Darlington Clinical Commissioning Group

NHS DARLINGTON CLINICAL COMMISSIONING GROUP

ORGANISATIONAL DEVELOPMENT PLAN

PHASE 2.2 TRANSITION

Version 1.5

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1. Who we are

The Government has set out a clear intention to ensure the commissioning of health services has a strong clinical focus where Clinical Commissioning Groups will be different from any predecessor NHS organisation. As the legislation is now agreed and further detail has unfolded, local arrangements are now in place to establish NHS Darlington Clinical Commissioning Group (NHS Darlington CCG) as a new NHS commissioning organisation from April 2013.

The membership of NHS Darlington CCG is drawn from the twelve practices which service the healthcare needs of the population of the Borough. Our CCG, formed in October 2011, is a member organisation comprising twelve member practices serving a population of approximately 100,400. The area covered by Darlington CCG is predominately urban centred on the town of Darlington and is coterminous with Darlington Borough Council (DBC). Despite the compact nature of the area there are some marked differences in health between wards of the Borough.

Primary Care clinicians in Darlington are seizing the opportunity to develop and embed leadership for clinical commissioning that puts our patients and our population at the heart of decision making in the local health service. In so doing our local primary care clinicians recognise the need to establish, develop and sustain a credible organisation that is fit to deliver this ambition.

This organisational development plan recognises that our CCG continues the significant journey from an advisory body under Practice Based Commissioning (PBC) to a public sector NHS organisation with statutory responsibilities, including commissioning of healthcare services, for the local population. The transition from the PBC model to statutory CCG demands vastly different skills, capacity and capability of the member practices. We are building on early commissioning experiences to ensure that the CCG now further develops the knowledge, skills and mind-set to shape care and services that improve outcomes for Darlington. However we do not underestimate the considerable stretch and challenge therein; in particular the cultural shift required to deliver the membership model; moving from a practice perspective to a population focus and responsibility and a demonstrable commitment to effective clinical leadership based on outputs.

This plan builds upon Phase 2 of the Transition Programme is intended to support the period from June 2012 to December 2012 of transition arrangements in the first instance, positioning the CCG such that it is ready and capable of submitting an application for authorisation to the NHS Commissioning Board authorisation authority and delivery of the first year of our commissioning plan (Deliver Darlington 2012/13).

At that key milestone this organisational development plan will be reviewed following feedback from the NHS Commissioning board authorisation process and further prioritised development needs reframed and put in place to support the CCG from January 2013 onwards.

Timeframes are crucial in establishing a track record as a viable clinical commissioning organisation and demonstrate the necessary competencies to apply for Wave 4 authorisation in November 2012 to become fully licensed as a statutory body at 31 March 2013.

1.1 Our Vision and Purpose

Darlington is a unique place in which to live and work, but not one without health challenges. Our role as a clinical commissioning group is to understand what our population both needs and wants, consider the evidence base and quality outcomes and then act to deliver these improvements within the defined financial framework. We are working jointly with our partners, including the local authority, to secure high quality services for the local population and drive up the quality of primary care services.

Vision and Strategic Aims

To give ourselves the best chance of success on behalf of our population, our vision alongside our partner organisations is:

"Working together to improve the health and well-being of Darlington"

For the population of Darlington this means:

- health services which are safe and of the highest quality
- best possible health outcomes
- joined up services which benefit patients and the public and give best value for money

In order to achieve this vision, we have developed **strategic aims** that cover and define the challenges facing us. These are:

- Improve the health status of the people of Darlington
- Address the needs of the changing age profile of the population of Darlington
- To take services closer to home for the people of Darlington
- To manage resources effectively and responsibly

Our Values

Over recent months and building on previous practice time out events, the member practices have established a set of values and ways of working that have been built into a 'compact' or agreement between the member practices. [See Figure 1]. Alongside the values set out in the NHS Constitution, these values guide our approach to clinical commissioning and responsibilities to the local community. Our values will be reviewed and refreshed as Darlington CCG moves through authorisation as a statutory body and beyond.

Figure 1.

1.2 The Local System

Within the PCT Cluster of County Durham and Darlington there are three CCGs, Darlington, North Durham and the Durham Dales, Easington and Sedgefield [DDES] CCG. Each CCG is now progressing towards a planned trajectory for authorisation and looking to be fully authorised by April 2013. A detailed project plan is in place for our CCG's key milestones in line with wave four application timelines and actions to be achieved. This project plan is helping to inform the development needs of the clinical commissioning group and our '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 two other sites 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. There is also a private hospital provider in Darlington [BMI Woodlands] providing a small but increasing amount of commissioned activity and additional capacity and patient choice within Darlington.

Community health services are also provided by County Durham and Darlington NHS Foundation Trust with community hospitals at Barnard Castle, Weardale, Sedgefield and Shotley Bridge. There is no community hospital site in Darlington.

The principle provider of Mental Health services, both acute and community are provided by Tees, Esk and Wear Valleys NHS Foundation Trust [TEWV]. There is a main inpatient and outpatient site at West Park on the outskirts of Darlington.

1.3 Our Challenge as "Intelligent" Clinical Commissioners

As clinical commissioners we aim to triangulate the evidence of need and views of patients and the public with the experience and insights of clinicians delivering services so that any changes made bring about real improvements in the health outcomes and experiences of our local population. We believe this will demonstrate the value added of clinical commissioning which stands out different to anything that has gone before.

Darlington CCG's Clear and Credible Plan describes our level of ambition and commissioning plan for the next five years. We have utilised data from public health as well as our own practice level data to fully understand the needs of the local population. This together with information on the patients' experiences of services they receive, insights from our clinicians working with patients on a daily basis, service performance and financial information has helped us to build a picture of the challenges and opportunities that face our population:

- The significant health issues affecting population of Darlington are premature deaths and poor quality of life from cancers, cardiovascular disease, chronic obstructive airways disease, stroke and dementia.
- Our ageing population will lead to increasing demand on healthcare, particularly patients with long term conditions and dementia which we cannot sustain given our funding scenarios over the next five years
- We need to improve the quality of care and reduce unwarranted variation in primary care in order to improve health outcomes and experience for patients

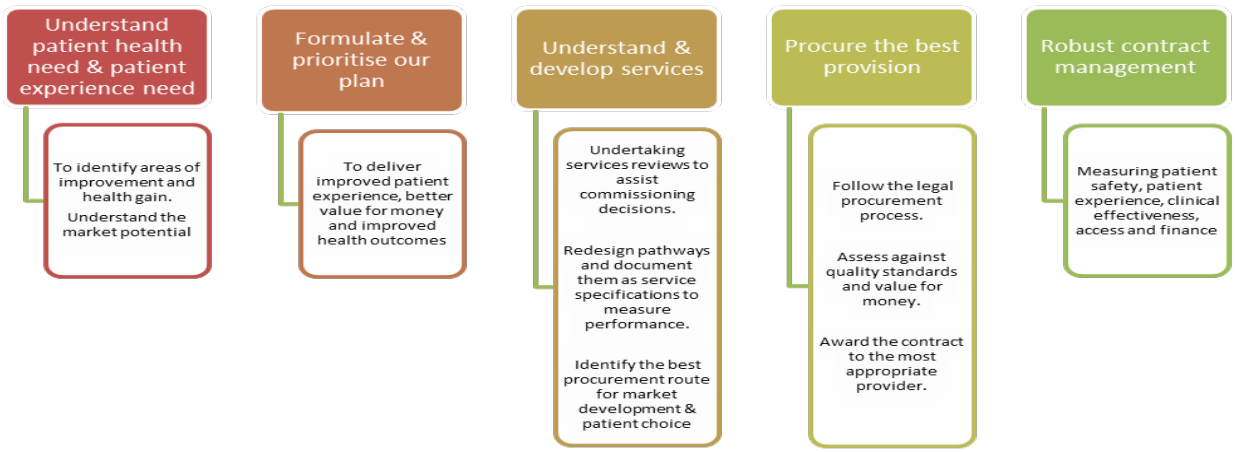
Developing our CCG as an "intelligent commissioner" is a priority where there is acknowledgement that the CCG is not about direct technical commissioning expertise but more about managing the system for effective commissioning. The CCG will therefore need to be clear on what skills and leadership behaviours will be provided by the "home team" at CCG level versus what commissioning expertise will be bought in from the North East Commissioning Support [NECS] or third party. This will require a close relationship of mutual dependence with the developing NECS where NECS is following the same authorisation trajectory as the CCGs.

Developing in parallel with the NECS and being mutually dependent on one another for securing authorisation, we will ensure best use of total workforce capacity and capability fashioned initially into a memorandum of understanding [in place end April 2012] and a more formal business agreement by October 2012. Whilst we are currently working closely with NECS colleagues during transition, as intelligent commissioners we will

develop plans for a formal and compliant procurement process for commissioning support services between 2013 to 2016.

In order to be effective commissioners we will take responsibility, in partnership with our patients and key partners, for managing the health system and adopting a robust commissioning process from understanding patient health needs and experience through to robust contract management of commissioned services [See Figure 2]. We aim to develop clear “hand offs” NECS whilst assuming overall responsibility and accountability for commissioning of services for the population of Darlington.

Figure 2. The business of commissioning



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

- The local management arrangements in the form of the “home team” is to be agreed by end July 2012 and then following a period of consultation with staff, phase three of alignment will take place (September 2012).
- Delegation of significant commissioning budget from 1 April 2012 and other responsibilities from 1 June 2012 and then a further phase in September 2012.
- The need to achieve economies of scale through developing CCG commissioning support systems and processes drawing on the expertise available in the PCT cluster up until end of March 2013, the North East Commissioning Support Service as well as our neighbouring CCGs.

- 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 collaboratively with DBC and the two other CCGs in the County Durham and Darlington PCT Cluster, especially in relation to potential shared management arrangements, risk sharing, managing of major contracts or scaling up commissioning intentions across a wider population to achieve economies of scale.

As a counterbalance to the above challenges, the strengthening 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. 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 along integration will be based on a detail option appraisal. However, such developments must not prejudice the primary organisational goal of authorisation for the CCG.

What will our CCG look like in One,Two or Three Years time?

In forming the CCG Darlington member practices are starting from a point of inclusivity and cohesiveness established over a long history of delivering primary medical services in Darlington. However the following are recognised as challenges in our early years of development :-

- a significant cultural shift is required with a need to move away from ‘them’ to ‘us’ ie delivering on the membership model underpinned by the focus on commissioning rather than provision of services;

- developing a systematic and structured approach to carefully listening to and responding to patients and the public to inform our commissioning decisions [meaningful voices for patients];

- genuine rigour in our approach to investing our healthcare budget ie a return on investment approach;

- move our thinking and approach from a practice perspective to a population focus and level of responsibility;

- in terms of clinical leadership and engagement a demonstrable commitment to making a shift from paying for time spent [in sessions] to paying clinicians for outputs.

2. Our Governance Arrangements

2.1 Sub Committee

Development of the CCG to take on responsibilities for commissioning health care services has been supported by the establishment of a sub committee of the PCT Cluster Board enabling clinical commissioning within an existing legal framework whilst providing assurance to the PCT Cluster Board. The sub committee was in place up to the end of June 2012 and comprised a non-executive director [Chair], CCG Chair and Vice Chair, GP Clinical Quality Lead, Interim Chief Operating Officer, Deputy Interim Chief Operating Officer, Lead Nurse, Director of Public Health and Local Authority Senior Officer.

2.2 Establishing Darlington CCG Governing Body

CCGs are a new kind of NHS organisation. They must be clinically led and built on the member practices that make up the membership of the CCG. It is our member practices that determine our constitution, governance and operating arrangements including the leadership of the CCG. This will require ensuring we have open, robust and transparent processes that can demonstrate our CCG is a safe and a statutory bodies that embodies the Nolan principles so that our local community and patients can have confidence that, within the resources available, they will receive the highest quality and outcomes of care.

Our 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. As from 1 April 2012 our accountability, decision making arrangements and the way we engage the twelve constituent member practices is shown in the figure three below.

The governing body arrangements to this point have given priority to inclusivity from all twelve member practices and includes practice manager and practice nurse representation as non-voting members; from this however a scaled down representative governing body will be established combining the previous CCG subcommittee and CCG governing body into a single organisational governance structure. It is anticipated these arrangements and any necessary committee arrangements [including an Executive] will be in place by end of September 2012. The Executive will include GP Chair and Vice Chair, Chief Officer [Designate], Chief Finance Officer and Chief Nurse. The Executive will have the following functions:-

- Deliver the business by ensuring that the CCG is functioning efficiently and effectively and is financially sound
- Manage delegated budgets and provides assurance to CCG Governing Body
- Set CCG priorities and work plan
- Implement the clear & credible plan priorities via Deliver Darlington
- Performance manage delivery

Figure 3. Darlington CCG Leadership, Engagement and Decision making

The Governing arrangements are being reviewed and confirmed over the period August to September 2012 and will be formally documented in a Constitution [to complete by end of October 2012].

3. Summary of Key Organisational Development Areas

This organisational development plan has been informed by previous work with the member practices and stakeholders as well as work with the NHS Institute for Innovation and Improvement and the Audit Commission in 2011.

In 2011 the PWC diagnostic tool was used to provide an initial baseline self-assessment of the CCG against the six authorisation domains. Table one shows the average score against each of the six domains. Not surprisingly, our scores reflect those expected of a newly forming organisation.

Table 1: Self -Assessment Scores

	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

This early diagnostic work and outputs continues to provide the foundation for the organisational development plan and at that point in time acknowledged the significant development and leadership journey ahead. The learning from the self assessment process provided the framework for strategic development and the consistent use of the authorisation domains enables reflection of progress and organisational development over time.

In order to deliver our organisational aspirations [described in full in our Clear and Credible Plan 2012-2017], we have developed a structured approach to organisational development for NHS Darlington CCG. This plan is organised into **seven key organisational development areas** and balances:-

- the development of NHS Darlington CCG as a member organisation and a statutory NHS body;
- development of our core commissioning business and
- Agreeing and formalising the working relationship with our commissioning support function.

Our seven key organisational development areas are:-

1. Organisational culture and ways of working
2. Leadership capacity and capability [clinical and non-clinical]
3. Good Governance
4. Workforce capacity and capability
5. Intelligent commissioner
6. Clinical Quality - including continuous improvement
7. Partnerships and engagement/relationship management

As a forming CCG the appropriate organisational culture, shared values and behaviours of member practices and staff are yet to be fully embedded but are recognised here as key components for a successful CCG and linked to all other elements of organisational development.

We have made good progress in developing our organisational identity and in building on the notion of a “one big practice” approach founded upon Darlington practices’ commitment to work inclusively and collectively and forward thinking for innovation. Furthermore member practices have established a set of values that have been built into a ‘compact’ or agreement [see figure 1] and will inform our approach to clinical commissioning and responsibilities to the local community:-

- Open, transparent and inclusive relationships between practices, practitioners and with patients the public and partners
- Commitment to improve the care and outcomes for people
- Fairness and equity in the use and deployment of resources
- Commitment to eliminate unwarranted variation
- Focused on transformation with a clear and credible clinical focus
- Foster strong clinical relationships as a driver for change

3.2 Leadership capacity and capability

Strong and credible leadership [clinical leaders and non-clinical leaders] will be critical to the successful development of the CCG and it is essential to developing and embedding the organisational culture and direction of the organisation and to motivate the staff within the organisation to make changes in what they do.

Our GP leads [Chair/Vice Chair] have an agreed succession plan to ensure continuity as the Chair designated steps back in the next few months. The Chair is already part of the National leadership programme and assessment centre arrangements. The Chief Officer (Designate) and Chief Finance Officer will be expected to have appropriate qualifications and key competencies and experience and been through similar leadership development programmes. We recognise these “top leaders” will require on-going development and support in their new roles as leaders of a new organisation and based on their diagnostics and assessment centre outputs.

Recruitment to key leadership roles in the CCG commenced in June 2012 and work has progressed to identify portfolios of work for the Executive members (GPs and Officers) and individual objectives and in turn individual development needs. At the time of writing the CCG workforce structures are out to consultation after which confirmed posts and portfolios of responsibility will be published.

The CCG has a distributed leadership arrangement. There are a number of experienced clinical and non-clinical leaders present beyond the governing body working on key CCG priorities 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. Work is well underway in order to increase leadership capacity as well as to specifically ensure clinical leadership succession planning to develop a cadre of new leaders for the future. We have developed a matrix of clinical leaders. All clinical leads have an agreed set of priorities [expected outputs] and milestones for delivery which are directly linked to our strategic aims and initiatives. We are committed to ensuring that development is offered to these individuals to develop their skills for leading service improvements and shaping commissioning decisions.

Some early training opportunities such as the Healthcare Financial Management Association [HFMA] modules have been offered to all members of the governing body, Executive team members and practice managers in Darlington. We have an identified Cauldicott Guardian and it is essential that this individual plus the Senior Information Risk Owner [SIRO] have development and training to deliver the roles safely and effectively.

We will continue to evaluate and review what leadership development is available to assess whether it will be able to meet current and future needs.

3.3 Good governance

The refreshed governance arrangements for Darlington CCG are based on a member organisation and involvement of all twelve member practices in managing the organisation and as part of the decision-making processes. Our Constitution describes how we will govern the organisation based on the Nolan Principles of good governance.

Establishing good governance arrangements has been a significant area of focus for our governing body development programme [April-June 2012] with external facilitation and support from Mazars. The programme of Governing Body development has included the following topics:-

- Principles of good governance and effective leadership and decision making
- Organisational vision, values and ways of working
- Effective risk management
- Developing the CCG Constitution
- Corporate and individual liability

The next phase of developing governance arrangements is to confirm our Constitution with the member practices [to complete at end October 2012]. The Constitution will evolve further as our organisation develops and matures but will be sensed checked consistently against why the organisation exists and what are we here to do.

3.4 Workforce capacity and capability

Our organisational delivery system is a combination of internal or “home team” workforce alongside the workforce configured as the North East

Commissioning Support [NECS]. There is also appreciation of the extended workforce within member practice teams who have an essential role in the planning, design and commissioning of services.

Darlington CCG will have a small "home team" who will carry the accountability and responsibility of the statutory body. There will be a high level of dependence on NECS expertise, capacity and capability for operational delivery of the commissioning process whilst building any gaps in internal skills.

Our recognised workforce development needs include:

- Core Mandatory training – for example health and safety, equality and diversity, recognising and reporting safeguarding issues children and adults.
- Understanding the business of commissioning [see figure 2]
- Patient and Public Engagement
- Pathway and service redesign
- Project management
- Quality and continuous improvement

The National Lot 1 offer has been designed to provide the wider CCG membership with an appropriate level of development and training covering areas such as governance, working with others, finance and procurement. This training has recently been offered to all "home team", NECS and practice staff and complements the bespoke training delivered to our governing body members.

3.5 Intelligent commissioner

From 01 April 2012, NHS Darlington CCG is to be established as the statutory NHS body responsible for the commissioning of health services for the population of Darlington. This means we need to have the right knowledge and skills to deliver our commissioning plans and make the best use of our resources whilst keeping our patients safe. Fundamental to this is our understanding of the end-to-end commissioning process, the impact of decisions we make on the health system, our financial astuteness, great leadership and effective relationship management skills. We need to understand and address poor patient experience and ensure our organisation thrives to the benefit of our patients and the public.

Key to our success as an intelligent commissioner is access to timely and accurate information. We need to source information and intelligence [ask the right questions to get the right information] and then use it to best effect in day-to-day decision-making.

Our significant presence on the Darlington Shadow Health and Wellbeing Board and involvement in the development of the Health and Wellbeing Strategy will ensure opportunities for whole systems working are maximised. It is important that member practices appreciate and understand the partnership working specifically with the local authority and the opportunity to

optimise outcomes for patients through effective joint commissioning arrangements. Another key area is the working arrangements and developing memorandum of understanding with our public health specialist support that will transfer to the local authority in April 2013. These two partnerships will form part of the governing body development programme in September 2012. Both local authority and public health involvement in our governing body arrangements is being captured as part of our Constitution.

3.6 Clinical quality

Our overall strategic aim is to improve the health and well-being of the population of Darlington. Clinical quality is viewed as an integral part of achieving this, ensuring that our patients experience safe and effective care and that their experience is positive across primary, secondary and tertiary care.

Clinical quality is one of the key determinants when establishing the priorities for service developments. We will ensure that the intelligence gathered from clinical quality informs what services we choose to review and how any changes in service delivery will impact on quality and the broader healthcare system.

The focus on driving up the quality of provision in primary care is a new responsibility for commissioning organisations. Although services will be commissioned through the NHS Commissioning Board, clinical commissioning will, on their behalf, address the quality and experience of patients in primary care. Combined with the development of primary care, this provides us with an exciting opportunity to enhance the care and provision across the wider health system. It is our intention to make the most of previous learning across County Durham and Darlington and sign up to the GP productive practice programme, which will not only improve the efficiency of practices it will improve the safety of patients.

3.7 Partnerships and engagement

We are confident we are progressively strengthening effective partnerships with the local authority in Darlington however we recognise there is some way to go in order to evidence strong and productive relationships with our providers and also effective and meaningful communication and engagement with our patients and the public.

Our framework for patient engagement and involvement in commissioning described fully in the clear and credible plan is a structured and systematic approach threaded through all key areas of work. Currently practice level engagement via patient fora is inconsistent across the twelve member practices. Equally there is a gap in our organisational structure for a patient ‘reference group’ . We are however looking for innovative ways to engage with patients and the public and, where appropriate, do this in conjunction with the local authority. We have well established links with Darlington LINk and together with employing the expertise of the NECS Patient and Public

Involvement and communications team we will significantly move forward our aspiration for meaningful voices for patients over the timeframe of this plan. Where appropriate we will aim to consult and communicate once with the people of Darlington for health and wellbeing issues. To this end we are developing a joint commications and engagement strategy alongside our local authority partners and with support from NECS. [Strategy to be completed by October 2012].

Our Lay member representative for Patient and Public Involvement [in post August 2012] will provide governing body level challenge and steer for how the organisation will strengthen and embed “meaningful voices for patients and the public” which inform the commissioning decisions we make.

An initial development sessions was offered by the PCT patient involvement team in May 2012, however further awareness raising and development for the extended workforce and governing body members is required to strengthen this area of priority.

4.0 Management of Risk

As a developing organisation, our 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. Our CCG is developing a Risk Register and a clear framework for managing its risks controlled through robust management, using a clear RAG rating to inform escalation policies. Table Two presents the Initial identified risks in relation to our new organisation

Risk is dynamic, it is likely that many other risks will be identified as the organisation develops. The assessment of key risks and mitigations will be overseen by our Executive and reported via our risk management framework and governance arrangements.

Table 2: Our Organisational Development Key Risks

Domain	Risk	S	L	R	Mitigation	Res S	Res L	Res R
Organisational Readiness	Failure to identify the right organisational development priorities that will support the CGG at the start and throughout the journey to becoming a viable and effective commissioner	5	3	15 Red	Use of external support and diagnostic tool to assess and agree priorities throughout the transition process. Take time to reflect changing needs and refresh plan over time	4	2	8 Amb
	Establishing unrealistic timescales that don't recognise the scale and depth of organisational development required to develop the capacity or the skills needed to assume responsibility from the PCT cluster	4	4	16 Red	Greater involvement of clinical leads in setting timescales based on the trajectory to be an authorised statutory body. Ensure development programme in place to support CCG members	4	3	12 Amb
	Not building effective relationships either internally with member practices or externally with our main providers, the local authority, NHS commissioning board and the local community	4	4	16 Red	A joint engagement strategy and implementation plan. Allocated representative from local authority aligned to the CCG, Lay representatives and optimise formal and informal lins with mental health and acute and community services providers.	3	3	9 Amb
	No effective and robust governance and performance arrangements to ensure the safe stewardship of the organisation	5	3	15 Red	Draft constitution developed. Legal check on compliance planned. Governance arrangements for delegation of commissioning budget and process in place for 1 April 2012. Committee structure agreed. Plans to further develop governance arrangements in place.	5	3	15 Red
	Not putting in place and developing the right leadership both clinically and managerially to enable to organisation to move forward	4	4	12 Red	OD plan identified a range of agreed actions to develop clinical leadership, emerging talent and put a CCG management support team in place. Senior clinical leaders in post with planned development programme for Chair and CO.	4	3	12 Amb
	Shortage of the right skills and resources to provide the technical commissioning and corporate support, whether directly employed in the CCG or undertaken by the CSU or other third party provider.	5	3	15 Red	OD plan identifies action to put in place CCG management support team and requirements needed from the commissioning support organisation. We know we need more skills in transformation, pathway design and development and procurement.	5	3	15 Red
Strategic Delivery	Insufficient leadership (clinical and non-clinical) capacity to support the plan	5	3	15 Red	Current clinical leadership capacity is identified with succession planning. There is a matrix of clinical leaders and a clinical lead identified against each commissioning initiative/ areas of delegated budget. There is a development programme within the OD plan to support current leaders and identify future emerging leaders.	4	3	12 Amb
	Lack of pathway redesign, project, procurement and transformation skills within the CCG or commissioning support organisation to support the plan.	5	3	15 Red	Organisational development plan identifies actions to secure resources through the NECS or source external support as and when required for specified projects	4	3	12 Amb
	Failure to establish to right level of commissioning technical expertise from the commissioning support organisation.	5	3	15 Red	Commissioning support arrangements are in development in the cluster and across the NE working to a similar trajectory as our CCG.	4	3	12 Amb

5.0 Development Support

In order to secure our goals and enhance our organisational capacity and capability, Darlington CCG will seek to engage other CCGs and the expertise and resources within PCT Cluster and wider to support its development.

Appendix One summarises the seven key priority areas and associated actions.

In addition to the national leadership offers our CCG will continue to secure a range of local and bespoke development opportunities appropriately targeted to the needs of Darlington CCG.

The CCG has identified £90,000 in 2012/13 to resource this Development Plan.

6.0 Accountability and Reporting Framework

In its development our CCG is supported by the PCT Cluster through the established transition plans, however the CCG will be accountable for the delivery of this development plan and the key areas identified. It is critical that the breadth of this work is acknowledged and actions progressed in line with our authorisation trajectory for wave four. This plan will be led and performance tracked and reported by the Executive with the Chief Officer [Designate] taking overall corporate responsibility.

An element of organisational success is knowing where we are at any one point in time. Progress against the seven key priority areas and detailed tasks in Appendix One will be tracked through the Executive and formally reported monthly. The plan will be revised in January 2013 following feedback from the NHS Commissioning Board Authority as part of the authorisation assessment. Post authorisation, the OD plan will have a quarterly formal evaluation and review.

Darlington CCG aspires to be a learning organisation and as such the OD plan will be recognised as dynamic and live document requiring significant and periodic refesh as the organisational maturity develops and priorities change over time.

Appendix One

DARLINGTON CLINICAL COMMISSIONING GROUP- RESOURCING OD PRIORITIES FOR PHASE 2.2

June 2012- December 2012

Priority Area 1: Organisational culture and ways of working							
Actions	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Embed the vision, purpose and required behaviours by cascading an agreement on ways of working	Practice level communications facilitated by member representatives via communication mechanisms GP intranet	CCG home team, CO, Executive team, governing body members, clinical leads; NECS Comms team	TBC	Nov 2012	1, 4, 6	In progress	"ways of working" ratified
Define the roles of member representatives and expectations required from the CCG	Role outline, CCG member practice agreement	CO, Executive team, and clinical leads	n/a	June 2012	1, 4, 6	Complete	Revisit over stages of development of the governing body
Shift the mind-set of the member practices from providers to commissioners	Governing body development programme; governing body agenda management Increased member practice involvement in the governing body	CO, Executive team,clinical leads,	n/a	Dec 2012	1, 4, 6	In progress	Initial work undertaken with Governing body members specifically, needs refining and widening out to

Priority Area 1: Organisational culture and ways of working							
Actions	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
	arrangments and sub committees						practice level and embedding
Ensure all home team CCG staff have agreed work objectives with defined outcomes	Objective setting process and appraisal mechanisms	CO, Executive team	n/a	October 2012	1, 4, 6	In progress	Initial work undertaken, needs refining and embedding further
Ensure all clinical CCG leads have agreed role outline and work objectives with defined outcomes	Setting key outputs of role and mechanisms for measuring	CO, Executive team, clinical leads	n/a	Sept 2012	1, 4, 6	In progress	Work commenced, needs follow up discussions with individuals and documented outputs and review points
Build upon the “one big practice” approach	Collaborative working on the primary care development workstream and other key priorities	CO, Executive team, clinical leads	n/a	ongoing	1,4,6	In progress	

Priority Area 2: Leadership capability and capacity							
Task	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Develop robust and transparent recruitment and selection processes for all senior lead roles	Processes and systems to be defined	CO, Executive Team	n/a	Sept 2012	1,6	In progress	Interim appointments in place. National process to be applied locally with regional HR policies
Identify gaps in current leadership capacity and capability- create solutions to resolve	Processes and systems to be defined	CO, Executive team	TBC	Dec 2012	1,6	Not started	To scope
Access Training and development to meet needs of leaders (based on diagnostics)	Nationally available training programmes Mentoring, Coaching	CO, Executive team	TBC	Dec 2012	1,6	In progress	Emerging leaders programme, NHS NELA programmes currently accessed
Agree Executive member portfolios	Discussion and agreement of organisational structure and home team roles	CO	n/a	Oct 2012	1,6	In progress	CCG/NECS structures to be determined by end July. Structures consultation then go live September-December 2012
Ensure robust contingency arrangements are in place to ensure business continuity if senior members are not available	Processes and systems, role definitions. Executive portfolios	CO, Executive team	n/a	Nov 2012	1, 6	Not started	

Priority Area 2: Leadership capability and capacity							
Task	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Succession planning for all senior leadership roles	Processes and systems to be defined	CO, Executive team	n/a	Nov 2012	1,6	In progress	Chair and Vice chair succession plan
Leadership of the annual commissioning cycle	Utilise the annual planning timeline. Making the best use of the PCT cluster legacy and NECS. Supervision & support from PCT cluster directors and NECS leads	CO, Executive, clinical leads,	in house	Dec 2012	1,2,3,4,5,6	In progress	

Priority Area 3: Good governance							
Task	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Appoint capable leaders of all kinds in the governing body	Process developed	CO, Executive team	n/a	Oct 2012	1,4,6	In progress	Interim appointments in place with process in hand for lay representatives.
Ensure good governance arrangements are in place- robust, clear and communicated to all members of CCG.	Clear processes and systems, Constitution, communications	CO, Executive team, Chair of Governing Body	n/a	Oct 2012	4	In progress	Amalgamation of Subcommittee and governing body at end July 2012. Refinements to the ultimate governance arrangements are underway. Detailed and communicated via the constitution
Governing body development programme	0.5 day workshops with documents created as outputs	Mazars and inhouse	£1000 per day @ half a day per month	Mar 2013	1, 4, 6	In progress	Monthly sessions commenced April 2012.
Governing Body committees to be determined including ToR	Processes being developed To be described in the Constitution	CO, Executive team	n/a	Sept 2012	1, 4	In progress	Initial proposal to Governing body in June 2012

Priority Area 3: Good governance							
Task	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Scope the selection and appointment/election/remuneration process for the various roles in the Governing Body and sub committees, including the Executive	Processes being developed	CO, Executive team	n/a	July 2012	1, 4, 6	In progress	
Develop and agree a constitution that is appropriate and complies with requirements of the health and Social Care Bill including setting out the procedures to be followed and arrangements made to secure transparency in decision making and provision for the governing body to meet in public	Use National Model Constitution Part of Governing body development programme	CO/Chairs/ NECS Governance Lead	n/a	First draft end May 2012 Final draft end October 2012	4	In progress	Refined at development session on 28 June Hempsons to do a legal check/compliance with H&SC bill
Ensure all core CCG staff have agreed work objectives with defined outcomes	Linked to priority area 1	CO	n/a				
Ensure all clinical CCG leads have agreed work objectives with defined outcomes	Linked to priority area 1	Chair	n/a				
Single governance structure	Joining of the CCG subcommittee with the Governing Body	CO/Chair of Governing body/CCG Chair subcomtte	n/a	July 2012	1, 4	Completed	
Develop financial acumen across senior members across the CCG workforce	HFMA e-learning modules	CFO	n/a	Sept 2012	4	In progress	Audit of uptake of training requested for end Sept

Priority Area 4: CCG Workforce capacity and capablility							
Task	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Ensure wider CCG members have an appreciation of NHS statutory body responsibilities, good governance, NHS finance, commissioning	Training programmes, skill/knowledge transfer by joint working and coproduction with NECS, coaching and shadowing	Lot 1 offer	Part of £10K	July 2012	1,4,6	Complete	Provider sourced and development session delivered
Ensure CCG staff have the right skills to be effective commissioners	Training programmes, skill/knowledge transfer by joint working and coproduction with NECS, coaching and shadowing	External training, NECS support, peer learning	£10K	Dec 2012	1, 4, 6	Not started	Need to source suppliers
Embed a programme management approach and project methodology	Training programme, job shadowing	External training, NECS support	£2K	Dec 2012	1, 3, 5, 6	Not started	Need to source suppliers
Develop service redesign skills and encourage transformation and innovation	Skill/knowledge transfer by joint working with support providers, coaching and shadowing	NECS	n/a	Dec 2012	1, 3, 5, 6	In progress	Learning from MSK pathway work to share and spread
Develop mandatory traning programme for CCG workforce and implement a mechanism for monitoring the development of the workforce Including Safeguard system incident reporting and development event for Gov Body members	E-learning, courses	External providers	£20K	Mar 2013	1, 4, 6	In progress	Adopt current PCT courses and e-learning. Need to identify additional mandatory training requirements

Priority Area 4: CCG Workforce capacity and capablility							
Task	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Competent in leading the commissioning development or decommissioning of services	Workforce supervision from commissioning support. Making the most of PCT cluster legacy processes. Joint working with Commissioning support and local authority	In house, NECS	n/a	December 2012	1,4,6	In progress	Learning from MSK pathway work to share and spread
Effective and meaningful engagement with patient, public and communities	Formal training sessions e-learning Joint working with local authority and LinKs Joint working with commissioning support	NECS PPI team, Local authority	n/a	Dec 2012	2	In progress	Initial event accessed to a low level from Darlington practices. Need to revisit.

Priority Area 5: Intelligent commissioner							
Task	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Develop relationship management skills to work effectively with partners (e.g. LA, patient groups, NECS, Cluster board, HWB board, NHS CB etc)	Use compacts, stakeholder analyses, review working arrangements regularly and document lessons learned/successes, training and engagement events, joint working	Sub groups, partners	Possible develop-ment workshops needed. Facilitator approx. £500 per day	Mar 2013	1, 2, 3, 4, 5, 6	In progress	Development opportunities as part of the HWB Board arrangements and Governing Body development programme- September 2012 workshop with LA & PH
Development of information utilisation to support commissioning decisions	Information at the point of use; finance, quality, performance. SNA data and health profile data. H&WB Board involvment Standard case for change Standardised commissioning process	In house NECS	n/a	ongoing	4	In progress	All Darlington practices moving to SystmOne. RAIDr in place with primary care Finance, performance & quality information already flows into the CCG
Effective commissioning Support arrangements to ensure robust commissioning and economies of scale	Joint development sessions with NECS. Integration of NECS workforce within our governance structure and operations	In house NECS	n/a	Dec 2012	1,2,3,4,5,6	In progress	MoU Relationship managers

Priority Area 6: Clinical quality and continuous improvement							
Task	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Increase capacity and capability as commissioners with regards to clinical quality	New CCG processes, training programmes, skill/knowledge transfer by joint working, coaching and shadowing	CNO and GP Quality lead, NECS	n/a	Dec 2012	1, 2, 3, 4, 5, 6	In progress	Pending recruitment of CN
Develop a mind-set of continuous improvement, build reform expertise	New processes, training programmes, skill/knowledge transfer by joint working, coaching and shadowing	NECS SHA innovation group, NELA	TBC	Mar 2013	1, 2, 3, 4, 5, 6	Not started	Need to identify requirements and who will lead this work. Use lessons from MSK pathway work
Integration of the GP productive practice into member practices	Linkage with NHSI Potential Phased roll out	NHSI, CNO, GP quality lead	£300 per practice	Dec 2013	1,2,3,4,5,6	Proposed	Discussed at primary care development workstream
Develop workforce capability to respond to patient/contracting concerns or incidents in a responsive manner to safeguard our patients	Standard quality improvement framework Quality improvement structure	In house NECS	n/a	Oct 2012	1,2,3,4,5,6	Under development	
Ensure that lessons learnt and good practice are shared and spread to enhance patient experience Darlington wide	Standard quality improvement framework Quality improvement structure	In house NECS	n/a	Oct 2012	1,2,3,4,5,6	Under development	

Priority Area 7: Partnerships and Engagement/relationship management							
Task	**Methods**	**Source**	**Cost**	**Deadline**	**Authorisation Domains**	**Status**	**Comments**
Develop relationship management skills to work effectively with partners (e.g. LA, patient groups, CSU, Cluster board, HWB board, NCB etc)	Use compacts, stakeholder analyses, review working arrangements regularly and document lessons learned/successes, training and engagement events, joint working	Sub groups, partners	Possible develop-ment workshops needed. Facilitator approx. £500 per day	Mar 2013	1, 2, 3, 4, 5, 6	In progress	Development opportunities as part of the HWB Board arrangements/ Governing Body development programme. Sept 2012 workshop with LA & PH
Use patient concerns and negative experiences to inform contracting and commissioning process- Links to priority area 6	Use of clinical quality information flow Use of member practice forums Embed communications and engagement strategy	In house Lay PPI, CNO.	n/a	Mar 2013	2, 4	In progress	
Capture the voice of the patient and their experience in a structured and systematic way – meaningful voices for patients and the public- links to priority area 6	Member practice forums to be established. CCG reference group and patient involvement in pathway redesign Close working with NECS PPI Embed H&WB Board National Learning Set 7 principles for hardwiring public engagement	In house NECS LA LINkS	n/a	Dec 2012	3	In progress	Some work joint with PCT/LA and CCG