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HEALTH AND SOCIAL CARE REFORM

DHSSPS

Modernisation and Improvement Programme Board (MIPB)

COMMISSIONING OF REGIONAL SERVICES

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MIPB 136/08

COMMISSIONING OF REGIONAL SERVICES

Introduction

This paper has been developed by the Commissioning workstream of the Regional Health and Social Care Board (RHSCB) project and will form a section of the overall operational framework for the RHSCB. It has been approved by the Modernisation and Improvement Programme Board and is now free for circulation to HSC staff and other relevant stakeholders. A copy of the paper will be placed on the Health and Social Care Reform section of the departmental website - www.dhsspsni.gov.uk/index/hss/rpa-home.htm

This paper outlines the criteria for determining those services that should be commissioned regionally; sets out an indicative list of those services; and outlines the practical working arrangements to secure a fully integrated approach across the RHSCB and the RAPHSW.

Further information on this document or the Regional Health and Social Care Board Project may be obtained from the Project Director ray.martin@dhsspsni.gov.uk tel: 90523398.

Modernisation and Improvement Programme Board

Background

1. This paper has been prepared by the Commissioning Workstream of the RHSCB Project Board. It is intended to provide an initial working model for the commissioning of regional services and there will be a need for further engagement with the new range of commissioners, when they are in place. Subject to final ministerial decisions, it is important to note at the outset that while the RHSCB will carry accountability for Commissioning, the RAPHSW has an accountability for providing its professional advice to the processes and the RHSCB will have a duty to pay 'due regard' to that advice.

Services to be commissioned regionally

2. One of the principles underpinning Commissioning in the Regional Health and Social Care Board (RHSCB) is that services should be commissioned as locally as possible. The RHSCB will, therefore, devolve commissioning to LCGs which, within a Governance and Operating Framework, will act as sub-committees of RHSCB.
3. LCGs will commission services for the population within the geographical area that they cover. Where LCGs determine, within agreed protocols, that it is in the wider interest to work together to commission a service regionally they will put in place efficient and effective arrangements for that purpose.
4. There are a number of reasons for commissioning some services at regional level rather than at LCG level. It is important that commissioners, at all levels in the system discuss and agree the services to be commissioned regionally.
5. Once the list is agreed, it will be necessary to have open, transparent processes for regional commissioning and local representation on any regional commissioning bodies/groups. This should ensure that we

have in place the planning and decision making processes necessary for efficient and fair management of the system and that regional commissioning of services is linked to local commissioning. This process should also be aided by having commissioning officers involved in both the local and regional aspects of commissioning for a client/patient group.

Criteria proposed for use in deciding whether a service should be commissioned locally or regionally

6. There are a few reasons why it might be best to commission some services at regional level: -
 - The first set of services might be identified on the basis of **financial risk**. Some services, were they to be commissioned or organised at local level, would be very small, costly and either unpredictably distributed in the population or strongly clustered. The combination of these factors would place any LCG at great financial risk should we opt to devolve commissioning below regional level. Examples of such services are those for Haemophilia, Enzyme Deficiency Disorders and specialist Forensic Psychiatry. An alternative to regional commissioning would be to have a financial cut off at - say £100,000 per episode where a service for a patient might be commissioned regionally. This latter, financial cut-off approach might in practice be bureaucratic, open to perverse incentives and be too unpredictable in practice without much/any advantage.
 - Another set of services comprises those that are **small and vulnerable** and where a fairly secure pattern of commissioning is required to ensure viability of the service in Northern Ireland. This does not mean that the service cannot be challenged or changed by reference to best practice. Amongst such services are Cystic

Fibrosis, Genetic Services, specialist Eating Disorder services and Specialist Child and Adolescent Mental Health Services.

- Another set of services is comprised of regional **monopoly, expensive services** where, unlike in GB we are more, (although not entirely), dependent on a local provider because it is less satisfactory for us to have to export significant numbers of patients. Regionally co-ordinated commissioning of these monopoly services, in practice, gives more leverage for change with local providers. Examples of such services are Plastic Surgery, Neurosurgery and Cardiac Surgery. These services need strong performance management to bring the contestability that might otherwise be brought by there being more local choice. We do not, however, have sufficient volume of population to allow more than one provider of these services in Northern Ireland. It may be that all Ireland approaches to some of these services will develop over time.
- Another set of issues relates to **Regional Network Development** where the main reason for across the region commissioning would be to see that a strong appropriate network was established, with an equitable distribution of capacity and an appropriate range of quality and access standards. This is in effect not 'regional commissioning' in the sense of the earlier discussion but is 'collaborative commissioning across the region' Some more work needs to be done to establish the precise role and accountability of Networks – to differentiate the commissioner and provider roles in them and the local and regional roles. We have currently a variety of Networks at different stages of development. Examples include - Renal, Cancer, Cardiology, T&O, Eating Disorders, Stroke, Critical Care.

7. Applying one or more of the above criteria to the services currently commissioned would lead to the following list of services as the basis for discussion and agreement in due course.

Regional Social Care Services

Mental Health

- Specialist Forensic Psychiatry
- Specialist Eating Disorders
- Mental Health and deafness
- Tier 4 Child and Adolescent Mental Health (Children's services?)
- Prison Health
- Specialist Psychosexual services
- Mental Health aspects of Brain Injury
- Neuropsychiatry
- Tier 4 Addiction services
- Family Trauma services
- Sexual Assault Resource Centre
- Specialist, Region-wide Voluntaries

Learning Disability

- Inpatient beds

Physical Disability

- Acquired Brain Injury inpatient Unit
- Spinal Injury Rehab. Unit
- Prosthetics/Orthotics service
- Wheelchair services

- High cost low volume continuing care and respite for people with severe, progressive neurological conditions such as Huntington's disease or motor neurone disease
- Specialist, Region-wide Voluntaries

Children's services

- Adoption
- Child and Adolescent Mental Health – Tier 4 services
- Secure residential care
- Intensive support/Regional Care centre places
- 'Differentiated' children's homes places
- Foster Care
- Child Protection
- Specialist, Region-wide Voluntaries

Regional Medical Services

- Blood transfusion Service
- Bone Marrow transplantation (Autologous and Allogenic)
- Cardiac Surgery/Thoracic Surgery
- Cochlear Implant Service Cystic Fibrosis
- Cystic Fibrosis
- Complex endocrine services
- Gynaecological oncology (at BCH site)
- GUM and HIV hospital services
- Hereditary Haemorrhagic disorders
- High cost drugs – for an agreed period after their introduction
- Immunology
- Inborn Errors of Metabolism
- Maxillo-Facial Surgery
- Medical Genetics (including enzyme deficiency services)
- Medical Physics

- Neonatal Intensive Care
- Nephrology and Renal Transplantation
- Neurology (adult – to be reviewed)
- Neurophysiology
- Neurosurgery
- NIAS Emergency Services
- Orthopaedics - paediatric
- Orthopaedics – spinal injury
- Orthopaedics – other specialised aspects
- Oncology – clinical
- Oncology – medical
- Oncology – children’s/adolescent
- Paediatric Cardiology and Paediatric Cardiac Surgery
- Paediatric ICU and recovery
- Paediatric Gastroenterology
- Paediatric Neurosurgery
- Paediatric Nephrology
- Paediatric Surgery
- Plastic Surgery and Burns
- Regional Intensive Care Unit
- Regional Infectious Diseases
- Regional Fertility Services
- Regional Pharmaceutical Support Services
- Regional Public Health Laboratory
- Regional Screening Services
- Regional Virus Laboratory
- Retrieval/ Transfer Services - adult
- Retrieval/transfer Services – Paediatric/Neonatal

8. This list of services should not be seen as definitive. While consultation has taken place with current commissioners and is based on their experience, there will be a need for further engagement with the new

range of commissioners in due course to agree the services list as well as the detailed processes for managing commissioning.

Practical arrangements needed for planning and decision making in respect of services to be commissioned at a regional level

9. **Planning** so that resolved, evidence based advice can be developed by officers with expertise and incorporated, in a timely way, in draft proposals and plans so that decision making can be facilitated
10. **Decision making** so that LCGs can agree Commissioning Plans either at an operational level or for incorporation into wider commissioning planning products that require formal endorsement of the RHSCB and the RAPHSW.

Planning Regional Medical Services

11. Health and Social Services Boards have had experience of regional commissioning in the arena of specialist medical services, for a number of years using a Regional Medical Services Team of officers from across the four Boards to carry out analysis, negotiate with providers and develop papers and plans which were taken to a cross - Board Regional Medical Services Group for discussion/amendment/endorsement prior to individual Boards incorporating the resultant actions in their plans. This process has worked relatively well. In a post RPA environment, it is proposed that the processes in respect of regional medical services would be strengthened and organised as follows: -
12. A multi-disciplinary team of officers from both the RHSCB and the RAPHSW would be constituted as the Regional Medical Services Team. Each member would have, as an agreed component of his/her personal job plan (annually reviewed), a specific commitment and an estimated time commitment to the Team. Members would also have

other components of their overall role in arenas away from regional medical services. Within the Team, members would organise themselves to ensure that for each of the main services an individual would have a lead role and would be backed up by a 'next on call' arrangement in the event of his/her unavailability for more than a couple of days.

13. Management arrangements will need to be put in place to ensure effective operation of the commissioning of regional medical services on a day-to-day basis. It is anticipated, therefore, (subject to final decisions on third line structures), that a Regional Medical Services Manager would be appointed regionally and assigned to the Team with a role to develop coherent plans for specialist medical services and develop and manage an annual work Programme for the Team. This officer would also have a key a role in wider strategic planning and acute services commissioning so that his/her knowledge based skills were maintained.
14. Over the period of the first full year of its operation, it is intended that, apart from developing the regional medical services components of annual plans and responding to relevant issues as they arise, the Team would compile a portfolio of concise briefing documents on high profile service issues. The individual documents and the port-folio would be kept up to date by the Regional Medical Services Manager and posted on a generally available e-network so that corporate knowledge is more robustly and publicly maintained than in the heads of individual experts.

Planning Regional Social Care Services

15. Unlike with regional medical services, it is not practical for regional community services to be planned by one Team because of the spread of services across programmes of care and the fact that it would be a poor use of scarce expert time to have people come together across

such a diverse agenda. It is proposed, therefore, that a small number of regional Teams are set up for service planning purposes with membership drawn from those officers who, in other parts of their job-plan, provide the expertise in relation to the relevant client group in one of the local areas. The Teams would fulfil the equivalent roles for regional community services as was described earlier for the regional medical services and would be facilitated in that regard by a Regional Social Care Services Manager (again subject to final decisions on third line structures).

Decision Making Processes in relation to Regional Medical and Regional Social Care Services

16. In the interests both of expeditious decision making and efficiency of use of staff and LCG time the officer Teams that work on Regional commissioning will be given formal remits that mandate them to make day to day decisions. The Teams will bring issues, (by way of papers containing recommendations), for higher order decisions to a Regional Services Group (RSG). It is suggested that this group should be comprised of 2 representatives of each of the LCGs (the LCGs to agree a balance of expertise and professional backgrounds from among their number, recognising that some of these staff will be provided by the Agency), plus two Directors of the RHSCB (one being the Director responsible for Commissioning) and two Directors from the RAPHSW (one being the Director of Public Health). This RSG would be mandated, through the formal Governance arrangements of the RHSCB and RAPHSW, the Operating Framework for LCGs and the internal working arrangements of each LCG, to make a range of decisions in respect of commissioning Regional services unless one or more of the LCGs does not agree the proposals. In any situation where consensus cannot be found in the RSG, the matter will be resolved through specified governance arrangements. In line with normal practice, the RHSCB will reserve in Standing Orders a small number of issues on which it will make strategic decisions and these would be

made collaboratively with the RAPHSW, if appropriate. The business agenda of the RSG would be agreed and managed by the Regional Medical Services and Regional Social Care Services Managers who would be in attendance at the RSG meetings and these officers would take back relevant issues to their respective Teams.

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