Appendix 1: Darlington Clinical Commissioning Group
Development Plan - October 2011

Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
1. CLINICAL FOCUS & ADDED VALUE						
The emerging CCG has clinical leaders that are able to influence and lead others to deliver on the emerging CCG's objectives of improving the health of the population and using the budget most wisely	• The CCG has few good clinical leads • Each Practice has a nominated lead for clinical commissioning • There are identified leads in pathfinder workstreams (unscheduled care, MSK, intermediate care, children's pathway) and other key priorities including Prescribing • Protected Learning Time has a commissioning element as well as other influencing/implementing change through education	• Insufficient clinical leadership capacity and capability across the organisation • Leads need to have a better understand the commissioning agenda and have mandated authority to make decisions on behalf of the Practice • Need to ensure flexibility in the way clinicians work with the CCG • No formal mechanism to identify new emerging talent • No formal mechanism for	• Develop additional clinical leadership capacity across the CCG – not just GPs • Role clarification for leads; agree expected outputs of role • Provide opportunities for a range of different learning opportunities (formal leadership programmes, e-learning, coaching, shadowing) • Establish a process for talent spotting and succession planning • Provide a range of training across the CCG in respect of change	CCG Board OD portfolio lead/Joint chairs	Oct 2011 - Oct 2012	• External support via National Leadership Academy; NHS Institute of Innovation and Improvement /Audit Commission; local programmes • Protected Learning Time sessions • Source and procure external expertise to work with the CCG board level leaders • Source and procure top leaders development

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
		succession planning • Limited knowledge within the existing team in respect of corporate functions e.g. corporate governance • No formal development for emerging top clinical leaders (aspiring CCG accountable officers, chairs)	management/continuous quality improvement e.g. LEAN, pathway planning, principles of project management for clinical leaders. • Provide learning and leadership development opportunities for current and aspiring top clinical leaders			programme for aspiring clinical leaders
The emerging CCG has a comprehensive, up-to-date understanding of the needs of its population, now and over the next 5 years such that, if asked, the emerging CCG leadership and constituent practices could describe the main health issues facing their (respective)	• Member practices can articulate own health issues at a Practice level • Extensive needs assessment taken place (SNA/Health profiles) • Regular updates from the Public Health Team • Practice level data made available for Darlington	• Limited Darlington population wide view. Darlington SNA and health profile data there but not utilised to best effect • Tendency to look at gaps rather than needs • Capacity to provide	• Work closely with Public Health and Darlington Borough Council to ensure Health Needs Assessment process is comprehensive • Ensure CCG members understand and then apply SNA/Health Profile data to planning	CCG Board Public Health link	Nov 2011 onwards	• Consider external support where appropriate for Health Needs Analysis Access local training and development opportunities • Access required

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
population	health profiling • CCG joint chair is on membership of Darlington Formative HWB Board	detailed and meaningful reports at CCG and Practice level which are fully analysed and understood by the Practices	priorities • Increase analytical skills and capacity • Further develop prioritisation methodology of need • Ensure CCG members understand the prioritisation methodology and its application • Agree format of health profile produced by Public Health to assist planning and prioritisation			level of analytical expertise from Public Health and CSU • Establish a robust arrangement with CSU for technical support
The emerging CCG understands how healthcare services, and healthcare providers, can meet the needs of the population, and the constraints on this.	• Some understanding of local providers • Limited understanding of potential new providers • Work on-going to understand lead	• The capacity to be engaged in contract round (required for authorisation) • Need to develop understanding of third sector	• Identify key contracting clinical leads and provide support to assist them in engaging effectively in contracting	AO and CCG chairs	Nov 2011	• Utilise a range of internal and external learning opportunities; formal training programmes.

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
	commissioner for main contract arrangements across the 3 CCGs in County Durham and Darlington • Local dialogue in place with CDDFT as main provider (key links established at a range of management and clinical levels) • CCG input in 2012/13 for locally derived CQUIN indicators	providers in the context of the whole pathway • Need to develop performance and quality data and reporting frameworks to enable the CCG to identify performance and quality issues of providers against commissioned services.	processes • Skills to analyse and report performance information from providers			• Establish a robust arrangement with CSU for technical analytical and performance reporting support
Values and behaviours are agreed by all the constituent practices of the emerging CCG. Through the way the emerging CCG works, behaviours that support its values are promoted and strengthened, whilst those behaviours that do not promote its values face sanctions.	• Vision, values and appropriate CCG behaviours developing in conjunction with member Practices	• Values and behaviours not yet fully documented and not embedded across CCG member practices • No sanctions in place	• CCG to formally adopt/agree and promote values and behaviours • Embed values and behaviours throughout the organisation	CCG Board OD portfolio lead	Values agreed end Nov 2011 Embed values on-going	• Access Internal and external support to board level and other CCG members to embed vision, values and behaviours

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
There is a conscious, and promoted, culture in the emerging CCG of systematically and continuously improving the quality of clinical care to improve health outcomes within the given budget.	• Some areas of good practice where focus on improving quality (pathfinder workstreams, referral management scheme) • Use of Protected Learning Time sessions for an annual programme of key areas for quality improvement • Commonality of purpose with ideas generated	• No systematic approach to quality improvement • Need a common understanding of what quality means • Current focus on financial pressures and referral management rather than quality of services for patients	• Strengthen evaluation methods and monitoring of service provision, follow through, share and spread approach • Support to clinical leads and pathway leads for continuous improvement methods • Ensure NICE guidance is taken into account and developed into pathways • Develop a forward plan for quality improvement initiatives • Set up a formal quality review mechanism as part of good governance arrangements	CCG Board Quality and Safety Lead	Nov 2011	• Access internal and external programmes • Utilise local expertise (internal CCG and CSU expertise)

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
2. ENGAGEMENT WITH PATIENTS/COMMUNITIES						
Patient and Public Engagement are embedded into the organisation and the full commissioning process.	• CCG recognises PPE as an essential element of CCG development but need Practices to shift to a wider commissioning focus (CF practice patient forums) • Some early work on joint engagement activities with Local Authority- joint engagement model emerging	• Need an inclusive approach which is consistent across commissioning processes (some gaps in knowledge)	• Develop an engagement strategy (joint with Darlington Borough Council) • Secure PPE expertise to develop the strategy	CCG Lay Board member	Nov 2011	• Utilise expertise locally (CSU and DBC PPE and communications teams), stakeholder groups including voluntary sector
To define, and deliver on its purpose, the emerging CCG has engaged with the different communities in the geographical area it covers.	• CCG aligned staff currently carrying out a stakeholder mapping exercise in conjunction with LA to ensure a comprehensive and inclusive approach. • Joint stakeholder event held CCG/DBC in September 2011 to gain insights into the public views on priorities for	• Some sectors of the public not currently reached and work underway to identify these	• Develop an engagement strategy (joint with Darlington Borough Council) which has comprehensive coverage for all sectors of the local population • Secure PPE expertise to develop the strategy	CCG Lay Board member	Nov 2011	• Utilise expertise locally (CSU and DBC PPE and communications teams) • Ensure support in place internally or via CSU

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
	Darlington • Joint engagement model developing with LA • Strengthening links with voluntary sector organisations and Local Involvement Network					

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
3. CLEAR & CREDIBLE PLAN						
There is a practical and implementable strategy, developed collaboratively, that clearly sets out the priorities for the emerging CCG and why those priorities are likely to lead to greatest health gain taking into account future changes.	• Early work about to get underway to reaffirm CCG vision and values and agree strategic objectives • Clear and Credible Plan framework agreed with defined timelines for completion • Additional resource funded by the PCT to support development of the CCP • CCG involvement in commissioning intensions for 2012/2013	• CCG does not have its Strategic Plan in place as yet	• Skills to develop an excellent strategic plan • Mechanism needed to develop the plan with key stakeholders • Process for prioritisation of objectives and commissioning intensions required • Establish links to other planning processes • Knowledge and understanding and skills in strategic planning and investment planning	CCG Deputy Director	Dec 2011	• Utilise external consultancy (PWC) and local CSU technical expertise from a wide range of commissioning support services

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
In order to achieve best outcomes for the population within the available resources the emerging CCG is equipped to ensure that the needs of the population are met by the providers of healthcare services. The emerging CCG has prioritised what it needs to do to achieve these outcomes within resources.	• The CCG is looking to increase its access to a range of data and information on which to base its commissioning decisions • The information currently presented needs on going refinement to ensure CCG board reporting through to Practice level reporting is meaningful and of use to identify key areas for change • RADR reporting tool is currently being rolled out	• Analytical expertise and capacity for retrospective and prospective analysis as well as scenario generation. • Analytical and costing expertise to support clinical pathway developments and impact assessment of current state vs. future state • Support to Practices to interpret information in a practical and accessible format e.g. Dashboards	• Secure analytical, planning, contracting and finance expertise and capacity to the CCG • Support practices to enable improved use of information from a wide range of sources • Where appropriate consider the value of information/data from other parts of the system (LA social care data)	Lead Director, chairs, CSU relationship manager	Dec 2011 – Mar 2012	• Agree and formalise the support from the CSU and/or internal • Consider support from LA where appropriate (e.g. LA analysts experienced in social care data)

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
There is a clear vision (narrative) of what the emerging CCG's purpose is and how it will achieve its purpose that is to achieve better patient outcomes within available resources, and discharge its statutory duties.	• Work commencing	• No overarching strategic plan in place	• Well-developed strategic planning skills and capacity • Clarify how the individual member practices will be engaged and supported to deliver the CCG objectives	CCG Board OD lead	Dec 2011	• Agree and formalise the support from the CSU.
There are clear, consistent and communicated reasons for the things that the emerging CCG is going to do, and how success will be tracked. These reasons are understood and accepted by Practices and providers.	• Darlington CCG Pathfinder projects are a good example of how this can be moved forward • The CCG acknowledges the need to identify clear measures to track impact of commissioning decisions this will be a key area of work for the on-going learning and development of the CCG • A communications strategy is being developed	• No overarching strategic plan in place • No clear communications strategy for the CCG	• CCG Board and aligned team need well developed communication skills and support available to them • Communications strategy needs to be in place which utilises a range of approaches and methods • Develop robust governance arrangements to support clear	CCG chairs	Nov 2011 – Mar 2012	• Agree support required from PPE, communications , planning and governance teams in CSU

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
			communications to member practices			

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
4. CAPACITY & CAPABLILITY						
Key elements of structural and cultural change (transition) plans are in place, with the skills required to support this, including project management and monitoring success.	• Organisational Development Plan documented (version 1) • Some progress to strengthen the governance and formalise current board arrangements	• Board level endorsement of OD plan • Lack of clarity on what the CCG responsibilities are. • Need clear roles and responsibilities • Define aligned functions and roles • No clear delegation of decision making and responsibilities	• Aligned staff with clear objectives and training to support delivery • Clarify clinical lead and other roles with agreed outputs within an accountability framework • Develop governance arrangements for the CCG based on levels of accountability and schemes of delegation.	AO	Nov 2011	• External/internal training/support programmes
The emerging CCG has the clinical, commercial, legal and other skills and capacity to negotiate, write and manage contracts for the provision of health services	• Capacity and capability currently with the PCT/CSU	• CCG members lack knowledge of commissioning, contracts and the contracting process. Also lack capacity and skills at CCG level to undertake contract	• Ensure Board members fully understand statutory responsibilities in preparation for full authorisation • Ensure a basic understanding across the organisation of	AO/CSU relationship manager	Nov 2011	• Internal support/ shadowing and access external learning opportunities • Access legal advice if required for business

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
		management • Lack of clarity on Federated approach • No performance management framework in place at CCG level • Not fully explored and established who will deliver these functions	Commissioning cycle; legal requirements associated with contracts; supplier relationships; information flows and analysis • Develop the CCG as an "informed client" • State what activities will be done within the CCG vs. bought in from CSU • Put in place an agreed and specification for CSU service lines specifying deliverables; outcomes; standards; KPIs and monitoring • Ensure internal business			contract with CSU

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
			management capacity and capability with appropriate interface with CSU			
The necessary administrative functions are in place to run the organisation.	• Some key elements in place (Board made up of member practices and other leads, reporting framework developing) • Aligned staff for senior management, and some technical support	• Gaps in administrative understanding, skills and capacity, including with regard to the provision and manipulation of data	• Complete next phase of alignment of staff • Set up appropriate CCG Board structure and sub structure arrangements • Clarify roles and portfolios with agreed objectives for senior leaders and others	CCG Lead Director/chair	Nov 2011	• Utilise internal and external training and development
Systems are in place to effectively monitor and track quality and safety so the emerging CCG has early warning of problems and there are clear processes for acting when problems are detected.	• Darlington clinical governance group no longer in place. Practice level clinical governance as providers • Currently the wider	• No CCG level policy and procedures in place	• Require basic understanding of clinical quality and patient safety • Identify a board level lead for quality and safety • Put in place policy and procedures for	CCG Board portfolio lead for Quality and Safety	Nov 2011	• Utilise current PCT expertise to support development of capacity and capability in the CCG • Access external

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
	commissioning role is dependent on the PCT		identification and proactive management of potential quality and safety issues • Develop a decision making process that explicitly incorporates quality and safety			learning
The emerging CCG has, or is able to assemble, the right commissioning skills and build the best operating model to most effectively commission services (in house, shared or bought in).	• Joint chairs in place • Lead Director and aligned staff for Darlington • Chairs operate at Federated level across County Durham and Darlington (informal arrangement to be reviewed) • Involved in development of CSU model • OD plan in development • Pathfinder programme of work	• Functions of Darlington CCG not yet agreed and what will be done at a confederated level across County Durham and Darlington • CCG level assignment of staff to complete •	• Roles and responsibilities clarified • Collaborative arrangements in place with other CCGs for defined areas of commissioning • Clarify workforce required in the CCG vs. shared with another CCG vs. externally provided via CSU	CCG Lead Director, Chair	Nov 2011	• Internal/ External learning and support

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
Effective integrated corporate governance systems of finance, probity, statutory duties and clinical quality, are in place. They go beyond being compliant with legal requirements, and identify and adopt good practice and innovation in the running of the organisation and fulfilling statutory duties.	• Currently covered by the PCT • Monthly finance reports prepared by PCT and reported via Darlington board • Appreciation of processes and statutory compliance (as provider small businesses)	• No policies and procedures for robust decision making and then communication of decisions • No performance monitoring frameworks • No risk management arrangements	• Develop policies, processes and procedures for integrated corporate governance • Develop robust reporting framework for Board level decision making • Develop risk and assurance mechanisms	CCG Director Lead, Governanc e lead	Nov 2011	• Internal support via PCT • Utilise where appropriate existing policies and procedures
There is capacity and capability in the organisation for robust financial management of budgets.	• PCT currently supply quality financial information • Practice level reporting for some areas of devolved budgets • Active prescribing committee oversees prescribing budget • Referral management scheme in place	• Lack of understanding of delegated budgets • No robust mechanisms for reporting to board level • Unclear accountability/owne rship for delegated budgets	• Basic level understanding of NHS financial management, systems and processes • Robust financial reporting in a form that is meaningful and useful to Board level and Practices • Clear accountability for delegated	CCG Board Finance lead	Nov 2011 - Mar 2012	• Utilise PCT expertise and capacity • Internal and external training and development to Board level and others

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
			budgets • Agree internal CCG level or CSU provided finance expertise			
The emerging CCG has a financial planning process that allows prioritisation of resource for commissioning services for its population and ensures that the funds are spent only as intended.	• Using capacity and capability of PCT financial planning team • PCT prioritisation tool and methodology used • Commissioning intensions developed from Practice level engagement feeding into ISOP and clear and credible plan for 2012/2013	• Currently there are no CCG specific policies, process and procedures for financial management, prioritisation and planning at CCG level	• Develop policies, processes and procedures for financial management, prioritisation and planning. • CCG requires basic understanding of financial management, prioritisation and planning • Agree internal CCG level or CSU provided finance planning expertise	CCG Board Finance Lead	Nov 2011 - Mar 2012	• Utilise PCT expertise and capacity • Internal and external training and development to Board level and others

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
The emerging CCG can stand up to public scrutiny regarding its spending of public funds.	• Currently use PCT process where the PCT has a good audit commission record • Devolved budgets stand up to public scrutiny • CCG has developed working relationships with health scrutiny committee • CCG joint chair is member of the Darlington formative health and wellbeing board	• No systems and processes in place as not yet a CCG responsibility	• The CCG requires robust systems and processes to be in place to enable scrutiny of all decisions on funding/spend	CCG Board Finance Lead	Nov 2011 - March 2012	• Utilise PCT expertise and capacity • Internal and external training and development to Board level and others • Access Effective Board development programmes

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5. COLLABORATIVE ARRANGEMENTS						
The emerging CCG has the skills to understand the relationships they, as an organisation, need as good commissioners, and how to get the most out of these relationships.	• The CCG has identified key stakeholders and understands the need for relationships but relationships and mechanisms not as yet formalised • Good relationships across member Practices, Practice Nurse Forum, Practice Managers Business meetings. • Work on-going to develop close working relationships with main acute/community provider at both a clinical and senior management level	• Need to strengthen some areas of engagement across the commissioning process	• Continue to assess and strengthen relationships	AO	Nov 2011	• Utilise expertise in PCT Communication s/ Engagement team)
The emerging CCG has arrangements to work collaboratively with other commissioners including the NHS Commissioning Board, other emerging CCGs,	• Lead commissioner arrangements discussed and agreed for CCGs across County Durham and Darlington	• Lead arrangements not yet formalised and communicated across the system	• Formalise the lead arrangements for County Durham and Darlington	AO	Nov 2011	• Utilise expertise in PCT

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
and Commissioning support services.	• Joint working with Darlington Borough Council on Pathfinder workstreams • CCGs Confederated approach (to be reviewed)	• No formal arrangement with the CSU based on agreed specifications for CSU support	• Establish a mechanism to jointly review the lead arrangement decisions • CCGs to agree joint objectives for co-ordinated commissioning. • Formalise the arrangement with the CSU based on agreed specifications for CSU support			• External support and development • PWC collaborative event Nov 2011l
There is access to the specialist skills and capacity to actively manage supplier relationships and clinical engagement.	• CCG recognises the value of engaging healthcare providers and clinicians • Regular informal arrangements with main acute/community provider • Matrix of clinical leads refreshed and aligned to pathfinder and commissioning intensions	• No formal arrangements with main providers; lead commissioner arrangements • Clinical leads need mandate and clear and agreed outputs for areas of work	• Formalise arrangements with main providers; lead commissioner arrangements • Role and responsibilities defined and support and performance management in place to achieve expected outputs aligned to	AO	Nov 2011	• Strengthen current arrangements for clinical leads • Programme and project management support and or training

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
	• Opportunities for service improvement identified within pathfinder programme e.g. MSK pathways; Urgent Care- creating opportunity to test clinical engagement/provider relationships • Speed dating events held in Darlington for primary care and consultants		CCG priorities.			
Recognising that at a time of change relationships can be lost; there is an excellent understanding of existing relationships and a robust handover mechanism	• CCG leadership involved in PCT transition board arrangements across a range of workstreams involving a broad spectrum of partner organisations	• Handover plan not yet fully described	• Timing and process for handover of functions from PCT to CCG	AO	Nov 2011	• Utilise PCT knowledge, skills, capacity and capability for safe and effective transition

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There are effective relationships with all the Local Authorities, district / Borough Councils and partnerships in the community.	• Effective working relationships with Darlington Borough Council, voluntary sector, LINKs	• CCG vision, strategic objectives not yet consistently communicated to partners	• Consistent stakeholder engagement and communication process to project clear statement on CCG strategic objectives and priorities	AO	Nov 2011	• Utilise PCT knowledge, skills, capacity and capability

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6. LEADERSHIP CAPACITY & CAPABLITY						
Leadership motivates individuals within the organisation to make changes in what they do	• Clinical leaders recognise their transferable skills	• Some gaps exist in the leadership capacity of change knowledge and skills of the CCG leaders	• Need support to develop the following skills and knowledge for the CCG board and all other levels • Change leadership knowledge and skills • Motivational skills • Coaching skills	CCG portfolio lead for OD and Chairs	Nov 2011	• Access local and external training and development opportunities
The right reporting mechanisms exist so the emerging CCG leadership is aware of progress in delivering their strategy.	• Current reporting mechanisms include monthly: • Pathfinder project • Prescribing • Finance reports (activity and spend) • Transformation Fund • Development Fund	• Gaps in understanding, skills and capacity about business analysis • Gaps in interpretation and analysis skills • Lack of defined reports and Inconsistent reporting	• Develop business knowledge and reporting skills and capacity • Basic understanding of performance and quality management and systems	CCG lead finance officer/CSU relationship manager/ informatics lead	Nov 2011	• Internal, practice and CSU support

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
		• Lack of an assurance process				
The emerging CCG is clear about how it makes decisions. The delegation of functions, duties and actions, and of decision making is clear. There is an appropriate distribution of power, responsibility and accountability amongst practices.	• Some local decision making processes in place however accountabilities and responsibilities have not been agreed and documented	• No universal clarity regarding the decision making processes in and for the CCG. • Clear and robust feedback mechanisms to practices, including the consequences of decisions. • Alignment needed to PCT sub-committee arrangements	• Develop robust governance arrangements with clear schemes of delegation from PCT cluster to CCG sub-committee and on to practice level • Understanding of Public Sector Board functions, systems and governance, including: • Risk management • Financial stewardship • Decision making • Quality Assurance • Probity • Legality • Role of Corporate trustee	AO and chairs	Nov 2011	• Utilise PCT expertise • Utilise National guidance documents as to what makes a good board • Learn from good practice in other CCGs • Support from Audit Commission

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
There is a leadership team in place with sufficient knowledge of commissioning processes to be able to ensure effective delivery. This knowledge includes how and where to acquire additional knowledge and skills and to enable sufficient challenge advice provided, if required.	• Some but not all have received commissioning training • Level of knowledge of commissioning is variable • Alignment of commissioning staff has added to skills, experience and knowledge • Organisational Development plan being developed	• Gaps exist in knowledge/skills commissioning process within the clinical leadership (needs to be quantified) • Lack of mechanisms in place to assure the CCG of knowledge and skills levels and continuous improvement.	• Level of understanding needed to interpret information from technical experts and to apply the information in making decisions • Capabilities across governance and finance, planning, negotiating and contract/performance management, innovation and quality improvement	CCG Board portfolio lead/ CSU relationship manager	Nov 2011	• Utilise PCT/CSU expertise and external development where required
The roles and responsibilities of the individual leaders, emerging CCG leadership, the emerging CCG, and the constituent practices are clear and aligned to the Vision, Values and Strategy.	• Some OD work to explore roles, vision, values and strategy in development	• Roles of all members need to be fully identified with job plans and personal development plans • The leadership roles and responsibilities are not universally	• Personal development plans required for each member with any identified specific training	Lead Director/Deputy/chairs	Nov 2011	• Utilise experience of PCT aligned team

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		understood and accepted				
The Leadership of the emerging CCG is able to make transparent, defensible, informed, robust and sustainable decisions about the allocation of public funds on the basis of systems that are compliant with legal, statutory and regulatory requirements and national governance policies.	• Currently dependant on PCT finance and governance teams	• The CCG has not yet determined how to robustly incorporate financial and commercial competency into how it makes decisions	• Basic understanding of NHS financial systems • Basic understanding of NHS specific costing processes • Alignment of qualified financial support • Improved availability of financial information • Clear accountability arrangements	CCG Board finance lead	Nov 2011	• Utilise local expertise, shadowing, support from CCG aligned team
Leadership understands how to involve those who will actually make things different, such that the success of the changes that are brought about is made most likely.	• Some identified areas of pathway and service redesign demonstrating engagement of clinicians and stakeholders including PPE • Practice level involvement in development of	• Require a documented and communicated plan for engagement and managing stakeholders in the changes, universally agreed and consistently	• Comprehensive stakeholder communications and engagement plan-joint with LA; consider use of voluntary sector to disseminate	LAY member/chair/medical director	Nov 2011-	• Local support from PPE/ communications teams (including LA) aligned and via CSU

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Area for Action	Current Position	Identified Gap	Development Need	Lead	Timescale	Method to address/ resource
	commissioning intensions • Some levers for change identified e.g. transformation funds, QOF	applied	communications			

NOTE:

Until appointments made to all senior leadership roles lead responsibility is assigned to known subcommittee level posts.