The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	Monday 28th November 2011
Title:	Commissioning Arrangements and LDP Process 2012/13
Executive Summary:	This report provides detailed information on the future commissioning arrangements and the potential impact on LDP negotiations for 2012/13.
Action Requested:	The Board are asked to note the report
Report of:	Maxine Espley, Director of Planning and Contracting
Author: **Contact Details:**	David Butterworth, Head of Commissioning and Contracting Tel: 01902 695945 Email: David.Butterworth@nhs.net
Resource Implications:	LDP and Contract negotiations for 2011/13 have commenced and Directors and Senior Management will review the service, contractual and financial implications throughout these negotiations.
Public or Private: **(with reasons if private)**	Public
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	'Equity and Excellence: Liberating the NHS' 'Health and Social Care Bill' The Operating Framework 2012/13 (to be published) PbR Tariff Guidance 2012/13 (to be published)
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details	
1.	**Introduction** The purpose of this paper is to provide information on the DH revised plans for Commissioning arrangements for 2012/13 onwards and the impact on the current LDP negotiations. This paper will therefore take into account the role of the NHS Commissioning Board (NHS CB), the SHA Clusters, PCT Clusters and the Clinical Commissioning Groups (CCGs). The paper outlines the need for RWHT to respond to the changing commissioning landscape.
2.	**Background** In July 2010, the coalition government launched an NHS white paper entitled: 'Equity and Excellence: Liberating the NHS'. The paper detailed the new vision and plans for the NHS including the creation of a NHS Commissioning Board and GP-led Commissioning Groups to replace the commissioning role of Primary Care Trusts. In response to feedback from professional bodies, interested parties and the general public, the Coalition Government established the **NHS Futures Forum** to review feedback and undertook structured 'Listening Events' leading to some changes within the Bill which have now been reviewed by Parliament. These changes include the strengthening of clinical engagement in the GP-led Commissioning Groups and clarification of the authorisation arrangements to be established for CCG's.
3. **3.1**	**New Organisational Arrangements** **NHS Commissioning Board (NHS CB)** The DH has ultimate accountability for the commissioning of provision and it is intended that a NHS CB will be developed for this purpose. The NHS CB will have responsibility for delivering the NHS Outcomes Framework supported by effective governance arrangements for accountability, choice and emergency planning. The NHS CB will be a new statutory body operating as a shadow authority from October 2011. From October 2012, the NHS CB will take on the limited statutory body accountability in respect of approving the authorisation of CCGs and full statutory accountability responsibilities from April 2012. The NHS CB will have commissioning responsibility for Primary Care Services and for Specialised Services. The NHS CB will develop commissioning guidelines, standard contracts and pricing mechanisms and manage the authorisation of CCGs and will be supported by sub national offices. The NHS CB is considering the formation of Clinical Senates with 15-20 across England. The Clinical Senates will provide a vehicle for cross specialty collaboration, strategic overviews and acting as an advisory body for specific areas of commissioning proposals including major service changes or service reconfigurations. It is likely that key membership of senates will include representation from CCGs.
3.2	**SHA Clusters** The DH have introduced SHA Clusters to manage the transitional risk around

	capacity, capability, new commissioning arrangements, and the development requirements for emerging CCGs. The 10 SHAs in England in 2011/12 have been restructured into 4 SHA Clusters from October 2011 as follows: • NHS North England • NHS South England • NHS London • NHS Midlands and East (replacing NHS West Midlands, NHS East Midlands and NHS East of England) It is expected that the SHA Clusters will become NHS CB Sub National Offices from April 2013, supporting the transitional arrangements until this time including the development of emerging CCGs. The SHA Clusters will work closely with PCT Clusters to align processes and systems in respect of performance management; quality and safety; workforce planning; emergency planning; medical recruitment and commissioner development. It is expected that the NHS Midlands and East SHA Cluster will provide guidance and direction to the local PCT Clusters and emerging CCGs in the development of the 2012/13 LDP and contractual arrangements.
3.3	**PCT Clusters** PCT Clusters were formed in April 2011, with 51 PCT Clusters in England with responsibility for 152 PCTs. The five PCT Clusters in the West Midlands are: • Arden • Birmingham and Solihull • Staffordshire • West Mercia • Black Country (Wolverhampton; Dudley; Walsall; Sandwell PCTs) The Chief Executive of the PCT Cluster is the accountable officer for each of these PCTs and there has been a single Executive Director Cluster Team in place since 2011/12. The DH published a shared operational model for PCT Clusters in July 2011, to ensure consistency and continuity across England including the responsibility to oversee and account for NHS care delivery and to support the development of CCGs. PCT Clusters will have responsibility to ensure that individual PCTs meet their legal, financial and performance responsibilities and many are centralising some key functions to ensure sustainable management capacity. PCT Clusters have overall responsibility to ensure each PCT meets the QIPP challenges and for ensuring that robust plans are in place for 2012/13, this will include a provision for CCGs to take a lead role in QIPP forward planning and Contracting (and contract negotiation) and preparation for the authorisation process. .

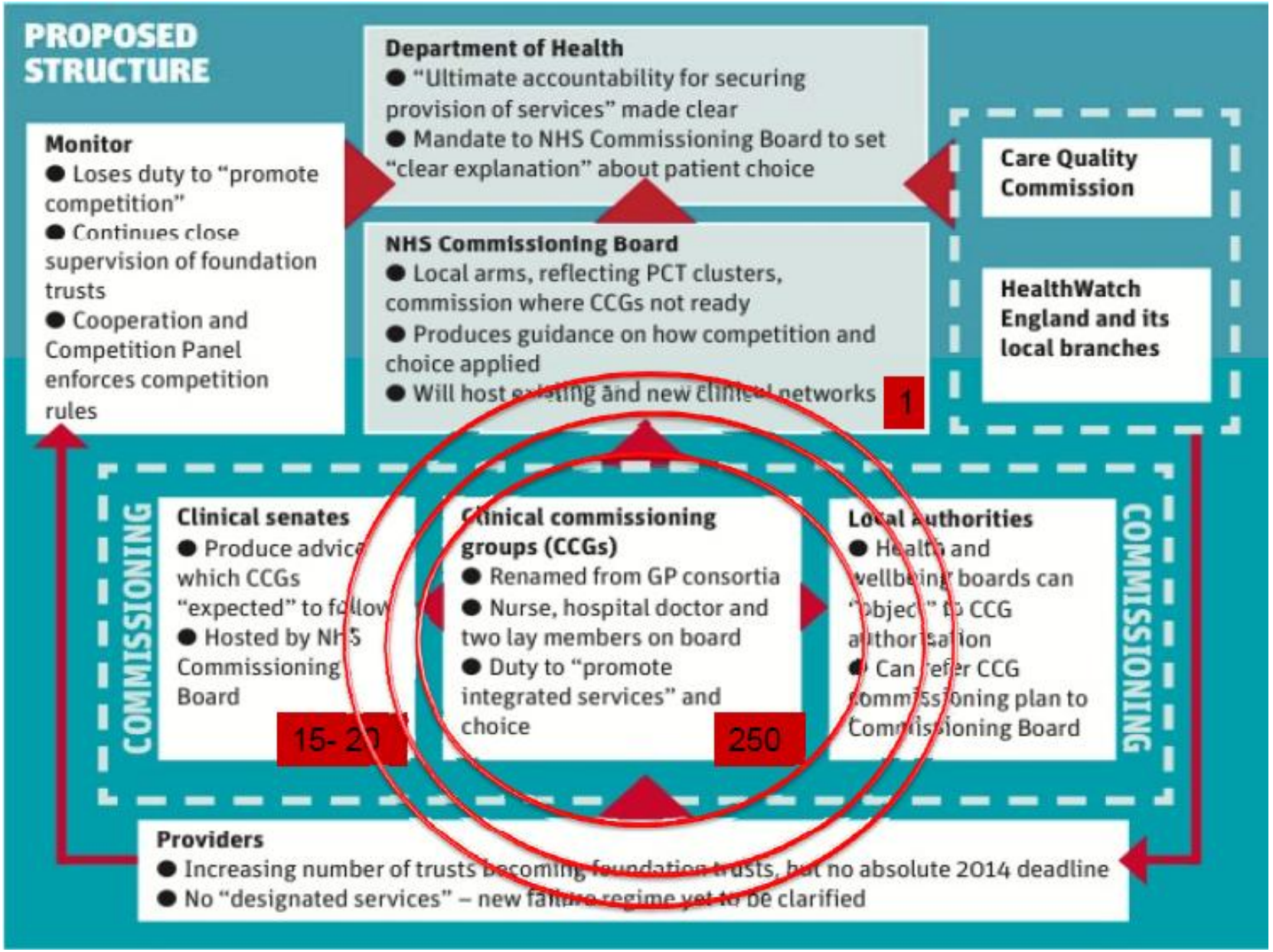
3.4	**Clinical Commissioning Groups (CCGs)** PCT Clusters and SHA Clusters will work in partnership to determine the viability of CCGs, but the authorisation responsibility will remain with the NHS CB. There are currently an estimated 331 emerging CCGs and this may reduce to approximately 250 following the initial phase of authorisation in respect of configuration and organisational viability due to be completed in December 2011. The CCGs will have statutory accountable status from April 2013 onwards and will report to the NHS CB. They will take on the responsibility to commission a wide range of NHS Services, but will not commission Primary Care Services or Specialised Services. The current proposed configuration of CCGs is a chair (GP), GP representatives including an Executive Board member, a Nurse and a Hospital Consultant with Executive Board responsibility. It is expected that CCG's will be supported by a Senior Management Team. All CCGs will work through an authorisation process from October 2011 until March 2013, and the development and support requirements throughout this process will be delivered by PCT Clusters, working in collaboration with SHA Clusters where appropriate. The six key domains for CCG authorisation will cover the following: • Strong clinical and professional focus • Effective patient and carer engagement • Credible QIPP/Financial plans that deliver National Standards • Effective governance arrangements • Collaborative working with local authorities/other CCGs/NHS CB • Great leadership, individually and collectively The 3 stages of authorisation will be: • Stage 1 – Risk Assessment of Configurations – SHA Clusters to complete by December 2011 • Stage 2 – Development Phase – PCT Clusters to support CCGs through 2012/13 to develop towards full authorisation. • Stage 3 – Authorisation – CCGs will need to demonstrate compliance across the six key domains, with their documentation included as an evidence base and there is a key requirement of key stake holder support. This will require Health and Well Being Boards to clarify their support or object to the authorisation of proposed emerging CCGs. NHS CB will lead this authorisation process throughout 2012/13, to decide upon authorisation stations for 2013/14. The CCGs authorisation process will lead to CCGs status authorised as follows: • **Shadow CCGs, not authorised** – For CCGs not in a position to commission from 2013 onwards and the NHS CB will deliver all function undertaken as accountable officer. It is envisaged this will be

	delivered through local offices of the NHS CB which may be by the designation of current PCT Clusters. • **Authorisation with conditions** – this will establish the level of authorisation and may exclude CCGs taking on a full range of commissioning (managing complex service change or commissioning complex services). • **Fully Authorised** – CCGs will commission all relevant services on behalf of their population. Note: See attached appendix 1 for new organisational structures.
3.5	**Specialised Services Commissioning** The ten Specialised Commissioning Teams have been restructured into four teams from October 2011, aligned with the SHA Clusters. The four specialist teams will continue to commission specialised services and it is expected to be a limited transfer of activity from PCT contracts in 2012/13 and a more significant increase in specialised services for 2013/14 (to coincide with CCG authorisation). For RWHT, the major change in 2012/13 will be the commissioning of the cystic fibrosis centres services with a group of 'Black Country' patients transfers from the Heartlands Hospital.
4.	**Impact on RWHT**
4.1	**Relationship Management** Directors and Senior Managers are reviewing the current and future relationship management arrangements to develop a strategy and plans that reflect the changing landscape of commissioning Directors are establishing direct contact and building relationships with PCT Cluster Directors and to agree collaborative strategies on Health Economy and LDP issues for 2012/13. Directors and Senior Managers are building upon the historical effective relationships with commissioners and establishing links with the emerging Clinical Commissioning Group, significant involvement is expected in 2012/13. The Medical Director is a member of the Clinical Cabinet arrangements in Wolverhampton.
4.2	**Commissioning and Contract Management** The senior management team are fully engaged in the current commissioning and contract management arrangements and formal monthly acute and community contract meetings and bi-monthly LDP Acute and Community contract meetings have been established. Senior managers are managing the commissioning and contract management arrangements with Specialised Services colleagues and this is expected to remain stable for the 2012/13 contract and LDP discussions. WCPCT have issued their Commissioning Intentions for 2012/13 and will include 44 QIPP Schemes for Acute Services and 8 QIPP Schemes for Community Services. RWHT have responded to these intentions and request

	a priority list of QIPP Schemes and other Commissioning Intentions, with detailed project plans and timescales. Te commissioner has so far given formal notice to de-commission the salaried dental service and tender against a revised specification The PCT Cluster have also issued a draft policy for 'Procedures of Limited Clinical Priority Guidelines' and RWHT has provided a detailed response. RWHT expect that the SHA Cluster and PCT Cluster will issue further policies to PCT Commissioners in preparation for 2012/13 Contract Negotiations, which may introduce a 'benchmark' management approach. RWHT have noted to the commissioners an intention to move from the current block contract arrangements for Community Services to cost and volume for 2012/13.
4.3	**Contract Changes for 2012/13** It is expected that there will be a single acute and community contract for 2012/13 but with separate schedules for finance and activity related to acute and community services. It is expected that the changes to the specialised services contract portfolios will be limited. New contract arrangements in respect of the development and implementation of the cystic fibrosis centre for 2012/13 (for specialised services) will be managed and RWHT will respond to the outcome and designation of the Black Country Vascular Centre. All commissioners are expected to identify the services they will market test following the Any Qualified Provider guidance and we await the clusters approach to this for 2012/13.
5.	**Key Planning Timetable Events** LDP meetings are planned with WCPCT and Specialised Services from November 2011 to May 2012. Key dates for the commissioning process: • Cluster wide plans for 2012/13 – draft submissions to the SHA Cluster by the 25th November 2011 • WCPCT provides RWHT with baseline activity assumptions – early December 2011 • RWHT to launch annual planning 2012/13 meetings with Directorates (November/December 2011). • National Contracts and PbR tariff guidance issued – early January 2012 • WCPCT and RWHT to agree baseline activity – End of January 2012 • WCPCT to agree to RWHT performance reporting and information requirements in contract schedules – Mid February 2012 • WCPCT initial contract offer – 19th February 2012 • **WCPCT RWHT contract agreement – 26th February 2012** • RWHT budget setting and CIP meetings – January to March 2012 • RWHT Directors and Senior Management Team to review the impact of QIPP Schemes, benefits realisation proposals and develop and implement a contracting strategy with commissioners – ongoing from

	December 2011 with completion required by end of February 2012.
6.	**Conclusion** This report has provided detail in relation to the current position in respect of commissioning arrangements and LDP challenges for 2012/13. Following the publication of the Operating Framework and PbR Tariff, further update will be provided to Trust Board and Trust Management Team to support and understand the impact of DH Policy arrangements for 2012/13. This will also take into consideration a review of the impact of the guidance, advice and support given by SHA Clusters and PCT Clusters on the 2012/13 negotiating process. There is an expectation that the 2012/13 LDP and consequent contract negotiations will be very challenging, specifically in respect of the income available to commissioners for contract negotiations, the service quality, standards and delivery requirements and the changing commissioner landscape.

Appendix 1


PROPOSED STRUCTURE
Department of Health
● "Ultimate accountability for securing provision of services" made clear
● Mandate to NHS Commissioning Board to set "clear explanation" about patient choice
Monitor
● Loses duty to "promote competition"
● Continues close supervision of foundation trusts
● Cooperation and Competition Panel enforces competition rules
NHS Commissioning Board
● Local arms, reflecting PCT clusters, commission where CCGs not ready
● Produces guidance on how competition and choice applied
● Will host existing and new clinical networks
1
Care Quality Commission
HealthWatch England and its local branches
COMMISSIONING
Clinical senates
● Produce advice which CCGs "expected" to follow
● Hosted by NHS Commissioning Board
15- 20
Clinical commissioning groups (CCGs)
● Renamed from GP consortia
● Nurse, hospital doctor and two lay members on board
● Duty to "promote integrated services" and choice
250
Local authorities
● Health and wellbeing boards can "object" to CCG authorisation
● Can refer CCG commissioning plan to Commissioning Board
COMMISSIONING
Providers
● Increasing number of trusts becoming foundation trusts, but no absolute 2014 deadline
● No "designated services" – new failure regime yet to be clarified