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an Fowk Siccar**

HEALTH AND SOCIAL CARE REFORM

DHSSPS

Modernisation and Improvement Programme Board (MIPB)

LOCAL COMMISSIONING GROUPS

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AN OPERATING FRAMEWORK

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MIPB 135/08

Local Commissioning Groups

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An Operating Framework

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 describes:

- the constitution and position of Local Commissioning Groups (LCGs) within the Regional Health and Social Care Board (RHSCB);
- the important role of LCGs in the commissioning process;
- the practical working arrangements to secure a fully integrated approach to local; and
- the governance arrangements for LCGs.

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

This framework sets out the governance and management arrangements relevant to the commissioning functions of the Regional Health & Social Care Board (RHSCB) and its Local Commissioning Groups (LCGs).

The RHSCB will be established formally on 1 April 2009, at which point it will assume responsibility for the commissioning functions currently carried out by the four Health and Social Services Boards. The Department of Health, Social Services & Public Safety (DHSSPS) will, in the interim, take forward the development of commissioning arrangements including the establishment of the RHSCB and its 5 LCGs, each covering populations in the range of 250,000 – 450,000. This work will be led by the RHSCB Project Board within the wider Modernisation and Improvement Programme.

LCG boundaries will initially be co-terminus with the 5 Health and Social Care Trusts (HSC Trusts), subject to review when the outcome of local government reform is known, whilst acknowledging that individual LCG commissioning must cross Trust boundaries in keeping with patient movement and care pathways.

2. RHSCB AND ITS LCGS

The RHSCB will inter alia be responsible for the following aspects of commissioning:

- The overall development and management of the commissioning system;
- Acting on behalf of the Minister in striving for significant improvements in efficiency and performance throughout the health and social care system to bring about improved services to patients, clients and carers;
- Implementing plans and accounting to the Minister to show progress against his stated expectations;
- The outcomes of commissioning functions discharged by the RHSCB through LCGs including the statutory responsibility to contain expenditure within allocated resources

- The provision of commissioning support and expertise to LCGs by staff employed by the RHSCB and by making and maintaining formal arrangements with the Regional Agency for Public Health and Social Well-being (RAPHSW) and the Regional Support Services Organisation (RSSO) for the appropriate provision of support and expertise from those organisations.

LCGs will be expressions of a devolved approach to commissioning health and social care. The status of LCGs as sub-committees of the RHSCB is established in primary legislation.

LCGs will have devolved responsibility for addressing the needs of their local populations, working within regional policy and strategy frameworks, available resources and performance targets. They will also have responsibility for fully integrated commissioning to deliver better health and wellbeing and improve health outcomes for their local populations as well as reducing health inequalities locally and across the population of Northern Ireland. They will be high performing decision-making groups with clear long term strategies to achieve the above improvements.

Significant planning, service procurement and performance management responsibility will be positioned with LCGs. Members will be appointed in accordance with Ministerial direction and will assume formal commissioning responsibilities for the year commencing 1 April 2009.

Membership of LCGs

LCGs are Sub-committees of the RHSCB, made up of independent, professional and locally elected members as follows:

- 2 voluntary sector/community representatives
- 4 local elected representatives
- 4 general medical practitioners
- 1 community pharmacist
- 1 general dental practitioner

- 2 social workers
- 1 public health specialist
- 1 nursing professional
- 1 allied health professional

The composition of LCGs recognises the unique contribution which can be made by primary care practitioners in relation to patient pathways, resource utilisation and the introduction of new care delivery models. Similarly the involvement of local elected representatives as LCG members brings an opportunity to further embed the aspirations and needs of communities in commissioning decisions.

The time commitment required of LCG members is not set out in primary legislation but it is proposed that for Chairs it should be 6 days per month and for other members 2 days per month. This commitment is intended to strike a balance between the need for engagement in key decision making processes and the need for independent practitioners to come from working environments where they maintain their professional expertise and do not place unfair burdens on practice partners etc. There are also issues of the overall cost of the system to be considered. The time commitment necessary to perform the functions will be kept under review by the RHSCB as the organisation matures.

Independent and lay members, including the Chairperson, are appointed by the RHSCB for a term of 4 years. Professional members are identified by the RHSCB to serve on LCGs. Although these appointments will not fall within the remit of the Commissioner for Public Appointments, the RHSCB will have due regard to the principles established in the Commissioner's Guidelines.

LCGs may wish to co-opt or ask others to attend their Sub-Committees to secure wider representation, but such members shall have no voting rights.

In the event of a vacancy arising, the RHSCB will determine how recruitment and selection should be conducted taking full account of relevant Departmental policy and guidance.

If a clinical or social services representative or independent contractor is suspended from their professional post or list, membership will be automatically suspended and will be terminated after 6 months if no resolution is found.

Membership will automatically cease if a lay member moves outside the LCG area; if an independent contractor ceases to practice in the LCG area; or if a local elected member loses their Local Council electoral mandate for a District/Borough Council ward within the LCG boundary.

Members, excluding the Chair, will have a time commitment of 2 days per month.

The RHSCB will allocate funding to LCGs to enable them to remunerate independent, lay and local government (if appropriate) members time in line with regional agreements. The Department/Minister may reserve the right to approve rates proposed by RHSCB.

Chairs of LCGs

The Chair of each LCG will be appointed from the independent contractor or lay members. He or she will have a time commitment of 6 days per month.

The Chairs will be responsible for ensuring that LCGs operate as cohesive and effective groups. LCG Chairs will be accountable to the Chair of the RHSCB and will have rights of attendance at RHSCB Board meetings.

3. COMMISSIONING

Commissioning principles and approach

Commissioning is the means of securing best value for patients/clients and the wider public in terms of:

- The best possible health and wellbeing outcomes, including reduced health inequalities
- The best possible health and social care;
- The resources made available by the tax payer.

Commissioning will be carried out in partnership with the RAPHSW and in collaboration with a range of stakeholders. Commissioning will encompass planning, resourcing and securing appropriate services from the 6 HSC Trusts (including the Northern Ireland Ambulance Service Trust) and other provider organisations and improving the health and well-being of the population by a variety of actions. Commissioning consists of:

- Assessing the needs of the whole population being served;
- Building the capacity of the population to improve their own health by partnership working in local areas;
- Working with key stakeholders to plan health and care services to meet current and emerging needs;
- Securing the delivery of efficient services and ensuring that they meet standards for safe, good quality care; and
- Using investment and performance management to develop and reform services.

The commissioning system must also have very strong links with local communities, and with voluntary and community sector organisations. The engagement of local communities is essential in securing the health and well being of their people.

As the needs of local populations differ and the pattern of current service varies from place to place, it is important that commissioning arrangements are rooted in good local knowledge and expertise.

Devolved Commissioning

LCGs will have devolved responsibility to commission services for the populations they cover, as set out in the Scheme of Delegation based on this Operating Framework. LCGs will have significant commissioning responsibility for the population they cover.

This will include the planning, procurement and performance management of commissioned health and social care services and of programmes relating to health and well-being. LCGs will not be responsible for the operational management of service delivery.

The principal functions of LCG members will collectively be:

- To take ownership and control of their local commissioning agenda;
- To set strategic direction and exercise effective oversight and management;

LCGs will be accountable to the RHSCB and the local population for how they plan, oversee investment and manage performance to improve health and wellbeing outcomes. They will make care commissioning decisions having due regard for:

- The identified needs of their population and
- Available resources

In forming their views LCGs will take account of:

- Care needs of their populations
- Ministerial and Regional Priorities
- Views of service users, carers and the wider public
- Views of, and performance by, Service Providers, and
- Available evidence and best practice.

LCGs will have:

- Devolved budgets for which they will be accountable to the RHSCB, which is accountable to the Minister;
- Flexibility to introduce initiatives to involve primary and community care practitioners and community and voluntary groups at a local level to actively engage in designing and reshaping services to better meet the needs of their local

communities. This should not however add further administrative overheads or create another level of bureaucracy;

- As a committee of the RHSCB, a statutory duty to 'pay due regard' to the views of the RAPHSW in addressing the wider determinants of health and well-being and reflecting this partnership in a joint Commissioning Plan;
- Arrangements in place for regular and meaningful engagement with elected representatives in District Councils and with voluntary advocacy groups, patients, clients, carers and the wider public.

LCGs will be required to:

- Adopt an inclusive approach to decision making recognising the distinctive contribution of all professional groups, lay representatives, patients, carers, the community and voluntary sector, locally elected representatives and the wider public;
- Play a critical role in relation to the improvement of public health and well being. They will forge partnerships with other relevant bodies, including the RAPHSW, to commission programmes of health improvement and to address health inequalities;
- Manage and undertake robust and regular needs assessments that establish a full understanding of current and future local health and social care needs and requirements;
- Prioritise investment according to local needs, service requirements and Ministerial policy and objectives;
- Be agents of innovation and continuous improvement;
- Work in partnership with providers, seeking to realise all opportunities to secure delivery of significantly higher standards for safe good quality care and improved health and well-being;
- Pursue all opportunities to secure enhanced value for money and improved resource utilisation.

Services should in the main be commissioned locally, at LCG level, and should be seen to be responsive to the needs of local communities. It is recognised that some services,

by virtue of their specialist nature, restricted volume or statutory accountability, must be commissioned collaboratively on a region-wide basis. LCGs will work through region-wide mechanisms. For example where:

- Some services are characterised by financial risk through being small in scale, costly and either unpredictably distributed or highly clustered. Examples of such services are those for Haemophilia, Enzyme Deficiency Disorders and specialist Forensic Psychiatry;
- Certain services for adults and children are of small scale and therefore vulnerable and where a fairly secure pattern of commissioning is required to ensure continued viability in service provision in Northern Ireland. Examples would include Genetic Services, Specialist Eating Disorder services, Autism services and specialist Child and Adolescent Mental Health services;
- Regional monopolies exist and where commissioning needs to be coordinated in order to maximise leverage. For example Plastic Surgery, Neurology and Cardiac Surgery. These services need strong performance management to bring the contestability that otherwise might be brought by there being alternative providers.
- Services for looked after children, for example Fostering, Adoption and Secure Accommodation, require a regional perspective to ensure that statutory functions are met consistently. The proposed model would allow local input and flexibility (and maximize local commissioning) so that vital links with other services, including primary care, are maintained.

Additionally it will be important that LCGs work collaboratively on areas of mutual interest and that across the region consistent approaches underpin needs assessment, service planning, procurement and performance management.

Strategic Direction

The LCGs will be the point of local leadership in commissioning health and social care. They will, therefore, need to have a clearly articulated vision and purpose, co-ordination and control of the commissioning function to deliver this and an ability to understand, interact with, respond and adapt to their own situation and the external environment.

Each LCG will be required to develop a strategic plan to improve the health and wellbeing, provide high quality health outcomes and reduce inequalities of its local population. The strategic plan, setting out the LCGs vision and strategic objectives, should be for a period determined by the RHSCB, probably for 3 years rolled forward annually, with regular review built in to ensure that it remains reflective of prioritised local need and regional and Ministerial priorities.

The strategic plan will be approved by the RHSCB and will be consistent with and reflected in the Commissioning Plan that is agreed by both the RHSCB and RAPHWS.

Annual Commissioning Plan

LCGs (working closely with the officers of the RAPHWS who are providing professional expertise to commissioning) will prepare an annual Commissioning Plan, in keeping with their strategic plan and in line with any format specified by the Department/Minister. It is expected that at a minimum, this plan will set out the commissioning intentions of the LCG including:

- Prioritised local needs
- How Ministerial priorities will be delivered
- The local as well as regional financial context
- Commissioning targets, objectives and associated financial implications
- A summary of performance against the previous year's targets and intentions, and
- Contextual information on how locally service reform and modernisation is being taken forward.

LCGs will plan and deliver new approaches to service delivery. This may involve investment in new service delivery arrangements or the movement of activity to alternative providers if this enables better quality, access or value for money. In general, there will be a progressive movement of work into community and primary care settings. LCGs will be required to ensure new service delivery arrangements are characterised by appropriate quality, clinical and financial governance processes.

LCGs should demonstrate in their annual commissioning plans that they have engaged with an appropriate range of professional expertise, community and voluntary groups and other stakeholders in decision making processes.

The Commissioning Plan of each LCG will be encompassed within the overall Northern Ireland Commissioning Plan that is agreed annually by the RHSCB and RAPHSW. The RHSCB will monitor the performance of each LCG in terms of the delivery of its Commissioning Plan.

4. GOVERNANCE AND STEWARDSHIP

Budgetary Arrangements

The RHSCB will adopt an approach to budget setting that is reflective of a new financial regime including the potential introduction of a shadow tariff based system from 2009.

In setting budgets for commissioning, the following principles will be applied:

- It must be consistent, fair and transparent
- It must be compatible with budget setting plans for 2009/10 onwards
- It should not adversely affect the financial stability of the RHSCB
- It must be simple and understandable.

The approach to budget-setting will use 'fair shares' principles, and will use the current weighted capitation approach, subject to ongoing refinement for resource allocation and any decisions by the Minister in relation to any transition arrangements to full application of capitation should the distance of specific LCGs from capitation shares be significant.

LCGs will be involved in the budget setting process to inform and influence the design of the financial regime for the RHSCB as it evolves.

Deployment of Resources

In principle, LCGs will direct the deployment of resources made available to them. This will include investments to support the development of new or redesigned services. Such investments will be enabled by the redirection of funds from existing services, 'new' monies allocated by the DHSSPS, or the utilisation of funding 'released' by the application of commissioning plans e.g. demand management programmes. This deployment of resources will be subject to the wishes of the Minister at any point in time.

Enabling Financial Balances

The RHSCB will monitor expenditure (actual and projected) against the budget allocated to each LCG. If there is a prospect of overspend, an LCG will be required to take action to ensure expenditure patterns are adjusted and contained within the available budget.

Accountability and Responsibility

The LCGs will be expected to:

- Maintain a sustainable financial position;
- Ensure ongoing financial management (actual performance against plan) and;
- Have accurate financial planning.

The RHSCB will be accountable for the outcomes of commissioning functions discharged by LCGs. This includes the statutory responsibility to contain expenditure within allocated resources.

Resolving Potential or Actual Conflicts of Interest

LCGs will be commissioners of services. They will be expected to act corporately in the interests of the population they serve even though each comes with his/her professional

background. Potential conflicts of interest may exist as some of the members of LCGs are providers of local services or members of organisations which may directly or indirectly benefit from decisions made by LCGs. Commissioning decisions may impact on the level or nature of provision of such services and have consequential financial implications.

A consistent approach will be applied across all LCGs in respect of the management of such conflicts of interest. A common set of procedures and processes will be defined by the RHSCB. These will be incorporated in a governance framework and applied to all LCGs. The governance framework will specifically address the fact that, in terms of management arrangements, there is clear separation of management of the GMS Contract from the management of service commissioning. Governance arrangements will also include:

- Requirement for individual declarations of potential conflicts of interest
- A duty on relevant RHSCB staff to identify potential conflicts of interest
- Actions to be taken should an actual conflict of interest arise
- Specific responsibilities of LCG Chair and RHSCB
- A robust mechanism put in place by the RHSCB to mitigate the risks associated with potential conflicts thereby protecting the interests of those involved and ensuring appropriate stewardship of public funds.

LCG Governance

LCGs will be committees of the RHSCB and will normally meet monthly (on at least 11 occasions per year). Expenditure associated with all additional meetings will be contained within the resources allocated by the RHSCB. Minutes of LCG meetings will be forwarded to the Chair and Chief Executive of the RHSCB.

A quorum shall comprise 9 members. If a member fails to attend 2/3rds of meetings without just cause, their membership will be reviewed and considered by the Chairman.

A robust governance framework, embracing the RHSCB and its LCGs will be developed by the Establishment Workstream during 2008/09.

LCG Operational Arrangements

Each LCG will be supported by professional expertise from the RHSCB, RSSO and RAPHSW providing a range of commissioning skills including information, strategic planning, nursing, social care, AHP, public health medicine, pharmacy, dentistry, performance management, procurement, financial controls, monitoring and regulation.

In the interests both of building local agendas into coherent regional approaches as well as being efficient in terms of staff deployment, the LCG commissioning support staff will also have roles in contributing to work at a regional level.

A senior officer of the RHSCB (title etc. to be agreed as part of the on-going decision making on organisational structures) will be designated as the point of executive leadership to each LCG. The officer will have a key role in ensuring that the LCGs for which he/she has responsibility has appropriate business support to allow it to fulfil its functions. This officer will, therefore, secure the necessary support to the LCG and ensure, in governance terms, a line of communication and interaction with the RHSCB.

The provision of strong financial support to LCGs will be particularly important. The RHSCB will identify an appropriate senior finance manager for each LCG to ensure this support is provided. This manager will work closely with the LCG(s) and will be a source of authoritative advice and guidance in respect of all relevant financial matters.

The RHSCB will provide staff with the requisite commissioning skills as well as a knowledge of, and credibility with, the local communities served by LCGs, to support each LCG. This will include support with:

- Assessment of health and well-being status of local population
- Identification of relevant public health and demographic trends
- Joint planning and co-ordination of activities with key partners

- Specification and procurement of health improvement programmes
- Assessment of impact of health and well being programmes
- Engaging service users, communities and service providers
- Appraisal of service options and care capacity requirements
- Developing and implementing commissioning plans and strategies
- Developing regionally consistent commissioning processes and systems
- Co-ordination of procurement processes including contracting, tendering etc
- Identification of new or enhanced providers in the health and social care market
- Analysis of activity, quality and outcome indicators against contractual expectations
- Under its statutory duty of quality, holding providers to account for continuous improvement in the safety and quality of services commissioned and obtaining assurance that safety and quality recommendations have been implemented
- Advice on intervention and responsive action if variation against contract occurs
- Analysis of financial aspects with advice on appropriate responsive action as necessary
- Analysis of and advice on compliance with standards (e.g. NICE, Service Frameworks, Child Protection).

Support and Development

In order to ensure that the LCG is able to take control of its local commissioning agenda, that all LCG members understand their role and have the skills to undertake this and are empowered to act corporately and collectively, a development programme will be organised. This will support the LCG in driving forward the strategy for their area and have an understanding of the key issues facing the LCG.

The development programme will have 3 strands:

- LCG members will be expected to participate in the Commissioner Capability Development Programme, provided by the RHSCB.
- Clinicians will be encouraged to participate in the Professional Leadership Development Programme and other personal development programmes to improve their leadership and management capabilities.

- An organisational development programme will be provided for LCGs to build team capability and functionality. This will be sponsored and funded by the RHSCB.

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