NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING – PUBLIC SESSION

13 DECEMBER 2016

Agenda item 11

Title of Report:	**The potential future of commissioning across the Black County**
Report of:	Trisha Curran – Interim Chief Officer
Contact:	Trisha Curran – Interim Chief Officer
Governing Body Action Required:	To agree the recommendations summarised below.
Purpose of Report:	Following a meeting of the AOs across the Black Country in October it was agreed that a single version of a paper would be taken to each of the four CCG Governing Bodies to discuss potential future commissioning arrangements. The objective is to establish, if possible, a common consensus for collaboration between the four CCGs. The attached paper was taken to each of the four Governing Bodies in November 2016. Our GB received it in private session as staff had not yet been briefed on the content and we wished to avoid unnecessary anxiety. **At its meeting in November the Governing Body agreed the recommendation that *"each of the four CCG Accountable Officers and Chairs be tasked to work together to produce a detailed proposal; including a staff engagement plan; on the detail of these arrangements for approval by each Governing Body*".** Staff have subsequently been fully briefed and are aware that this does not change the CCG's statutory duties or considerable local (Wolverhampton) place-based agenda.

	RECOMMENDATIONS: The Governing Body is asked to; 1. **Receive** this report and attachment in public session. 2. **Note** that the potential collaboration of any commissioning functions will not cede sovereignty of any funds or obviate the statutory duties of the CCG. 3. **Note** that CCG staff have been briefed on the contents of this paper and will be kept updated on discussions. 4. **Agree** to receive further updates on any proposals about future commissioning as they develop.
Public or Private:	Public session
Relevance to CCG Priority:	This document is material to all of the CCG's priorities and nothing contained within the attached report is contrary to those priorities.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation • **Domain2:** Performance – delivery of commitments and improved outcomes • **Domain 3:** Financial Management • **Domain 4:** Planning (Long Term and Short Term) • **Domain 5:** Delegated Functions	This report is material to all of the current domains within the CCG BAF.

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Medicines Management Implications discussed with Medicines Management team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Signed off by Report Owner (Must be completed)	**Trisha Curran**	**01/12/16**

1. BACKGROUND AND CURRENT SITUATION

1.1 Planning Guidance for 2017/18 - 2018/19

1.2 The current planning guidance requires us to establish 2 year contracts through to April 2019 and for contract negotiations to be concluded by Christmas 2016.

1.3 However, once these negotiations are concluded, this offers the potential for some breathing space, to enable our CCGs to restructure and/or establish new collaborative arrangements; set clear strategic priorities; and undertake any necessary reviews / preparatory work prior to establishing contracts post April 2019.

1.4 The suggestion is that the four CCGs should give serious consideration to how they collectively might best maximise our potential for the future by establishing new working arrangements that take best advantage of the skills and capabilities of our teams; and also enhance our capabilities where needed.

2. Statutory Responsibilities

2.1 There are no statutory mechanisms for merging CCGs; and each CCG has to continue to fulfil its own statutory responsibilities – so, for the sake of clarity, a merger of CCGs is not an option to consider.

3. Current Collaboration

3.1 Our current CCGs already collaborate as part of a wider group on the commissioning of WMAS and NHS111.

3.2 We have also collaborated in the development of the STP and on the work streams within that – noticeably on Mental Health, Maternity and local placed-based delivery. However none of these arrangements incorporate shared decision-making or shared commissioning resource.

4. BLACK COUNTRY STP

4.1 The latest version of the STP includes a section on the potential future commissioning arrangements for the Black Country.

4.2 The future shape of service commissioning within and across the Black Country needs to be aligned with the evolving nature of service provision. What is set out here reflects initial exploratory work by a number of our commissioning bodies. We will now test and refine our approach with all our commissioning partners.

4.3 The Black Country is currently served by ten commissioning organisations across health and social care; this is likely to lead to:

- Duplication of activity and cost;
- Unnecessary complexity in models of care and in commissioning procedures (including procurement);
- Unwarranted variation in service delivery and outcomes.

4.4 Working together within the STP presents us with real opportunities to address these challenges and to look more strategically at the provision of services across the Black Country, including how they interact with services in neighbouring areas. This work will be led through an STP commissioner group including NHS and Local Authority partners.

4.5 New ways of working together as commissioners are required to support the delivery of our local Accountable Care Organisation models, so we aim to simplify and standardise commissioning mechanisms across the Black Country in order to support Better Health and Better Care, and to remove duplicated costs by:

- Identifying priority areas for streamlining and standardisation – both quick wins and major opportunities; and
- Identifying and evaluating alternative mechanisms through which streamlining and standardisation can best be enabled.

4.6 The current NHS planning guidance requires NHS commissioners to agree two-year contracts with providers for 2017/19. This will not only create some medium-term stability for the system but will also afford the opportunity to review our commissioning arrangements in preparation for commissioning services for beyond April 2019.

4.7 The Black Country STP sets out two main structures for the delivery of health and social care transformation across the Black Country:

a) Local Place-based Delivery of Care

This includes the implementation of the new care models such as the Multispecialty Community Provider (MCP) models in West Birmingham (Modality) and in Dudley Wolverhampton has implemented the Primary Care Home (PCH) model across the majority of practices and has also a Primary and Acute Care System (PACS) type model with the remainder of its

practices. As set out above, each of our local areas will have its own locally-appropriate model for delivering place-based care.

b) Extended Provider Collaboration

This includes the MERIT vanguard and Transforming Care Together Partnership for mental health services, and collaboration on service delivery and support services between the Trusts running our four acute hospitals.

4.8 There is, therefore, a clear benefit in organising commissioning arrangements across the Black Country to enable and enhance the implementation of these two complementary strands. Further consideration also needs to be given to the consequential impact on CCGs once the new models of care have been fully commissioned.

4.9 The key considerations for each of these issues are set out below, reflecting our core principles of subsidiarity and collective added value.

5. Local Place-based Commissioning

5.1 Each local place-based model shares key characteristics on the need for local public accountability, supporting local community resilience and public health and wellbeing, and the integration of health and social care. Commissioning local place-based care is therefore built on a foundation of partnership working between respective Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). Each local system within the STP will continue to strengthen these partnerships as the basis for commissioning the local placed-based model.

5.2 Despite existing contractual arrangements and restrictions leading to services generally being commissioned independently from each other (and often without the right incentives to deliver the agreed model of care), current service delivery is largely being implemented through collaboration between providers and commissioners. To fully support providers in achieving the desired outcomes, however, it will be necessary to change future contracts. This will most likely include moving to Whole Population Based (WPB) arrangements that focus on the achievement of improved outcomes for patients in a local area. This represents a significant change from the current contracts, particularly in health services, that are largely based on activity measures for different items of service.

5.3 NHS England has recently issued new frameworks for new models of care, including MCPs and PACS models. These frameworks will subsequently lead to the development of new national contractual frameworks which will enable us to commission local services in a way that supports the preferred model of care. There

are some common principles to these new frameworks, regardless of which model is adopted, and these give a clear emphasis on local population delivery and a priority on achieving improvements in outcomes. It will therefore be desirable to implement these new forms of contracts from April 2019. There is already active engagement in supporting the development of these new contractual models, providing two of the six national test sites via the Dudley and West Birmingham MCPs, and the development of the Primary Care Home and Chambers across Wolverhampton, and the PACs model at RWT. This creates a further opportunity to use local learning to establish a shared understanding and capability across Black Country CCGs so that, subject to local determination on timing and methodology, we are able to progressively implement these new contractual models in each local system from April 2019.

6. Black Country System-wide Commissioning

6.1 Earlier sections of our plan set out a clear need for collaboration between our acute service providers. In addition, our Clinical Reference Group (CRG) has reviewed the national Right Care evidence and determined that there are a number of services which would benefit from a strategic clinical review in order to determine the model of service delivery best placed to optimise patient outcomes, the quality of care, and efficiency in service delivery. Those services include:

- Cardiovascular Disease (e.g. heart attacks, stroke);
- Endocrine conditions (e.g. Diabetes)
- Genito-urinary conditions (e.g. Chronic Kidney Disease)
- Musculoskeletal conditions (e.g. hip replacement); and
- Cancer.

6.2 Our shared objective is to commission acute service delivery so that everyone across the Black Country can be assured that they will receive the same high quality standard of care regardless of which local hospital they attend. Consequently it will be important for the Black Country CCGs to collaborate in commissioning these services to the same standards, particularly as our providers are themselves increasingly collaborating on service delivery. This approach will also help to provide a collective commissioning approach to the realisation of efficiencies across our system.

6.3 The first stage in this process would be to initiate the proposed clinically-led strategic review. This would be followed by establishing a shared approach to commissioning those services across the four Black Country CCGs, so that from April 2019 the services can be commissioned through a single shared process across the whole of

the Black Country. The review process is expected to begin in early 2017 and is likely to be an iterative process (see diagram below).

6.4 In addition to our local-initiated work, NHSE Midlands and East's Specialised Commissioning Strategic Framework develops a vision to deliver services such as chemotherapy and renal dialysis through networks of provision based around larger specialist providers supporting local services. Specialised Commissioning teams will be working with providers and STPs to identify opportunities for consolidating services and developing networks. In the Midlands and East region, the larger specialist providers can be categorised into two tiers:

- Tier 1 providers are those that have a large and diverse specialised commissioning portfolio and provide a number of level 1 national services; and
- Tier 2 providers are those which have a large and diverse specialised commissioning portfolio and are a sub-regional specialised centre for a number of services, or a Major Trauma Centre.

7. OUR CLINICAL REVIEW PROCESS

7.1 Although a substantial range of specialist services are provided in Black Country hospitals, there are no resident Tier 1 providers (patients travel to Birmingham hospitals) and the Royal Wolverhampton NHS Trust is the only Tier 2 provider. This creates the need for a network of acute collaboration across the Black Country. The framework specifies 36 specialised services which could be devolved through the West Midlands Specialised commissioning board to a Black Country commissioning footprint.

7.2 Key drivers for commissioning at greater scale include where:

- Outcomes could be improved through service consolidation (e.g. to secure the appropriate clinical competencies)
- Services have interdependencies with other STP footprints (e.g. the configuration of specialist networks including emergency services, trauma care, PPCI)
- Services may not be sustainable as separate local entities (e.g. due to workforce shortage and/or high agency costs)
- Equity of access to high quality care can be improved.

7.3 This offers the opportunity to align a Black Country wide CCG shared approach to commissioning acute services with the specialised services framework for commissioning through our local Tier 2 provider to create an integrated Black

Country approach to the commissioning of all major acute services. Our intention would therefore be to work with NHS England to create a joint capacity and capability to commission all of these services from April 2019 on the basis of a single acute network of provision across the Black Country working to the same standards of care.

7.4 This work will also include an assessment of the potential impact of the Midland Metropolitan Hospital across the Black Country and, where necessary, the development of plans to address any adverse impact.

8. IMPACT OF NEW CARE MODEL IMPLEMENTATION

8.1 One aspect of the new care models programme is the opportunity for providers to take on responsibility for providing care to a whole population (e.g. through 'accountable care' type arrangements or Whole Population Budgets). This raises questions about the opportunities for CCGs to contract out some of their functions to providers in a way not possible before. Whilst the details on what is appropriate will be different for each local system and will be dependent upon the preferred model of care, each CCG Governing Body and its constituent members will need to consider the potential benefits this offers for enhancing the capabilities of local providers and the implementation of the new care models to drive better outcomes and efficiency.

8.2 As we move towards outcomes based commissioning and contracting which these new care models afford, the skills and capabilities of commissioners will also need to change. As the component parts of the commissioning system of the STP are addressing these challenges at different paces and with differing timescales, there exists the opportunity for greater collaboration between CCGs to facilitate and accelerate the adoption of new models.

8.3 As CCGs evolve to maximise their future effectiveness, it will also be important to consider opportunities for integration of some functions with the regulators, particularly NHS England and the Care Quality Commission, such as service assurance activities. As well as supporting the standardisation of care and the resulting improvement in patient outcomes, this may also enable additional cost savings through a reduction in the tiers of performance management and assurance processes.

8.4 A key area in which local commissioners have already been actively collaborating is in relation to urgent and emergency care.

9. Local placed-based care

9.1 Each CCG will need to continue to engage in its own planning and development of its own placed-based delivery model. And in particular, will need to collaborate with its local council on this work. So there are aspects of each CCG's activities that it will need to be fully retained in each CCG; and there will be aspects of CCG's work which they may wish to improve through enhanced collaboration with their local council.

9.2 However, there are areas relating to local placed-based delivery where common approaches across CCGs would be helpful, such as:

- Taking advantage of the new contracts, when they become available, to properly incentivise delivery of the local model of care between providers.
- Sharing understanding and solutions on the impact of social care in a system;
- The skills and knowledge being developed to implement the new capitation/outcome-based contracts (regardless of the preferred organisational forms);
- Determining the boundary between local placed-based models and the services which would benefit from Black Country-wide integration

9.3 Black Country wide joint working

9.4 Our current arrangements involve little joint resources or decision-making and as a consequence we are not leveraging or steering any significant change from our providers. So it is clear from the current financial challenges that we all face that we need to improve our impact.

9.5 There are some obvious benefits to adopting a more formalised joint arrangement for commissioning some of our services at scale across the Black Country:

- Ensuring consistent standards of delivery in key services, such as Maternity and Mental Health;
- Maximising the benefits of the 'devolution' of specialised services commissioning;
- Sharing our skills and capabilities to realise the maximum possible benefits from our providers;
- Ensuring we can oversee and incentivise the collaboration that we require from our providers.

10 RECOMMENDATIONS

The four CCG governing bodies are being asked to consider the following: **and AGREE that;**

10.1 After the current contract negotiations there would be substantial benefit in establishing more formalised collaborative commissioning arrangements across the four Black Country CCGs.

10.2 Because each CCG must retain its own statutory functions and because there is a considerable local placed-based agenda; it is preferable for each CCG to retain their own Accountable Officer for the foreseeable future.

10.3 The four CCGs should formalise (after this year's contract negotiations) the existing collaborations on the strategic clinical review of services; mental health and maternity.

10.4 The four CCGs should seek to establish a joint commissioning arrangement for acute and specialised services commissioning.

10.5 The four CCGs should seek to establish formal arrangements for sharing expertise in other relevant areas.

10.6 The CCG Accountable Officers and Chairs be tasked by the Governing Bodies to work together to produce a detailed proposal; including a staff engagement plan; on the detail of these arrangements for approval by each Governing Body.

The Governing Body is ASKED TO;

10.7 **Receive** and **note** this report.

10.8 **Discuss** its contents and raise any issues of concern to be fed back to the three other CCGs in the Black Country and their respective Governing Bodies.

10.9 **Comment** on each of the recommendations contained in 10.1 – 10.6

10.10 **Note** that the potential collaboration of any commissioning functions will not cede sovereignty of any funds or obviate the statutory duties of the CCG.

10.11 **Note** that there is a GB development session on 22 November 2016 when colleagues may wish to discuss this paper further after a period of reflection.

10.12 **Agree** to receive further updates on any proposals about future commissioning as they develop.

10.13 **Note** that these proposals will be of potential concern to staff requiring sensitive handling.

Trisha Curran
Interim Chief Officer
31 October 2016