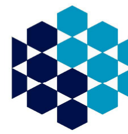


Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk
AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí
MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

HEALTH AND SOCIAL CARE REFORM

DHSSPS

Modernisation and Improvement Programme Board (MIPB)

HSCB - A COMMISSIONING FRAMEWORK FOR HEALTH AND SOCIAL CARE

JANUARY 2009

MIPB 09/09

Introduction

The Commissioning Framework is the covering paper for a compendium of linked papers which describe in more detail how the overall Commissioning system could work in practice.

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

The Commissioning Framework describes: -

- The purpose of Commissioning
- The business of Commissioning
- The organising Framework underpinning Health and Social Care Commissioning
- The governance structures in the Health and Social Care system with particular reference to Commissioning relationships
- The 'Special Relationship' between the RHSCB and the RAPHSW
- The operation of Local Commissioning Groups as Commissioners
- Primary Care Commissioning
- Moving from Service Planning to Securing the Delivery of Services
- Arrangements for sub-contracting procurement to Trusts
- Links between Commissioning and Performance Management
- Commissioner Development

Further information on this document may be obtained from Anne Lynch - alynch@ehssb.n-i.nhs.uk, Tel. 90321313

Modernisation and Improvement Programme Board

Contents

1.0 Introduction

2.0 Purpose of Commissioning

3.0 Business of Commissioning

4.0 The Organising Framework Underpinning Health and Social Care Commissioning

5.0 Governance Structures in the Health and Social Care System with Particular Reference to Commissioning Relationships

6.0 The 'Special Relationship' between the RHSCB and the RAPHSW

7.0 The Operation of Local Commissioning Groups as Commissioners

8.0 Primary Care Commissioning

9.0 Moving from Service Planning to Securing the Delivery of Services

10.0 Arrangements for Sub-contracting Procurement to Trusts

11.0 Links between Commissioning and Performance Management

12.0 Commissioner Development

A Commissioning Framework for Health and Social Care

1.0 Introduction

1.1 The purpose of a Commissioning Framework is to bring together in one place a description of what commissioning is in the Northern Ireland context and how it will be done for Health and Social Care in the reformed system that will pertain post April 2009.

1.2 The Framework is a compendium of more detailed papers describing specific key processes that are linked together to form a comprehensive approach that marks commissioning out from other main features of the new system e.g. policy making, provision of services, public health and social well-being, regulation, support services and patient and client advocacy.

2.0 The Purpose of Commissioning

2.1 The purpose of commissioning is to improve and protect the health and social well-being of the people of Northern Ireland and reduce differences in access to good health and quality of life.

3.0 The Business of Commissioning

3.1 For the purposes of helping to organise the work of the post RPA organisations, commissioning has been defined as comprising the following processes:

- Assessing the health and social well-being needs of groups, populations and communities of interest;
- Prioritising needs within available resources;
- Building the capacity of the population to improve their own health and social well-being by partnership working on the determinants of health and social well-being in local areas;
- Engaging with patients/clients/carers/families and other key stakeholders at local level in planning health and social care services to meet current and emerging needs;
- Securing, through Service and Budget Agreements, the delivery of value for money services that meet standards and service frameworks for safe, effective, high quality care;
- Safeguarding the vulnerable;
- Using investment, performance management and other initiatives to develop and reform services.

3.2 In the context of Northern Ireland Health and Social Care, commissioning should be seen as an ‘end to end’ process in a number of senses:

- It is directed towards securing the provision of health and social services and other related interventions that address the needs of people from pre-conception to death.
- It addresses the promotion of health and social well-being, maintenance of optimum independent functioning, acute intervention, rehabilitation, care and support for older people, people with chronic ill health or disability and palliative care.
- It organises action around a ‘commissioning cycle’ (at least at a conceptual level), that moves through from assessing needs, strategic planning, priority setting, securing resources to address needs, agreeing with providers the delivery of appropriate services, monitoring that delivery, evaluating impact and feeding back that assessment into the new baseline position in terms of how needs have changed. (In practice the actions are more iterative than smoothly cyclical).

4.0 The Organising Framework Underpinning Health and Social Care Commissioning

The Commissioning Cycle

4.1 The basic processes are summarised in the diagram at Fig.1

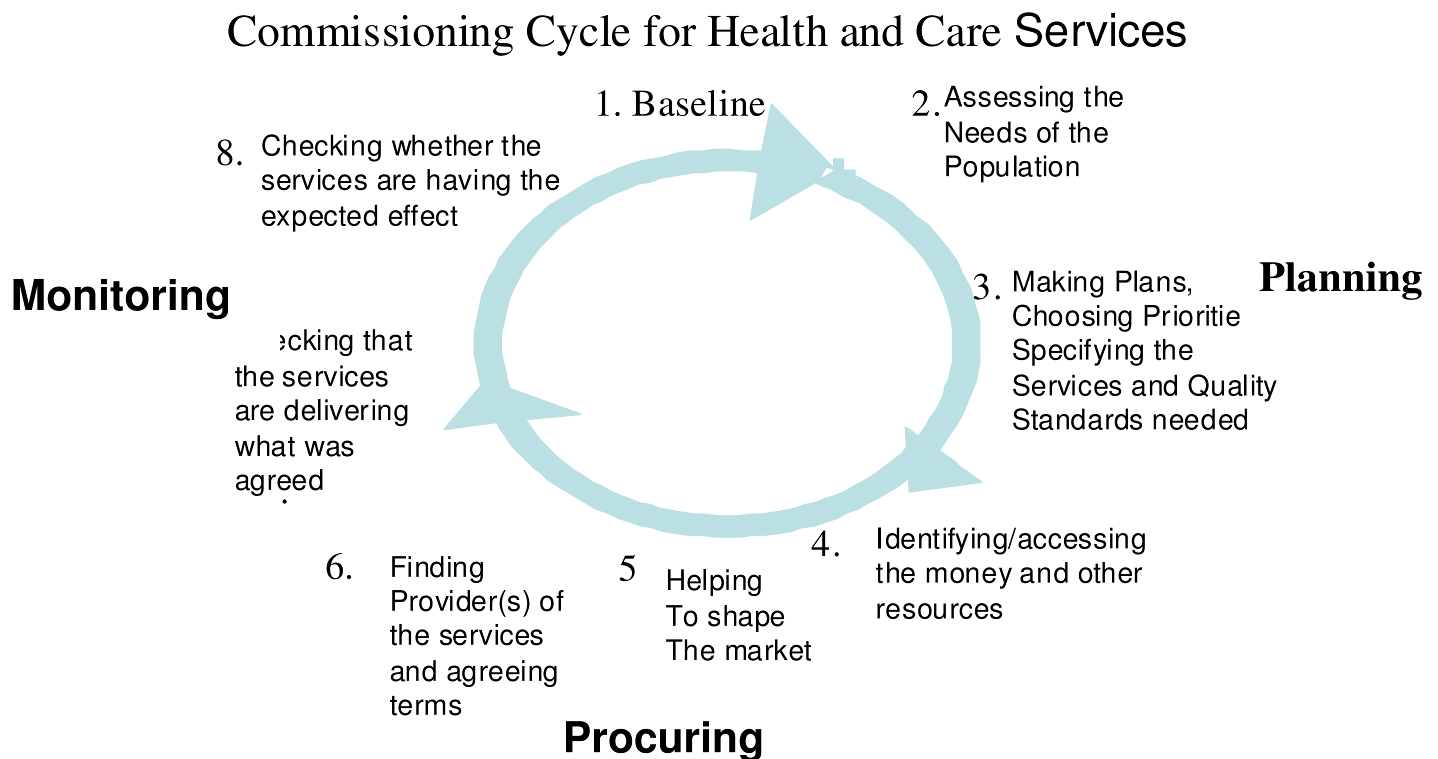


Fig.1 The Commissioning Cycle

4.2 In working through the Commissioning Cycle, a focus on the underlying purpose of commissioning, described above, is maintained. That focus sees a progressive improvement in services brought about by investment based on evidence of effectiveness, a drive for quality and efficiency (bench-marked against peers), a focus on the 'upstream' agenda where possible i.e. preventing problems arising and an influence over policy development based on familiarity with the changing needs of the population and close engagement with providers, consumers, partners and advocates. Securing planned progression in health and social well-being and service provision is represented in Fig 2.

Planned Progression

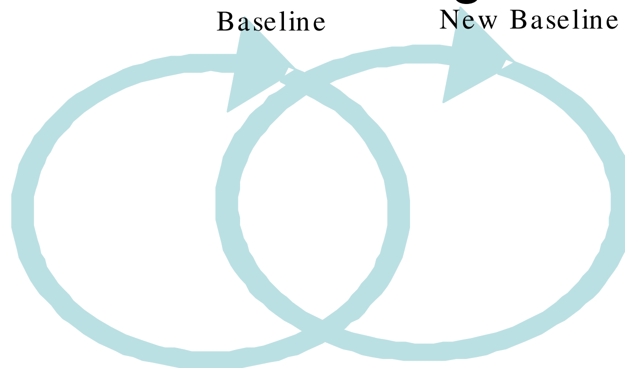
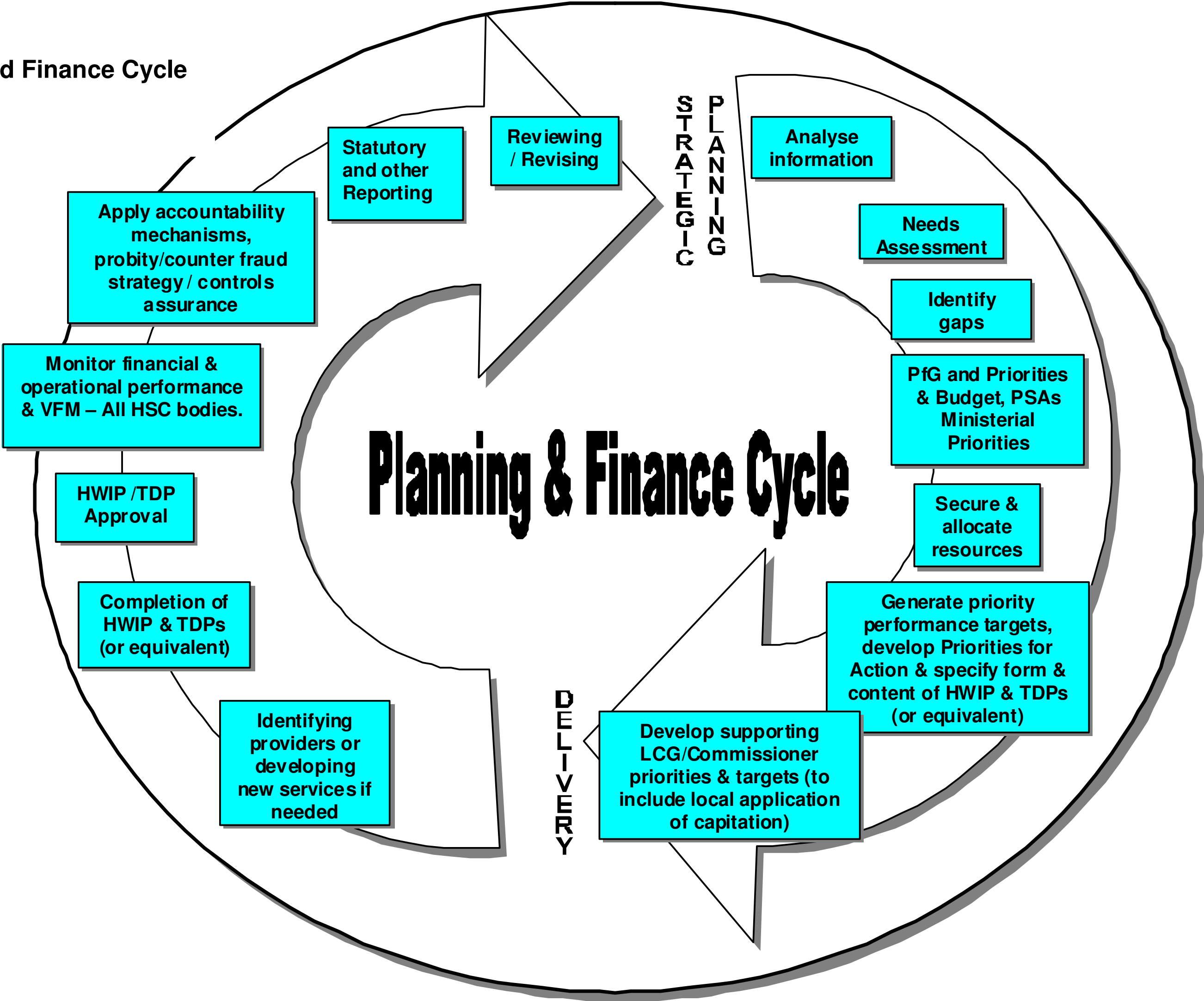


Fig. 2 Planned progression

4.3 In the context of the Northern Ireland Government system, planning and finance system, the Commissioning Cycle is an annual process undertaken by each of the Government Departments and represented for Health and Social Services in Fig 3.

Fig. 3 Planning and Finance Cycle



Geographical Populations and Programmes of Care

4.4 Commissioning is distinctive in that it takes a population focus rather than being primarily engaged with the operational aspects of service provision or the interests of an institution or particular service.

4.5 To be most effective, commissioning has to balance a geographical orientation to population with a client-group orientation. A geographical orientation can better reflect the needs of natural communities and the organisation of local health and social care economies, including hospitals, community networks and the network of geographically based partners necessary to help meet the challenges of improving health and social well-being.

4.6 On the other hand, organising commissioning around ‘communities of interest’ or client-groups or Programmes of Care can ensure that the needs of service users and carers are addressed holistically and services are planned in a coordinated way to meet particular needs.

4.7 Both approaches have merit and both will operate within the reformed Health and Social Care commissioning system. While the establishment of Local Commissioning Groups gives a prominence to geography, this will be balanced by Programme of Care teams within LCGs. These teams can also link across LCG boundaries where necessary, to form regional strategic planning networks relevant to client or ‘community of interest’ groups.

Devolved Commissioning

4.8 In the reformed system post April 09, we will operate a devolved approach to commissioning built around 5 geographically based Local Commissioning Groups that are co-terminus with the boundaries of the 5 Health and Social Care Trusts Fig 4.

Fig. 4 Local Commissioning Groups co-terminous with Trusts

5.0 Governance Structures in the Health and Social Care System with Particular Reference to Commissioning Relationships

5.1 The Accountability and Governance arrangements for the reformed Health and Social Care system post April 09 are enshrined in the 'Framework Document' referred to in the primary legislation.

5.2 A diagrammatic summary of these arrangements is provided at Fig 5.

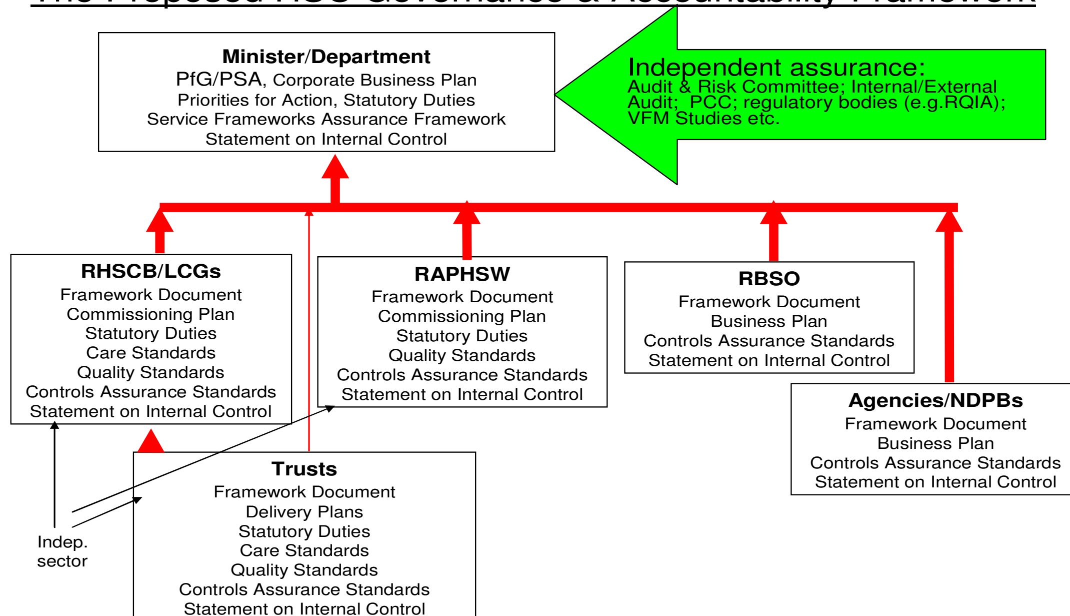


Fig. 5 Governance and Accountability framework

6.0 The 'Special Relationship' between the RHSCB and the RAPHSW

6.1 The RHSCB (the Board) and RAPHSW (the Agency) have separate accountabilities as organisations within the new structure but will require to have a very close working relationship if each is to meet its mandate to bring the expertise and resource available to bear on health and well-being improvement and commissioning high quality services to support individuals, carers and families and to meet need.

6.2 The Board and Agency are jointly charged with bringing forward an agreed Commissioning Plan on an annual basis. This Commissioning Plan would be developed within the context represented in Fig 3.

6.3 The relationship between the Board and Agency in terms of developing this agreed Commissioning Plan is shown in Fig 6. The relationship is described more fully in two papers - *Paper 1 – 'Working relationship between the Regional Health and Social Care Board (RHSCB) and the Regional Agency for Public Health and Social Wellbeing (RAPHSW)' from the overall system design perspective and Paper 2, 'RHSCB and RAPHSW – Working together on a daily basis'*

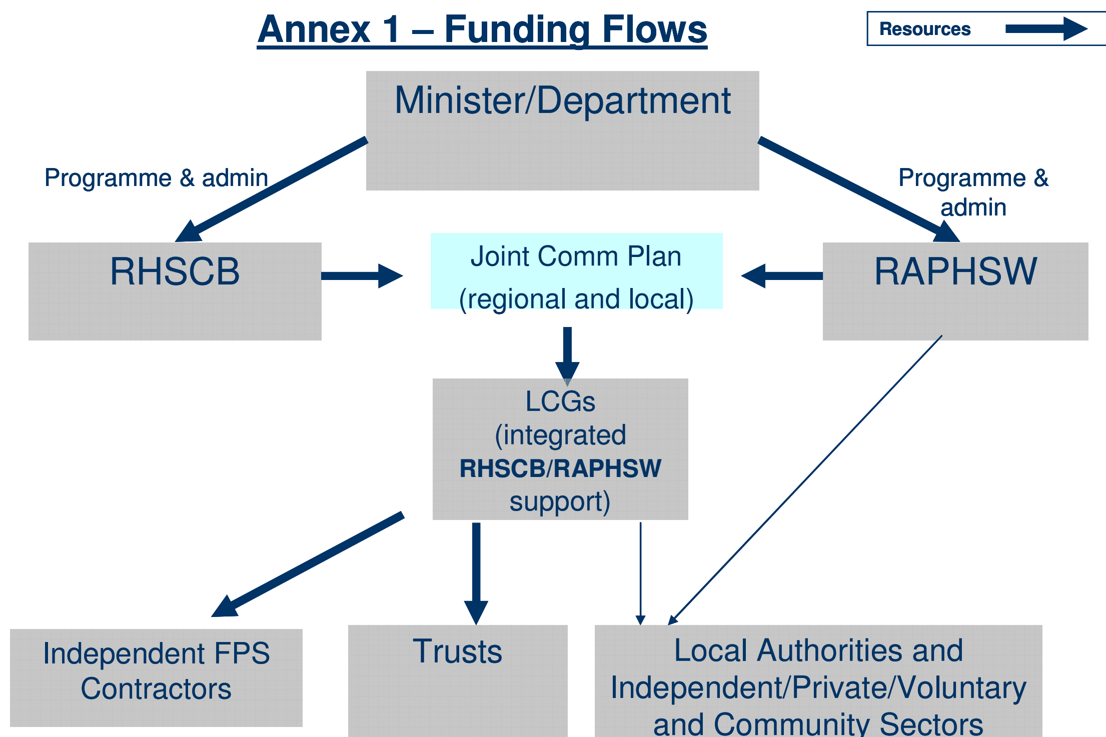


Fig 6 Development of a Commissioning Plan

7.0 The Operation of LCGs as Commissioners

Governance and Accountability

7.1 LCGs are the main 'engines' for commissioning in the Health and social Care arrangements post April 2009.

7.2 The framework governing their operating arrangements is described in *Paper 3 – 'Local Commissioning Groups – An Operating Framework'*

Stakeholder Engagement

7.3 Commissioning will be done in as collaborative a way with Stakeholders as possible. The range of Stakeholders is represented in Fig 7. The process for engaging Stakeholders is described in detail in *Paper 4 – 'Guidance for the Regional Health and Social Care Board, Local Commissioning Groups and the Regional Agency for Public Health and Social Wellbeing on Stakeholder Involvement'.*

7.4 It is intended that the operation of the processes described in this paper will fulfil, for those in the RHSCB and RAPHSW involved in commissioning, the requirements in legislation to have a 'Consultation Scheme'.

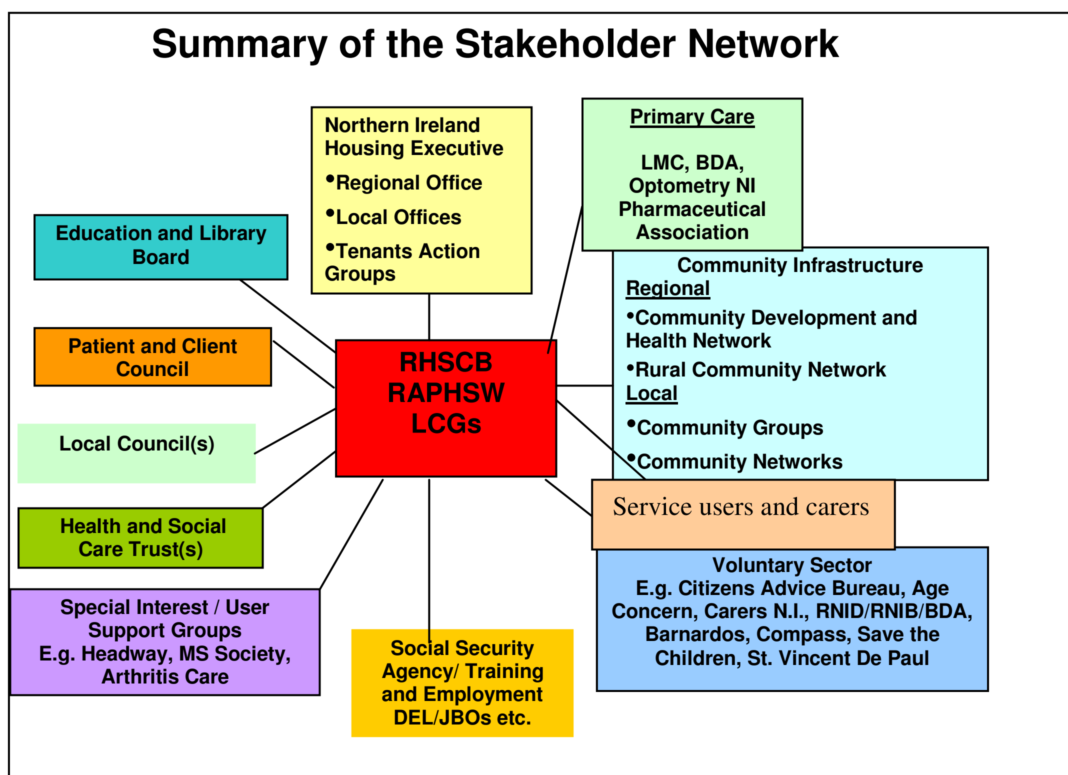


Fig.7 Stakeholder Engagement

The Arrangements for Commissioning Regional services

7.5 While a key underpinning principle of the new commissioning arrangements is that there should be a local focus where possible, it is clearly necessary and desirable that LCGs collaborate across boundaries to commission a range of ‘regional’ services and to be involved in strategic planning.

7.6 The planning and decision making processes in relation to Regional Services is set out in *Paper 5 – ‘Commissioning Regional Services.’*

8.0 Primary Care Commissioning

8.1 Whilst community health and social care services will continue to be commissioned mainly from statutory providers through Service and Budget Agreements (SBA), the future commissioning of services from independent family practitioner contractors will continue to reflect the negotiation of their contracts by DHSSPS.

8.2 These arrangements will recognise regional priorities, including service framework standards.

8.3 Local Commissioning Groups will identify local priorities and may use Local Enhanced Services (LES's) as a mechanism for securing service delivery. Negotiation of service specifications, including remuneration, will take place between officers of the RHSCB and the relevant professional body, e.g. Local Medical Committee, Local Dental Committee. In approving service specifications, it will be important for the RHSCB to ensure that appropriate checks and balances are put in place so that potential conflicts of interest do not impede the successful commissioning of local services through independent contractor groups represented on LCGs.

8.4 Likewise, if the funding streams for independent contracts are devolved to LCG level, then the RHSCB will need to ensure propriety in managing decisions around the division of these funds between different service streams.

8.5 The ongoing regionalisation of GP Out-of Hours services, now commissioned through a single service specification, would best be served by a regional framework, one which facilitates necessary local variation.

9.0 Moving from Service Planning to Securing the Delivery of Services

Principles underpinning the Commissioner/Provider relationship

9.1 Returning to points 7 and 8 of Fig.1, a crucial part of commissioning is turning plans into services on the ground and checking in due course whether the services that were commissioned are being provided and are having the expected effects.

9.2 It will be a core expectation of both Commissioners and Providers of Health and Social Care for the future that they conclude Service and Budget Agreements in a timely way at the start of the financial year, that these SBAs are negotiated in as much relevant detail as time permits before the due date for completion and that they are then signed by both parties. SBAs will, as a matter of course, include explicit reference to developmental work or any issues that remain to be agreed in greater

detail on the back of collaborative engagement during the remainder of the year.

9.3 While the operation of the contractual relationship between Commissioners and statutory Providers is not legally binding, it is proposed that, for the future, it should be made more formal in terms of the expectations placed on the parties.

9.4 If the Principles governing the Commissioner/Provider relationship are ‘felt-fair’ and clear, it is thought to be more likely that while, the parties will continue to have their legitimate specific interests and perspectives, they will be committed to a collaborative and risk sharing culture.

9.5 The Principles governing the contractual relationship between Commissioners and Providers that sees Providers providing services in return for resource are as follows: -

i That all financial resources that are devolved by the Dept. to the RHSCB are, initially, Commissioner resources and these resources pass from Commissioners to Providers on foot of formal Service and Budget Agreements (SBA) that link the activity/output/outcome to be supplied with the payment to be made.

ii Where the full outputs agreed in the SBA are being provided at a real cost saving relative to the resources agreed by the Commissioners, the Provider should (within the policy and priority context endorsed by the Minister and Department), have the opportunity to use such in-year savings to enhance care and support or remedy short-comings in infrastructure.

iii If in-year easements arise because of some delay in implementing/delivering an output expected in the SBA, the easements revert to the Commissioners for further deployment at their discretion (again obviously within the policy and priority context endorsed by the Minister and Department).

iv Principle 2 allowed the Provider to retain savings where expected outputs are being delivered in -year. On the other hand, if the Provider incurs unanticipated additional costs, they should expect to absorb a reasonable level of such costs with the proviso that some very exceptional circumstances might be identified where re-negotiation in year would be appropriate.

v In the event that a provider is experiencing a sustained level of demand above capacity, discussions should be held with the appropriate Commissioner(s) to agree an appropriate remedy.

vi Where the current pattern of services is to be re-profiled, this is a joint Commissioner Provider responsibility in terms of agreeing financial provisions. If the Commissioner knows the cost consequences of the re-profiling of service, these cost consequences should be planned for and incorporated in SBAs with bridging finance, timeframes and milestones agreed.

vii As Commissioners and Providers embark on the SBA at the outset of the year, a balance can be struck in terms of in-year resourcing between any known best practice bench-mark cost and current provider costs, on the basis that a strategy is agreed to address any gap.

viii Where there is no easy output measure (as is the case with many community based service areas currently), resource will be agreed based on discussion about appropriate input costs, tailored to complexity and required standards.

ix Capital developments and their revenue consequences will be planned together with due regard for affordability as well as strategic appropriateness from the perspective of Commissioners.

x There is a tradition of a mixed economy for the provision of social care and community services and this will continue to be the preferred model. In terms of health services, the Independent Sector will be used by Commissioners in situations where there is an underlying insufficiency in capacity in the statutory providers or where there is a temporary peak in demand or where the Commissioner judges that there is the potential to drive down costs or to provide a balanced mixed economy of services.

The Approach to Developing and Monitoring Service and Budget Agreements and Service Level Agreements

9.6 The processes that will be used to set up and maintain formal contractual relationships with Providers will tie in with the underpinning philosophy of devolved commissioning with regional coherence. LCGs will make their decisions about local priorities, agendas and service volumes within the framework of Ministerial policy. They will, however, work collaboratively to share the work-load attached to translating that into formal agreements with Providers that have the appropriate measure of consistency of approach. The measures that will be used to deliver this are are set out in the remainder of this section.

9.7 The contractual processes that leads to Service and Budget Agreements (SBAs) with statutory providers or Service Level Agreements (SLAs) with independent sector providers will pay due regard to the planning and Finance Cycle illustrated in Fig. 3. Where these agreements are with HSC Trusts they will be rolled forward annually and called Service and Budget Agreements (SBAs). Where they are with independent sector providers, they will be Service Level Agreements (SLAs) and will cover a variety of timescales.

9.8 The procurement or service contracting functions of the RHSCB will be organised and managed regionally but done on behalf of LCGs with the staff who support each LCG taking a key role in developing and agreeing the substance and content of the SBA and maintaining the two-way communication link with their LCG.

9.9 Rather than have all 5 LCGs negotiating separately with each of the five Trusts on behalf of their population, the 'host' LCG whose geographical locality is coterminous with a Trust, will take a lead role in procurement matters with the local Trust on behalf of all LCGs i.e. organising meetings, collating information etc. but all LCGs will be represented at key negotiation meetings with providers and each LCG will sign off relevant SBAs.

9.10 This should mean a reasonably streamlined approach to complex service procurement interaction between Commissioners and Providers.

9.11 In terms of content of SBAs, it is intended that there will be a common approach across Northern Ireland to standardising issues such as: -

- Terms and Conditions of Contract,
- Quality Standards,
- Types of information to be supplied and timing of information flows in relation to both quality and activity
- The use of information modelling systems for capacity planning etc
- The financial regime that Commissioners will apply to procurement issues
- Governance arrangements for taking forward Service Developments
- Development of 'product definition' i.e. more standardised approaches to describing and comparing services – especially where there has not been a well-developed system for data definition

9.12 Once SBAs have been concluded, there will also be a work-sharing, collaborative approach across LCGs to monitoring delivery of the services expected from providers. Commissioners will also agree work programmes for evaluating the delivery or efficacy of particular aspects of the service as this becomes necessary.

10.0 Arrangements for Sub-Contracting Procurement to Trusts

10.1 Currently the Boards collectively make Service Level Agreements directly with a range of non-statutory providers to a value of approximately £50m per annum. A Northern Ireland wide stock-take of this expenditure is being undertaken at present by the four Boards and recommendations as to future process will be made in due course.

10.2 Over and above this class of arrangements, Trusts currently act as sub-contractors with third party service providers and secure service to the value of some £550m-£600m per annum. The significant majority of these funds fall into a category of service that would be viewed as direct care provision that needs to be arranged for individuals as part of their care pathway.

10.3 In the interests of having the decisions as close as possible to when and where the service users and carers require them, it would not be desirable or indeed feasible for Commissioners to manage the Service Level Agreements involved in this work, directly.

10.4 There is, however, considerable scope for more standardisation to be brought to procurement of these services and collaborative work between the Department, Boards and Trusts has been undertaken in this area. *Paper 6 'Procurement of Social Care by Trusts'* sets out proposals for how sub-contracting by Commissioners to Health and Social Care Trusts will be developed from April 09.

11.0 Links between Commissioning and Performance Management

11.1 Monitoring performance of providers against the agreements they make in relation to service delivery is a key part of the Commissioning Cycle and Commissioners will continue to ensure that this role remains core to how they work with Providers.

11.2 Over and above but dove-tailing with that service delivery monitoring role and the role of Commissioners in service development and improvement, will be the role fulfilled by the Performance Management arm of RHSCB on behalf of the system. That role and the processes and techniques to be used, is set out in *Paper 7 - 'Performance Management and Service improvement in the health and Social Care system'.*

12.0 Commissioner Development

12.1 A change of organisational arrangements as significant as those to come into force in Health and Social Care in April 09 will mean that for both those who have familiarity with the service and those new to it, there will be a need to develop new skills, make new team arrangements (even across organisational boundaries) and learn about complex issues and good practice.

12.2 One of the ways of helping this to happen is to have a tailored Commissioner Development Programme. A business case to allow such a programme to be commissioned is underway and the programme should be available as the new organisational arrangements come on stream.

Jan 2009

Document History:

Anne lynch	Commissioning sub-group RHSCB Work-stream
Owner:	Dr Andrew McCormick, MIP SRO
Client:	Modernisation and Improvement Programme Board (MIPB)

This document required the following approvals

Title	Name	Date of Approval	Version
Modernisation and Improvement Programme Senior Responsible Owner (SRO) and Modernisation and Improvement Programme Board (MIPB) members	Dr Andrew McCormick, Permanent Secretary Linda Devlin Julie Thompson Sean Donaghy Michael McBride, David Bingham Hugh Mullen Linda Brown Sean Holland Colm Donaghy Karen Meehan Tom Creighton, Philip Robinson Ken Jarrold, Bernard Mitchell George O'Neill John Compton Edward Rooney Maeve Hully	22nd January 2009	1.0

This document has been distributed to:

Title	Name	Date of Issue	Version
Chief Executives of HSC Boards, Trusts and Agencies.		13th February 2009	1.0
Chairs of Boards & LCG Chairs, Trusts and Agencies		13th February 2009	1.0
Chairpersons and Chief Executives (Designate) of: - Business Services Organisations - Health ad Social Care Board - Patient and Client Council - Public Health Agency		13th February 2009	1.0
Departmental Board		13th February 2009	1.0
MIP Project SRO's		13th February 2009	1.0
MIP Project Directors		13th February 2009	1.0
DHSSPS Website and Intranet		13th February 2009	1.0