Haringey Council

NOTICE OF MEETING

Scrutiny Review - Health and Social Care Commissioning

TUESDAY, 25TH JANUARY, 2011 at 17:00 HRS - OUTSIDE VENUE.

MEMBERS: Councillors Browne, Scott, Watson and Winskill (Chair)

AGENDA

1. APOLOGIES FOR ABSENCE

To hear any apologies for absence.

2. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (late items will be considered under the agenda item which they appear. New items will be dealt with at item 7 below).

3. DECLARATIONS OF INTEREST

A member with a personal interest in a matter who attends a meeting of the authority at which the matter is being considered must disclose to that meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.

A member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a member of the public with knowledge of the relevant facts would reasonable regard as so significant that it is likely to prejudice the member's judgement of the public interest and if this interest affects their financial position or the financial position of a person or body as described in paragraph 8 of the Code of Conduct and/or it is related to the determining of any approval, consent, license, permission or registration in relation to them or any person or body described in paragraph 8 of the Code of Conduct.

4. REVIEW SCOPING REPORT (PAGES 1 - 38)

To discuss, make any changes to, and approve the draft scoping report for the review.

5. STROKE PATHWAY

To hear from Tristan Brice (Stroke Co-ordinator) and Anne Daley (Asst. Director for Adults and Older People, NHS Haringey) on the Stroke pathway.

6. HIGH INTENSITY USERS

To hear from Anne Daley (Asst. Director for Adults and Older People, NHS Haringey), on the High Intensity User pathway.

7. NEW ITEMS OF URGENT BUSINESS

To consider any items admitted under Item 2 above.

Ken Pryor
Deputy Head of Local Democracy and Member Services
5th Floor
River Park House
225 High Road
Wood Green
London N22 8HQ

Melanie Ponomarenko
Principal Scrutiny Support Officer
Tel: 020 8489 2933
Email:
Melanie.Ponomarenko@haringey.gov.uk

This page is intentionally left blank

Agenda Item 4

Haringey Council

Agenda item:

[No.]

[Name of Meeting] **On [Date]**

Report Title. **Scoping report – Scrutiny review of Commissioning**

Report of **Cllr Winskill, Chair of the review panel**

Signed :

Contact Officer : **Melanie Ponomarenko, Principal Scrutiny Support Officer**

Tel: **0208 489 2933**

Email: **Melanie.Ponomarenko@haringey.gov.uk**

Wards(s) affected: **[All / Some (Specify)]**	Report for: **[Key / Non-Key Decision]**

1. Purpose of the report (That is, the decision required)

1.1. For the Overview and Scrutiny Committee to consider and approve the scope and terms of reference for the scrutiny review of the Commissioning.

2. Introduction by Cabinet Member (if necessary)

2.1. N/A

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

3.1. This review links with the Sustainable Community Strategy Outcomes of:

-

4. Recommendations

4.1. That the Terms of Reference and scope of the review be agreed.

5. Reason for recommendation(s)

5.1. To enable the panel to progress in its work on the review.

6. Other options considered

6.1. N/A

7. Chief Financial Officer Comments

7.1. To be included in final draft for Overview and Scrutiny Committee

8. Head of Legal Services Comments

8.1. To be included in final draft for Overview and Scrutiny Committee

9. Head of Procurement Comments – [Required for Procurement Committee]

9.1. N/A

10. Equalities & Community Cohesion Comments

10.1. To be included in final draft for Overview and Scrutiny Committee

11. Consultation

11.1. The review will seek the views of a range of stakeholders including statutory partners, the voluntary and community sector and service users.

12. Service Financial Comments

12.1. This review will be carried out within the current resources of the Overview and Scrutiny Service.

12.2. Any financial implications of the final report will be covered within that report.

13. Use of appendices /Tables and photographs

Appendix A – Background Briefing on the NHS White Paper: Equity and Excellence and accompanying consultation documents

Appendix B – Cabinet report on Strategic Commissioning Programme

14. Local Government (Access to Information) Act 1985

- Equity and Excellence: Liberating the NHS, Department of Health, July 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
- Sustainable Community Strategy, Haringey Council, 2007-2016
- Haringey Strategic Commissioning Framework, Haringey Strategic Partnership, 2010
- The State of Social Care 2009, Care Quality Commission, 2010
- Nuffield Trust, Only Connect: Policy options for integrating health and social care, April 2009
- Turning Point Centre of Excellence in Connected Care, Benefits realization: assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care, February 2010
- Personal Social Services Research Unit, National Evaluation of Partnerships for Older People Projects. Final Report, January 2010
- The State of Social Care 2009, Care Quality Commission, 2010, Page 49
- Audit Commission, Means to an end: joint financing across health and social care, October 2009
- Health Act 1999, Parliament, http://www.legislation.gov.uk/ukpga/1999/8/contents
- Audit Commission, Means to an end: joint financing across health and social care, October 2009
- Strategic Commissioning Policy, Cabinet Report, Haringey Council, March 2010 http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=118&MId=3896

1. Background

1.1. The Overview and Scrutiny Committee commissioned a task and finish review into health and social care commissioning as part of their 2010/11 work programme. This followed conversations with the Well-Being Partnership Board and relevant Officers in the Council and across the partnership and is also in light of the NHS White Paper: Equity and Excellence[1], published in summer 2010.

2. What is Commissioning?

2.1. The Haringey Strategic Partnership Strategic Commissioning Framework[2] defines strategic commissioning as:

[1] Equity and Excellence: Liberating the NHS, Department of Health, July 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

[2] Haringey Strategic Commissioning Framework, Haringey Strategic Partnership, 2010

"*The cycle of assessing the needs of people and communities in Haringey, designing effective services and support, influencing the market to secure services, monitoring and reviewing the impact of commissioned services*."

and uses the following diagram to show the stages of the commissioning cycle:

3. National Context

3.1. The NHS White Paper: Equity and Excellence[3] was published in July 2010, along with accompanying consultation papers. These papers set out the Governments long term vision for the National Health Service (see Appendix A for full briefing).

3.2. A Bill is expected shortly to take forward these proposals.

3.3. The following points are of particularly note for this review:

- £80bn worth of commissioning to be shifted from 152 Primary Care Trusts (PCTS) to new compulsory GP consortia by 2013

[3] Equity and Excellence: Liberating the NHS, Department of Health, July 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

- PCTs will be abolished from April 2013 and Strategic Health Authorities (SHAs) by 2012/2013
- responsibility for public health and local health strategy will be transferred to local authorities.
- local authorities will get new powers in relation to joining up commissioning of local NHS services including promoting integration and partnership working.
- local authorities will progress integration between health and social care.

Local Democratic Legitimacy in health

3.4. **Improving integrated working**

- Aims to strengthen integration in a number of ways including:
  - Extending the availability of personal budgets in the NHS and social care, with joint assessments and care planning.
  - Payment systems being used to support joint working, e.g. around hospital readmissions.
  - Freeing up providers for example, the govt is proposing to remove constraints for foundation trusts which could, for example, enable them to expand into social care.
- The Govt believes there is scope for stronger institutional arrangements, within Local Authorities, led by elected members, to support partnership working across health, social care and public health.
- Discussed the option of "leav[ing] it up to" NHS Commissioners and Local Authorities as to whether they want to work together and top devise their own local arrangements if they wish or by the establishment of a statutory role (this is the Govt preferred option).

Commissioning for Patients

3.5. **Proposals**

- The intention is to put GP commissioning on a statutory basis. Every GP practice will be a member of a consortium.
- Most commissioning arrangements to be made by consortia of GP practices which will be made accountable to the proposed NHS Commissioning Board.
- The Govt. envisages that a smaller group of practitioners will lead the consortium.
- Corsortia will be able to employ staff or buy in support from external organisations (including LA, voluntary sector and independent providers) to carry out certain functions, for example to analyse population needs, manage contracts and monitor expenditure and outcomes.

3.6. **GP consortia** will:

- commission the majority of NHS Services on behalf of patients including: elective and rehabilitative care; urgent and emergency care; most community health services; mental health services; and learning disability services.

- Manage allocated budgets from NHS Commissioning Board and deciding how best to use the resources for the needs of their patients (these budgets will be kept separate from GP practice income).
- Work closely with patients and local communities, including through LINks (HealthWatch).
- Determining healthcare needs, including contributing to Joint Strategic Needs Assessments.
- To fulfil effectively their duties in areas such as safeguarding of children.

3.7. The **NHS Commissioning Board** will:

- Be an independent statutory authority that provides national leadership.
- Promote patient and public involvement
- Be accountable to the Secretary of State.
- Ensure the development of consortia and hold them to account for outcomes and financial performance
- Allocate and account for NHS resources e.g. calculate practice-level budgets and allocate these resources directly to consortia.
- Develop a commissioning outcomes framework, with support from NICE.

3.8. **Health and Wellbeing Board**

- The proposed new local authority **health and wellbeing boards** would enable consortia alongside other partners to contribute to joint action to promote the health and well-being.

3.9. **The State of Social Care in England**[4] looks at how well health and social care are performing on a number of aspects across England. Of particular relevance to this review are their findings on the joining up health care and social care:

- Joined up health and social care improves service user experiences and outcomes and makes it easier for service users, their families and carers to navigate the care pathway.

- A Nuffield Trust[5] study of one locality showed 90% of people who received social care also received secondary health care over a three year period.

- Preventative, joined up approaches to care should help improve efficiency, which will in turn achieve cost savings.
    - Services that work well together have shown they can provide greater Value for Money and cost effectiveness.

- A review and critical appraisal of studies evaluating health and social care from an economic perspective found that integrated early intervention programmes can generate savings of between £1.20 and £2.65 for every £1 spent[6].

[4] The State of Social Care 2009, Care Quality Commission, 2010
[5] Nuffield Trust, Only Connect: Policy options for integrating health and social care, April 2009

- Partnerships for Older People Projects (POPP) evaluation found that POPP services were helping reduce emergency bed days and that every additional investment of £1 in them produced £1.20 additional benefit in savings on emergency bed days[7].

- Truly joined up approach, with a move away from territorial budgets is essential in making the most of any financial savings.

    - Money could be used to fund other community intervention and prevention services.
    - "PCTs, Councils and hospitals will need to take a long term view of this in order to avoid, as far as practical, the defensive reaction that is inevitable in the current economic downturn and additional pressures being placed on budgets[8]".

- An Audit Commission[9] report found that joint financing should focus on outcomes for service users as opposed processes or the specific method by which the service is paid for.

- Transformation of services may be cost neutral but if this transformation results in more empowerment and a better quality of life for service users then this represents better value for money.

3.9.1 Strategic approaches to joining up care

- Where the management of health care and social care was aligned there is an improvement in the coordination of planning and subsequently the quality of care.

- Where health care and social care services were integrated at both team and management levels, and where staff worked in integrated community teams, their services were more likely to offer a high standard or care and a greater range of services.

3.9.2 Strategic flexibility

- The Health Act 1999[10] and subsequent legislation introduced a number of flexibilities allowing organisations to integrate their managerial and strategic activities:

---

[6] Turning Point Centre of Excellence in Connected Care, Benefits realization: assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care, February 2010

[7] Personal Social Services Research Unit, National Evaluation of Partnerships for Older People Projects. Final Report, January 2010

[8] The State of Social Care 2009, Care Quality Commission, 2010, Page 49

[9] Audit Commission, Means to an end: joint financing across health and social care, October 2009

- Lead Commissioning – one authority transfers resources to the other which then takes the lead in commissioning both health and social care.
- Pooled Budgets – where both authorities transfer resources into a single budget that is managed by one of the authorities on behalf of both.

- The Audit Commission has found that not all NHS bodies and Councils understand what options are available to them or how to make them work[11]

- The level of integration between organisations had a significant impact on whether people using the services, and their carers, could get the right help at the right time.

4. Local Context

4.1. A Strategic Commissioning Policy[12] was discussed at Cabinet in March 2010 and includes the following key policy principles:

- Efficient and effective delivery of services – the commissioning of user-focused, outcome based services that include the views of residents.
- Understanding and clarity of local needs.
- Support the development of capacity in the third sectors to be able to deliver services.
- Ensure that individualisation, personalisation and choice become embedded in services.
- Work with voluntary organisation to help facilitate and develop that sector.
- Allow for flexibility in terms of the contractual vehicle used to deliver services.

4.2. The report also led to the development of Strategic Commissioning pilots in the Council. A Cabinet report on this can be found in Appendix B.

5. A Scrutiny Review

5.1. A recurring challenge in the provision of social/clinical care occurs where these two groups/services meet - or in many cases don't meet. Many attempts to tie-up and co-ordinate have only been partially successful. This is perhaps because social and community care regimes are incidental to care pathways rather than being an integral part of them. This is further informed by the fact that many users have multiple conditions and multiple needs and increasingly greater choice and control over the services which they receive

5.2. The move to GP commissioning provides an opportunity to look at the approach to overall commissioning for users of not just clinical services but also adult, child, mental health, and community and preventative/universal services.

---

[10] http://www.legislation.gov.uk/ukpga/1999/8/contents

[11] Audit Commission, Means to an end: joint financing across health and social care, October 2009

[12] Strategic Commissioning Policy, Haringey Council, March 2010
http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=118&MId=3896

5.3. For the purpose of this review it is proposed to look at the following areas as pathways which are working well:

- Stroke
- High Intensity Users

as well as looking at the following areas in more detail as areas where the Panel feels they can add particular value:

- Elderly, particularly Dementia
- Community Children's Services
- Mental health

5.4. Further information on the policy and context of these areas will be provided as background for the panel meetings at which these pathways are considered.

6. Terms of Reference

"How can we commission a seamless pathway across health and social care"

7. Objectives of the review:

- Identify where there are best practice examples of seamless service commissioning.
- Identify where there are most difficulties from a patient/service user perspective in Haringey.
- Identify lessons which can be learnt which can be applied for commissioning in Haringey.
- Contribute to the shaping of commissioning in Haringey.
- Make evidence based recommendations to aid the commissioning of seamless pathways of care.

7.1. With reference to **Value for money** the review aims to consider the following questions:

- Do costs compare well with others (allowing for external factors)?
- Are costs commensurate with service delivery, performance and outcomes achieved?
- Do costs reflect policy decisions?
- How is Value for Money monitored and reviewed?
- How is procurement managed?

8. Methodology

- Panel meetings
- Consultation with service users

- Consultation with the voluntary and community sector
- Consultation with statutory stakeholders
- Policy and best practice secondary research

1.1. Panel Membership

- Cllr Winskill (Chair)
- Cllr Browne
- Cllr Scott
- Cllr Watson

1.2. Stakeholders

Adult Services	
NHS Haringey	
Whittington	
North Middlesex Hospital	
Local Involvement Network	
Children and Young People's Services	
GP Collaborative Leads	
Pharmacy Liaison and Commissioning Group	
Alzheimer's Society	
Polar Bear	

9. Timescale

9.1. The review aims to report to the Overview and Scrutiny Committee by the end of the 2010/11 municipal year. The recommendations will then go to Cabinet and any other relevant bodies following this.

	Jan	Feb	March	April	May	June	July
Scoping							
Meetings	1	2	3	4			
Visits							
Reporting							
OSC							
Cabinet							

9.2. The proposed meeting structure is as follows:

Evidence Sessions		
Meeting 1	25th January 5-7pm	Stroke High Intensity Users

Meeting 2	Thursday 3rd February 4.30-6.30pm	Elderly, specifically Dementia
Meeting 3	Tuesday 1st March 5.30-7.30pm	Children's community services
Meeting 4	Tuesday 29th March 5.30-7.30pm	Mental Health
Panel Member Visits		
	TBC	
	TBC	

10. Independent Expert Advice

10.1. In addition, the Panel may wish to consider if their work would be assisted by the provision of some independent expert advice. This could "add value" to the review by:

- Impartially evaluating current practice providing advice on successful approaches and strategies that are being employed elsewhere
- Suggesting possible lines of inquiry
- Commenting on the final report and, in particular, the feasibility of draft recommendations.

This page is intentionally left blank

Haringey Council

Briefing for:	Attendees of the Overview and Scrutiny Committee NHS White paper workshop on Monday 13th September.

Title:	**"Liberating the NHS" – Department of Health consultation on the future of the NHS**

Purpose of briefing:	To provide attendees to the NHS White paper workshop with some background information on proposals in the NHS White Paper and accompanying consultation papers.

Contact Officer:	Melanie Ponomarenko Principal Scrutiny Support Officer Melanie.Ponomarenko@Haringey.gov.uk Tel: 0208 489 2933 Carmel Keeley, Jodie Szwedzinski and Naomi Lowde Strategic Planning and Policy Team, ACCS Phone: 020 8489 2308 Email: Carmel.Keeley@haringey.gov.uk Liz Marnham Policy Officer Corporate Policy and Performance Email: liz.marnham@haringey.gov.uk Tel: 020 8489 2514

Date:	7th September 2010

Appendices	**Appendix 1: Timeline for implementation of NHS White Paper** **Appendix 2: Current and Future structure of the NHS**

1. **Background**
   - The Coalition Government have published a number of consultation documents along with the overarching NHS White Paper (Equity and excellence: Liberating the NHS). These are:

     - Local Democratic Legitimacy in health
     - Commissioning for Patients
     - Regulating Healthcare Providers
     - Transparency in Outcomes

   - These papers set out the Governments long term vision for the National Health Service.

2. **Responding to the consultation**
   - The closing date for responses to the overarching White Paper is 5th October. The closing date for responses to the accompanying consultation papers is 11th October.

   - The Department of Health is asking for responses to be emailed to NHSWhitePaper@dh.gsi.gov.uk.

3. **Equity and Excellence: Liberating the NHS**

   - **The White Paper outlines plans to:**
     - shift the total £80bn worth of commissioning from 152 Primary Care Trusts (PCTS) to new compulsory GP consortia by 2013
     - produce an outcomes framework for health and social care to replace the current targets
     - set up an NHS Commissioning Board in England by 2011. This will commission GPs and specialist services
     - open up health provision to “any willing provider” extending the private provider market
     - abolish PCTs from April 2013 and Strategic Health Authorities (SHAs) by 2012/2013
     - strengthen local democratic legitimacy of the NHS
     - transfer responsibility for public health and local health strategy to local authorities. Local authorities will employ a Joint Director of Public Health appointed with the newly created Public Health Service. A ring-fenced Health Improvement budget will be allocated. The Secretary of State will set national objectives for health improvement
     - set up new statutory local authority Health and Well-being Boards by April 2012
     - local authorities will get new powers in relation to joining up commissioning of local NHS services including promoting integration and partnership working, leading Joint Strategic Needs Assessments and building partnerships for service change and priorities. These will replace existing statutory health scrutiny functions
     - local authorities will progress integration between health and social care
     - local authorities will be given the role of co-ordinating health care, social care and health improvement. This function will replace current statutory health scrutiny powers as accountability for co-ordinating change will now rest with Councils rather than the NHS

- National Institute for Health and Clinical Excellence (NICE) will set standards for both health and social care. (NICE will produce 150 standards each with 5 -10 concise quality statements)
- local authorities will retain statutory duty to support patient and public involvement. As a patient voice, HealthWatch will be created as part of the Care Quality Commission (CQC) with local branches, building on the Local Involvement Networks (LINks)
- Monitor, the independent regulator, of NHS foundation trusts will become the financial regulator
- CQC will be the quality regulator and inspect and license providers in conjunction with Monitor
- an expansion of Personal Health Budgets, currently being piloted
- an end to national pay settlements in health

4. Local Democratic Legitimacy in health

Proposals

- Local Authorities to have an enhanced role in health:
  - Leading on JSNAs
  - Supporting local voice and the exercise of patient choice
  - Promoting joined up commissioning of local NHS services, social care and health improvement
  - Leading on local health improvement and prevention activity.

HealthWatch

- Local Involvement Networks (LINks) will become HealthWatch.
- HealthWatch will undertake the functions of LINks as well as additional functions and responsibilities, matched by additional funding. These include:
  - NHS Complaints advocacy services – the Govt. is proposing that responsibility is devolved to Local Authorities to commission through local or national HealthWatch.
  - Supporting individuals to exercise choice, for example helping them chose a GP practice.
- Local Authorities will:
  - Continue to fund and contract HealthWatch services.
  - Continue to hold them to account for service delivery and value for money.
  - Ensure that the focus of HealthWatch is representative of the local community.
- In the event of under-performance the LA will be able to re-tender the contract.
- HealthWatch will be able to report concerns to HealthWatch England (this will form a statutory part of the Care Quality Commission).

Improving integrated working

- Aims to strengthen integration in a number of ways including:
  - Extending the availability of personal budgets in the NHS and social care, with joint assessments and care planning.
  - Payment systems being used to support joint working, e.g. around hospital readmissions.
  - Freeing up providers for example, the govt is proposing to remove constraints for foundation trusts which could, for example, enable them to expand into social care.

- The Govt believes there is scope for stronger institutional arrangements, within Local Authorities, led by elected members, to support partnership working across health, social care and public health.
- Option of "leav[ing] it up to" NHS Commissioners and Local Authorities as to whether they want to work together and top devise their own local arrangements if they wish or by the establishment of a statutory role (this is the Govt preferred option).

Statutory Health and Wellbeing Boards

- Would have four main functions:
    1. Assess needs of local population and lead JSN
    2. Promote integration and partnership, including around joint commissioning
    3. Support joint commissioning and pooled budget arrangements
    4. Undertake scrutiny role in relation to major service redesign
- Statutory obligation for LA and commissioners to participate as members of the board and act in partnership on the above functions.
- Would have an 'escalation role' e.g. should the Local Children's Safeguarding Board have concerns about local safeguarding arrangements they could raise this with the Health and Wellbeing Board who could in turn escalate to the NHS Commissioning Board should local resolution not be forthcoming.
- Members would include: Leader, social care, NHS Commissioners, patient champions, local govt including DPH, HealthWatch and GP consortia. Would also include representation from NHS Commissioning Board where relevant issues are being discussed. Elected members would decide who chaired the board.

Overview and Scrutiny Function

- Statutory health scrutiny powers would transfer to the Health and Wellbeing Boards.
- Govt believes this would give HealthWatch a stronger formal role as it would have representation on the Health and Wellbeing boards.
- Consultation document notes that "a formal health scrutiny function will continue to be important within the local authority, and the local authority will need to assure itself that it has a process in place to adequately scrutinise the functioning of the health and wellbeing board and health improvement policy decisions" (p13)

Local authority leadership for health improvement

- Local improvement activity would be transferred to Local Authorities once PCTs ceased to exist, along with an, as yet, unspecified resource allocation.
- A National Public Health Service (PHS) will be created to secure the delivery of public health that need to be undertaken at a national level.
- Local Directors of Public Health will be jointly appointed between Local Authorities and the PHS, they will have a ring-fenced budget and will be directly accountable to the LA and, through the PHS, the Secretary of State.
- The Secretary of State, through the PHS, will agree with Local Authorities the local application of national health improvement outcomes.
    - Local authorities will determine how best to secure these outcomes.

5. Commissioning for Patients

Proposals

- The intention is to put GP commissioning on a statutory basis. Every GP practice will be a member of a consortium.
- Most commissioning arrangements to be made by consortia of GP practices which will be made accountable to the proposed NHS Commissioning Board.

- The Govt. envisages that a smaller group of practitioners will lead the consortium.
- Corsortia will be able to employ staff or buy in support from external organisations (including LA, voluntary sector and independent providers) to carry out certain functions, for example to analyse population needs, manage contracts and monitor expenditure and outcomes.

GP consortia will:

- commission the majority of NHS Services on behalf of patients including: elective and rehabilitative care; urgent and emergency care; most community health services; mental health services; and learning disability services.
- Manage allocated budgets from NHS Commissioning Board and deciding how best to use the resources for the needs of their patients (these budgets will be kept separate from GP practice income).
- Work closely with patients and local communities, including through LINks (HealthWatch).
- Determining healthcare needs, including contributing to JSNAs.
- To fulfil effectively their duties in areas such as safeguarding of children.

The **NHS Commissioning Board** will:

- Be an independent statutory authority that provides national leadership.
- Promote patient and public involvement
- Be accountable to the Secretary of State.
- Ensure the development of consortia and hold them to account for outcomes and financial performance
- Allocate and account for NHS resources e.g. calculate practice-level budgets and allocate these resources directly to consortia.
- Develop a commissioning outcomes framework, with support from NICE.

Health and Wellbeing Board

- The proposed new local authority **health and wellbeing boards** would enable consortia alongside other partners to contribute to joint action to promote the health and well-being.

Financial risk

- The principles for managing over and under spends, will be agreed between the NHS Commissioning Board, the DoH and HM Treasury.
- There will also be incentives, including benefits for good financial management.
- The NHS Commissioning Board will have intervention powers in the event of poor financial management.

Transparency and fairness

- The Department of Health proposes that wherever possible services should be commissioned that enable patients to choose from any willing provider.

6. Regulating Healthcare Providers

Freeing providers

- The Government's intention is to focus foundation trusts on improving outcomes and innovate improvements to care for patients' better care. Patients will choose care from the provider they want. The Government will give more freedoms to foundation trusts such as removal of the private income cap to expand private

healthcare provision; and some trusts, such as community services, will be able to operate with staff-only membership.

- The consultation also proposes that all NHS trusts must become foundation trusts in three years. In the transition period to the new system, Monitor will continue to apply its current standards to those organisations applying to become Foundation Trusts.

- The legislative framework for trusts will continue to have their unique legal form. They will be regulated in the same way as other providers, whether from the private or voluntary sector. Any surplus will be reinvested or to pay off debts rather than distributed externally.

Economic regulation

- Monitor will be the economic regulator for health and adult social care in England. Its main duty will be to protect the interests of patients and the public and exercise functions in three areas: regulating prices, promoting competition and supporting service continuity. Its statutory remit will be limited to the provision of health and adult social care services.

Licensing

- In the new system, the CQC and Monitor will be jointly responsible for quality assurance, inspection and enforcement. It will be a requirement of Monitor's licence that organisations have gained CQC registration. Monitor will need to license some providers of NHS services for delivering its regulatory functions. This will supersede and replace elements of Monitor's existing authorisation and compliance regime.

- CQC and Monitor will retain separate responsibilities, however both regulators will need to work together to develop streamlined procedures. Monitor's powers to regulate prices and license providers will only cover NHS services. Monitor will be responsible for developing a general licence and special licence conditions (for individual providers in certain cases) for all relevant providers of NHS services. Providers of other care services, including adult social care, would still be required to register with the CQC but would not be required to hold Monitor's licence.

Price regulation and setting

- Monitor will be responsible for setting prices and devising a pricing methodology for NHS-funded services to promote fair competition and drive productivity. This will include price caps for services subject to national tariffs.

- Monitor and the NHS Commissioning Board will need to work closely together in deciding which services should be subject to national tariffs, and in developing appropriate currencies for pricing and payment purposes. Monitor will also need to consult with the Board on its proposed methodology and prices for services under national tariffs, variations to the tariff in individual cases and in relation to some pricing disputes.

Promoting competition

- The NHS Commissioning Board will have a duty to promote patient choice. All patients will have choice and control over their treatment and choice of any willing provider.

- Monitor will have a duty to promote competition. It will have powers to impose remedies and sanctions to address restrictions on competition, through its licensing regime, and through concurrent powers with the Office of Fair Trading (OFT) to enforce key aspects of competition law. Monitor will have powers to enforce competition law and impose sanctions and remedies in relation to providers of health or adult social care services irrespective of whether they are required to hold a licence.

- Monitor will have powers to investigate and remedy complaints regarding commissioners' procurement decisions and other anticompetitive conduct; and to regulate mergers to maintain sufficient competition in the public interest.

Supporting continuity of services

- Consortia of GP practices will commission the vast majority of NHS services for their patients, including elective hospital care, rehabilitative care, urgent and emergency care, most community services, and mental health services. Commissioners will retain primary responsibility for ensuring the continuity of service provision, although Monitor may intervene to ensure continued access to key services in limited circumstances.

- Foundation trusts are not allowed to withdraw 'mandatory services' without Monitor's permission. In the event of special administration Monitor will be responsible for funding arrangements to finance the continued provision of services and they will decide on the best approach, including determining an appropriate approach to risk assessment.

Implications for local authorities

- The consultation document specifically refers to Monitor's role in relation to both health and social care. For example, 'providing equitable access to essential health and adult social care services' and 'making best use of limited NHS and adult social care resources' (3.2). Its strategic remit will be confined to health and adult social care, for example – it will not cover supply of pharmaceuticals. However, the document does not give any examples of how it will exercise its functions over social care, and, in relation to licensing, social care is specifically excluded. The reason given is that there are already mature markets and choice in social care.

7. Transparency in outcomes

- The Government's proposals are based on their belief that, for the past ten years, doctors and nurses have been forced to meet government targets that often did little to improve patients' health. The Government plans to free the NHS to work towards what really matters to patients and clinicians – what actually happens to the patient's health as a result of the treatment and care they receive. They intend to do this by creating an NHS that is transparent about the outcomes it is achieving for patients.

What will the NHS Outcomes Framework do?

- It will motivate service improvements and ensure there is accountability for performance at the most senior levels. It will do this by:
    - helping patients, the public and Parliament understand how well the NHS overall is doing in terms of improving the health outcomes of the patients it treats and cares for.

- allowing the Secretary of State for Health to hold the new NHS Commissioning **Board to account** for the outcomes it is securing for patients. This new Board will be independent of the Government and responsible for allocating a budget of approximately £80bn to groups of GPs who will then purchase healthcare services to meet the needs of their local populations.
- having **greater transparency** to drive improvements in what actually happens to patients' health as a result of the treatment and care they receive.

Principles of the NHS Outcomes Framework

- Accountability and transparency.
- Balanced – outcomes will be chosen to look across the whole NHS.
- Internationally comparable – to compare the NHS against other countries.
- Focused on what matters to patients and clinicians.
- Promoting excellence and equality.
- Focused on outcomes that the NHS can influence but working in partnership with other public services where required
- Evolving **over time** – the NHS Outcomes Framework will be based on what we can measure now, but will be updated in coming years.

What will be included in the NHS Outcomes Framework?

- The proposed NHS Outcomes Framework is structured around five very high level outcome domains. **These are intended to cover everything the NHS is there to do**. These five outcome domains are:

Outcome domain:	Underlying principles used to decide on outcome indicators for each domain:	This domain will measure:
1. Preventing people from dying prematurely	• People should not die early where medical intervention could make a difference • Focus on what the NHS can do	Effectiveness
2. Enhancing the quality of life for people with long-term conditions	• Treating the individual • Functional and episodic outcomes • Meeting the needs of all age groups	
3. Helping people to recover from episodes of ill health or following injury	• Preventing conditions from becoming more serious • Helping people recover from serious illness or injury	Patient experience

Outcome domain:	Underlying principles used to decide on outcome indicators for each domain:	This domain will measure:
4. Ensuring people have a positive experience of care	• Patient experience must be a vital element of the NHS Outcomes Framework • Existing arrangements for collecting patient experience information do not lend themselves well to the requirements of the Framework • It is necessary to measure patient experience now, to drive a step change in improvement • Ensuring that a balanced approach is achieved – so that this work fully supports and complements locally-led innovation and focused improvement activity	
5. Treating & caring for people in a safe environment & protecting them from avoidable harm	• Protecting people from further harm • An open and honest culture • Learning from mistakes	Safety

- Each of the five domains will have:
  - An overarching outcome indicator (or set of indicators) to measure the overall progress of the NHS across the breadth of activity covered by the domain.
  - A small number of specific improvement areas (five or more is suggested) where the evidence suggests better outcomes are possible or areas that are identified as being particularly important to patients.
  - Supporting Quality Standards developed by the National Institute for Health and Clinical Excellence (NICE) to help patients, clinicians and commissioners understand how to deliver better care.

Annex A on page 45 of the consultation report sets out a list of potential indicators for each domain. It is acknowledged that the delivery of outcomes is likely to vary according to geographical area and across different population groups. The framework should not be considered as a performance management tool for NHS providers – **the Care Quality Commission will continue to be responsible for ensuring that providers meet minimum standards and essential levels of quality and safety**.

Appendix 1: Timeline for implementation of NHS White Paper

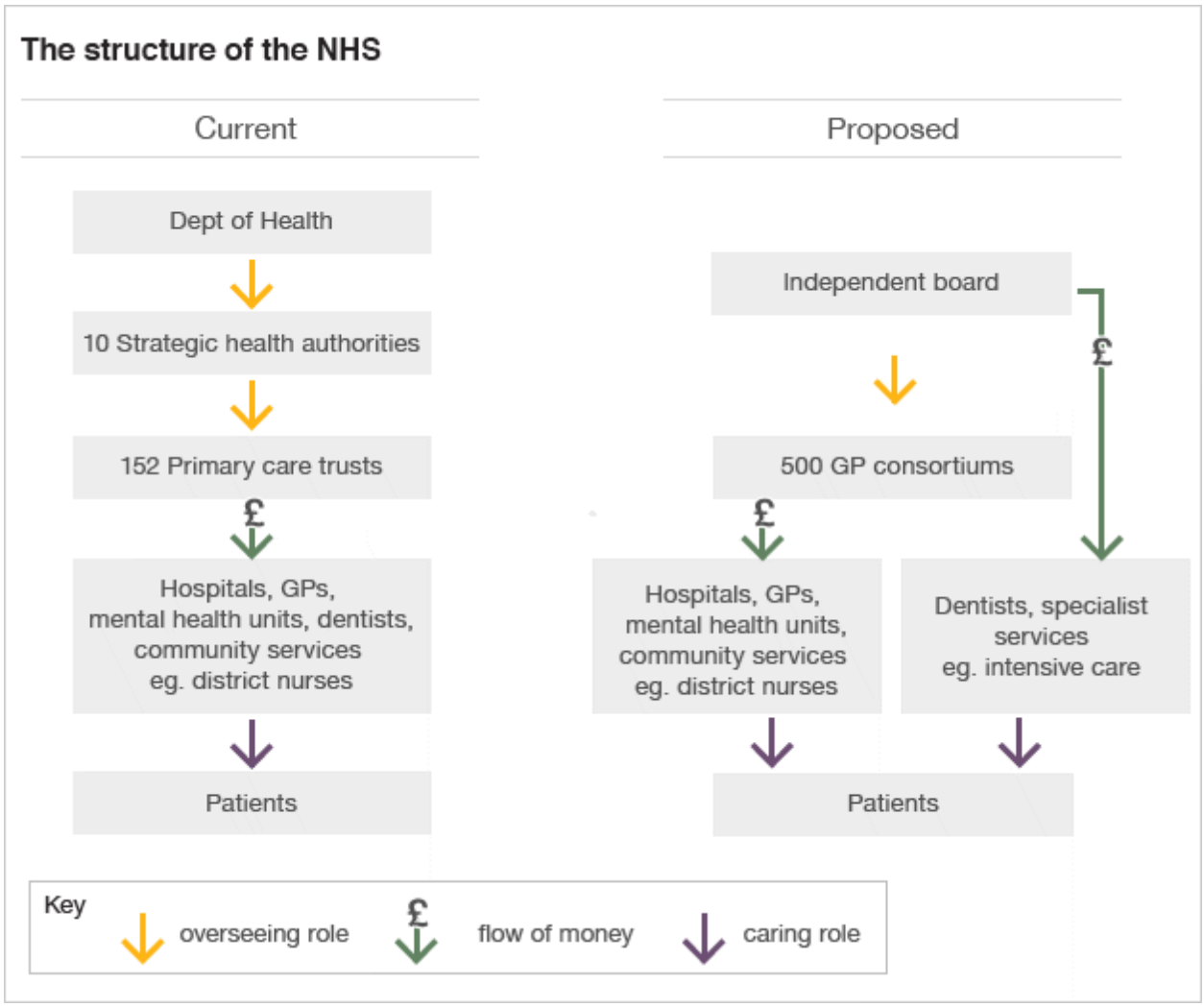
Timetable for action
The high level timetable below outlines the Government's proposals (subject to Parliamentary approval for legislation)

Commitment	Date
Further publications on: • framework for transition • NHS outcomes framework • commissioning for patients • local democratic legitimacy in health • freeing providers and economic regulation	July 2010
Report of the arm's length bodies review published	Summer 2010
Health Bill introduced in Parliament	Autumn 2010
Further publications on: • vision for adult social care • information strategy • patient choice • a provider-led education and training • review of data returns	By end 2010
Separation of SHAs' commissioning and provider oversight functions	
Public Health White Paper	Late 2010
Commitment Date Introduction of choice for: • care for long-term conditions • diagnostic testing, and post-diagnosis	From 2011
White Paper on social care reform	2011
Choice of consultant-led team	By April 2011
Shadow NHS Commissioning Board established as a special health authority	April 2011
Arrangements to support shadow health and wellbeing partnerships begin to be put in place	
Quality accounts expanded to all providers of NHS care	
Cancer Drug Fund established	
Choice of treatment and provider in some mental health services	From April 2011
Improved outcomes from NHS Outcomes Framework	
Expand validity, collection and use of PROMs	
Develop pathway tariffs for use by commissioners	

Commitment	Date
Quality accounts: nationally comparable information published	June 2011
Report on the funding of long-term care and support	By July 2011
Hospitals required to be open about mistakes	Summer 2011
GP consortia established in shadow form	2011/12
Tariffs: • Adult mental health currencies developed • National currencies introduced for critical care • Further incentives to reduce avoidable readmissions • Best-practice tariffs introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs, and some orthopaedic surgery	2011/12
NHS Outcomes Framework fully implemented	By April 2012
Commitment Date Majority of reforms come into effect: • NHS Commissioning Board fully established • New local authority health and wellbeing boards in place • Limits on the ability of the Secretary of State to micromanage and intervene • Public record of all meetings between the Board and the Secretary of State • Public Health Service in place, with ring-fenced budget and local health improvement led by Directors of Public Health in local authorities • NICE put on a firmer statutory footing • HealthWatch established • Monitor established as economic regulator	April 2012
International Classification of Disease (ICD) 10 clinical diagnosis coding system introduced	From 2012/13
NHS Commissioning Board makes allocations for 2013/14 direct to GP consortia	Autumn 2012
Free choice of GP practice	2012
Formal establishment of all GP consortia	
SHAs are abolished	2012/13
GP consortia hold contracts with providers	April 2013
PCTs are abolished	From April 2013
All NHS trusts become, or are part of, foundation trusts	2013/14
All providers subject to Monitor regulation	
Choice of treatment and provider for patients in the vast majority of NHS-funded services	By 2013/14
Introduction of value-based approach to the way that drug	

Commitment	Date
companies are paid for NHS medicines	
NHS management costs reduced by over 45%	By end 2014
NICE expected to produce 150 quality standards	By July 2015

Appendix 2: Current and Future structure of the NHS – BBC website



This page is intentionally left blank

Haringey Council

Agenda item:

[No.]

Cabinet **On 16/11/2010**

Report Title. Update on Strategic Commissioning Programme

Report of **Niall Bolger , Director of Urban Environment**

Signed : pp Tim Bellamy 3/11/2010.

Contact Officer : Niall Bolger 020 8489 4523

Wards(s) affected: **All**	Report for: **Key**

1. Purpose of the report

1.1. Cabinet received a report on the council's proposed Strategic Commissioning Policy in March 2010. This is an update report on the progress of the early implementation of the Strategic Commissioning Programme, identifying lessons learnt from the pilot projects, identifying a model for commissioning in Haringey , establishing commissioning standards and setting objectives for commissioning activity, together with a timetable for the decisions required on the pilot projects and the wider roll out of the approach to support the delivery of the Haringey Efficiency and Savings Programme .It sets out a model which will help members to focus upon the decisions to be made .

2. Introduction by Cabinet Member –

2.1. This report sets out the one of the foundations for the future organisation of the way the council will deliver its services. The report builds upon develops the commissioning framework considered by cabinet earlier this year. The council faces the severe financial constraints over the next few years and our ability to effectively commission in a manner which meets our strategic objectives will be critical to the overall success of the council.

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

3.1 The approach underpins the delivery of the vision for L B Haringey – 'A Council we are all proud of – Delivering high quality , cost effective services

3.2 It also underpins the Haringey Strategic partnership vision of a 'A place for diverse communities that people are proud to belong to ' where people are truly at the heart of change

3.3 The approach will also support the delivery of the council's priorities :

- A safer future for all
- Brighter futures for Children and Families
- A cleaner greener and more sustainable future
- Homes and neighbourhoods fit for the future
- Spending wisely and investing in the future

4. Recommendations

Cabinet is recommended:

(i) to agree the strategic commissioning model as Haringey's future Commissioning Framework; and

(ii) to adopt this approach and (change) methodology in respect of other key Council Services.

5 Reasons for Recommendations

5.1 There are a number of imperatives driving this approach, including;

- The need to improve services in a period of fundamental change,
- Reducing costs in a period of unparalleled resource constraints,
- The evaluation of services to ensure they are understood from the user's perspective,
- Strategic Commissioning will form a fundamental part of the direction of travel for LB Haringey. This will require an evolutionary approach to the Strategic Commissioning Policy in terms of governance and delivery.

5.2 The Strategic Commissioning policy agreed by cabinet in March 2010 is firmly based on strong public sector values. It provides an approach to ensuring that the residents and businesses of Haringey receive better public services which are grounded in recycling resources in the local economy. The focus will always be on maximising positive outcomes in terms of public benefit, rather than approaches that are based on narrow outputs. However, the Council recognises that services must be at a price that people wish to pay (whether through their contribution as Council Tax or by direct payment) and our commissioning intentions are premised on the fact that we need to manage within constrained resources - we will seek to reduce costs wherever possible in line with our communities' priorities in order to secure continuous attention to the value for money of the services we provide for our residents. This is particularly important in light of the reductions in council's future finances.

5.3 Whilst ensuring a continued focus on positive outcomes, public services must be prepared to take evidence based; pragmatic and innovative approaches to the way services are delivered. This will lead to the greater involvement of citizens and the third and fourth sectors in the development and delivery of service models. There are clearly a range of options for service design and delivery, which does not necessarily mean that the Council will provide them directly.

6. Other Options considered

6.1. The development of the Strategic Commissioning framework reflects the necessity to respond to the changing pressures and context in which the council works by reviewing the way in which it commissions its services. It has therefore not been appropriate to consider other options, however as services are re-commissioned options for the future delivery of these services will be considered.

7. Summary

7.1 Background

7.1.1 It is clear that a comprehensive approach to strategic commissioning is critical to meeting the Council's objectives and priorities in a period of reduced resources and changing expectations on public service. It has been identified as a key delivery stream within the Haringey Efficiency and Savings programme through which the Council is seeking to deliver better outcomes and meet local needs in the context of reduced resources, changing aspirations, new parameters of national policy and continuing increases in demand.

7.1.2 There is a need for a common organisational culture for meeting local priorities, which uses a common vocabulary and approach in deciding what priorities are critical, what options for meeting them are possible, and what arrangements are required to achieve the desired outcomes and results. The outcomes that the Council is seeking must be clear, and the means to deliver those (through direct provision, contracts, grant aided services, management buy-outs, partnership arrangements, delegation to other agencies or other mechanisms of procurement) follow from those outcomes , rather than form the starting point for seeking efficiencies and establishing commissioning arrangements.

7.1.3. The original Commissioning and Procurement Policy set out a robust and comprehensive methodology for how to market test and procure services that the Council wished to provide. This framework is set out in Appendix 1. However it did not provide a means of fundamentally challenging whether these activities needed to be undertaken at all, or whether the results sought could be achieved through alternative means.

7.1.4. The new context is that Strategic Commissioning provides a framework to undertake a fundamental review identifying the demand supply and need for services to achieving those outcomes that the Council sets as its priorities. The key requirements of a Strategic Commissioning approach are that it should enable the Council to reduce cost and improve

Efficiency; decommission and stop providing non-priority activities and measure outcomes against its priorities.

7.2 Progress on Commissioning Pilots

7.2.1 Although four pilot projects were identified to test the commissioning framework set out In Appendix 1 , significant commissioning of services has been undertaken within the council for a number of years , particularly within Adults , Children's and Urban Environment , including the ongoing development of joint commissioning of services with other partners and public sector organisations The undertaking of the pilots was to bring together the specialisms, experience and skills of the staff undertaking commissioning within their individual services into a wider virtual team to support a consistent council wide approach to develop a commissioning culture for all council services .

7.2.2 Four pilot areas of commissioning activity were identified in the original programme brief and set out in the reports to CEMB and Cabinet in October 2009 and March 2010. These have been subsequently confirmed as:-

- Extra Care Housing ;
- Disaffected and vulnerable young people;
- Parking and Sustainable Transport;
- Regulatory Services.

7.2.3 The programme envisaged that on the basis of a scope agreed with the relevant department and with resources made available from the service area, the commissioning pilots would:-

- test the application of the commissioning policy to the area of service;
- identify specific commissioning objectives;
- quantify the scale, timescales, risks and opportunities for realising efficiencies and/or changing the service model;
- realise efficiencies within 2010/11 financial year and future years ;
- provide learning to allow a revision and agreement of the commissioning policy;
- identify the skills and competencies required for effective commissioning activity; and,
- propose steps to deploy or develop these skills and competencies to meet future commissioning intentions.

7.3 Lessons learnt

7.3.1 Commissioning is primarily about defining outcomes and results for citizens/customers, the procurement process provides the mechanisms to be employed to deliver the outcomes. The role of the local authority is changing rapidly away from being the main provider or purchaser of services towards a strategic role, working with partners to ensure that valued public services are available – but these may be supplied from a variety of providers and agencies. Commissioning is therefore about having a process to inform decisions and set priorities. Strategic Commissioning includes, and relies on, effective procurement, but is much

more about the role of the local authority and providing the leadership and direction to deliver better outcomes. This is particularly true as the pattern of provision is likely to change and shrink and will be shaped much more by direct customer choice and direct. Demand (from citizens, residents, businesses, communities) may be met by supply from a range of sources, many of which may not involve the local authority directly.

7.3.2 The work on the pilots has established some clear requirements for effective commissioning work. There is a need for strategic oversight – to coordinate, prioritize and forward plan, to support joint working and partnerships and to ensure that specific services fit with a corporate approach to commissioning.

7.3.3. The development of strategic commissioning approach needs to reflect strong relationships with policy and finance and must be informed by a robust analysis of need. This has been particularly illustrated through the work on the Extra Care and Vulnerable Young People pilots. Projects must be able to source key skills and resources – for example data interrogation and analysis, financial modelling, project management and change management, and communication and marketing capacity.

7.3.4. Methods and tools used in the pilots have included the following:

- Robust and detailed financial modeling of the outcomes
- Research and analysis of practice and experience elsewhere
- Customer insight and experience mapping
- Professional good practice models and performance data
- Consultation, engagement and marketing
- Collaboration with partners
- Income generation
- Make or buy choices
- Fundamental challenge to presumption of separate and independent capacity and provision by each separate agency

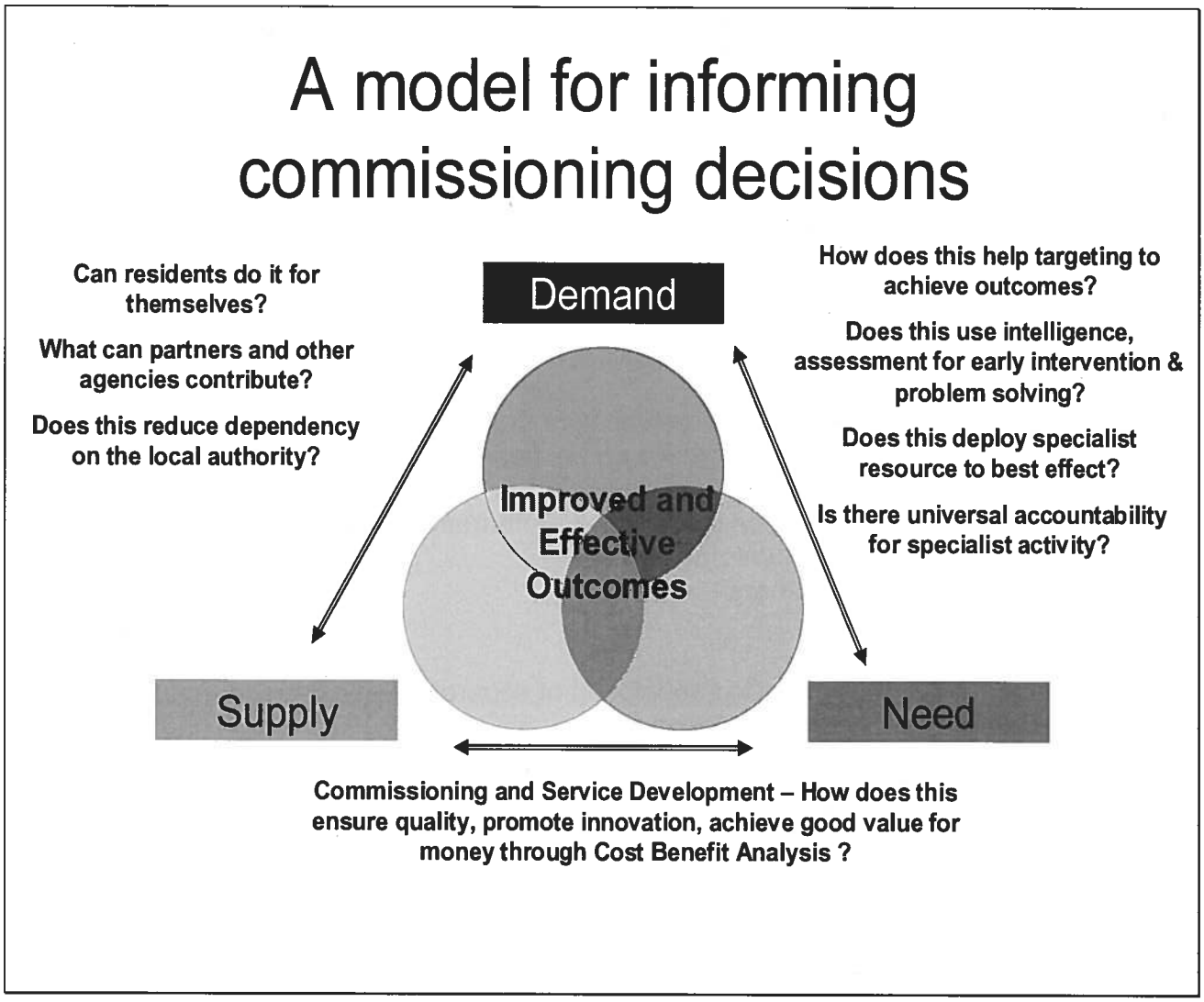
7.3.5 The evidence from pilot work suggests that commissioning, procurement and purchasing functions are currently delivered in a fragmented approach by different areas of the council. Commissioning expertise is dispersed across the council. The skills and competencies for supporting commissioning already exist but are undervalued and subsumed within a focus on operational delivery. Some skills and competencies are in need of further strengthening such as financial modelling etc.

7.4 Commissioning Model

7.4.1 Members and partners need to be fully engaged in setting priorities and ensuring outcomes are delivered .The diagram of the model below has been developed through the experience of the pilots and a series of workshops as the Strategic Commissioning Programme has developed. It is presented for endorsement as an approach that can be applied across all services as a way of informing commissioning decisions, and articulating the different perspectives of demand, supply and need that need to be balanced through effective commissioning. The model fits with the overall definition of commissioning adopted b y the

Council:

"The process, system and means of securing long-term, sustainable outcomes which meet the needs of our diverse customers and communities whilst providing excellent value for money". Haringey's Strategic Commissioning Policy



7.4.2 An example of the use of this model to inform decision making would be as follows:

The plans for a new Re-ablement Service for Haringey's most vulnerable older residents[1] will transform the existing rapid response and in-house home care service into a Re-ablement Service at the point of hospital discharge. Evidence shows that investing in an

[1] As presented to the Leader's Conference, September 2010

effective Re-ablement service can prevent hospital re-admission and reduce demand for costly long-term care packages by 30 - 40%[2]; while improving the independence of Haringey's vulnerable older people. In terms of the commissioning model above, the example demonstrates how redesigning the service can help to manage future demand, maximising both the efficient use of resources and outcomes for residents.

7.4.3 The model above links the key components for successful commissioning of demand for service, need for service and supply of service, with the questions that need to be answered to set the outcomes. These questions can be referenced to the key priorities that the council wishes to deliver. These are :

- A safer future for all
- Brighter futures for Children and Families
- A cleaner greener and more sustainable future
- Homes and neighbourhoods fit for the future
- Spending wisely and investing in the future

7.4.4 The future model for public services arising from the implementation of strategic commissioning will result in a pattern of services that is likely to have most of the following characteristics. In two to three years we expect many more services for citizens and residents to be:

- Centred on customers' needs rather than the existing pattern of provision
- Primarily delivered through universal and community settings
- More targeted at those with priority needs
- Based on evidence of improving results
- Recognising the varied and multiple ways in which individuals, families, communities and organisations can relate to services, for example as resident, citizen, customer (paying), user (non-paying), business, subject of regulation or enforcement, complainant or advocate/petitioner.
- Seeking to prevent crises through support and practical help rather than through enforcement, formal proceedings and the need for intervention
- Specific and time-limited, reflecting interventions for a purpose rather than open-ended entitlements to provision
- Encouraging citizens to build their own capacity, develop resilience and reduce dependency on accessing formal services
- Aimed as achieving specific outcomes or results agreed with the user
- Family, community and neighbourhood based, delivered at home or through a accessible location rather than at a given service site
- Linked to other services rather than stand alone, working across professional and agency boundaries in the interests of the resident, citizen or customer
- Able to access timely and appropriate specialist input, commissioned borough or city wide but deployed locally
- More responsive to issues of poverty, deprivation, ethnicity, disability and social exclusion

[2] Source: Department of Health Care Services Efficiency Programme (CSED)

- Delivered in closer co-operation with other agencies and partners, who met defined standards of quality, performance and value for money
- Extensive development of need to develop new and current markets within the voluntary sector to deliver future services to customers and clients particularly as the council moves from giving grants to commissioning services from the 3rd Sector
- The need to make new markets as the type of service provided to clients is changed e.g. the Personalisation agenda in Adult Services.
- Commissioned to published standards, to meet shared priorities identified in the Community Strategy and other published plans.
- Identifying the risks to the organisation and the customer and clients it services of the changes to the way services are commissioned and decommissioned in the future.

7.5 Next Steps

7.5.1. The next steps are the consideration of the individual reports from each of the pilot projects which will be considered by cabinet over the next 2 meetings, including Parking and Sustainable Transport which is to be considered later on the agenda.

7.5.2 The future projects will be determined by the decisions made on the priorities and areas for review within the Strategic Commissioning Stream within the Haringey Efficiency and Savings Programme.

8 Chief Financial Officer Comments

8.1 This report identifies at paragraph 7.2.2 the four initial pilot projects which will themselves be the subject of individual reports to Cabinet which will contain specific Financial comments.

8.2 This report is agreeing a methodology and a way forward and thus is not specifically about savings to be achieved from the pilots or any other projects. However, in order to address the significant financial challenges facing the Council going forward the need to identify considerable savings will need to be a key feature of future commissioning.

8.3 Some specialist commissioning support has been used in 2010-11 in order to support this work stream. This is due to cease shortly and therefore the management and delivery of the pilot and other projects will need to be met from existing resources."

9 Head of Legal Services Comments

9.1 Legal Services is supportive of this Policy Initiative. There are no specific legal issues at this time as the clients are already obtaining legal advice on the specialist areas covered by the policy e.g. Social care work: waste management contracts.

10 Equalities &Community Cohesion Comments

10.1 The equalities service is supportive of this policy initiative and note the need to consider equalities and diversity is sues has been acknowledged in the report. The service recommends that an equalities impact assessment is undertaken to ensure there is equality of opportunity for all. It is recommended that equal opportunities monitoring of strategic commissioning arrangements is carried out.

11 Consultation

11.1 Consultation will be undertaken with partners and voluntary groups as the pilots progress

12 Service Financial Comments

12.1 Please refer to section 8

13 Use of appendices /Tables and photographs

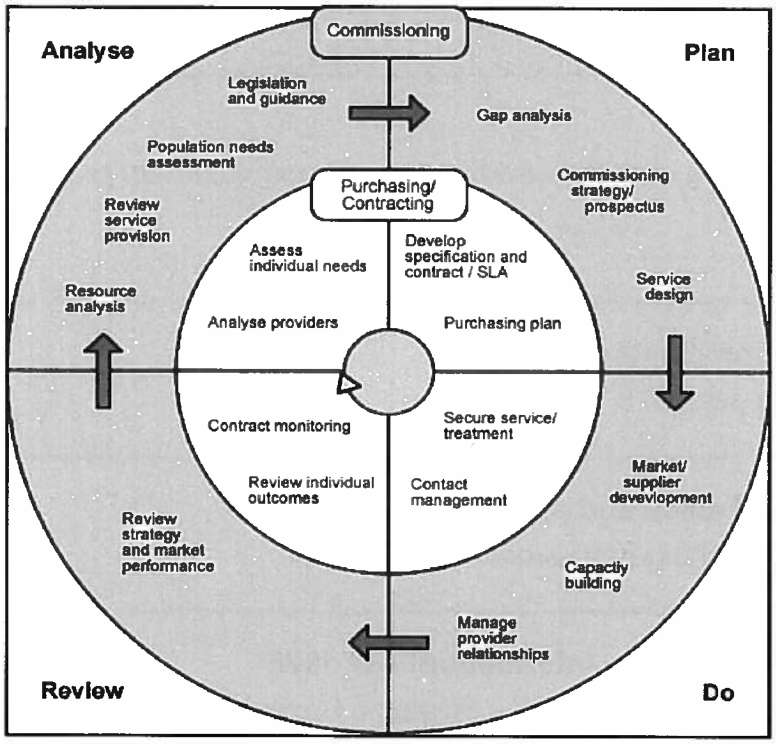
Appendix 1 – Commissioning framework

14 Local Government (Access to Information) Act 1985

14.1 Report to Cabinet 23rd March 2010 – Strategic Commissioning Policy

Appendix 1 Standard Model of Commissioning (currently used within the HSP)

1. Summarise Model



In simple terms:

- Assessing the needs of people and communities and identifying gaps – **Analyse**
- Specify what is required and develop ways to meet need with the available resources– **Plan**
- Influencing the market and secure the required services – **Do**
- Monitoring and reviewing the impact of services and learning for the future commissioning cycles – **Review**

This model will underpin our approach to commissioning and informs the step-by-step process for commissioning described below

These key elements of our approach inform the step-by-step commissioning process explained below.

The Step	Description
Analyse	
One Understanding Needs	Consider evidence base to understand needs of the local community and the priority outcomes for LB Haringey / HSP / LAA
Two Setting Commissioning Priorities	Consider: ▪ baseline performance and direction of travel on key targets; ▪ Areas of potential greatest financial gain; This will inform the services to be reviewed
Three Evaluating the service	▪ Understand the market, the need now and in the future ▪ Evaluate the current and future service against "PEP" – Performance, Efficiency and Perception ▪ Examine how the service contributes to the corporate and partnership's priorities and the sustainable development of Haringey
Plan	
Four Refining and identifying the options	▪ Research, information gathering and interviews with other providers, clients and relevant organisations to inform options for appraisal Identify "best in class practice" and examine its replicability for Haringey
Five Designing the Brief	Development of appraising criteria and business needs based on identified outcomes (service and community) and PEP
Six Assessing and Approving the brief	Assess options against the agreed criteria and business needs
Do	
Seven Commissioning	Undertake tender exercise (Preferably by Competitive Dialogue but may include Open Tender or Restricted Procedure) resulting in recommendations to CEMB / Members
Eight Approving the contract	Approve award of contract
Nine Contracting	Negotiate detailed SLA with successful delivery organisation
Review	
Ten Ongoing Contract Monitoring	▪ Ensuring that services are being delivered and achieving their outcomes, Robust performance management and taking proactive steps to address poor performance

Eleven Evaluation	Evaluate performance against contract specification, desired outcomes and key performance measures
Twelve Reviewing needs and priorities	Review of performance measures through a two way dialogue between commissioner and provider that allow for emerging priorities to be addressed