, directors of public health, children's services, and adult social services, with at least one democratically elected councillor and a representative of HealthWatch. The boards will assess local needs and develop a shared strategy to address them, providing a strategic framework for individual commissioner's plans. Shadow health and wellbeing boards will be in place in each local authority by April 2012 and will be established from 2013.

Joint Health and Wellbeing Strategy (JHWS): JSNAs will be the means by which local leaders work together to understand and agree the needs of all local people, with the JHWS setting the priorities for collective action. Taken together they will be the pillars of local decision-making, focussing leaders on the priorities for action and providing the evidence base for decisions about local services.

Joint Strategic Needs Assessment (JSNA): JSNAs will be the primary process for local leaders to identify local health and care needs, and build a robust evidence base on which local commissioning plans can be developed.

LINks: LINks (or Local Involvement Networks) are community-based, locally accountable networks of individuals, groups and organisations designed to strengthen the patient, public and user voice in the commissioning, provision and scrutiny of local services. They will be replaced by local HealthWatch from April 2013.

Local HealthWatch: HealthWatch will be the new consumer champion for health and social care. It will exist in two distinct forms – local HealthWatch, at local level, and HealthWatch England, at national level. HealthWatch England will start in October 2012; local HealthWatch will start in April 2013, and will replace LINks.

Multi-professional clinical community: Refers to the full range of clinicians (medical and non-medical) across health and social care.

NHSCBA: The NHS Commissioning Board Authority is a special health authority set up in October 2010 with the purpose of preparing for the creation of the NHSCB.

NHSCB: The NHS Commissioning Board is to be created under the Health & Social Care Act 2012 to be responsible for arranging for the provision of health services in England.

NHS Constitution: The Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and the pledges which the NHS is committed to achieve, together with the responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this Constitution in their decisions and actions.

NHS Continuing Healthcare: NHS Continuing Healthcare is a package of care that is arranged and funded solely by the NHS where an individual is assessed as having a primary health need. The National Framework for NHS Continuing Healthcare sets out the process for establishing eligibility for NHS Continuing Healthcare and the principles of care planning and dispute resolution relevant to that process. NHS bodies and local authorities have a responsibility to ensure that the assessment of eligibility for NHS Continuing Healthcare and its provision take place in a timely and consistent manner.

NHS Information Governance toolkit: The information governance toolkit is an online system that will allow CCGs to assess themselves against Department of Health information governance policies and standards. It also allows members of the public to view CCG assessments.

NHS outcomes framework: The NHS outcomes framework contains a balanced set of national outcomes goals and supporting indicators which patients, the public and Parliament will be able to use to judge the overall progress of the NHS. The framework also provides a mechanism by which the Secretary of State for Health can hold the NHS Commissioning Board to account for the outcomes it is securing for patients through its role in allocating resources and overseeing the commissioning process that will be led locally by CCGs.

National Reporting and Learning System (NRLS): The system enables patient safety incident reports to be submitted to a national database. Most incidents are submitted to the NRLS electronically from local risk management systems. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

Public sector Equality Duty (PSED): The public sector Equality Duty, at section 149 of the Equality Act, requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out their activities.

Quality, Innovation, Productivity and Prevention (QIPP): Over 2011-12 – 2014-15 the NHS will face significant additional demand for services arising from the age and lifestyle of the population as well as the need to fund new technologies and drugs. To meet this challenge, the NHS needs to deliver recurrent efficiency savings of up to £20 billion by 2014-15. Quality, Innovation, Productivity and Prevention (QIPP) is the response to the challenge of improving the quality of care the NHS delivers whilst at the same time making these savings.

Quality and Outcomes Framework (QOF): The QOF is a voluntary incentive scheme that rewards GP practices for implementing systematic improvements in quality of care for patients based on their performance against indicators. The QOF is part of the General Medical Services Contract.

Shadow CCGs: Legally these CCGs have the same status as CCGs that are described here as established 'with conditions' but the term is used operationally where the conditions are significant and it cannot properly be described as authorised to take on its functions as a CCG, i.e. it is established but not authorised. The NHSCB will make alternative arrangements for commissioning for that population from April 2013 until the shadow CCG is ready to move forward to authorisation.

Towards authorisation: Refers to *Developing clinical commissioning groups: Towards authorisation* which was published in September 2011. This set out initial thinking on authorisation.

SLA: A service level agreement is a negotiated agreement between two parties. It is not commonly legally binding although it may form part of a formal contract. SLAs would commonly include definition of services, performance measurement, problem management, and termination of agreement.

Section 75 agreement: Partnership arrangements between the NHS organisation and local authority which include budget-pooling, lead commissioning or sharing other resources. So-called because they were enabled by 'section 75' of the NHS Act 2006.