



national association of primary care



cutting through complexity

NAPC/KPMG Commissioning Foundation Series

Good Governance for Clinical Commissioning Groups

An introductory guide

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Preface

Background

Since the publication of the White Paper, *Liberating the NHS*, in July 2010, the National Association of Primary Care, together with one of its leading partners, KPMG, have been industrious in their support of the clinical commissioning agenda. To this end, the two organisations launched in the winter of 2010 their 'Commissioning Foundation' to support pathfinders and innovators on their journey towards statutory status, bringing before them the finest examples and experience of commissioning throughout the developed world.

As a further extension of the work of the Commissioning Foundation, the organisations now bring you their latest offering, *Good Governance*, an invaluable tool for emergent CCGs in their next steps towards authorisation.

'Clinical commissioning groups (CCGs) will need to combine the nature of a statutory body with that of a membership organisation if they are to achieve their full potential in improving the health of their population. This is genuinely an opportunity to break new ground internationally in the pursuit of greater value health care. This guide provides a solid foundation on which emergent CCGs can build and as such should be regarded as an invitation to innovate.'

Dr Jonathan Marshall, Chairman, NAPC.

Gary Belfield, of KPMG, says: *'CCGs will be responsible for 60 per cent of the NHS spend from 2013 onwards. This is a significant responsibility for relatively new organisations and leaders of what will be publicly accountable bodies. It is imperative that CCGs are run in a way to give confidence that decisions are taken in an appropriate, transparent way. Good governance is at the heart of a well-run CCG. This guide sets out the current best practice to help CCGs develop their own local governance arrangements.'*

Introduction

The Health and Social Care Bill currently going through parliament (Department of Health 2011d) sets out a new structure for commissioning of NHS services, which sees primary care trusts (PCTs) abolished from 2013 and replaced by GP-led clinical commissioning groups (CCGs). An authorisation process, overseen by the NHS Commissioning Board, will assess the readiness of individual CCGs to undertake commissioning responsibilities. A key part of this assessment will be scrutiny of a CCG's governance structures.

We have tried to be as accurate as possible in representing the content of the draft Health and Social Care Bill and the latest published guidance from the Department of Health. As the Health and Social Care Bill is still making its way through parliament and guidance is still being developed, there will undoubtedly be changes to the content of both in the coming months. This guide is not intended to replace legal advice for developing CCGs and should not be read as such.

This guide is intended to help the newly formed CCGs understand the principles and function of good governance, particularly as these relate to their new statutory role, accountable to parliament combined with their role as a membership organisation, accountable to and for their practices. This dual accountability is a new challenge but also provides new opportunities to create the added value from clinical commissioning. The NHS Commissioning Board will set out specific guidance on minimum governance requirements and standards for CCGs. This guide is intended to provide a useful context and supplement to that and a foundation on which CCGs can build new and innovative governance arrangements for the future.

Failures in governance are easy to identify; with little prompting most of us could come up with a long list from both the public and private sector. But articulating and understanding what is 'good governance' is harder.

We begin by looking at the principles that underpin good governance. We then explore some of the key dimensions of good governance for CCGs, setting out their statutory obligations (as described in the Bill currently going through parliament), best practice from the private and public sector, and case study examples

to bring the principles of good governance to life. We conclude with some reflections on the key challenges for CCGs as they develop their governance systems, learning from other examples of GP commissioning, in this country and abroad.

What is good governance?

The function of good governance is to '*ensure that an organisation fulfils its overall purpose, achieves its intended outcomes for citizens or service users, and operates in an effective, efficient and ethical manner*'. (Office of Public Management and Chartered Institute of Public Finance & Accountancy 2004).

Much of the stimulus for good governance came first from the corporate sector, where concerns about company failures drove the development of codes of governance. The Cadbury Report (Cadbury Committee 1992) laid the foundation for this, now articulated in The UK Corporate Governance Code (Financial Reporting Council 2010). Also in recent years significant failings in governance in NHS organisations, combined with Monitor's attention to governance within the authorisation process for foundation trusts, has been instrumental in raising awareness of and improving governance within the NHS. In the case of CCGs, governance is a governing body responsibility. The Department of Health argued that each '*Board's prime duty is to ensure good governance*' (Appointments Commission/Department of Health 2003, p3). The underlying principles of all good governance (Financial Reporting Council 2010, p1) are:

- accountability
- transparency
- probity
- focus on the sustainable success of an entity over the longer term.

Some of the most notable governance and organisational failures can be linked to a failure to adopt these principles. For example, in the banking sector, the pursuit of short-term goals alongside a lack of transparency; at Mid Staffordshire NHS Foundation Trust, a lack of accountability and transparency. These core principles represent the 'spirit' of good governance. While codes

of governance can set out good practice in critical areas, the lesson from those organisations that have failed is that following the spirit of the guidance is just as important, if not more so. We explore, below, each of the underpinning principles in turn and their implications for CCGs.

Accountability

CCGs will be held to account in a variety of ways, both formal and informal (see Figure 1 p7). Their primary, formal line of accountability is to the NHS Commissioning Board. As a public body they are also accountable to their local population. Their strategic alignment with their local health and wellbeing board will facilitate this, but CCGs will also be expected to demonstrate public and patient involvement in their decision-making. There is also a mutual accountability between the CCG governing body and its member practices. The governing body will need to hold practices to account for individual commissioning decisions, while the governing body will need to demonstrate to member practices that it is adhering to the common purpose and values in its deployment of resources and operations.

Transparency

The drive for greater transparency tends to be relatively uncontroversial. CCG governing bodies and their member practices will need to be transparent in their decision-making; transparency does not mean that everything will have to be in the public domain, but the Health and Social Care Bill contains requirements to support this, for example, the requirement to hold CCG meetings in public.

Probity

Probity is the principle of having strong moral standards and leadership based on honesty and decency. It will be the responsibility of the governing bodies to make sure that probity is maintained. CCG governing bodies will need to establish values and standards of conduct for all members of staff. All members of the CCGs will need to demonstrate high ethical standards in their behaviour.

The seven principles of public life, called the 'Nolan principles' were published in 1995 by the Committee on Standards in Public Life and should be adhered to by anyone who holds a position in public life, including members of CCG governing bodies (see highlighted text, overleaf).

Focus on the sustainable success of an entity over the longer term

The governing body must ensure the sustainable success of the organisation over the longer term. For CCGs this means that the governing body must take account of the longer term consequences in setting the business model and strategy.

‘Nolan principles’

- **Selflessness** Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness** Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** Holders of public office should promote and support these principles by leadership and example.

Committee on Standards in Public Life (1995)

In conclusion, good governance flows from a shared ethos or culture, as well as systems and structures. It cannot be reduced to a set of rules, or achieved fully by compliance with a set of requirements. The spirit and ethos of good governance can be expressed as values and demonstrated as behaviours (OPM/CIPFA 2004).

Governance in NHS organisations is often described as ‘integrated governance’ (Bullivant and Corbett-Nolan 2011) combining corporate, clinical, financial, information and research governance, and all of these factors will need to be considered by the CCGs in developing their governance framework.

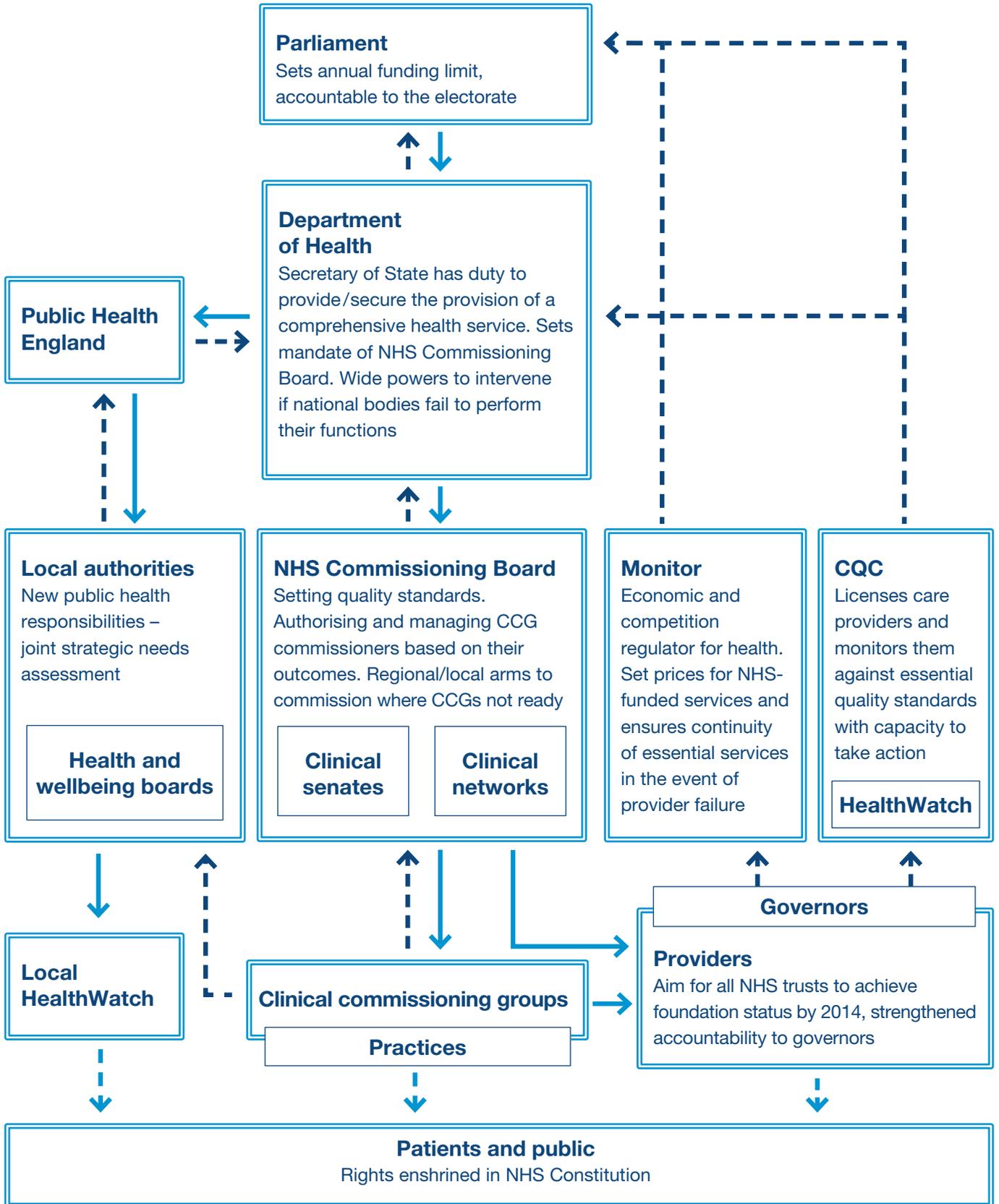
In this guide we describe how governing bodies of clinical commissioning groups can deliver good governance through understanding and action in four key areas:

- how the governing body is **constituted**: as a statutory organisation and the implications of this
- how the governing body is **structured**: its leadership, its membership and its relationship to its constituent practices
- how the governing body **operates**: how it makes decisions, including managing conflicts of interest, and engages with stakeholders
- what the governing body **does**: in particular, setting strategy, vision and values, exercising financial control and risk management.

Figure 1: New structure of NHS – Lines of accountability and funding

KEY

- Accountability
- Informal - - -
- Formal/regulator - - -
- Funding - - -



The constitution of clinical commissioning groups: the implications for governance

Each clinical commissioning group is required to develop a constitution, which will set out its duties, how it relates to its member practices, and statutory requirements, many of which are clearly designed to encourage good governance. We discuss many of these issues, for example, decision-making and the appointment of the governing body, later in this guide.

Health and Social Care Bill

The Bill specifies that the constitution must set out:

- the CCG – name, members and area covered
- the arrangements made for the discharge of its functions including how it will determine terms and conditions for staff
- the committees and sub-committees of the CCG which must include audit and remuneration committees
- how members of the board and committees will be appointed and remunerated
- schemes of delegation to members or employees, the board and committees
- how the CCG will deal with conflict of interest for members or employees
- how the CCG will ensure decisions are made transparently (and must include that meetings of the board will be open to the public except when the CCG considers that would not be in the public interest)
- the procedure to be followed by the CCG in making decisions and for dealing with conflicts of interests of members or employees of the clinical commissioning group
- how the CCG will involve individuals who are being provided with services in any proposals about changes and developments to the range of services or how those services are provided and the principles which the CCG will follow in implementing changes.

Interim guidance

Interim guidance on a model constitution for Pathfinder CCGs is available on the Department of Health website (Hempsons and NHS North East 2011).

In developing the constitution, the underlying principle is that CCGs, once authorised, will combine their role as a membership organisation accountable to their practices with their role as a statutory body, accountable to parliament. This statutory status sets the context for any CCG's governance framework, and it is critical that members of the CCG and the governing body understand the full implications of this.

As the name suggests, a statutory organisation is an organisation created by statute. Once established, a statutory organisation can only be disbanded by statute, though legislation can provide for the dissolution and merger of individual statutory organisations (and the current draft legislation does allow for this). A statutory organisation is ultimately accountable to parliament through the Secretary of State. The powers and duties of statutory organisations are set out in the statute that creates them. Doing anything other than these would be outside the legal power of the organisation. Governing bodies of CCGs will need to ensure that they are not operating outside their statutory remit and that the constitution clearly defines their duties within the statutory framework that has been laid out.

The remit as currently described within the draft legislation (Department of Health 2011d, p7) is as follows.

*(1) Each clinical commissioning group may **arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement:***

(a) in the physical and mental health of the persons for whom it has responsibility, or

(b) in the prevention, diagnosis and treatment of illness in those persons.

*(2) A clinical commissioning group **may not arrange for the provision of a service or facility if the Board (NHS Commissioning Board) has a duty to arrange for its provision***

The current legislation also allows for additional regulations or 'standing rules' that will enable the NHS Commissioning Board to direct CCGs in how, and for whom, they should commission services. Governing bodies need to be aware of their legal duty to comply with any directives from the NHS Commissioning Board. In addition to the remit set out under the current draft legislation, there is a range of duties that apply to all statutory organisations and that CCGs will therefore need to comply with. Some examples of these are listed in the highlighted text below.

and they will need to work effectively and collaboratively with their constituent practices to ensure that there is alignment between the actions of individual practices and those of the governing body. We explore this more fully in the next section.

Duties of a statutory organisation

- to demonstrate value for money and adhere to procurement regulations
- to adhere to equality legislation
- to stay within set revenue and capital resource limits set for the financial year and break even each financial year.

All clinical commissioning groups will be required to have an 'experienced and qualified' accountable officer. This is a key governance role. The accountable officer will be accountable to the NHS Commissioning Board and will help to provide a direct line of accountability from the clinical commissioning group to parliament for the use of NHS resources. CCGs will also need to appoint a qualified chief financial officer. Current guidance suggests that CCGs may opt to combine the role of accountable officer with that of chief financial officer. They may also opt for a GP leader to act as accountable officer, providing they can demonstrate the appropriate qualification. The NAPC is shortly to publish further guidance on this role (Cilag 2011).

It can be seen from the above, that by virtue of being a statutory organisation, CCGs will have strict legal boundaries to their activities and have a wide range of legal statutory duties and that the NHS Commissioning Board will have the capacity to direct their activities both through the line of accountability to the accountable officer and under statute. CCGs will also have freedoms

The composition of the governing body and its relationship to member practices

In this section we look at the make-up of the governing body. The guidance issued so far (see below) suggests that the CCG governing body will be made up from representatives from four different constituencies:

- GPs representing the CCG membership
- executive officers including the accountable officer
- at least two lay members (one of whom will act as chair or deputy chair)
- at least two other clinicians – to bring an understanding of nursing and specialist care.

CCG governing body: statutory and authorisation requirements

Health and Social Care Bill

- CCGs must have a governing body compliant with the Act and subsequent regulations.
- CCGs must adhere to the principles of good governance including ‘Nolan principles’.
- The NHS Commissioning Board may make further regulations for boards including:
 - governing bodies must include the accountable officer of the clinical commissioning group
 - how members are to be appointed
 - maximum and minimum numbers of members
 - types of members (options being considered include – a nurse, a doctor who is a secondary care specialist, a director of public health, a local authority representative)
 - qualification, length of tenure, eligibility for reappointment.

As organisations built around a membership rather than an employee base, CCGs are different from other NHS statutory organisations. In this respect they have more in common with GP federations in this country and abroad. There are also analogies to local authorities and

the role played by elected members. CCGs therefore need to consider not only who will sit in the governing body but how the governing body relates to the CCG member practices.

CCGs will need to set out in their constitution the basis on which the members of their governing body are appointed. They will also need to set out the scheme of delegation, including the decision-making power of the governing body. Assuming that the NHS Commissioning Board is not prescriptive in this area, CCGs will therefore have a number of choices.

First, how much decision-making power they want to reserve to the governing body; does the governing body decide everything or are there issues which they would want to put to the whole CCG membership? In the case study below we look at one model developed by a GP co-operative.

Second, on what basis would they want to appoint GP members to the governing body? Do they want to elect them or appoint them? In either case, would they want the GP to have specific portfolios or be linked to a particular geography? They could choose to have some GPs elected and some appointed for specific skill sets.

Overall, the CCG needs to ensure that: *‘The board and its committees should have the appropriate balance of skills experience, independence and knowledge... to enable them to discharge their respective duties and responsibilities effectively’* (FRC 2010, p6). Given the different constituencies and backgrounds that members will be drawn from and the likely variation in skills and capabilities, the CCG will need to provide induction programmes tailored to individual needs, with opportunities for members to update their skills and knowledge on a regular basis. As membership organisations CCGs should also consider how they strengthen the contribution of member practices to the CCG more generally. This could include a support package for practice leads including a clear job description and person specification. We talk further about practice engagement in the next section.

The experience of GP federations and independent practitioner associations in New Zealand is that

training and induction can be particularly important for community or patient representatives who may have gaps in their knowledge and understanding. GPs are also likely to have knowledge and skills gaps, particularly about governance and team working, for example, how to manage meetings. Finally, there needs to be clarity about the roles and responsibilities of every member on the governing body, executive and non-executive.

Evidence shows that boards cannot be effective if they are too large, as decision-making and debate becomes unmanageable (Eversheds 2011). The general consensus seems to be that a membership of between 8 and 12 is likely to be most effective. The CCG may also choose to restrict the number on the board with voting rights and extend membership to others without voting rights.

The role of the chair will be critical to the success of the governing body. As the Financial Reporting Council (FRC) (2011, p6) said, '*Good boards are created by good chairmen.*' Chairs have a range of important responsibilities:

- leadership of the governing body, setting the agenda and ensuring its effectiveness in all aspects
- ensuring the provision of accurate, timely information to other members of the governing body
- ensuring effective communication with practices, staff and the public
- arranging the regular evaluation of the performance of the governing body, its committees and individual directors
- facilitating the effective contribution of other governing body members, particularly lay representatives and ensuring constructive relationships within the governing body.

(Source: Appointments Commission/Department of Health 2003, p16).

The chair, working closely with the accountable officer, should ensure that the governing body's agenda takes account of the full business of the CCG and appropriately reflects the strategic challenges faced by the CCG. While the current legislation does not specify

the need for CCGs to appoint a company secretary, good practice from the corporate sector and experience in foundation trusts suggests this is also a key role in the governance of an organisation. The role of the secretary is to play a leading role in governance, supporting the chair and helping the governing body and committees to function effectively. They can have a key role in ensuring good communication between the governing body, senior management and committees and helping to ensure compliance with legislation and regulations.

Within governing body meetings, the chair's role is to ensure the best possible quality of debate and to manage the governing body to achieve this. The chair needs to ensure that clear decisions are reached. The information that underpins decisions should be rigorous and evidence-based wherever possible. Chairs are encouraged to review *The Intelligent Commissioning Board* (Dr Foster 2006). We explore decision-making more fully later in this guide (see p12–14).

The culture and values in an organisation are heavily influenced by the organisation's leadership (Sonnenfeld 2002). The behaviour of the governing body and its priorities send powerful signals to the rest of the organisation about what is valued, and the chair plays a critical role in creating the right environment for positive behaviour.

Chairs also have a broader set of responsibilities, facilitating the collective development of the governing body. This should include thinking about the composition of the governing body and its members' personal development. Finally, the relationship between the chair and the accountable officer will be a pivotal one, and will require time and investment from both sides.

Case study – the membership of the governing body and working with constituent practices (adapted from Royal College of General Practitioners Federations Toolkit)

Context

Establishment of a GP co-operative as not-for-profit company with a number of subsidiaries. The co-operative delivers primary care services to a population of 500,000. There are 90 practices in the co-operative, which includes more than 300 clinicians (250 GPs and 50 nurses).

Governing body model

Overseeing the co-operative and its subsidiary companies is a board of directors consisting of five GP directors (elected from the membership on an annual basis), chief executive, medical director, finance director. Decisions by the board are translated into action by the executive team (chief executive, medical director, finance director, operations director, director of quality and compliance, clinical director of medicine). An operations board manages projects at an operational level (head of human resources, business development manager).

The leadership team consults the membership about any significant decisions, such as a change in direction for the organisation. Depending on the issue, it may hold a general meeting or conduct a survey with a subsection of the membership. It then communicates any decision and monitors its implementation.

Top tips

Composition of governing body

- Optimal size of the governing body is between 8 and 12.
- The CCG needs to set out the respective roles and responsibilities of all the members of the governing body in the constitution.
- CCGs should consider tailored job descriptions for each member of the governing body, reflecting their responsibilities to the governing body and the membership of the CCG.
- All members of the governing body should have an appropriate induction and development programme.
- The skills of the chair are critical in a well-functioning board, and chairs should have well-developed interpersonal skills to support effective decision-making.
- An external assessment of the performance of the governing body should be undertaken (ideally annually) leading to a development plan.
- There should be active support to member practices to strengthen their contribution to the work of the CCG. This could include a support package for practice leads.
- Members should adhere to the 'Nolan principles' of public life: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

The operation of the governing body

Once the structure is successfully established, governing bodies will need to establish rules and mechanisms for how they will operate. We examine five key areas here:

- decision-making
- the role of sub-committees
- working with other CCGs
- use of commissioning support
- engaging with stakeholders.

Making informed, transparent decisions (including managing conflicts of interest)

'Well informed and high quality decision-making is a critical requirement for a board to be effective and does not happen by accident. Flawed decisions can be made with the best intentions, with competent individuals believing passionately that they are making a sound judgement, when they are not.' (FRC 2011, p8)

Decision-making and managing conflicts of interest: statutory and authorisation requirements

The Health and Social Care Bill states that the constitution must specify:

- the procedure to be followed by the clinical commissioning group in making decisions and for dealing with conflicts of interests of members or employees of the group
- the arrangements made by the CCG for ensuring that there is transparency about the decisions of the governing body and the manner in which they are made, including provision for meetings of governing bodies to be open to the public.

High-quality decision-making will be one of the most important and yet most difficult acts for a CCG's governing body. It will be particularly difficult because of the complexity of the issues they face, the many

competing priorities and the potential for conflicts of interest. In this section we explore strategies that will help CCGs to make good decisions and manage potential conflicts of interest.

Good-quality information and analysis is the foundation of good decision-making at board level, yet is often lacking. A recent analysis of NHS trust boards (Institute of Chartered Secretaries and Administrators 2011) revealed that the information presented to boards was of variable quality and frequently lacked any trend or forward-looking analysis or links to the broader strategic context. The Audit Commission (2003) found that governance failures can arise if:

- there was a failure to challenge within the governing body – information was accepted at face value
- organisations failed to fully recognise the impact of external policy decisions
- non-executive members were not fully informed about the true state of affairs by the executive team
- decisions were based on wrong or out-of-date information
- basic information systems were of a poor quality, especially where information management is undervalued.

Dr Foster in *The Intelligent Commissioning Board* (2006) provides helpful advice on setting agendas and the provision of information to support good commissioning decisions.

They recommend that information should:

- be clearly and simply presented, including graphic overviews and brief commentary
- be forward-looking, presenting trends in performance
- be timely
- direct the governing body's attention to significant risks, issues and exceptions

- provide a level of detail appropriate to the governing body's role (that is, providing direction and oversight not operational management).

A frequent complaint by board members is that meetings fail to take decisions. Board members get frustrated when they think they are not helping the organisation to move on. As we highlighted earlier, the chair can play a critical role here.

Governing bodies often find it hard to take decisions that bring their personal values and government policy into conflict. Some boards define clear ethical standards for the board that can be used or referred to when making difficult decisions which impact on service quality. Interpersonal factors also play an important part in decision-making. A culture of trust and candour can support good decision-making, while the presence of individuals who dominate discussion and prevent open discussion with all members of the governing body can inhibit good decision-making.

Finally, a key challenge for CCG governing bodies will be ensuring that they manage conflicts of interest effectively. Doctors have strict professional duties about conflicts of interest. They include a duty that if a doctor has a financial or commercial interest in an organisation to which he or she plans to refer a patient for treatment or investigation, he or she must tell the patient about his or her interest. If a doctor has a financial or commercial interest in any CCG commissioning or procurement decision, he or she should declare his or her interest and exclude him or herself from the decision-making process. It is particularly important to ensure clear demarcation between GPs' engagement in providing and commissioning of services. In order for there to be a conflict of interest it is not necessary for the member to gain actual benefit whether financial or otherwise, just a potential to do so or a perception of impaired judgement.

Interim guidance on governance for pathfinder CCGs (Hempsons and NHS North East 2011), available on the Department of Health website, suggests ways to address conflicts of interest in the CCG's constitution. The guidance recommends the use of a register of interests and members absencing themselves from

meetings, in which a conflict of interest may arise. There are also a number of other safeguards that CCGs can put in place (see box below). Critically they need to ensure that the underlying principles of transparency, accountability and probity are seen to support all decision-making.

Top tips

Ensuring good decision-making

- Ensure the governing body has access to the necessary data and information on which to make the decision.
- Do not accept information at face value – challenge conclusions and seek underpinning evidence.
- Allow time in meetings for debate and challenge, especially for contentious issues.
- Ensure the governing body's documentation is of a high quality.
- Ensure clarity on actions required, timescales and responsibilities. The chair plays a critical role here, assigning accountability for decisions and good-quality debate.
- The governing body should clarify in writing the types of decisions that are delegated to the executive and those that are reserved to the governing body.
- Governing bodies may want to define ethical standards to assist in making difficult decisions.
- Agendas should be designed to ensure that items that are valued are at the beginning of the agenda.

Managing conflicts of interest

- Create and keep updated a register of members' interests so that the governing body and others are aware of any real or perceived conflicts of interest.

- Where there are potential conflicts of interest put in place additional safeguards, for example – use of external/independent advice or oversight (eg, a local overview and scrutiny committee); introducing a devil’s advocate to provide challenge; establishing a sole purpose sub-committee, or convening additional meetings; ensuring transparency about the process used to arrive at decisions; ensure anyone with a potential conflict of interest is excluded from the decision-making process.
- Ensure all procurement and contracting decisions comply with the law and best practice guidance.

The role of sub-committees

If governing bodies are to work effectively in their strategic role and focus on strategic issues, some more detailed matters will need to be carried out by committees. The legislation currently specifies these must include at least an audit committee and a remuneration committee. Committees can also have members who are not members of governing bodies so that a wider range of skills and expertise are available.

Sub-committees: statutory and authorisation requirements

The Health and Social Care Bill states:

- the governing body must have an audit committee and a remuneration committee.

The audit committee

The role of the audit committee is to seek assurance that financial reporting, and more broadly the internal controls, in the organisation are working effectively. *‘The role of the audit committee has moved on from looking at purely financial controls and approval of the financial statements, to considering the whole system of internal control.’* (Audit Commission 2009). The audit committee

will offer advice to the governing body about how reliable and robust the processes of internal control are, and it might also have oversight of risk management for the organisation (explored more fully on pp23–25). The chair of the audit committee should not also be the chair of the governing body, and at least one member of the committee should have a financial background, given the financial nature of many of the issues discussed. The Healthcare Financial Management Association, together with the Department of Health, published an updated version of *The Audit Committee Handbook* in 2011 which assists audit committees in their role and provides a summary of duties.

The remuneration committee

The role of the remuneration committee is to make recommendations to the governing body about the pay and terms of service for the accountable officer and other executives in the organisation, taking account of nationally determined guidance on pay, conditions and pensions and any remuneration or allowances for members of the governing body. It might also have a role in advising the governing body on succession planning.

Other standing committees

While effective governing bodies have a minimal number of standing committees, other committees can be useful where there is a need to debate issues in more depth and focus before reporting to the governing body. Many NHS organisations have established a quality sub-committee that seeks assurance that there are effective arrangements for monitoring and improving the quality of care that is commissioned on behalf of patients.

All committees should have clear terms of reference, outlining explicit powers and reporting structures. They need also to have sufficient authority to debate and implement changes without the full governing body having to repeat every discussion.

Top tips

Committees

- There must be an audit and remuneration committee with clear terms of reference.
- The audit committee should have at least one member with a financial background.
- CCGs may wish to consider establishing a quality committee.

Working with other CCGs and local authorities

It is likely that many CCGs will enter into collaborative or federated arrangements with other CCGs and potentially with local authorities if they seek to develop pooled health and social care budgets for particular groups. The current draft legislation (see highlighted text below) is very permissive, allowing clinical commissioning groups to delegate or share their commissioning functions, including the pooling of financial and staffing resources. However, the legislation is also clear that delegation of function does not equate to delegation of responsibility and so clinical commissioning groups entering into such arrangements will need to put appropriate risk management processes in place if they enter into these arrangements.

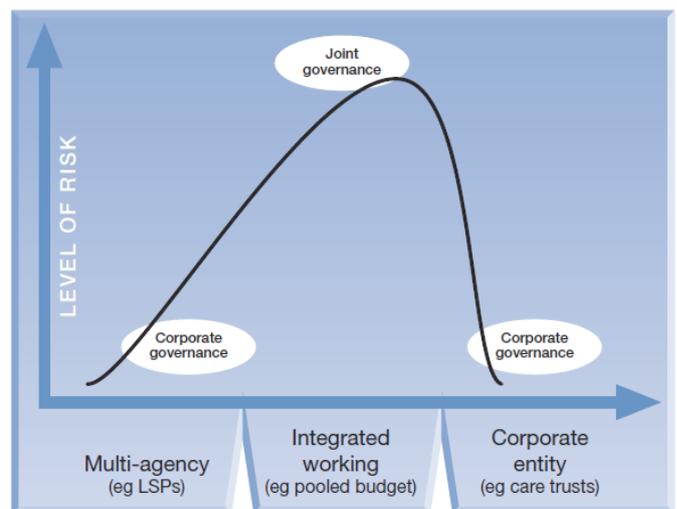
Working with other CCGs and local authorities: statutory and authorisation requirements

Under the Health and Social Care Bill a clinical commissioning group can arrange for one or more clinical commissioning groups to exercise any of the commissioning functions on its behalf or for clinical commissioning groups to exercise any of their commissioning functions jointly. This includes the capacity to make payments to each other, share staffing resources or create a pooled fund. However, any arrangements made do not affect the liability of a clinical commissioning group for the exercise of any of its functions.

Regulations may provide for any prescribed functions of a clinical commissioning group to be exercised jointly with a local health board or for any functions exercisable jointly by a clinical commissioning group and a local health board to be exercised by a joint committee of the group and the board.

An Audit Commission review of partnership working in the public sector highlighted that partnerships can bring risks as well as opportunities and governance can be problematic. Working across organisations can *'generate confusion and weaken accountability'* (Audit Commission 2005, p2). They identified that the governance risks were dependent on the degree of integration (see below).

Figure 2: Governance risks: different levels of integration present different governance risks



Source: Audit Commission (2005)

As the partners' activities become progressively more integrated it becomes harder to clarify lines of accountability. The Audit Commission underlines the importance of clarity on decision-making about finances and line management responsibilities where posts are shared. There is also useful learning from the experience of joint working across health and social care (Audit Commission 2009), which underlines the importance of clearly documenting accountabilities and roles and responsibilities.

Top tips

Working with other CCGs and local authorities

- In order to secure buy-in, leaders will need to actively communicate the purpose of working with an external partner at an early stage with all members of the CCG.
- There should be agreed aims and outcomes across all the organisations involved.
- There must be clarity of lines of accountability and communication between the individual statutory governing bodies including:
 - the line management of joint appointments
 - joint monitoring and reporting arrangements
 - how surpluses and deficits will be dealt with.
- Mechanisms should be put in place to regularly review arrangements.

The use of commissioning support

CCGs are likely to use external commissioning support to ensure access to sufficient skills and make best use of economies of scale. In the first instance they may rely on support delivered through the NHS Commissioning Board but over time are likely to become more dependent on external independent companies or social enterprises.

Many of the points made above in relation to working with other CCGs are relevant to the use of commissioning support, but there is also useful experience from PCTs' use of external support. A recent review from The King's Fund (Naylor and Goodwin 2010) highlighted the key ingredients for successful partnership working with external organisations (see Top tips below). A key element for all joint working, and one that is often ignored, is a shared vision, values and culture. Cultural obstacles can be significantly more powerful than organisational ones.

Top tips

Use of commissioning support

There should be clearly articulated goals that are understood by both parties, and that are defined in terms of the CCG's needs rather than the commissioning support expertise and products.

The CCG and commissioning support should agree the best means of achieving these goals, including the requirements and expectations of both parties.

There should be flexibility, ensuring that the external partner does not impose a 'ready-made' solution.

Effective stakeholder engagement and accountability

CCGs operate within complex systems, and a key part of governance arrangements will be clarity about how CCG governing bodies will engage with this wide range of stakeholders, both inside and outside the CCG.

Internal engagement

Successfully combining the constituent practices as a unified CCG around a common purpose will be critical if the CCG is to be effective in translating the knowledge of local GPs and primary care staff into commissioning decisions, and will require successful mechanisms for communication throughout the CCG. It could also present a significant challenge to CCG governing bodies. Unlike the board of an NHS trust, CCGs will not employ their members so they will need to adopt new and innovative approaches to support this engagement. There may also be a challenge due to the drive to create larger CCGs in order to contain management costs. CCGs will need to configure themselves to deliver the advantages of both scale and individual practice unit engagement

The evidence from previous primary care commissioning (Smith and Goodwin 2006) is that larger primary care-based organisations struggled to engage practices.

Internal stakeholder engagement: statutory and authorisation requirements

Health and Social Care Bill

- CCGs must secure effective participation by each member of the CCG in the exercise of the groups' functions.

Authorisation guidance to date (Department of Health 2011a, 2011b)

- CCGs must have significant engagement with constituent practices.
-

As newly established bodies CCGs are largely in uncharted territory in terms of how they successfully engage with constituent practices, but there is some useful learning from the development of GP federations and practice-based commissioning (RCGP 2010). Advice offered by the GPs interviewed as part of this work is given in the 'Top tips' overleaf. Learning from the broader management literature underlines the importance of engaging all constituent practices in developing a shared vision and values for the CCG. It will also be important to put in place a communications strategy to ensure regular ongoing engagement between constituent practices and the governing body, recognising the time pressures on GPs – contact will need to be 'brief and useful'.

Finally, many primary care organisations have used education, benchmarking and peer review, as both an improvement and engagement tool. This could be problematic for CCGs given that the NHS Commissioning Board will be responsible for the performance management of GPs as providers. The governance arrangements for this should be viewed in a system-wide perspective to support the continuing development of quality within primary care. However, if GP practices are to receive some sort of financial premium for their commissioning activities one might expect this to be linked to a series of balanced performance indicators that can be shared and benchmarked across the CCG.

Top tips

Internal engagement

- Appoint leaders with credibility, so that they can get buy-in locally.
 - Leaders need to motivate participation and engagement from member practices through encouraging a sense of common purpose, mastery and self-direction.
 - Create an atmosphere of trust between practices and the CCG (demonstrating that being part of the CCG will be beneficial for GPs and patients).
 - Have a code of conduct or other written agreement that binds together GPs, managers and practice staff. and reinforcing the sense of mutual accountability between the CCG governing body and its member practices.
 - Develop opportunities for practices to take on leadership roles outside the governing body, eg, through taking on leadership roles for specific clinical areas.
 - Use education, benchmarking and peer review as tools for improvement and engagement.
 - Involve patients at all levels.
 - Actively seek feedback from staff and patients.
-

Case study: (adapted from RCGP Federations Toolkit)

Context

GP federation made from a relatively loose association of practices seeking to adopt a more formal federated structure.

Action taken

Federation focused on getting practices to come together to create a shared vision, share ideas and skills and provide opportunities for informal networking. Education was also an important thread in developing collaborative working. The federation was initially driven forward by a few committed individuals, but through taking active steps to engage practices was able to grow support.

involved in commissioning and in any changes to commissioning arrangements where these would result in changes to delivery of or access to services. A description of how it will do this and the principles which the CCG will follow must be included in the constitution.

Authorisation guidance to date (Department of Health 2011a, 2011b)

CCGs must have:

- meaningful engagement with communities including patients, the public
- engagement with public health and social care
- engagement with other local clinicians.

External engagement

An effective governing body will make stakeholder engagement a key mechanism for demonstrating openness, transparency and accountability. One of the challenges facing CCG governing bodies will be the complexity and range of stakeholders that they need to engage with, including patients and the wider public and a host of community, private and public organisations. The first task will be to identify these stakeholders, clearly mapping relationships.

External engagement: statutory and authorisation requirements

Health and Social Care Bill

- CCGs must work in partnership with local authorities, including joint strategic needs assessment and joint health and wellbeing board strategies to which they must then have regard.
- CCGs must ensure that individuals to whom the services are being or may be provided are

CCGs are statutory bodies, and as such need to demonstrate that they:

- have delivered value for money from taxpayers' resources
- secured high-quality care for patients
- addressed the health needs of their local population.

CCGs need to put patients and their experience centre stage, ensuring mechanisms for systematic collection and analysis of feedback, and then demonstrate how this information actively informs decision-making. Actively engaging with the local HealthWatch is one route but GP practices may also have developed innovative mechanisms for involving patients which could be harnessed.

CCG governing bodies will also need a coherent strategy for engaging other institutional stakeholders, particularly health and wellbeing boards, local authority directors of public health and directors of social services, and clinicians outside the CCG, including the local clinical senate.

Health and wellbeing boards

'Health and wellbeing boards will be a forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of HealthWatch to discuss how to work together to better the health and well-being outcomes of the people in their area. By involving democratically elected representatives and patient representatives, and bringing them together with local commissioners across health, public health, and social care, we will significantly strengthen the democratic legitimacy of commissioning decisions, as well as providing a forum for challenge, discussion, and the involvement of local people.'

(Department of Health 2011c)

CCGs will operate within a complex system and will share responsibilities with other partners in the local system for ensuring the provision of high-quality services and maintaining public confidence in the system. CCGs will have to look beyond their immediate organisation, co-operating, engaging and collaborating with a range of organisations. Useful mechanisms can include board-to-board meetings with relevant organisations in the system, such as the local provider NHS trust, as well as engagement through the health and wellbeing board and the joint strategic needs assessment process. Developing clear, shared policies of how local players in the system will work together will be important for boards from the outset.

As a statutory NHS organisation, the CCG will have certain duties around consultation. For example, under the NHS Act 2006, commissioners are required to undertake public consultation on any proposals for 'significant' service change, such as the reconfiguration of clinical services. Formal consultation is often a time-consuming process and might include a health impact assessment, consultation period of more than three months and an extensive public engagement strategy. No formal decisions on change can be made until the consultation is completed. Boards will need to assure themselves that the processes used are appropriate and that they are applied in the right circumstances.

Top tips

External engagement

- Identify key stakeholders from the outset.
 - Agree clear accountabilities and reporting structures with other institutional stakeholders.
 - Governing bodies should have a clear strategy for how they will engage with patients and the public.
 - Governing bodies should assure themselves that statutory duties around consultation are appropriately met.
-

The governing body of clinical commissioning groups and its role

In this final section we explore some of the key activities that support good governance in any organisation:

- setting strategy
- financial control
- risk management.

Setting strategy

'Having a clear organisational purpose and set of objectives is a hallmark of good governance.' (OPM and CIPFA 2004). Clarity about what an organisation is trying to achieve not only supports good organisational decision-making but also helps to align decisions made by individuals at all levels within an organisation. Only with a strategy can the governing body provide leadership to the organisation. However, as the Audit Commission (2009) pointed out, the number of strategic aims and objectives needs to be limited if they are to be widely understood and cascaded.

Statute lays out a number of areas that any CCG's strategy will need to address (see highlighted text below) but the precise focus of any CCG strategy should be decided locally.

Strategy: statutory and authorisation requirements

Health and Social Care Bill

- CCGs must have regard to the need to reduce inequalities between patients with respect to both their ability to access health services and the outcomes achieved.
- CCGs have a duty to promote integration of health care services and health-related and social care services.
- CCGs have a duty to promote innovation and have regard to the need to promote research
- CCGs must act with a view to promoting the NHS constitution.

Authorisation guidance to date (Department of Health 2011a, 2011b)

- CCGs must have a credible Quality, Innovation, Productivity and Prevention (QIPP) plan.

The National Leadership Council (2010) underlined the importance of the process used for developing strategy, and of engaging an organisation's members in this process. For a CCG it will be critical that its vision and purpose is owned by all the member practices.

Many governing bodies complain that they don't spend enough time on strategy. In particular, they have not spent the time discussing the purpose of the organisation, their individual and collective vision for the organisation and their personal values. Nor have they talked openly about national policy, local implementation and how this squares with their own values. Members of governing bodies should expect strategy development to be an ongoing process; the discussion might start with an annual retreat and then ongoing discussions, with different issues being addressed at separate meetings.

Finally, strategy alone is not enough. As Ramsay and Fulop (2010) note, *'15% of the benefit from strategy comes from the intrinsic excellence of the strategy itself and 85% from the excellence of the implementation, which is primarily achieved through programme management'*.

Top tips

Developing strategy

The National Leadership Council (2010, p10) set out some of the hallmarks of an effective strategy. These included:

- a compelling vision for the future, underpinned with clear strategic objectives that are reflected in an explicit statement of desired outcomes and key performance indicators
- a clear statement of the organisation's purpose
- an approach that takes appropriate account of the external context in which an organisation is operating
- a perspective which balances the priority given to national and local performance indicators and targets
- evidence that the strategy has been shaped by the 'intelligence' made available to the governing body
- demonstrable links to the needs of users, patients and communities – with priority given to inclusion, safety and quality – for CCGs the local joint strategic needs assessment (JSNA) set out by health and wellbeing boards will be a key resource and reference point
- a longer term view (with at least three to five year planning horizon) including a long-term financial model and risk analysis.

Exerting financial control and securing value for money

Financial stewardship is an essential element of governance, and the ability of CCGs to demonstrate financial control and probity is likely to be a key element of the authorisation process (see highlighted text opposite).

Financial control: statutory and authorisation requirements

Health and Social Care Bill

- CCGs must exercise their functions effectively, efficiently and economically.
- CCGs must keep proper audited accounts.

Authorisation guidance to date (Department of Health 2011a, 2011b)

- CCGs must have an experienced and qualified chief financial officer.
- CCGs must be able to deliver financial control and probity.
- CCGs must have credible commissioning support arrangements in place to ensure robust commissioning and economies of scale.
- CCGs must have a credible QIPP plan.

The financial responsibilities of CCG governing bodies can be divided into two key areas.

First, **day-to-day financial control of the organisation**. This is effectively an operational risk of the business, which should be managed by business processes and might include budget control systems, together with cash management systems. Governing bodies, supported by the audit committee, will need to ensure that there are strong financial control mechanisms. The Audit Commission (2009) highlights the Standing Financial Instructions (SFIs) as key: *'The SFIs detail the financial responsibilities, policies and procedures adopted by a trust.'*

In addition to ensuring the right processes and mechanisms are in place, effective information flows are fundamental to monitoring financial performance. Research showed that foundation trusts that were in breach of Monitor's authorisation in 2010 were often not using sufficiently high-quality data in a timely manner

(Monitor 2010). CCG governing bodies will need to ensure that they receive financial reports on a regular basis that contain appropriate information for decision-making.

The second area of financial control, and by far the greater challenge for CCGs, will be around developing **a strategic understanding of the CCGs' business model** for the commissioning of services. This will involve establishing good predictors of the population's medium-term demand for services (requiring access to data analysis skills) and robust contract approval and management processes that allow the governing body to have an overarching view of the financial risks the CCG is running, not only on individual provider contracts, but the cumulative financial risk across all commissioning activity. It is the lack of this strategic overview of finance which often leads to financial failure of organisations. Long-term financial modelling and financial trend analysis, as opposed to snapshots of income and expenditure at a given point in time, will be key for CCG leaders to deliver financial sustainability of all organisations.

Case study: financial risk

Context

The management board of an organisation did not have sufficient financial capability. The board relied on personal assurance from the finance team on the financial health of the organisation. They were therefore unable to spot the early signs of financial distress such as late creditor payments and reducing cash balances. They also failed to identify the weakness of the underlying business model and that the income of the organisation was too low relative to the fixed costs.

In this case study a change in leadership resulted in the poor financial reporting practices being identified and the organisation having to restate its accounts, recording significant losses relative to turnover. The organisation now lurches from cashflow crisis to cashflow crisis and it is only a matter of time before it will have to merge or be dissolved.

CCGs can avoid this type of outcome if they follow the advice of the top tips opposite.

Top tips

Financial control

- All members of governing bodies should ensure their financial skills are sufficiently developed (through high-quality training) to ensure that they can effectively engage in financial debate, discussion and challenge.
- Members of governing bodies should not be afraid of asking the 'dumb question' on finance as the non-specialist often can see the 'wood for the trees'.
- All governing bodies should use scenario planning around their financial model, which clearly identifies the risks associated with the model and allows the governing body to identify possible financial weaknesses.
- Governing bodies should assure themselves that effective standing financial instructions and other business processes are in place and test compliance by effective use of internal audit and management testing.
- Financial reporting to the governing body should be both clear and timely (attempting to avoid data time lags).
- Financial information should include financial trend analysis with reports stating projections rather than merely historic reporting; avoid the equivalent of driving a car using only the rear view mirror.
- CCGs should avoid basing confidence in performance on the trust in colleagues to deliver. Instead they should base their judgement on robust data, which is subject to regular testing by internal audit.

Risk management

Risk management: statutory and authorisation requirements

Authorisation guidance to date

- CCGs must be able to deliver all their statutory functions.
- CCGs must be able to manage risk.

The UK Corporate Governance Code issued in May 2010 states that boards '*should maintain sound risk management and internal control systems*'. Risk management is often seen as the role of the audit committee, but, as the Financial Reporting Council paper on boards and risk states: '*Responsibility for reviewing internal controls and the process of risk management might be delegated to board committees, but this did not detract from the Board's strategic responsibility for risk decision-taking*' (FRC 2011).

Key elements of a governing body's responsibility for risk are:

- determining the organisation's approach to risk
- setting and instilling the right culture throughout the organisation
- identifying the risks in the strategy, including risks from external factors that could undermine its strategy, reputation or long-term viability
- overseeing the effectiveness of the organisation's processes and controls
- ensuring the organisation has effective crisis management systems.

(Adapted from FRC 2011)

It is critical that a CCG identifies the strategic risks that may stop it achieving its purpose. All too often leaders

of organisations fail to identify the strategic risks that are potential 'show stoppers' because the governing body focuses on the operational risks that are both easier to understand and, quite often, to manage.

Governance in NHS organisations is often described as 'integrated governance', combining corporate, financial, clinical, information and research governance, and all of these factors will need to be considered by the CCGs in developing their risk management framework. Clinical risk may be considered by a quality sub-committee, ensuring appropriate clinical governance controls are in place. Information governance covers the handling of all organisational information, encompassing legislation including the Data Protection and Freedom of Information Acts. Research governance is key to the CCG being able to uphold its duty to promote research, ensuring that research is conducted to high scientific and ethical standards. Each of these elements will require appropriate controls, which ultimately will need to be monitored by the governing body.

A useful technique in managing risk is to develop an 'assurance map' that identifies the different sources of assurance around key risks and controls. An assurance map is usually presented in the form of a colour-coded grid that has the key business risks and the forms of assurance (with their relative strength). This can help to focus discussion in the governing body and its supporting committees and to identify gaps that may need to be filled by internal or external sources of assurance.

These elements are echoed in the Audit Commission's report, *Taking it on Trust*: '*Each trust should publicise a clear definition of risk to reduce potential inconsistency in its approach. It should also set out what level of risk it is prepared to accept for each different type of risk.*' For example, it can be helpful to agree triggers or criteria that determine with risks should be considered by the governing body. Another key finding of that report was that trusts had often identified large numbers of risks which were not always aligned to the organisation's strategic objectives. '*Aggregating the risks would enable the board and relevant sub-committees to sharpen their focus*' (Audit Commission 2009).

Case study: risk management

In this case study we provide an example of where a hospital board used strategic risk management well.

The governing body used the analytical skills and capabilities of its members (especially those with commercial knowledge) to analyse the external risks associated with a proposed PFI development. They identified the key strategic risks associated with PFI contractual constraints, the relatively high costs of the PFI compared to alternative funding and the risk of significant changes in NHS funding. The decision of a hospital board to stop the re-building of a significant part of its estate under a proposed PFI contract ensured its financial sustainability.

Key contributors to success were:

- sitting back and looking at high-level risks such as the wider economic environment rather than focusing purely on the NHS context
- exercising independent corporate leadership (ie, the ability of the board not to necessarily follow the NHS trend).

Top tips

Risk management

- Governing bodies should focus on outward facing as well as internal strategic risks.
- The strategic risks of the organisation should drive the agendas of governing bodies so that those risks are effectively monitored and controlled.
- Governing bodies should develop a risk map to review their assurance processes and identify any gaps. This should include corporate, financial, clinical, information and research governance risks.
- The risk management process should ensure that operational risks that threaten the organisation's ability to achieve its objectives are escalated to the governing body, but senior leaders should not be preoccupied by operational risk. This will require the organisation to clarify what level of risk should be managed by the governing body.
- Although audit committees may take responsibility for reviewing the effectiveness of risk management processes, the governing body takes overall responsibility for operating the risk management system.

Conclusion

Good governance provides the foundation for organisational high performance. Securing good governance, and the pursuit of the underpinning principles of accountability, transparency, probity, and long-term sustainability, alongside the ‘Nolan principles’ of public life, need to be a core focus for the governing bodies of CCGs. This guide has laid out how these principles may be applied in practice, by ensuring that CCG governing bodies:

- have the right **structures** in place
- develop effective **processes**
- ensure these structures and processes are directed towards improved **outcomes**.

Much of our advice comes from previous experience in this country, from the corporate sector and the NHS. We have not drawn extensively on international examples of GP-led commissioning or provider organisations. This is because the statutory nature of CCGs sets them apart from international examples that are in the main GP-owned private companies, such as IPAs in New Zealand or accountable care organisations in the United States. The fact that CCGs are statutory bodies, accountable to parliament, as well as being active membership organisations, provides them with a unique set of challenges.

We believe that there is a risk that operating as a statutory body could potentially threaten the entrepreneurial drive and innovation found elsewhere. CCGs might find themselves looking up to the NHS Commissioning Board for direction rather than out to their constituent practices and local communities. It will therefore be essential for the CCG governing body to counteract this threat by developing a sense of common purpose and vision within the CCG and with the local community. This common purpose and vision will also help to bind member practices together.

The lines of accountability and the regulatory landscape in which the CCG will be operating will also evolve as SHA and PCT clusters are abolished, the NHS Commissioning Board is established, and Monitor takes on new responsibilities. It is very important that all CCG members, and particularly the governing body, fully understand this landscape and its implications for their operation.

The governance agenda throws up a range of personal and organisational development issues. It is vital that the development programmes now being commissioned for and delivered to CCGs equip CCG leaders with the skills needed for good governance and help inculcate these values into these new organisations. A key first step would be establishing the shared vision and values. Another major priority should be decision-making skills. Even well-established boards struggle with this. Decision-making skills should be a core part of CCG leaders’ personal skills development. Mechanisms to manage conflicts of interest need to be built in at the outset. This also suggests some targeted development of the prospective chairs of the CCGs, who will play a pivotal role in this area.

Finally, we would wish to emphasise that it will take time for new structures and processes to bed down, and the environment within which CCGs are working and the people they will be working with will be evolving and changing. CCG governing bodies need to regularly review their own performance and that of their members. Good governance is an ongoing journey, not a one-off exercise to enable CCGs to jump through the hoop of authorisation. The NAPC plans to support member CCGs to develop and innovate through the NAPC/KPMG Commissioning Foundation using a variety of means including webinars and masterclasses. The aim is to bring in new perspectives from outside of the NHS in England so that CCG leaders can reflect on and determine how best to develop their governance arrangements.

Annex

The authorisation process

All GP practices will be required to belong to a CCG that will be held to account by the NHS Commissioning Board. CCGs will not have responsibility for commissioning primary medical services or some national and specialist services. CCGs are commissioning bodies and not providers of services. Individual GP practices may also continue to provide services themselves, or to belong to federations of practices or organisations which provide services, but this will not be the role of CCGs.

The Health and Social Care Bill sets out a range of requirements for CCGs that will need to be met before authorisation. The Bill also allows for the NHS Commissioning Board to establish further regulations relating to authorisation, but these will not become clear until the Bill is passed and the NHS Commissioning Board is fully established (it is now established in shadow form as a special health authority). In advance of this, guidance to CCGs from the Department of Health provides some indicators of what these requirements may be.

The Health and Social Care Bill allows for a two-part process, which will permit the CCG to be formally established as a statutory body. The Department of Health has outlined a roadmap to authorisation, based on a phased approach (Department of Health 2011a). It will be a staged process:

- initial development phase
- application
- full 'authorisation process'
- annual assessment.

The full authorisation process will require CCGs to submit evidence to demonstrate their capability across a wide set of domains, including constitutional and governance arrangements. The NHS Commissioning Board will then satisfy itself about the validity of the evidence and use information from other sources to understand how the CCG has developed.

There will be three outcomes to authorisation: shadow CCGs (established but not authorised to undertake commissioning); authorised with conditions and fully authorised.

The Department of Health has indicated that further guidance on the authorisation process will be published in early 2012.

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