



Department of
**Health, Social Services
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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

HEALTH AND SOCIAL CARE REFORM

DHSSPS

Modernisation and Improvement

Programme Board (MIPB)

RAPHSW

Input to the

Commissioning Process

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Introduction

This paper has been developed by the Commissioning workstream of the Regional Agency for Public Health and Social Wellbeing (the Agency) project and should be read in conjunction with the documents on Regional Commissioning and the LCG Operating Framework, which have already been approved by the Modernisation and Improvement Board (MIPB). In common with those documents, this paper will eventually be reflected in an overall Commissioning Framework for the Health and Social Care in Northern Ireland. This paper concentrates on the Agency's role in the commissioning process and will assist the work of the Agency Establishment workstream.

This document has been developed in liaison with a wide range of stakeholders and has been endorsed by the Agency Project Board.

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

Further information on this document or the Regional Agency for Public Health and Social Wellbeing may be obtained from the Project Director.

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Section 1

1.1 This paper has been produced by the commissioning workstream of the project to establish a Regional Agency for Public Health and Social Well-being (the Agency). It should be read in conjunction with the documents on Regional Commissioning and the LCG Operating Framework, which have already been approved by the Modernisation and Improvement Board. In common with those documents, this paper will eventually be reflected in an overall Commissioning Framework for the Health and Social Care in Northern Ireland. This paper concentrates on the Agency's role in the commissioning process and will assist the work of the Agency Establishment workstream.

1.2 Successful commissioning will require close cooperation and collaborative working between the Regional Health and Social Care Board, with its five Local Commissioning Groups (LCGs), and the Agency. This paper describes the arrangements to ensure that the Board and LCGs receive timely, high quality input to their commissioning responsibilities from healthcare professionals in the Agency, primarily public health doctors, nurses and allied health professionals. The intention is to foster a culture of close working between the RHSCB and Agency in the development and assurance of an annual commissioning plan for health and social care.

1.3 Commissioning of Health Protection, Health Improvement and Screening are considered in those workstreams' papers. For the purposes of this paper, where the term commissioning is used it refers to commissioning services unless otherwise specified.

1.4 Existing commissioning knowledge, skill and expertise from public health, AHPs and nursing staff has been developed in the context of the 9 Programmes of Care and it would be important that these skill sets are incorporated into future arrangements.

1.5 The importance of the Public Health input into emergency planning should be incorporated into the commissioning process for the NI Ambulance Service.

1.6 The importance of health protection, health improvement and mental health services, including addictions, should be reflected in the commissioning of health care within the NI Prison Service.

Section 2 – Scope of the commissioning function in the Agency

2.1 The Agency role in commissioning is to improve the health and wellbeing of the population through providing high quality, independent public health advice to support the commissioning and performance management processes of the Board corporate and LCGs.

2.2 The Agency input to commissioning will be based on team structures working cooperatively with appropriate Board staff. Each organisation will have identified lead responsibility for specific areas of work.

3. Roles and Responsibilities of Commissioning

The roles of DHSSPS and Board are not further considered in this paper.

Role of the Agency in Commissioning

3.1 The Agency will provide the professional expertise from public health, AHP and nursing into all of the actions listed below.

Therefore it will:

- Develop and agree joint commissioning plans that secure high quality, safe services that meet patient need and Ministerial priorities with the Board within the resources available
- Be full and active members of commissioning teams at local and regional level
- Lead on the commissioning and service improvement of agreed areas of work
- Provide professional advice to formal performance management arrangements of the Board and to service improvement work of the Board, where the Board is the lead organisation
- Provide professional advice to local and regional commissioning structures
- Provide input to service evaluation and review
- Provide professional advice and lead on the commissioning of screening programmes
- Ensure that quality and safety are addressed through commissioning by monitoring quality and safety of services commissioned, including adherence to good practice standards and the application of learning from incidents, inquiries and complaints
- Assess the health and wellbeing needs of the population and of specific communities through assimilation of data and information from multiple sources

- Identify, access, analyse and interpret information which is population and evidence based, to support high quality commissioning
- Apply up to date knowledge of research literature, evidence of good practice, benchmarking, healthcare systems and quality data
- Work on strategic development, service improvement, prioritisation and service redesign
- Participate in local commissioning decisions as nominated members of Local Commissioning Groups
- Provide support and advice to DHSSPS regarding their policy development and standard setting
- Provide public health advice to influence optimum health outcomes from the development of primary care schemes including Local Enhanced Services and Direct Enhanced Services
- Implement strategies, including moving the balance of care from the acute sector to primary care in respect of chronic disease management
- Ensure clinical networks are appropriately engaged in the commissioning process
- Monitor the impact of commissioning against health and well being improvement (reduction in need/inequality)
- Work with RHSCB colleagues to identify future needs and resources as part of the CSR process
- Provide professional advice to the 'ECR' process including drug treatments and other high cost regimes
- Provide professional advice to appropriate commissioning-based FOI requests, AQ's etc
- Engage with users and user groups as appropriate

- Work with the Patient and Client Council to improve the patient and client experience
- Engage in partnerships and community participation working together with providers and others to build capacity

Responsibilities of the Agency in Respect of Commissioning

3.2 The fundamental responsibility of the Agency in relation to commissioning is to ensure that Health and Wellbeing Improvement is adequately reflected in all aspects of commissioning and ensure that inequalities are addressed through the commissioning process. This will be achieved through agreement of commissioning plans with the Board.

3.3 To fulfil these responsibilities the Agency will need to:

- Ensure that health protection and health improvement issues are incorporated into commissioning plans
- Support development, implementation and evaluation of service frameworks (ensuring incorporation into commissioning plans)
- Assure the competence and credibility of the professional input to commissioning
- Support continuing professional development of all staff
- Undertake staff appraisal and support the revalidation process for all relevant staff and to undertake annual job plan review. For staff on the consultant contract there should be an appropriate balance between direct and supporting activities
- Ensure the best use of the public health resource and maximise the added value of this resource
- Ensure professional input to regulatory processes

- Incorporate the service (treatment) requirements for the full range of screening programmes (both cancer and non-cancer) into commissioning plans
- Ensure integration of the three domains of Public Health both regionally and locally
- Ensure that the Agency provides opportunities for training for all relevant disciplines and supports the formal Public Health Training programme
- Provide administrative support as required within the Agency. However, for those working within the commissioning function, administrative support will be required from the Board and LCG's.

Section 4 – Business Model for Agency input to Commissioning Core model

4.1 The business model has to support both local and regional commissioning. In the new structures, commissioning and its associated functions will be provided by staff who are employed by primarily two separate organisations – the Regional Public Health and Social Well being Agency and the Regional Health and Social Care Board. To ensure a culture of joint working, the core vehicle for delivering commissioning and its associated functions will be joint Board and Agency commissioning teams. The teams will include relevant staff from the Board and Agency; they will be task focused and will draw up commissioning plans for agreement by the Board and Agency. The lead accountability for a particular task will reflect the core roles of the Board and Agency.

4.2 Where the Board has lead accountability for a task, the Agency would be accountable for the support it provides to the Board in that

task, e.g. commissioning health and social care services. The Board and Agency teams will be most successful if they work in a spirit of collaboration and support, ensuring that each receives the input it requires to exercise its functions. Joint commissioning teams with a designated lead will ensure clarity of accountability and a single interface for specific work areas or projects between the Board/Agency and providers.

4.3 The level of AHP resource potentially available to support commissioning at both local and regional, commissioning is limited. Arrangements will have to be carefully constructed to maximise the AHP contribution to commissioning (see Appendix 4).

Regional Commissioning

4.4 The model and framework for regional commissioning has been agreed by the Modernisation and Improvement Project Board (MIPB). Agency staff will support regional commissioning in the following way:

- A regional commissioning team will be established for regional and supra-regional acute services (including children services). This team will be drawn from Board and Agency staff who have specific knowledge and/ or expertise of the relevant service areas and who may also be supporting acute commissioning in the local support units. This will ensure local needs are reflected in regionally commissioned services. The commissioning team would also have a number of sub-groups to cover different clinical areas
- A regional commissioning team approach will also apply to non-acute services based on a number of sub-groups to cover different care or programme areas. The relevant Board and Agency staff on these teams may also work in a local support unit

- The regional team both for acute and non-acute commissioning will require a structure for decision-making. Reference is made to this in the commissioning paper of the Board workstream. This structure should have 2 members from each of the LCGs (suitably selected to include a balance of expertise and professional backgrounds from among their number) and led by the Director of Commissioning from the Board. The Director of Social services should be represented for the non-acute programme. The Director of Nursing and the Director of Public Health or their nominees should represent the Agency. This decision making structure should also encompass other services which have more than one provider and commissioner or where services are in transition (e.g. Trauma and Orthopaedics and biologic therapies)
- With respect to decision-making within the Agency, tier 3 leads for health protection, health improvement and commissioning, including screening, will work with other tier 3 colleagues and the Directors of the Agency to consider and agree commissioning plans from the Board/Agency commissioning teams.

Local Commissioning

4.5 The framework for Local Commissioning Groups has been agreed by MIPB. Local Commissioning Groups (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. Agency staff will be members of Local Commissioning Groups who 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.

4.6 LCGs will be supported by Board and Agency staff based in Support Units and working in a range of functional joint commissioning teams. These teams will be the primary contact between ‘commissioners’ and providers.

4.7 In respect of PfA monitoring, relevant Agency staff from the commissioning teams will support performance management colleagues in holding providers to account for performance. Where escalation is required they will work with providers to achieve improvement in performance.

4.8 Agency staff who are members of commissioning teams in individual support units will require a regular forum to meet with their counterparts in other support units and in the Agency. The tier 3 leads would be responsible for ensuring that arrangements are in place to enable Agency staff involved in commissioning (including those who are LCG Board members) to share and discuss issues with their colleagues in other support units and with colleagues in health protection and health improvement.

Section 5 – Accountability arrangements

5.1 The Agency will be held to account by the DHSSPS for the support it gives to the Board in commissioning health and social care services.

5.2 The accountability arrangements for teams within the support units will be in keeping with the agreed operating framework for LCGs. However, for the Agency, the line of accountability for input to commissioning is from individual members of staff to the tier 3 lead for

Commissioning and Screening and through them to the Director of Public Health and Chief Executive. This would also be a structure for appraisal. Equivalent staff with a nursing or AHP background would be accountable to the Director of Nursing and Allied Health Professions.

5.3 Agency members of the LCG will have the same accountability (as all other LCG members) to the Chairman of the LCG as in any committee structure.

Appendix 1

PRINCIPLES FOR THE AGENCY (WORKING WITH THE BOARD) IN RESPECT OF COMMISSIONING

- All commissioning activities should reflect health and wellbeing improvement
- Commissioning should seek to address inequalities
- Multidisciplinary input to commissioning across the programmes of care
- Team working will facilitate cross cover to facilitate business continuity i.e. business should continue when an individual is unavailable. There should not however be unnecessary duplication of effort
- Input to screening programmes (separate paper/section)
- Input to the commissioning process should be commensurate to the level of spend and/or complexity and/or current strategies/priorities
- The commissioning process should ensure that the service and treatment consequences of screening programmes are adequate and reflected in service and budget agreements
- Need to engage Health protection (including emergency planning) into commissioning
- There should be a balance of local and regional working and local views should be reflected in the regional process
- Need to ensure that staff who have roles in more than one domain are able to contribute in each area

- The working arrangements for Agency and Board staff must accommodate team working
- Staff from the Agency must have access to relevant staff employed by the Board to ensure that the commissioning process can be appropriately undertaken
- Information sources housed at the Board or the RSSO must be appropriately available to staff of the Agency
- There should be the opportunity to influence the range of information available and the analyses performed
- Those whose work is mainly with the Board must have access to the Agency and staff to facilitate CPD, audit and other professional activities
- The Agency must facilitate integration of the 3 domains of Public Health
- The new system must support training
- Need adequate administrative support for those 'out-posted'
- The professional teams will need to be flexible in respect of working location and may require a system of 'hot desks' in the various Board and LCG locations
- Need robust communication and ICT systems and a more developed video conferencing culture
- Need to maintain the capacity for surge capacity e.g. health protection outbreaks, look-back exercises

OPERATING PRINCIPLES/PHILOSOPHIES

1. Only centralise functions that have to be
2. Where functions are centralised it should be possible for the workforce to work from a local base
3. There must be adequate resource for local function (it should be the main focus)
4. Individuals should have a combination of specialist expertise and local geographical knowledge except where there is a highly specialised role which can only be undertaken in one location
5. The integration of the three domains should be facilitated. Separation and fragmentation should be avoided
6. There should be opportunities for individuals to maintain and develop skills and work in different areas
7. There should be a balance between direct and supporting activities

Appendix 2

THE AGENCY INPUT TO THE LOCAL COMMISSIONING GROUP

A series of questions were asked regarding this role (appendix 3)

The Agency has the potential to have three members of staff on the 'board' of the Local Commissioning Group including nursing, allied health professionals and public health.

The exact role and function of the 'board' of the Local Commissioning Group will depend on the operating framework for the commissioning system. This will consequently influence the role of Agency members. The 'board' members should be nominated by directors of the Agency. The Agency members should have equal status to all other members of the Board.

It is likely that the Agency members of the Board will also have duties in the relevant business support unit. However this was not perceived as essential.

Those agency staff working in the business units and LCG 'board' members should be perceived as having equal status (this is not a DPH role).

All Medical public health staff supporting the commissioning function, including those who are members of the 'board', should be accountable (through the relevant head of department if appropriate) to the Regional Director of Public Health. The nursing and AHP staff should also have professional and management accountability to the Agency (the exact relationship will depend on structures within the Agency). Members of

the 'board' would have a responsibility to the Chairman as in any committee structure.

The individual public health 'board' members would not be expected to be expert in all programmes and domains however they should be in a position to be adequately briefed and/or to be able to invite colleagues to attend the 'board' for specific issues. Given the combination of nursing and AHP and medical public health members it should be possible to get a balance of expertise.

Appendix 3

SEMI STRUCTURED QUESTIONNAIRE TO COMMISSIONERS

1. The LCG Board member

What is the role and function of each individual from the Agency?

This is a 2 session per month commitment to each of 5 LCGs for nursing, AHPs and Public Health.

1. Is the role as a corporate member? Yes/No

2. Is the LCG 'agency' Board member part of the business support structure? Yes/No

3. What is the LCG member relationship to public health and other Agency staff in the business support unit?

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4. Who is the LCG member accountable to:

a. Managerially.....

b. Professionally.....

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5. Does the individual cover

a. All 3 domains.....

b. 9 programmes.....

6. What is the process of 'selection'?

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Comments.....

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Appendix 4

AHP Input of the Regional Public Health and Social Wellbeing Agency to Commissioning

It is recognised that the current level of Allied Health Professional (AHP¹) input does not adequately meet the needs of the existing Board agendas. It does not allow AHP commissioners to fully contribute to the multi-disciplinary nature of commissioning to the same extent as other professions and as a result some key commissioning decisions have to be taken in the absence of specialist AHP knowledge, advice and challenge. There is a risk that the skills of the AHPs will neither be recognised nor maximised in the best interests of patient care.

There are currently 4 wte AHP posts in N. Ireland (1 per HPSS Board). Approximately 0.7 wte of each post supports the commissioning function.

Given that AHPs are integral to all programmes of care and work across the spectrum of primary, community, secondary and tertiary care, each AHP commissioner is expected to provide professional input to:

- 1 HPSS Board
- Regional Commissioning, Acute, Non-acute Services and Screening
- One or more Local Commissioning Groups

¹ 7 AHP Professions;

Dietetics, Occupational Therapy, Orthoptics, Physiotherapy, Podiatry, Radiography & Speech and Language Therapy.

This includes:

- Nine Programmes of Care
 - Primary Care
 - Mental Health
 - Learning Disability
 - Physical Disability
 - Health Promotion
 - Family and Child care
 - Maternal and Child health
 - Elderly
 - Acute
- Specialist or disease specific areas e.g. Diabetes, Palliative Care, etc
- HP performance management and
- AHP quality and safety

When AHPs are engaged in the multi-disciplinary commissioning process they offer a unique skill set which includes:

- Using their unique insights to help influence, shape and implement approaches and culture across the Allied Health Professions leading to service improvements and developments
- Providing a thorough knowledge about how AHP services are delivered and what the experience and expectations are of patients and users

- Possessing a political astuteness in order to decide what can and cannot be done when setting challenging AHP targets and identifying AHP service improvements etc
- Understanding the climate and culture of the AHP professions in the context of the wider health and social care environment
- Knowing who the key influencers are – both internally and externally to the organisation- and how to involve them as required
- Taking calculated risks with the aim of delivering added value to AHP services and the wider health and social care system
- Demonstrating a highly visible, authoritative and democratic AHP leadership
- Creating the conditions for and achieving results by working in partnership with Trust AHPs and a wide range of other agencies and individuals over whom they have no formal authority
- Influencing relationships with Trust AHPs which are critical to achieving change

Future AHP input to commissioning

The particular skills and expertise of the 7 Allied Health Professions play a central role in health and social care and will be essential to the delivery of commissioning objectives. The opportunity now exists to explore a number of workforce models to address this critical workforce issue in order to secure the best possible health and wellbeing outcomes for patients.

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