REGIONAL VOICES

for an informed, connected and influential third sector

Clinical Commissioning and the Health Transition Period

Draft

This document provides a summary of the main developments in relation to clinical commissioning as at August 2011. The information is correct at the time of writing but, with changes happening so quickly, the information could be superseded. Updates to this document will therefore be provided when necessary. This briefing has been updated since the "listening exercise".

It should also be noted that this document outlines the intention behind Clinical Commissioning Groups and other structures. Within each Strategic Health Authority (SHA) area, Clinical Commissioning Groups are developing locally to suit local needs and priorities. There may therefore be some differences in how the changes in commissioning are being implemented in various parts of the country.

This document aims to provide a quick reference guide to developments in relation to health care. Changes within public health and adult social care will be covered within future publications.

If you have any questions about the content of this document, please use the contact details below.

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Introduction

Through the Health and Social Care Bill, now progressing through Parliament, the NHS is undergoing a significant restructure which will abolish Strategic Health Authorities (SHAs) at regional level (October 2012) and Primary Care Trusts (PCTs) (2013) at local level. In their place will be local Clinical Commissioning Groups (CCGs) which will make the majority of commissioning decisions for the local population, and a national NHS Commissioning Board to oversee the CCGs and commission some low volume services. The aim behind these changes is to ensure clinical decisions lie at the heart of the commissioning process and to place decision making as close to the patient as possible.

'Emerging' Clinical Commissioning Groups

The Government initially intended for local clinical commissioning to be led by "GP Consortia", however following the listening exercise the membership of these have been expanded to become Clinical Commissioning Groups (CCGs). Rather than being purely GP driven as was initially envisaged, CCGs governance will be expected to involve a wider professional membership and to include at least one registered nurse and one doctor who is a secondary care specialist. In addition, there will be a minimum of two lay members, one to champion patient and public involvement the other to oversee governance, including audit, remuneration and managing conflicts of interest.

There are now 257 "Pathfinder" CCGs covering approximately 97% of the population.

Despite these fast and radical changes, the reality on the ground for the majority of GPs will not be significantly different on a day to day basis and it will be a small group of clinicians within each CCG driving the developments forwards and becoming the leaders of these new organisations. These individuals will be taking part in a range of development opportunities to ensure that they are ready to lead the CCG when they are fully formed.

It should be noted that no emerging CCG will become a fully functioning statutory organisation until April 2013. Until this point, statutory accountability remains with the PCT although increasing amounts of decision making and budgets may be delegated over time by the PCT as the CCGs become more capable and prepared. This process aims to ensure that groups of clinicians can get increasingly involved in the clinical decisions whilst initially being supported by PCTs who will dedicate specific resources and individuals to them. The distinction that the overall statutory accountability remains with the PCT until April 2013 is important for the voluntary and community sector as responsibilities transfer and highlights the need to continue some degree of engagement with PCTs while focusing on developing a relationship with relevant CCGs.

From April 2013 it should be noted that all providers of a personal medical services contract (the NHS contract held with GPs) will have to be a member of a CCG in order to continue working within the NHS.

From now until 2013, all emerging CCGs will be going through a development phase. During this phase the emerging CCGs should be referred to as 'emerging' or as 'pathfinders'. During this period, CCGs may change in size or in focus etc. depending on what has been shown to work, and changes in relationships – both internally, and with their key stakeholders. The landscape is likely to be different to the final picture once the Health and Social Care Bill has progressed and much of the learning undertaken.

Some CCGs have begun the process of authorisation, and therefore will be established as statutory bodies from 2013 and able to take on some commissioning responsibility before that. However, in some areas, a minority of commissioning groups may not be ready to take on full statutory responsibilities by April 2013. Where a group is not yet ready the NHS Commissioning Board (NCB) will commission on its behalf. This may be a locally based wing of the NCB.

The changes during the transition will inevitably present challenges for the voluntary and community sector to work with CCGs. The size and position of the boundaries of CCGs are likely to be different from other geographic footprints. This may mean, for example, that an organisation now needs to work with more than one CCG where they previously worked with one PCT. Following the "listening exercise", the Government has stated that CCGs should not normally cross local authority boundaries unless this can be justified. In addition, those services which refocus their organisational priorities to fit with the emerging CCG in their area, may find these need to be changed again as learning develops. Regional Voices is currently producing an area on its website to keep the sector up to date on developments and to assist people work with the emerging structures.

A full list of all pathfinders can be found at
http://healthandcare.dh.gov.uk/context/consortia/

The process for agreeing pathfinder status is being managed locally by SHAs. All emerging CCGs that wish to do so should be able to join the pathfinder programme unless they are ***unable*** to demonstrate:

- Evidence of local GP leadership and support
- Evidence of Local Authority engagement, or
- An ability to contribute to the delivery of the local QIPP agenda in their locality (QIPP stands for Quality, Innovation, Productivity and Prevention and is the NHS drive for efficiency)

Overseeing the transition of Clinical Commissioning Groups

Strategic Health Authorities currently have responsibility for overseeing the transition in each region, and assisting the emerging CCGs to develop and

prepare for authorisation as statutory NHS bodies. Each of the ten individual SHA has a lead appointed for the development of CCGs and is developing training and development opportunities for CCGs within their region.

SHAs, however, will be abolished in April 13 and are beginning to be scaled down in size. From October 2011, clusters of SHAs will merge to support the transitional work both of the NHS Commissioning Board and of the NHS Trust Development Authority (which supports the formation of Foundation Trusts). These cluster together previous SHAs into four NHS Commissioning Board "sectors":

(1) NHS North of England (North East, North West and Yorkshire and Humber)
(2) NHS South of England (South West, South Central and South East Coast)
(3) NHS Midlands and East (West Midlands, East Midlands and East of England)
(4) NHS London

Once SHAs are abolished, many of their functions in relation to providing support to CCGs will transfer to the NHS Commissioning Board.

Within each region the Regional Voices partner organisation is working with the SHA lead to ensure that the voluntary and community sector is included in all developments and that the sector locally are brought in to work with CCG as they emerge. By its nature, this work varies across each region. The Regional Voices website therefore has further details.

Support and Development of Clinical Commissioning Groups

Pathfinders will share examples of good practice around the country through the Pathfinder Learning Network. In addition, the Department of Health and the SHAs are working with pathfinders to support them in developing a suite of good practice documents to ensure that CCG are both fully supported, and that they are not all trying to 'reinvent the wheel'.
http://healthandcare.dh.gov.uk/category/pathfinder-learning-network/

Each pathfinder will need to decide for itself:

1. What functions it will fulfil internally
2. What functions it will share across the CCG or with local authorities
3. What they might buy in from other organisations e.g. commissioning support, insight and expertise (such as that provided by many voluntary and community sector organisations) etc.

During the transition period, pathfinders will determine some initial areas to focus upon and to then share their learning with other emerging CCG. For example, some may choose to focus on the Valuing People Now work, whilst others may decide to look at links with the voluntary and community sector. At a regional level, CCGs are being 'gently encouraged' to consider certain

areas to focus on although ultimately this decision rests with the CCG itself. It is still to early at this stage to identify the priority areas of all CCGs but is something that Regional Voices intends to publish on its website once these details are known as it could influence how the voluntary and community sector chooses to organise itself initially in terms of working with pathfinders.

Following the listening exercise two further supports will be put in place for CCGs, to be hosted by the NCB:

(1) Clinical networks which will advice on single areas of care such as cancer
(2) Clinical senates, in each area of the country, to provide multi-professional advice on local commissioning plans

Health and Wellbeing Boards (HWB)

Local authorities will lead on developing HWBs within every upper-tier local authority area (with the flexibility to bring in district councils where appropriate). Alongside the pathfinder CCG programme, a similar programme of work is developing with early implementer Health and Wellbeing Boards. There are already 132 local areas involved in a network of early implementers around the country and all councils have now been invited to join the network. These early implementers will similarly focus on different aspects of potential practice with a view to sharing learning.

Health and Wellbeing Boards are intended to amplify the voice of local people, by involving local councillors and patient representatives in shaping and influencing the strategic direction of the health and social care system in their area. The Boards will assess local needs and develop a shared strategy to address them, providing a strategic framework for local commissioning plans.

The main functions of the Boards will be to:

- Understand local health and wellbeing needs, and develop a strategy for how health, public health, social care and children's services can work together to address them
- More closely involve local people, through councillors and patient representatives, in influencing the strategy for health and well-being in their area
- Encourage organisations arranging (commissioning) health or social care service provision to work together in a more integrated manner
- Encourage closer working between clinical commissioners, adult and children's social care commissioners and public health commissioners.

CCGs will be required to use the joint strategic needs assessment (JSNA) and joint health and wellbeing strategy developed with the HWB when drawing up their commissioning plans.

The proposed minimum membership of the Health and Wellbeing Board includes elected representatives, CCGs, Directors of Public Health, Directors of Adult and Children's Social Services, local HealthWatch, with the NHS

Commissioning Board being invited to join discussions at the boards as appropriate. The voluntary and community sector is included in the list of others the Boards may wish to include and will want to closely engage in their work, alongside other organisations that provide health and care, clinicians and others who have an important contribution to make. The sector will therefore want to engage early with local authorities as they begin to develop the boards locally.

Some Boards have taken the view that the voluntary and community sector will be represented on Health and Wellbeing Boards through the place allocated to HealthWatch. However, it is recognised widely in the sector that, although there should be strong links with HealthWatch, that the voluntary and community sector also offers a wider perspective, going beyond traditional health and social care structures, and this is something that will be critical in better joining up of health, public health and social care. It is therefore something that Regional Voices will continue to work with the Department of Health on during the transition and we would encourage local organisations to engage with their emerging Boards at the earliest opportunity.

HealthWatch

During the transition period, Local Involvement Networks (LINks) will evolve into new local organisations called local HealthWatch, which will be formally established in October 2012. Local HealthWatch will have enhanced responsibilities to help individuals by providing assistance on how to access services or information. From April 2013, individual local authorities may also decide that local HealthWatch will provide advocacy services to those making, or wishing to make, a complaint about the NHS, or in choosing a GP practice. 75 LINks have become a 'Pathfinder' HealthWatch, assisting in the transition to local HealthWatch: http://healthandcare.dh.gov.uk/local-healthwatch-pathfinders-announced/. From 2012, local HealthWatch will be supported by HealthWatch England, an independent arm of the Care Quality Commission. HealthWatch England will have the power to establish a citizens' panel to look at how choice and competition are working, and inform HealthWatch's annual report to Parliament.

PCT Clusters

Since June this year, PCTs have merged into clusters to help ensure management capacity and accountability is maintained as the system goes through the transition. They have 6 main functions:

- Ensuring continuity for the delivery of existing PCT functions
- Allow space to enable emerging CCGs to operate effectively
- Provide a basis for the development of a range of commissioning support arrangements
- Provide space for the development of new arrangements with Local Authorities, and particularly HWBs.
- Provide opportunities for NHS staff
- Support the reform of provider organisations e.g. ensuring progress of Trusts through the Foundation Trust pipeline.

These PCT Clusters will be functional just for the period of transition. PCT clusters are essentially be made up of geographically appropriate groups of existing PCTs coming together to create a new structure. In most areas of the country, these have formed along similar boundaries to the old SHAs (before these were merged to become regional in 2006).

Although PCT clusters exist, with a dedicated Chief Executive role and other staff, they will not be statutory organisations. Accountability at a local level remains with the PCT, which will continue functioning until April 2013.

The NHS Commissioning Board

At a national level, the NHS Commissioning Board will be established in shadow form from October 2011. Sir David Nicholson, currently the NHS Chief Executive, will be the Chief Executive of the NHS Commissioning Board. The NHS Commissioning Board will:

- Support improvements in quality and outcomes
- Increase public and patient involvement in choice, championing the interests of patients rather than of providers.
- Ensure that there is a full and comprehensive system of CCGs, support them and hold them to account, including working in partnership with local Government and other organisations.
- Directly commissioning certain services including primary medical care, other family health services, regional and nationalised commissioning, healthcare for those in prison or custody and some aspects of military health care.
- Allocate and account for NHS resources.
- Lead on promoting equality and reducing health inequalities

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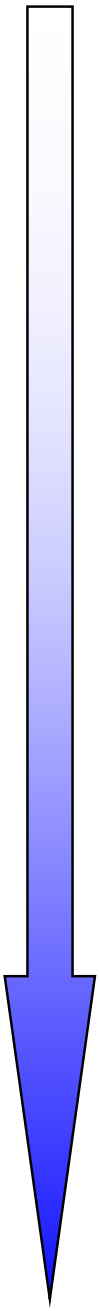
REGIONAL VOICES *for an informed, connected and influential third sector*

In each of the nine English regions there is a network which champions the engagement of the third sector within the region. They provide the bridge between local and national policy and share good practice across the region. On a national level, Regional Voices connects each of the regional networks, enabling the critical connection between national, regional and local infrastructure.

Regional Voices is funded through the Department of Health Third Sector Strategic Partners Programme to ensure input from the sector in developing health and social care policy and to support organisations to improve health and social care services. As one of the sixteen Strategic Partners, Regional Voices is strengthening links between the Department of Health and the third sector.

Appendix 1: The Transition Timeline



April 2011	Emerging CCGs began to take on delegated authority (overall accountability still rests with the PCT)
June 2011	Clustering of PCTs complete and operational
July 2011	Fifth cohort of pathfinder CCGs announced. There are now 257 CCGs covering about 97% of the population
August 2011	Early Local HealthWatch "pathfinders" announced
October 2011	NHS Commissioning Board sets up in shadow form (as a Special Health Authority)
	HealthWatch England established in shadow form
April 2012	Choice to be extended using Any Qualified Provider for selected mental health and community services
October 2012	NHS Commissioning Board formally established
	Local HealthWatch fully established
	HealthWatch England fully established
	CCGs can begin to be authorised to take on as much delegated authority as possible (overall accountability still ultimately rests with the PCT)
	Health and Wellbeing Boards established in shadow form
April 2013	CCG take full control of budgets, where they are ready for responsibilities. Supported by the NHS Commissioning Board until they are ready.
	PCTs, SHAs and cluster arrangements abolished
	Health and Wellbeing Boards formally established