Introduction

Welcome to the first edition of ACE Focus, a series of publications from Achieving Commissioning Excellence (ACE), a service to support clinical commissioners including the website: www.nhsace.com.

Achieving Commissioning Excellence is produced by NHS Alliance in association with NHS Clinical Commissioners. NHS Clinical Commissioners (a coalition of the NHS Alliance and the National Association of Primary Care in partnership with the NHS Confederation) is the new membership service to give clinical commissioners a strong, independent collective voice. Achieving Commissioning Excellence is sponsored by Novartis.

This issue focuses on the lessons from applications in the first wave of authorisation, drawing on the experiences of several Wave One CCG leaders – and an assessor who’s a second-wave CCG leader.

Our aim is to compile timely, topical lessons that can be of practical use to the leaders of CCGs applying in Waves Two, Three and Four.

This does not pretend to be a definitive study of authorisation: it is a series of snapshots, experiences and observations. We thank all participants for their time and enthusiasm to share their learning. We hope it will be useful to you.

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Making the most of authorisation: safety and self-improvement

Julie Wood, National Director of Clinical Commissioning for NHS Alliance and Interim Commissioning Development Director, NHS Clinical Commissioners.

The aim of this document – our first print publication for Achieving Commissioning Excellence, but also available on our interactive website – is to record and share the positives and learning from CCG pathfinders in the first wave of authorisation by the NHS Commissioning Board. CCG authorisation is a learning process for both parties.

One important thing is for CCG pathfinders to use the authorisation process wisely, to help you on your journey and not to fall into the trap of seeing it as an isolated process.

A CCG with whom I worked found their mock authorisation panel very developmental for the isolated process.

Julie Wood, National Director of Clinical Commissioning for NHS Alliance and Interim Commissioning Development Director, NHS Clinical Commissioners.

CCGs are not expected to be perfect in all areas, but are expected to be safe – so expect to be tested on being safe. Also, expect to be interrogated on stuff: how your patient feedback triangulates with your quality report and having the right inputs and outputs at locality level. Make sure your documents and evidence offer ‘face validity’ and some degree of reassurance that you don’t have a potential Mid Staffs.

One of the most common mistakes or misconceptions around authorisation is a desire to believe that more is more. CCGs are designed to be different: the approach is about integrated governance; not more governance. If your documents say that you’re handling governance this way, make sure that in practice, you really do. Be clear (again) that evidence supports your practice.

In your application, you must self-critically against the draft criteria, including things like compliance with the NHS Constitution, and environmental sustainability. Ask yourself how you can prove what you’re saying about being compliant against environmental sustainability, if that’s an emphasis.

When you’re preparing for your assessment panels, let the power of your clinician’s come across. Let their leadership, innovation and enthusiasm come across; absolutely don’t try to corporatis or gag them. It’s incredibly powerful to let them enthuse about the changes they are leading.

Finally, here’s a suggested slide rule to measure all your preparations – does it help you deliver your vision as a CCG and will it also deliver against OQPP / the Nicholson challenge etc and the Commissioning Outcomes Framework? You need a through-line from your vision to the NHS Operating Framework, to Commissioning Outcomes Framework and OQPP to better care for your patients.

Assessing CCGs: an applicant-and-panellist’s tale

Richard Alsop, Chief Commissioning Officer of Nene CCG, outlines his work as a Wave Two CCG pathfinder applicant and also in assessing a Wave One CCG.

If you’re sitting there confronted with a poorly-signposted document, it’s really difficult to do what is required in the time available, so you just may not find some things that would be helpful to the applicant CCG. A smaller number of documents with really good signposting will be better, letting the assessor find what they need and be confident this CCG knows what they’re doing.

Doing our CCG’s submission, I found the knowledge management system more helpful than I was expecting: it helps you manage your workflow through the process, and lets you know where you’re up to in terms of documents loaded, and does automatically lead you to signposting.

In terms of my work as an assessor, the main experiences divide between the work on domain assessment (desk top research), and then the panel visit.

In the domain assessment, if you’re sitting there confronted with a poorly-signposted document, it’s really difficult to do what is required in the time available, so you just may not find some things that would be helpful to the applicant CCG. A smaller number of documents with really good signposting will be better, letting the assessor find what they need and be confident this CCG knows what they’re doing.

It was also helpful where a CCG had bundled several documents together into a PDF and signposted within that, rather than uploading 15 different ones.

There’s also a risk of over-signposting, taking any piece of evidence vaguely in the area for a domain if you signpost every tangentially relevant bit, then it takes the assessor a while to get to the killer bit. The way out is probably not to signpost marginally useful bits of evidence or not include them if you have compelling evidence elsewhere.

When it comes to the panel visits, first impressions count. From our arrival, actually seeing the CCG taking it seriously, caring about creating the right effect and looking like a professional outfit made a great impression.

The fundamental lesson is that you need to demonstrate an ambition beyond authorisation. Authorisation should be about the minimum safe entry level. If an assessor can see vision, ambition and a desire to be better, that will speak volumes.

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Another key lesson seems to be: don’t regard authorisation as the son of World Class Commissioning, nor as a pass-fail thing (although it may feel like that). It’s important to remember that authorisation is a maturity model, which is about CCGs being safe to proceed. It’s the end of your journey, not the end.
Authorisation: a technical, precise process, changing as we go

Lee Beresford, Cat de Jonge and Gemma Gamble of Wakefield CCG discuss key lessons from their journey towards authorisation.

The process of moving towards authorisation has been very useful, which was perhaps not what we anticipated prior to starting out. As we’ve gone through it, it’s very apparent that each one of the 119 criteria have to be met. Initial comparisons with World-Class Commissioning have proven to be off the mark – this is a very technical and precise process.

Being a Wave One pathfinder, we always knew we’d be on the tip of the curve. That expectation has been borne out. We’ve been getting guidance daily, and changes of direction on (sometimes) an hourly basis — which is all natural when trying to manage a huge change process like this. We expected that, and we were not disappointed!

There were some ‘known unknowns’— occasions when we faced a lack of clarity. Clearly, this is a very legal process, so for future waves, it would be useful to include audit in terms of checking through your progress.

Authorisation is a huge undertaking for us as a relatively small team of people, and there’s a risk of losing sight of the wood for the trees. That’s why I think having a reality check from someone with an audit background would be helpful.

Some criteria are very specific (although they are linked overall), but I think you need someone with an eye for detail to review what you’re trying to accomplish to help you do a thorough enough job.

There was some confusion early on before the legislation was finalised, and we fell slightly into the trap of believing early on that being a Wave One pathfinder was part of the initial set of GP commissioning consortia pathfinders, and so we were about a year ahead of the rest of us. The NHSCB did not say that documents must be near-final drafts as regards governance arrangements, which was not obvious in the technical structure for submission.

There were some pleasant surprises: our desktop summary report included pats on back where it observed we were progressing well. That was a nice acknowledgement of our progress.

The assessors seem to come from quite different backgrounds, and have differing levels of experience. Colleagues tell us that this is playing out in unexpected ways, with some panels adopting a very structured and rigid approach.

The key assessor was initially presented as a key link person to work alongside the CCG throughout the process, and act as the go-between between the CCG and the site visit panel. Then last week, we were told there will be no contact with key assessor until the day of the panel.

Some things that really matter to us as a CCG, such as engagement and bringing patients along with us, have been passed, and that’s comforting. Some of the more structural transfers of responsibility are still underway, so we’re submitting a plan for a plan, trying to cover the trickier aspects. And it’s not clearly stated what kind of plan would be adequate, which in sporting terms feels like a foul – as if they’re making up some of the rules as fast as we go along.

This is being done on the hoof, and changing as we go. And we have great sympathy because it’s not easy for the people making the rules, but in our experience they’re not going all the way to mitigate the negative feel of that.

The things we use to keep us focused included our choice to work as a small, tight team, of dedicated individuals, selected from different backgrounds, and to ensure it was a document they recognised and owned.

A teething issue for the NHSCB and CCGs was exactly how to signpost the documents submitted in evidence during the desk top review. It’s been clear from the start that this process is fundamental, but it was difficult to do in such a way that suited all three kinds of assessor. Quite a few Wave One sites were asked to do more work on signposting following the submission to allow the assessors to be pointed more easily at the exact paragraph we were submitting in evidence.

If we had our time again our approach would be to describe the ‘story arc’ which linked the documents together and submit that as a key signposting tool, rather than relying on the assessors to have NHS experience and be able to make some of those connections for themselves.

Authorisation is an exacting process but one which will hopefully become clearer and easier through Waves Two, Three and Four. It can’t be understated how crucial good preparation is, and it’s also important to read the guidance documents carefully and thoroughly. Most of all, take time to tell your story as clearly as you can to demonstrate your CCG is fit for purpose.

Lee Beresford, Cat de Jonge and Gemma Gamble of Wakefield CCG discuss key lessons from their journey towards authorisation.

This is being done on the hoof, and changing as we go… it’s not easy for the people making up the rules, but in our experience it’s better to be more open about these sorts of issues.

Having a reality check from someone with an audit background would be helpful.

A quick tip is to make sure your major documents are in top-flight form to be in the best position going into your site visit – and your constitution is a major part of this as it will outline all of your governance arrangements – or should!
Steal good practice, fit your work into their format and focus on responsibilities

Niti Pall of Sandwell and West Birmingham CCG outlines the fruits and frustrations of the authorisation journey.

We've just finished our authorisation document, and my overall reflections are that it felt very cobbled together. Guidance has changed quite a bit. Locally, we had started work to be a pathfinder way in advance, but we'd done it in different formats, and so had to change it to make it suitable for the forms that came through.

We'd done a lot on patient engagement, and how to show patient and public engagement: we did that really well, but in a different format, one that was about making it a core part of the way we do business here. We'd also started an end of life care strategy, based on a user-experience-led approach. And it's been hard to get others to see that as patient engagement, and we had to convert it into their format. The lesson from which is: look at what you've done, don't re-invent the wheel, keep it simple and repurpose into their format.

The process felt like being caught in glue again, and like world-class commissioning. I nearly lost the will to live, and had to refocus and break it down, and we've had really good management support to see that through and put it all back together again. Our chair was very focused on this, and we've had really good clinical leadership.

The process probably helps to focus minds on what the CCG's responsibilities are going to be. That's been a shock to some younger entrants; we oldsters have seen it before.

I see this as a hurdle to get to authorisation and then we get to the real job: it has to be done, it's a means to an end. And when authorisation is done and dusted, I don't think people will open the document again.

We've focused on statutory responsibilities and delegated authorities: financially, performance, audit and risk management. Our lay vice-chair has to be done; it's a means to an end. And when authorisation is done and dusted, I don't think people will open the document again.

But it has led to a lot of disengagement; to energy being focused on financial, performance, audit and risk management. Our lay vice-chair has seen it before.

Three broad lessons for CCG colleagues moving to authorisation: firstly, you need your patient and population engagement platform to be really good. If you lose sight of that, you lose sight of what you are doing this for. Second, keep focused by getting really good managerial support on your project; to break down, write and collate it all and let you do what you are good at. Third, share that with all your members: this is something we didn't do well - your stakeholders, board and members should all be familiar with the process and product. If you don't do this, then when someone on your authorisation committee asks 'why did you make such and such a decision?', you will not be able to answer properly.

We have had some pleasant surprises: one was seeing just how much we have done on patient engagement, hundreds of examples. It was also good to see how engaged our lay members are – chair and members, all really wanted to help. And our Health and Wellbeing Boards have genuinely been engaging very pleasant surprises.

The next step is the move to panel assessment, and we're trying to get ourselves ready. And everything else is in total chaos, the PCT is imploding, the SHA is dying on its feet, the commissioning support service is turning into a commissioning support unit - so finding the right people to talk to is really tough.

The key message is that this is a process, a means to an end and it's going to happen. Hold your nerve: it's what happens after this that is important, not what's happening now.

The risk is that this leads to us all staring at our navels and focusing on the 'how' not on what you want to achieve, or the things that really need doing.

So we've been doing things to keep that clinical engagement in parallel. The officers on our board have been doing that.

The process felt like being caught in glue again, and like world-class commissioning.

If I were to pick out three key lessons, the first would be a piece of advice. Accept that authorisation is not going to be something that is automatically part of what you planned in developing your CCG, and that you'll need to dedicate significant time to it. The sheer amount of time needed took us a bit by surprise. So did the amount of signposting required in our authorisation documents, which I'll come back to shortly.

The second is equally important: keep it simple. Make it obvious that in your locality something has happened to drive change in how you work and commission services – but don't over-elaborate. Describe it; provide evidence; move on to the next area.

The third is not to assume your assessors are too expert about your locality and focal issues, be they geographic, provider related or whatever. We thought we were relatively mature and had a fair amount already in place, having merged with our PCT and worked as one service. CCG leaders need to sell your story and get a high level of understanding. An area like ours has particular issues related to geography which someone who does not know the area may not understand.

Another detail issue: check and keep on top of your stakeholder survey, and ensure that all your stakeholders are able to access it (locally, we had some technical issues).

Rightly rigorous

Authorisation is a rigorous process, but rightly so given that we are spending public money.

You do really have to focus on the process, but the things we're most proud of are not about the authorisation - process things - we're proud of clinical things, which are about how we want to work locally.

In telling your story, emphasise areas where the CCG has identified areas where quality for patients can be improved; and the actions you've taken as a result. That is a chance to show off joint working and listening to patients and members about quality issues.

Having been through our panel day, our experience was that the tone of day depends on the panel members. Ours set a very good tone in how the panel conducted themselves. I was slightly sceptical that it would be as constructive and exploratory as it was: it was very helpful.

Signposting within your authorisation documents is so hugely important. Know where to find your evidence to back up all your statements and ambitions.

That signposting pays dividends when you get your panel visit. You will have a list of their red key lines of inquiry, and you have to focus on turning each one green, or your day could end up in a vague discussion about the NHS.

You need a real goal-focus, and to make it obvious why you are safe to be rated green in each of those areas. We did a pack for ourselves and the panel members, signposting to evidence for each key line of inquiry – they found that really helpful.

One example, was that we had a red because our conflict of interest policy needed updating (as the national example wasn’t released until after we submitted it), we had done the update and had it in our pack with the red line inquiries addressed.

Looking back, the panel day was a really good experience for involving stakeholders, so we focused on our relationship with our local authority and a senior person from our local authority came in for the morning. Our panel had a senior local government person, and that was really useful because he could tell what we had been doing together.

Final thought: focus on the panel’s key lines of inquiry and pick out local examples that are useful to tell your story – and ensure every document is well-signposted.
Useful web links

NHS Clinical Commissioners
www.nhscc.org

NHS Alliance
www.nhsalliance.org

NAPC
www.napc.co.uk

NHS Confederation
www.nhsconfed.org

NHS Commissioning Board
www.commissioningboard.nhs.uk

NICE
www.nice.org.uk

NHS Information Centre
www.ic.nhs.uk

NHS Atlas of Variation
www.rightcare.nhs.uk

Cochrane Collaborative
www.cochrane.org

Kings Fund
www.kingsfund.org.uk

Nuffield Trust
www.nuffieldtrust.org.uk

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