NHS Lancashire

UPDATE REPORT IN THE PROGRESS IN IMPLEMENTING THE HEALTH AND SOCIAL CARE ACT (Appendices A and B refer)

1 Purpose

The purpose of this report is to update the Board on the implementation of the proposals contained within the Health and Social Care Act.

2 Background

The Government has reinforced its commitment to the NHS's founding principles but has recognised that standing still will not protect the NHS and that modernisation is essential. The pressures on the NHS are increasing; demand is growing rapidly as the population ages and long term conditions become more common; more sophisticated and expensive treatment options are becoming available. There is a recognition that there is a need for improvement and the Health and Social Care Act provides for a radical re-structuring of the NHS to address these issues.

3 The Health and Social Care Act 2012

The new Act which received Royal Assent on 27 March 2012 is designed to meet these challenges by making the NHS more responsive, efficient and accountable. The key legislative changes are:

- Clinically led commissioning
- Provider regulation to support innovative services
- A greater voice for patients
- A new focus for Public Health
- Greater accountability locally and nationally
- Streamlined arms-length bodies

The Act which completed its passage through Parliament in March 2012 provides clarity and certainty about future direction after a lengthy and protracted period of uncertainty. The real momentum now moves to putting the new health and social care system into place by 1 April 2013 which will deliver these changes on the ground.

A copy of how the structure of the NHS Commissioning Framework will be changed is attached at Appendix A.

4 The new Commissioning System and Structures

This report sets out how the new commissioning structures will operate together with a brief description of their role and functions. Where possible the information has been presented in a context local to Lancashire. The proposals in respect of the transition of Public Health functions into the local authority are the subject of a separate report on this agenda.

4.1 Clinical Commissioning Groups (CCGs)

Local CCGs will sit at the heart of the new system and will bring GPs and other clinicians together to design and implement better systems of care which are focused on delivering better outcomes responding to the needs and wishes of local patients and reducing health inequalities.

The vast majority of aspiring CCGs of which there are around 250 in the county have confirmed their member practices and established an effective geographic area. In Lancashire, there will be eight CCGs, six of which are co-terminous with the Lancashire County Council footprint and two, NHS Blackpool CCG and NHS Blackburn with Darwen CCG, which are co-terminous with their respective unitary authorities, progressing through the authorisation process as follows:

Name of CCG	Population size	Number of constituent practices	Commissioning budget
NHS Lancashire North	158,843	13	£183m
NHS Fylde and Wyre	151,707	21	£233m
NHS Blackpool	178,831	24	£187m
NHS West Lancashire	111,848	23	£120m
NHS Greater Preston	212,000	34	£202m
NHS Chorley and South Ribble	170,000	31	£196m
NHS Blackburn with Darwen	167,000	29	£262m
NHS East Lancashire	371,073	63	£710m

The CCG boundaries are shown on the map at Appendix B.

CCGs will be responsible for commissioning a wide range of services from local acute trust/foundation trust providers' i.e. secondary care, mental health and learning disabilities services and for performance managing the activity levels, quality and patient safety standards and outcomes of those providers. They will work closely with the local authority to integrate health and social care in order to provide services closer to home and to enable patients especially those with long term conditions to remain in their communities.

CCGs will not be required to commission either specialist services i.e. tertiary/complex services, primary care services e.g. GPs, Dentists, Pharmacists or services for particular groups such as Offenders, Armed Forces personnel and Veterans. All of these services which require detailed and specific expertise or which might present conflict of interest to CCGs will be commissioned on a national or regional basis.

The eight emerging CCGs are already operating under delegated authority, increasingly taking on day-to-day commissioning responsibilities on behalf of their local PCTs. This year all eight were involved in developing and negotiating the annual contract with their local provider of secondary and community care and mental health services and they will

progressively move into leading the performance management meetings and the contract negotiations for 2013-14.

In order to become a statutory organisation in their own right and to assume full accountability each CCG has to go through a nationally managed authorisation process between now and March 2013. The content of authorisation is built around six domains and has been developed through a wide range of stakeholder involvement including patients, carers, clinicians and partner organisations.

The six domains are:

Domain 1: A strong clinical and multi-professional focus which brings real added value

Domain 2: Meaningful engagement with patients, carers and their communities

Domain 3: Clear and credible plans which continue to deliver the QIPP (Quality, Innovation, Productivity & Prevention) challenge within financial resources

Domain 4: Proper constitutional arrangements with the capacity and capability to deliver all their duties and responsibilities

Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS National Commissioning Board as well as appropriate commissioning support

Domain 6: Great leaders who individually and collectively make a difference

The thresholds within each domain have been set to ensure CCGs have autonomy to innovate in how they deliver improved outcomes and at the same time are safe as statutory bodies responsible for commissioning health services. The criteria in relation to risk on quality, safety and financial management and related governance, planning and capacity and capability therefore have relatively high thresholds.

The authorisation process is divided into three stages:

1. **Pre-application** – beginning with a self assessment diagnostic. All eight Lancashire CCGs have successfully completed this stage.

2. **Application** – each aspiring CCG will need to submit an application form to the NHS Commissioning Board. The form will provide some detail about the CCG, list the evidence which the CCG is submitting to support its application and enable the CCG to declare compliance with certain criteria

   All Lancashire CCGs are currently preparing their evidence in support of their application.

3. **NHSCB Assessment** – the formal assessment will be based on the evidence gained from several key components including a 360^0 survey, a desk top review, case studies and site visits.

There are three possible outcomes for each CCG and each outcome will be accompanied by a development plan which has been agreed by the NHS Commissioning Board. The three outcomes are:

1. **Authorised** – The CCG can assume the full powers and responsibilities

2. **Authorised with conditions** – the CCG has not met all of the thresholds and will be authorised with limits or directions on how it carries out its functions

3. **Established but not authorised** – this is where the CCGs are established but with conditions that are such that it cannot take on its functions as a CCG. In this case the NHSCB will have to make alternative arrangements for commissioning for that CCG area until the shadow CCG is ready to move forward.

Guidance has been published to support CCGs through the process and a regular series of workshops is supporting specific areas of activity and development.

The timetable for application and assessment has been set out in four waves and CCGs are currently being asked to indicate which Wave they would prefer as determined by their own confidence in their state of readiness.

The deadlines for the four waves are:

	360^0 Stakeholder Survey	**Application Submitted**	**Decision by:**
Wave 1:	June	July	31 October
Wave 2:	July	September	30 November
Wave 3:	September	October	31 December
Wave 4:	October	November	31 January

Locally, the CCGs are still determining which Wave they are intending to apply although the indications are that two of them will seek to apply in Wave 1 with the others in Waves 2 or 3.

4.2 The NHS Commissioning Board

The overarching role of the Board is to ensure that the NHS delivers better outcomes for patients within its available resources. It will do this through its leadership on delivering the NHS Outcomes Framework, supported by its accountability framework for CCGs, its framework for ensuring choice and competition and its framework for emergency planning and resilience.

It is not possible to devolve all commissioning to CCGs nor to expect them to commission services from their member practices and so the government has established the NHS Commissioning Board (as yet in shadow form). The Board will be a national body and its role will include supporting, developing and holding to account an effective and comprehensive system of clinical commissioning groups. The Board will ensure that the whole new architecture is cohesive, co-ordinated and efficient.

The Board has been in place for several months, most of the very senior appointments have been made and two public Board meetings have taken place.

The Board will be organised into nine national Directorates, four slim sub-national regions and a national network of local offices. This means that the local office for Lancashire will sit within the North of England region and is similar to the current configuration of the PCT Cluster (NHS Lancashire) and SHA North. The bulk of the staff employed by the NHSCB will be based in the local office and their key functions will include oversight of the CCGs, be members of local Health and Well Being Boards and

the direct commissioning of primary care services, specialised NHS services, military health services, offender health services and a range of public health services.

Interviews for the Regional Director level post are set for early May and it is expected that appointments will be made to the local office structure shortly after that.

4.3 Commissioning Support

A key feature of both the eight CCGs and the NHSCB local office is that the staffing structures will be kept to a minimum and they will be expected to acquire additional services from Commissioning Support Organisations. These CSOs whilst initially hosted by the NHSCB are expected to be outsourced by 2016. The Lancashire and Cumbria joint venture is developing well and robustly and will offer services in areas such as contract management, service redesign, analytical support and other professional services.

The Lancashire and Cumbria unit has already successfully passed the first checkpoint and is well regarded on a national level. It is required to go through a similar authorisation process to CCGs designed to test its marketing strategy, business plan, commercial acumen and ability to deliver high quality services locally on a sustainable basis. The success of this operation is critical to the viability of CCGs as the CSO will provide much of the information and analysis to enable the CCGs to challenge local providers and meet their aspirations on outcomes and against national targets.

Other parts of the new system which will have implications for Lancashire include:

- **Health Education England** – this body will make sure that the health workforce has the right skills, behaviours and training and is available in the right numbers in the right locations to support the delivery of excellent healthcare and health improvement.

- **Health Research Authority** – this has the responsibility of protecting and promoting the interests of patients in health research

- **NHS Property Services Limited** – will hold property for use by community and primary care services including use by social enterprise concerns. It will also cut the costs of administering the estate by consolidating the management functions and disposing of surplus property.

- **Shared Services for national bodies** – shared services solutions are being developed for finance, payroll, communications, Human Resources, IT infrastructure and estates.

5 People transition

Ensuring that staff transition processes operate smoothly and efficiently is at the heart of all the transition processes. Whilst the constrained financial framework means that there will not be roles for everyone in the future it is essential that staff with the necessary skills, experience and organisational knowledge move into new roles to sustain the continued development of services. It is vital that the organisation treats staff with dignity and respect and makes sure that processes are simple, transparent and fair over the next twelve months. Much of the HR Framework has been developed nationally, these overall timetable and deadlines are nationally determined and the scope for local input has been limited. This has led to some anxiety locally but now that the process is underway the anxieties are reducing. The rationale for managing the processes and timeframes nationally is to try and ensure that every member of staff has as much

information as possible about potential roles in successor organisations when considering how the changes might affect them.

In most instances transfers will be confirmed by transfer orders to protect employees' current terms and conditions as if TUPE applies. The aim is that by December 2012 all staff will know their future. A whole series of development and support packages are being made available to individuals and teams to help them to prepare for changes. Whilst there is a recognition that there will not be new job roles for everyone, every effort is being made to secure jobs for as many people as possible and therefore keep redundancy costs to a minimum.

6 Recommendations

The Health and Well Being board is asked to note the report.

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May 2012