DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	UPDATE ON THE DEVELOPMENT OF THE SOUTHAMPTON CLINICAL COMMISSIONING GROUP
DATE OF DECISION:	10 NOVEMBER 2011
REPORT OF:	DR STEVE TOWNSEND CHAIR, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP (CCG)
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This paper seeks to update the Panel on the developments regarding clinical commissioning, since the last update in February 2011.

RECOMMENDATIONS:

(i) To note the progress towards becoming a statutory Clinical Commissioning Group.

(ii) To seek support from the Panel for the Clinical Commissioning Group to begin the process of applying to the NHS Commissioning Board for authorisation.

REASONS FOR REPORT RECOMMENDATIONS

1. The formation of Clinical Commissioning Groups is be part of the Health and Social Bill 2011.

2. To engage with the Panel at an early stage on progress of the development of the CCG in Southampton City

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. Southampton City GPs originally agreed that they would form a Clinical Commissioning Group that was co-terminous with the City of Southampton. This was supported by the panel. Our approach has been confirmed by the NHS Future Forum, and we intend to apply to the NHS Commissioning Board for authorisation on this basis

DETAIL (Including consultation carried out)

4. The Health and Social Care Bill presently before Parliament proposes reforms that will bring about the largest reorganisation of the NHS since its inception. Primary Care Trusts (PCTs) and Health Authorities will be disbanded and replaced by Clinical Commissioning Groups (formerly General Practitioner Commissioning Consortia) and the NHS Commissioning Board. Local Health and Wellbeing Boards will be set up to coordinate healthcare activity with the

aim of making the NHS more accountable to the communities it serves.

As a first step, the PCTs have been clustered, and on 1st June Southampton City PCT became part of the SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) cluster. Legally the cluster is a subcommittee of the four PCTs, and Clinical Commissioning Group is a subcommittee of the cluster.

The NHS Commissioning Board will be established as a 'special health authority' during Autumn 2011 and, subject to the satisfactory passage of legislation, will be constituted in its substantive form in the summer of 2012. The NHS Commissioning Board will be responsible for overseeing the establishment of CCGs and will take on other commissioning responsibilities, such as general practice, dental and pharmacy contracting from April 2013.

CCGs will be able to submit their applications to become authorised during the summer of 2012 and may become authorised from October 2012, so that they become statutory bodies. This will allow them to hire staff and to enter into contracts. However, they cannot operate independently until PCTs are abolished in April 2013. They will all be established by April 2013, but those that fail to meet the requirements of authorisation will have relevant functions carried out on their behalf by the NHS Commissioning Board.

Southampton City CCG aspires to have the maximum permissible delegated responsibility from the SHIP Cluster from April 2012. This will allow us to operate as if we were an authorised CCG, under the supervision of the cluster. To do this, we will need to submit an application to become authorised during the summer of 2012. The Board will be elected next spring to ensure that we have stable leadership during this period.

The authorisation process will require us to demonstrate capacity and capability across six domains (see Annex 1). The authorisation process is likely to consist of:

- 360 degree feedback from stakeholders, with a particular emphasis from the shadow Health and Well Being Board.
- A robust, technical assessment of long term plans.
- A desktop review of policies and working arrangements
- Case studies demonstrating delivery during transitional period
- Face to face panel interview

While we do not have to excel in all of these domains, we intend to become a competent and credible commissioning organisation, rather than just "ticking the boxes". A development plan will be published in November 2011

The CCG Board and the new arrangements continue to deliver increased clinical involvement within commissioning. An added focus is being placed upon the three localities to increase both the voice and contribution of grass roots GPs in the agenda. The priorities for this year remain around delivering

the Quality, Innovation, Productivity and Prevention (QIPP) agenda and ensuring the new CCG inherits a local health economy that is financially viable and of high quality.

Key Milestones

Date	Milestone
Winter 2011	NHS Commissioning Board comes is established temporarily as a 'special health authority'.
Spring 2012	Re-election of 6 GP Leaders Finalise draft application for authorisation
Summer 2012	NHS Commissioning Board is constituted in substantive form (subject to legislation). Submit application to become authorised.
October 2012 – April 2012	CCGs become authorised
April 2013	All CCGs authorised PCTs disbanded.

RESOURCE IMPLICATIONS

Capital/Revenue

5. None

Property/Other

6. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

7. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

8. None

POLICY FRAMEWORK IMPLICATIONS

9. None

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KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	The Six Domains of the Authorisation Process

Documents In Members' Rooms

1.	None.

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	No

Other Background Documents

Integrated Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Appendix 1- Six Domains of the Authorisation Process

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 how they will ensure inclusion of patients, carers, public, communities of interest and geography, health and wellbeing boards and local authorities. They should include mechanisms for gaining a broad range of views then analysing and acting on these. It should be evident how the views of individual patients are translated into commissioning decisions and how the voice of each practice population will be sought and acted on. CCGs need to promote shared decision-making with patients, about their care.
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 processes in place to commission effectively each and every one of those services for which they are responsible, from the early health needs assessment through service design, planning and reconfiguration to procurement, contract monitoring and quality control.
Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support;	CCGs need robust arrangements for working with other CCGs in order to commission key services across wider geographies and play their part in major service reconfiguration. They also need strong shared leadership with local authorities to develop joint health and wellbeing strategies, and strong arrangements for joint commissioning with local authorities to commission services where integration of health and social care is vital and the ability to secure expert public health advice when this is needed. They also need to have credible commissioning support arrangements in place to ensure robust commissioning and economies of scale. They need to be able to support the NHS Commissioning Board in its role of commissioner of primary care and work with the Board as a partner to integrate commissioning where appropriate.
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.