Darlington Shadow Clinical Commissioning Group

DEVELOPMENT PLAN

2011/12

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1 Introduction

Primary Care clinicians in Darlington intend to seize the opportunity to develop and embed leadership for clinical commissioning that puts the patients and the local population at the heart of decision making in the local health service. In so doing clinicians recognise the need to establish, develop and sustain a credible organisation that is fit to deliver this ambition. This development plan recognises that the shadow Clinical Commissioning Group (CCG) continued the journey from an advisory body under Practice Based Commissioning (PBC) to a clinical decision making and commissioning organisation as a CCG that is authorised without conditions and has set a clear direction of travel to realise its ambition.

The purpose of this development plan is to articulate what needs to be done in order that the CCG can, at this early stage, progress along its chosen development path towards authorisation. In doing so it sets out detailed plans for the immediate term [Phase 2 of the Transition Programme, October 2011 through to March 2012] as well as the framework for the medium term [March 2012 to October 2012] and longer term. The development plan includes formal review processes along its development journey, to ensure that it remains relevant to the needs of the CCG as it progresses along its chosen path to authorisation as the statutory body responsibility for commissioning for health and health care services for people in Darlington.

Importantly the development plan does not stand in isolation, and should always be read alongside the a suite of other critical plans that the CCG is making, in particular its **Clear and Credible Plan** [due December 2011], **Commissioning Intentions** [due January 2012] and the **Cluster Transition Plan** [in place].

This Plan sets the clear and firm foundation to establish, develop and sustain an effective commissioning organisation that has the capacity and capability to improve health and secure appropriate health care services for the people of Darlington. Detailed actions are described in Appendix One that supports Darlington shadow CCG through the authorisation process and beyond to become a successful commissioning organisation.

2. Background

2.1 General

The Government has set out a clear intention to ensure the commissioning of health services has a strong clinical focus where CCGs will be different from any predecessor NHS organisation. As further detail has unfolded, local arrangements have been set in place to enable Darlington locality to form as an shadow CCG. Darlington's shadow CCG aspires to be an early authorised statutory body, October 2012 and has set out on an ambitious development pathway. Darlington CCG is built on the GP practices that make up the membership of the CCG. The member practices must decide, through developing its constitution, and within a framework of legislation, how the CCG will operate and ensure that the organisation is led and governed in an

open and transparent way (Towards Establishment, Department of Health December 2011).

2.2 Legacy

Darlington has a a singular identity and currently also exists as a PCT under shared management arrangements with County Durham PCT. It is predominately a large market town with a rural hinterland. Its primary care family comprises twelve practices, operating under Personal Medical Services [10] and APMS [2] arrangements, further details can be found at Appendix Two, serving a population of approximately 100,400. The ten established practices [PMS practices] share a long heritage of involvement in planning for their patients; through PCG / PCT and co-working as part of Darlington PBC arrangements. This has been augmented recently by the two APMS practices [managed by Intrahealth and County Durham and Darlington NHS Foundation Trust) ensuring comprehensive coverage of the registered population. The integration of these practices into the CCG will require further discussion within the CCG and practices as part of the developing relationship to understand the “gives” and the “gets” and including refreshing of the local compact.

Under PBC, resources were focussed on influencing commissioning decisions to improve the health and well-being of the registered population of Darlington at both practice and locality level. Commissioning knowledge and skills within Darlington have therefore been developed. More latterly, December 2010 practices came together to form a first wave ‘pathfinder’ to pursue a number of complex and strategic commissioning themes, including review of urgent care, musculo-skeletal [MSK] services and to exploit joint work with the local authority.

As a pathfinder Darlington has taken responsibility for urgent care, elective care, prescribing and continuing care and has co-worked with six other Pathfinders across County Durham and Darlington wide in a federated model of working. It is intended that this collaborative approach will continue with the other local shadow CCGs covering North Durham and Durham Dales, Easington and Sedgefield respectively.

Importantly Darlington practices have already demonstrated how clinical commissioning can improve pathways and health outcomes for local people. However, the transition from the PBC model to statutory CCG will demand vastly different skills, capacity and capability of the member practices, specifically the clinicians supported by skilled managers and CCG workforce is recognised and central to taking this development plan forward.

The Pathfinder projects are already providing evidence of local clinical leadership and engagement underpinned by a better understanding of local population needs and system wide opportunities to improve patient outcomes and quality of service provided. This learning must be built upon to ensure that the CCG develops the knowledge, skills and mindset to shape care and services that improve outcomes for Darlington.

In Darlington clinical leadership has not been vested in a single individual, but distributed amongst a team of three lead GPs. This arrangement has worked well but needs now to be reviewed and extended further.

2.3 Local System

Within the PCT Cluster of County Durham and Darlington there are three shadow CCGs, Darlington, North Durham and the Durham Dales, Easington and Sedgefield CCG, of which Darlington is the smallest. Durham Dales, Easington and Sedgefield and North Durham. Each CCG is at a formative stage and looking to be fully authorised by April 2013, following a parallel critical path towards authorisation. A detailed project plan has been developed for CCGs capturing key milestones and actions to be achieved. It is proposed that this should be a shared project plan and should help to inform the development needs of the clinical commissioners and their 'home' team (i.e. aligned CCG management team).

Darlington CCG is served by one main acute provider (County Durham and Darlington NHS Foundation Trust) with a major hospital site in the centre of town at Darlington Memorial Hospital (DMH). The Foundation Trust also provides acute services from a second site in Durham and at Bishop Auckland. Most of the initial patient flows are into the local acute hospital with a much smaller number into the acute hospitals in Durham North Yorkshire and Teesside.

Community health services are also provided by County Durham and Darlington NHS Foundation Trust following the Transforming Community Services and have community hospitals at Barnard Castle, Weardale, Sedgefield and Shotley Bridge.

The principle provider of Mental Health services, both acute and community are provided by Tees, Esk and Wear Valleys NHS Foundation Trust [TEWV].

3. Our Challenge

3.1 Our Population

The area covered by Darlington CCG is predominately urban centred on the town of Darlington and is coterminous with Darlington Borough Council (DBC) where the Darlington Strategic Needs Assessment (SNA) is utilised as the common underpinning resource to inform key priorities and planning for the population of Darlington. Despite the compact nature of the area there are some marked differences in health between wards of the Borough.

The partnership with the local authority provides a unique opportunity to focus on the needs of the local community. The consolidation of close working relationships with Darlington Borough Council can enable a clear advantage for both organisations to optimise the impact of joined up commissioning decisions on the health and well-being of local people. The developing relationship between clinical commissioners and local authority is regarded as a key success factor in the long term viability of the CCG as well as

supporting the development and impact of the Health and Wellbeing Board arrangements

The SNA indicates that nearly a quarter of the residents of Darlington live in the most deprived areas of England. Furthermore, just under a quarter or residents live in the least deprived areas which signifies a major disparity across the town of the varying levels of health and deprivation. Men from the least deprived areas of Darlington live 11 years longer than those from the most deprived areas; with the difference in life expectancy for women between these two areas is 9 years.

Although the average skills level of adults locally is higher than the national average, over 10% of the population have no qualifications at all and literacy and numercy are clear priority areas for imporovement. There is a relative high traveller population locally.

The proportion of the population aged over 50 years old in Darlington is increasing with the majority of older people now live more independently within their own homes. The number of people aged 85 years and over is projected to increase by almost two thirds by 2023. A large rise is predicted in the number of people diagnosed with dementia, predicted to increase by 61% by 2026 and current statistics show that 19.3% of the Darlington population live with a long-term limiting condition, which again is above the England average.

The rates of premature death in Darlington are highter than England. Two thirds of premature deaths are accounted for by cardiovascular disease and cancer. COPD is also leading cause of mortality as well as a poor quality of life. Darlington experiences significantly higher morbidity than the England average in the following areas:

- Lifestyle (smoking, healthy eating, binge drinking).
- Over 65's "not in good health"
- Incapacity benefit for mental illness
- Hospital stays for alcohol related harm
- Drug misuse

3.2 Our Organisation

In addition to the population health challenges, the shadow CCG recognises particular challenges around its own operation. These include the following:

- The local management arrangements to support CCGs need to be strengthened with an initial focus being to develop and implement a leadership and accountability structure in readiness for authorisation as a stand-alone statutory body. Building on established relationships with main provider organisations and local authority, the CCG leadership team will quickly develop and formalise these arrangements in readiness for the delegation of significant commissioning budget and responsibilities from 1 April 2012 onwards. Organisationally, management arrangements will

continue to be ‘flexed’ in line with the capacity and capability needs of the CCG development and PCT ’close down’ in line with national policy.

- There will be a need to achieve economies of scale through developing CCG commissioning support systems and processes drawing on the expertise available in the PCT cluster, commissioning support as an informed client as well as neighbouring CCGs.

- Building on the pathfinder commissioning projects and commissioning intentions a clear and credible plan will need to be developed and shared with main providers to support its overall vision and objectives as an effective clinical commissioner

- The size of the budget delegated to the CCG will be proportionate to the population size and as such Darlington will be exposed to significant financial risk as a standalone organisation. Equally the CCG may experience less authority with providers within contracting and negotiation arrangements. It is therefore essential that the leadership team optimises the opportunity to work collectively with DBC and the two other shadow CCGs in the County Durham and Darlington PCT Cluster, especially in relation to potential shared management arrangements, risk sharing, managing of major contract or scaling up commissioning intentions across a wider population to achieve economies of scale.

Strategically the CCG would wish to work in partnership with DBC, and would wish to develop robust arrangements and in the longer term consolidate arrangements in new organisational form. Any decision to progress alonger integration will be based on a detail option appraisal. However, such developments must not prejudice the primary organisational goal of early authorisation for the CCG.

This organisational development plan is intended to support phase two of transition arrangements in the first instance, positioning the CCG such that it is ready and capable of assuming responsibility for full delegation of the commissioning budget and the commissioning system by April 2012. At that key milestone this initial organisational development plan will be reviewed and further prioritised development needs reframed and put in place to support the CCG from 1 April 2012 onwards. This timeframe is crucial in establishing a track record as a viable clinical commissioning organisation and demonstrate the necessary competencies to apply for authorisation in October 2012 to become fully licensed as a statutory body at 31 March 2013.

Develop the CCG as an “intelligent commissioner” where there is acknowledgement that the CCG is not about direct provision technical commissioning expertise but more about managing the system for effective commissioning. The CCG will therefore need to be clear on what skills and behaviours will be provided by the “home team” at CCG level versus what commissioning expertise will be bought in from a commissioning support unit (CSU) or third party. This will require a close relationship of mutual dependence with the developing CSU where the CSU is following the same authorisation trajectory as the CCGs.

The CCG is committed to working with partners to establish robust arrangements to support effective commissioning arrangements. In so doing the CCG will not be distracted from establishing itself as a authorised body and will look in the first instance to the local CSU. Should the local CSU falter in its own accreditation process then the CCG will review how best to secure commissioning support for its authorisation and activities.

The CCG recognises but remains undaunted by the health and service challenges with which it is presented, nor does it underestimate the significant organisational challenges it will need to overcome along its development path, for example assuming new roles and responsibilities as it takes on greater delegation from the PCT Cluster during transition.

4. Our Opportunity

There is clear commitment throughout the shadow CCG to "To improve the health and well-being of Darlington" and this critical mission will need to be refreshed regularly as part of the journey of development for the nascent CCG, as will the vision that the CCG should have an ambition that seeks to secure for local people nothing less than "Excellence Always", meeting the needs of the poultion and bring services closer to where people live their lives and endeavouring always to exceed expectations.

As a fledgling PBC group local practices established a series of values that have been built into a 'compact' between the CCG and its member practices:

- Open, transparent and inclusive relationship between practices, practitioners and with patients the public and partners
- Improve the care and outcomes for people
- Fairness and equity in the use and deployment of resources
- Eliminate unwarranted variation
- Transformation with clear and credible clinical focus
- Strong clinical relationships as a driver for change

Again these values will be scrutinised and renewed as the CCG moves towards authorisation as a statutory body serving the people in Darlington and can build upon the strategic delivery of 'One Darlington, Perfectly Placed'.

The strategic aims for the CCG are to

- Improve the health of people in Darlington
- Tackle the challenges of the aging population
- Make services accessible and responsive to the needs of the community
- Manage resources efficiently and effectively

Specific goals will be set out in the Clear and Credible Plan and it is clear that even at this formative stage the CCG is formed to:

- Commission effective and efficient health care services;
- Harness clinical engagement and innovation to improve services;
- Focus on commissioning for outcomes for patients and the whole population;
- Work with partners to strengthen integration of patient pathways where appropriate;
- Improve the quality of medical service provided by practices;
- Promote equity in the provision of services, including "hard to reach" groups.

These values and goals have been reflected in the development of a local compact\agreement with practices as members of the CCG. The tangible benefits of which can readily be demonstrated, for example practices have contributed practice data to the SNA and agreed move to SystmOne as the preferred clinical system early in the next financial year.

5 Governance

5.1 Development

Development of the CCG to taken on responsibilities for commissioning health care services has been supported by the establishment of a sub committee of the PCT Cluster Board, enabling the delegation of responsibilities to local clinicians. The role of the sub committee is set out below:

- Enables clinical commissioning within extant legal framework
- Provides assurance to the PCT Cluster Board through an agreed framework
- Support the development of a sustainable clinically led commissioning

The support for the CCG will be enhanced during Phase 2.1 of transition and the further alignment of staff by the end of December 2011, including dedicated senior manangement support capable of taking the CCG successfully through authorisation.

5.2 Clinical Board

Member practices are the fulcrum of the CCG that brings together clinical decision making and engaging and involving patients, the public and partners and this will be reflected in both the governance and wider manangement arrangements. The member practices will through its 'Clinical Board' and the development of a formal constitution that sets out how and by whom decisions will be taken within the CCG. The remit of the Board is as follows

- Ensure clinical focus and leadership
- Determine Clinical Strategy
- Approve clinical priorities and clinical pathways
- Approve clinical members of the executive
- Clinical scrutiny of commissioning & practices
- Secure clinical ownership, sustains relationships with member practices
- Set quality standard for member practices and monitors adherence

The CCG will be is supported by a leadership team in the form of the 'Executive' that will run the day to day commissioning activities. The Executive comprises GP leads and senior manangement of the CCG and has the following functions.

- Deliver the business by ensuring that the CCG is functioning efficiently & effectively and is financially sound
- Develop organisation\effective partnerships
- Manages delegated budgets and provides assurance to CCG Committee
- Set CCG priorities and work plan
- Implement clear & credible plan\commissioning intentions\clinical strategies & priorities
- Performance manage delivery

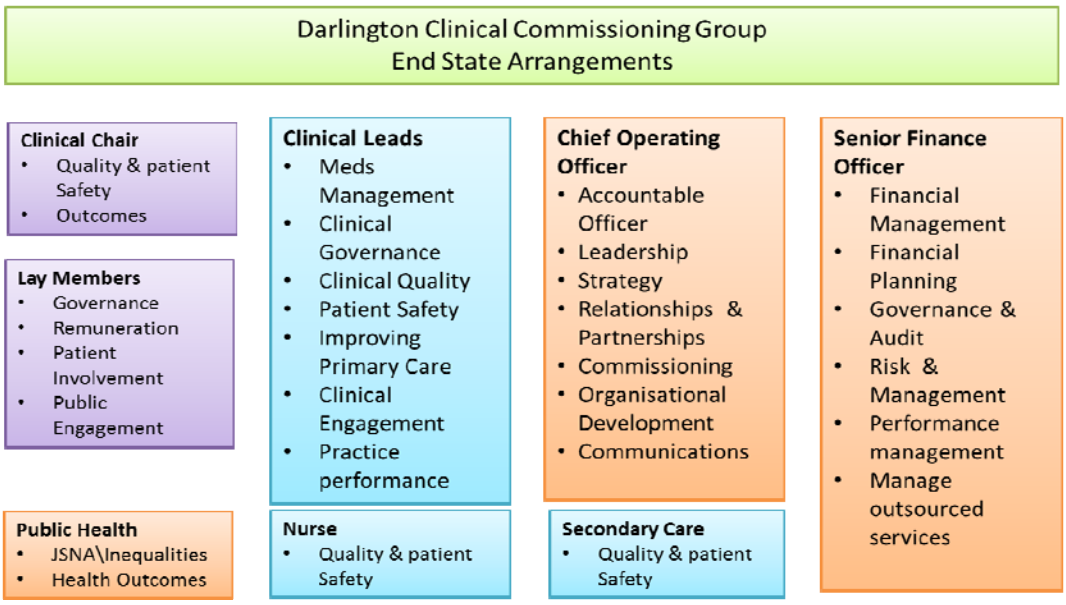
5.3 *Clinical Leadership*

The commiiment is that the CCG will be a clinically led commissioner and this will be delivered through a distributive leadership model supported by high quality and capable management. As a relatively small organisation the CCG will demonstrate its effectiveness from the Consultation Room through to the Board Room.

In December 2011 the CCG set out process to develop a structured approach, including performance manangement, so that the demands and rewards shadow from from clinical leadership can be clearly articulated. The approach is based upon three levels of clinical leadership as follows

- Strategic - GP Chair, Practice Leads & Priority Pathways
- Task Specific - usually timelimited
- Disease Areas - i.e. COPD, Diabetes, MSK

The organisational model proposed for Darlington CCG is for a non clinical accountable officer and the 'end state' arrangements for the senior leadership is set out opposite:



The interim arrangements will reflect these arrangements alongside the Governing Body, Executive Manangement and membership body and it is intended that shadow arrangements are in place by April 2012 with Clinical GP Chair, Interim Chief Operating Officer, Lay Member with responsibilities assurance and patient engagement, senior finance officer, nurse andsecondary care clinician through the sub committee.

As an effective and collaborative commissioner Darlington CCG is leading the formalisation of arrangements and governance with other CCGs within the cluster with regard to undertake those commissioning actoivities that can be done more effectively and efficiently across CCGs in the first instance. Again these arrangements will be in place no later than April 2012.

6 Towards Authorisation

6.1 Overview

Subject to the passage of legislation the Department of Health has set out a phased approach to CCGs being authorised, comprising [a] risk assessment of proposed configuration [b] development path of gaining experience and building up a 'track record' alongside the PCT Cluster and finally the mechanics of authorisation. The expectation that the CCG will lead the planning round 2012/13, commissioning intentions, delivery of QIPP, improve standards in primary care, tackle inequalities with partners and engage with communities will be key short term programmes within the CCG. In so doing the CCG will have a clear focus as being an evidenced-based outcome-focussed commissioner.

It is understood that CCGs will be tested against six domains of competence and a key task for the CCG will be to establish a systematic and non-bureaucratic

process for gathering its portfolio of evidence for submission to the National Commissioning Board in line with .

6.2 Clinical focus and Added Value

The real challenge for clinical commissioning is to demonstrate a strong clinical and multi-professional focus which brings real added value. The CCG needs clinical leaders who are able to influence and lead others to deliver on improving the health of the population and using the budget most wisely.

The CCG has a limited but growing number of clinical leaders at present including the three chairs, pathfinder leads locality leads for some specific clinical areas and nominated commissioning leads from each practice. Work has been undertaken to define clearly the roles and responsibilities of leads and also to define the support commitment from the organisation. Here the CCGs approach, based on a distributive model has already been articulated but will also need to secure leadership against the broader areas of governance, public patient involvement, quality and safety. Individuals who are interested in taking on these roles, especially at the strategic level will require bespoke development and training delivered as a board development programme. The training resource is still to be identified as at this early stage and exact requirements need to be teased out.

Resource will need to be invested in securing the fullest ownership for the CCG across the primary care clinical community.

6.3 Engagement with patients, carers and their communities

The meaningful involvement and engagement of local public and patients is fundamental to the development of the CCG an intelligent commissioning organisation and as an effective statutory NHS organisation. It must demonstrate that this is fully embedded into the shadow organisation and the full commissioning process as a priority.

Members of the CCG understand the benefits and also the statutory requirements of meaningful involvement, including the strategic involvement of partner agencies, inspection bodies and the local authority overview and scrutiny committee. Support for this learning will be provided in conjunction with the patient and public engagement team.

An immediate priority is to consolidate the arrangements for active engagement with and involvement of patients and the public in commissioning, including the recruitment of a lay person to champion this important area. It will be crtical to the success of the CCG that this person is supported by a structured approach that builds on the existing arrangements and bridges active participation through practices as well as on specific tasks, such as commissioning decisions and development of patient pathways. The CCG has already developed partnership approach with DBC, ‘talking together’, and will want to explore at an early stage the creation of a ‘membership’ council’ of local people.

6.4 Clear and Credible Plan

In order to be able to accept ful delegated responsibilities as well as to develop as an effective commissioning organisation the CCG must set out how it will deliver quality, innovation, productivity and prevention [QIPP] challenge within financial resources, in line with national requirements, excellent outcomes and local joint health and well-being strategies. To do this it is developing ambitious, but practical plans to implement its strategies, developed with stakeholders and owned by members and partners. Plans need to clearly set out priorities and why they will lead to greatest health gain taking into account future changes and the contribution understood by all within the local health and social care system.

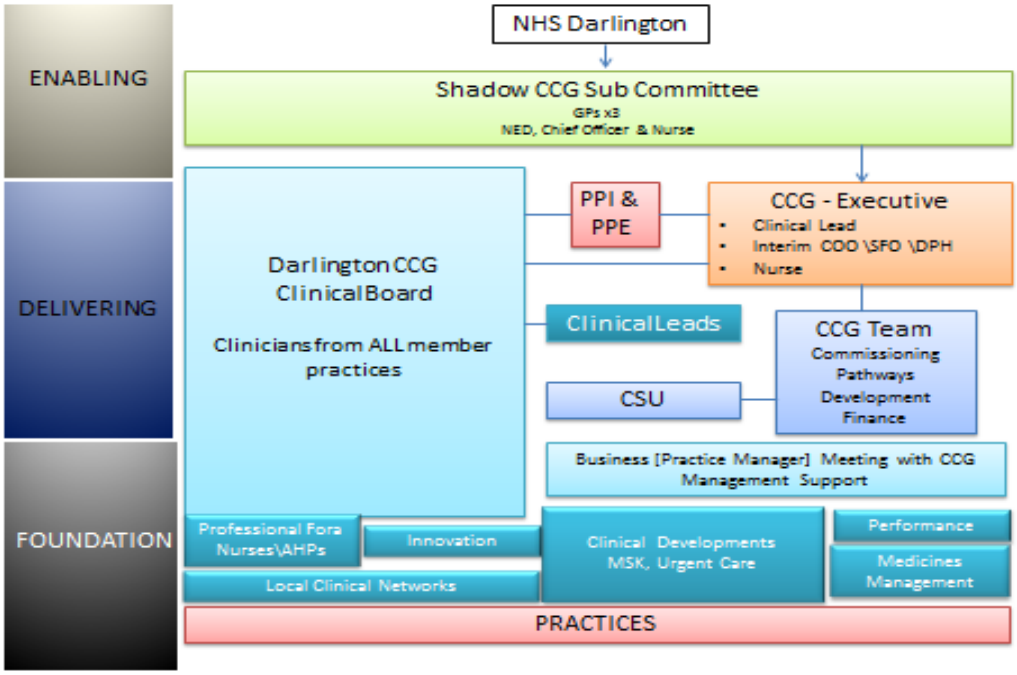
Work is well advanced on the development of the Clear and Credible Plan with support sought from PCT Cluster, commissioning support arrangements and partners. The final draft plan will be available in Janury 2012

6.5 Capacity and Capability

The CCG will need to establish proper constitutional and governance arrangements, with the capacity and capability to deliver their duties and responsibilities including financial control, as well as effectively commission all the services for which they are responsible.

The CCG is setting out good governance arrangements supported by both structural and cultural changes in order to support the ambition of the CCG up to and after authorisation. Safe and secure governance arrangements for the CCG are being developed alongside the CCG Subcommittee with the support of the PCT Cluster. Whilst the PCT continues to be the “Accountable NHS Body”, the CCG is constituted as a subcommittee of the cluster board with responsibilities delegated to them from the PCT. The CCG Subcommittee membership are in place with members will receive bespoke training to understand the scope of their new responsibilities, accountability and team building. These arrangements will continue to develop as the CCGs sets out its constitutional arrangements in line with requirements.

The interim arrangements build upon the member practice as the foundation of the new commissioning organisation and are set out overleaf



6.6 Collaborative Arrangements

Within the new NHS architecture, the CCG will be unable to achieve its goals and responsibilities in isolation. It needs to ensure it has the knowledge and skills to understand the relationships they need as good commissioners and good corporate citizens, and how to get the most out of these relationships. It can only do this by working through other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support and this is clearly understood. Indeed the CCG has a track record of good collaborative working with other commissioners, particularly local CCGs, DBC and the shadow NHS Commissioning Board. The three local CCGs are formalising their arrangements with clear governance in a federated manner and risk sharing.

The CCG intends to deepen its already close working relationship with Darlington Borough Council, particularly in their commissioning functions for local people and work is already underway to develop the public sector partnership.

Work is also underway with colleagues in the PCTs to determine how the CCG will access the commissioning support it needs. Whilst limited staff will sit within the CCG itself, most technical capability and expertise will be drawn from the developing Commissioning Support Unit at local and potentially north east-wide levels. The CCG will be involved in formulating the 'core offer' both for commissioning support and public health.

6.7 Leadership

Clinical commissioning needs great leaders who individually and collectively can make the difference. Strong and credible leadership will be critical to the

successful development of the CCG and it is essential to begin to develop the tone and direction of the organisation and to motivate the staff within the organisation to make changes in what they do. There are a number of experienced clinical and non-clinical leaders working on CCG programmes who have already demonstrated that they are able to successfully motivate their peers and, working with a range of stakeholders, bring about changes to improve local health services. Urgent work is underway in order to increase leadership capacity as well as to ensure leadership succession planning to develop a cadre of new leaders for the future.

It will be critical that support for the current clinical leadership team is confirmed through a renewed mandate before the CCG assumes full delegated authority.

The CCG recognises that there needs to be increased skills and knowledge both of leadership and of commissioning processes and therefore encourages and supports both clinical leads and aligned staff to take up training in leadership skills. It will be looking to secure development of its chief officer through the Top Leaders Programme. Some of the additional early training opportunities were piloted by the NHS institute of Innovation and Improvement. The CCG is now evaluating and reviewing what is available to assess whether it will be able to meet current and future needs. A structured and more bespoke programme of leadership training and development is required building on ad hoc training and development already undertaken. This will be designed once an assessment of skills has been undertaken. This will be partly informed by the self-assessment work done already and it is further proposed that key leaders will be supported to develop their own individual personal development plans.

These domains were critically tested by the CCG in working through the PWC Self-assessment tool for shadow CCGs and a summary of the reports and detailed actions are set out in the Appendices One and Three.

7 Success

In setting out on a development path it important for the CCG to retain focus on the core mission and purpose of the organisation. Strategically the success of Darlington CCG as a commissioner must be measured in terms of its impact upon the health and well-being of Darlington, delivered through its Clear and Credible Plan.

Key measures of this will inevitably include

- Demonstrable improvements in the health status of local people and a narrowing of the inequalities within the town
- The quality standards delivered by providers and the safety of the services commissioned
- Delivery of care closer to where people live with the consequential reduced reliance on hospital based services.

8 Development Work

This Development Plan been informed by a significant amount of work with practices and local stakeholders throughout 2011 comprising but not exclusive to:

- 'How is Darlington's GP consortium taking shape'? Commissioned research project (March 2011)
- GP Led Commissioning and the Future (April 2011)
- NHS Institute for Innovation and Improvement/Audit Commission diagnostic day (July 2011)
- Darlington Borough Council/ Darlington emerging CCG joint project "Proof of Concept"(Summer –Autumn 2011)
- Board event – completion of PWC Diagnostic Assessment Tool for CCGs (September 2011)
- Protected Learning Time Event (September 2011)
- Clear & Credible pLan Intiation and Collaborative Events, November 2011

Following work with the NHS Institute for Innovation and Improvement and the Audit Commission in July 2011, a draft organisational development plan was put together. This draft alongside previous organisational development events and the PWC diagnostic tool have formed the foundation for this development plan.

The NHS Institute/Audit Commission event recognised the progress made by Darlington CCG and identified further development challenges to becoming a strong and capable commissioning organisation. The table below shows the average score against each of the six domains within the PWC diagnostic tool.

	Domain	Average Score
1	Clinical Focus and Added Value	32%
2	Engagement with Patients / Communities	40%
3	Clear and Credible Plan	30%
4	Capacity and Capability	24%
5	Collaborative Arrangements	40%
6	Leadership Capacity and Capability	34%

To fully understand the stage of development that each score represents the table below links the five levels of organisational maturity to the numerical scores:

Level and %	Maturity level
1. (0 - 20%)	Not a CCG priority, as yet
2. (20 -40%)	Getting started
3. (40 -60%)	In development
4. (60 -80%)	Being rolled out
5. (80 -100%)	Fully in place

A detailed assessment against each sub-competency area, including a brief assessment of the current position, gaps, identified development need and how this need will be addressed with defined timescales is set out at Appendix One.

All areas will be examined to inform the further development of the CCG and refreshed as the self-assessment tool is revisited routinely as the CCG moves along its development path to authorisation. As well as setting new goals the tool will be used to determine the extent to which organisational and development goals have been delivered.

9 Summary of Key Development Areas – Phase 2

The CCG has identified a number of initial prioritised development areas within phase 2 of transition arrangements, from now through to March 2012.
A summary of the key milestones are set out below with fuller details of actions required from this point in time through to beyond the authorisation process being found at Appendix One.

The priority areas have been drawn from a detailed project plan which is part of the Cluster Transition Plan setting out the actions and time scales for the critical path from now to authorisation. See Appendix Four (project plan) and Appendix Five (milestones).

As a new formative organisation the CCG has identified **five key priorities** that form the building blocks for organisational development, namely

- Leadership [clinical and non-clinical] – in place to lead and develop the new CCG and deliver the grip to demonstrable 'track record'
- "Board" development - with clear governance arrangements that can secure the delivery of the clear and credible plan
- Team development – through a shared vision, values and behaviours that harnesses the capability of member practices to deliver improved outcomes for the people of Darlington
- Intelligent commissioner – capability to secure the right support to ensure that the CCG becomes an effective commissioner
- Partnerships and engagement/relationship management. – developing relationships to support 'One Darlington, Perfectly Placed'

10. Accountability

In its development, the CCG is supported by its member practices and the PCT Cluster through the established Transition Plans. However, the CCG will be accountable for delivery of this development plan and the priorities identified.

The initial priorities set out overleaf will be will be revisited routinely by the senior leadership team and accounted for as part of the routine performance reviews with the PCT Cluster, to reflect changes as the organisation moves forward along the authorisation trajectory.

Initial Priority Areas for Action	Timeline
Strengthen clinical leadership in Darlington • Leadership development of current and shadow clinical leaders • Identify gaps in leadership capacity and capablity and identify solutions to resolve • succession planning - identify and nurture leaders for the future	Nov 2011 to Oct 2012
Develop and embed the Clear and credible plan	From Nov 2011
Secure CCG management support [aligned staff and commissioning support]	Nov 2011 to Jan 2012
Consolidate leadership arrangements [clinical and non- clinical] arrangements	Nov 2011 to Jan 2012
Renew shared mission, vision and values for Darlington CCG ensure they widely disseminated and embedded in practice	Nov 2011 to Mar 2012
Clarify CCG roles and responsibilities aligned to vision, values and strategy	Nov 2011 to Mar 2012
Agree the CCG compact with member practices and key local partners [Darlington Partnership and Darlington Borough Council]	Nov 2011 to Mar 2012
• Lead the planning round 2012/13 –commissioning intensions, QIPP, Primary Care, Tackling Inequalities and Engagement. • Agree approach with other CCGs, setting up mechanism to enable way of working	Nov 2011 to Mar 2012 Nov 2011 to Mar 2012
• Establish formal CCG subcommittee structure • Establish CCG sub- structure arrangements within a robust governance framework with appropriate schemes of delegation.	Nov 2011 to Mar 2012 Nov 2011 to Mar 2012
• Put in place effective arrangements for financial management, planning and governance	Nov 2011 to Mar 2012
Develop the CCG as an Intelligent Commissioner\Customer • Understand what is required from the home team skills, capacity and capability vs what will be bought in from CSU. • Support/assure the authorisation of the CSU • Implement a formal business agreement with the CSU	Nov 2011 to Mar 2012 March 2012 March 2012
• Strengthen Partnership with Darlington Borough Council – Health & Well Being\ Darlington Partnership	Nov 11 to Mar 2012

11. Resources

The CCG has identified a minimum of £90,000 to resource this Development Plan in 2011/12 and would expect to re-provide this in 2012/13 to support the development of the CCG team.

12. Culture and Leadership

Whilst the shadow CCG is supported in its aspiration to be fully authorised, without conditions, by April 2013, by local practices, practitioners and partners, importantly the Borough Council, it is important that it set the right 'tone' in terms of culture and leadership. As a forming CCG the appropriate organisational culture, shared values and behaviours of member practices and staff are yet to be fully considered but are recognised here as key

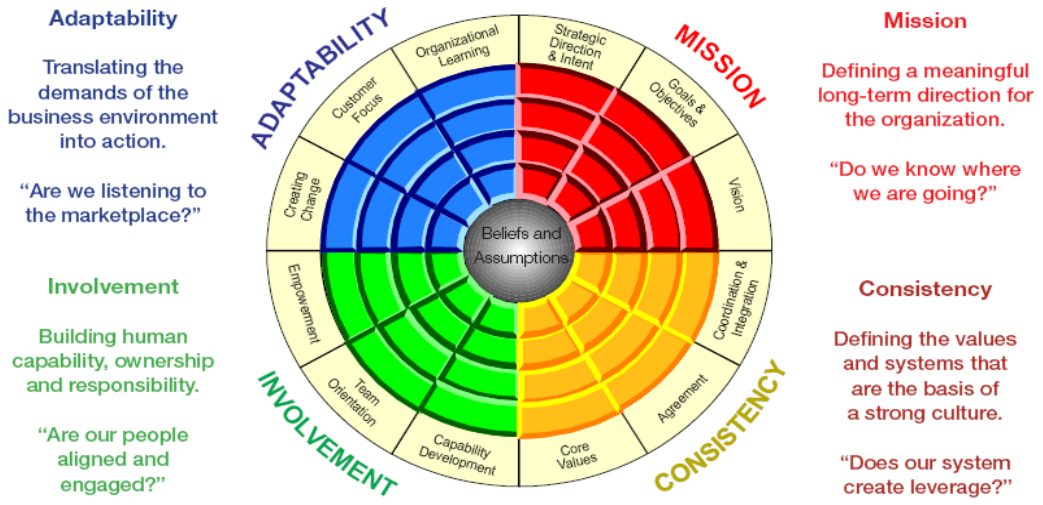
components for a successful CCG and linked to all other elements of organisational development.

The CCG has undertaken a range of diagnostic and self-assessment programmes which have identified a number of capacity and capability strengths as well as many significant areas for development.

The key role of leadership, at all levels of the organisation, in developing relationships with partners and in developing the organisation itself has been acknowledged as well as the importance of succession planning. These areas are captured and threaded through both this plan and the clear and credible plan.

When considering organisational development needs the CCG will look to consider the Denison model of organisational development. The Denison model will provide a foundation for understanding those cultural attributes of the organisation that will support the CCGs ability to achieve its strategic objectives as well as others that potentially could act as a barrier to success as the CCG continues on the path to fulfil a defined organisational mission.

The Denison Model



13. Management of Risk

As a developing organisation the CCG is required to oversee the delivery of the system at the same time as it develops and eventually operates the architecture of the new system. The CCG will develop a Risk Register and a clear framework for managing its risks controlled through robust management, using a clear RAG rating to inform escalation policies

Initial identified risks in relation to a new organisation are:

- Failure to identify the right organisational development priorities that will support at the start and throughout the journey to become a viable and effective commissioner.

- Imposition of unrealistic timescales that don't recognise the scale and depth of organisation development needed to develop capacity or skills needed to take forward responsibilities from the PCT cluster.

- Fragility of relationships with partners, particularly member practices and externally with main providers, the local authority, commissioning board and the local community.

- Ineffective governance and performance arrangements to ensure the safe stewardship of the organisation.

- Failure to develop the right leadership both clinically and managerially to enable to organisation to move forward.

- Not putting in place the right capacity, skills and resources to provide the technical commissioning support and corporate support, whether directly employed in the CCG, undertaken by the CSU or bought in from a third party.

Risk is dynamic it is likely that many other risks will be identified as the organisation develops.

14 Development Support

In order to secure its' goals and enhance its organisational capacity and capability, Darlington CCG will seek to engage other CCGs and the expertise and resources within PCT Cluster to support its development. In addition to the national offers of the Pathfinder Learning Network, national leadership offers, governance frameworks etc, the CCG will look to secure a range of local and bespoke development opportunities appropriately targeted to the needs of Darlington and this development plan as it evolves throughout the transition phase and beyond. Appendix Six outlines the actions and resourcing needed against the five initial key priorities (leadership, board and team development, intelligent commissioner, partnerships and engagement/relationship management).

15 Next Steps

This development plan confirms that whilst Darlington CCG has a number of capacity and capability strengths these are matched by many areas for development. At this early stage it is critical that the breadth of this work is acknowledged and actions progressed. This work needs to be embedded through the governance and management support arrangements of the CCG subcommittee. The following are three key steps.

The Interim Chief Operating Officer has been given personal and corporate responsibility for the further development of the CCG organisation and will be responsible for delivery of the plan.

- A programme management approach will be developed to assure the CCG Subcommittee, the CCG and the Cluster of delivery of the plan including routine reporting back to the CCG Subcommittee.
- The review of PWC Diagnostic tool with 360 degree feedback from partners, practitioners and staff up to and beyond the authorisation timeframe will validate and enhance this development plan allowing for timely reflection upon CCG values, culture, behaviour and wider organisational health.

Darlington
Shadow Clinical Commissioning Group

November 2011

Appendices

One	Detailed OD Actions Developed following initial Self-Assessment work.
Two	Darlington CCG: Schedule of Member Practices
Three	Diagnostic Self-Assessment: Outcome Reports
Four	Project plan – Actions and time scales for critical path
Five	CCG Development Path: Major Milestones
Six	OD priorities- Resourcing requirements