

## Review of Commissioning Arrangements for Specialised Services



## Introduction

This briefing was written by Alyson Morley, Policy Officer at the Democratic Health Network, as part of the DHN's support to the CfPS Expert Advisory Team.

Health commissioning is a key driver of many of the government's priorities for the NHS: increasing choice; developing patient-centred services; achieving value for money; promoting the development of community based health services; and promoting a greater integration between health and social care. Much of the discussion and guidance on commissioning has focused on practice-based commissioning by GPs, clusters of GPs or by PCTs. But there remains a wide range of services and treatments that do not fall under the remit of practice-based commissioning. This briefing summarises and comments upon the recommendations of a review of specialised commissioning, requested by Lord Warner (Minister for Health Reform) in October 2005. A copy of the review is available at: <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningSpecialisedServices/fs/en>T.

The purpose of the review was to recommend improvements to the structure, organisation and powers of commissioners to ensure that the commissioning process is robust, fair, understood by all, offers value for money and engages patients. The review also recognises that effective commissioning of specialised services will depend on commissioners having appropriate tools and guidance, the first of which will be a Commissioning Framework, expected in early summer 2006. It will outline the overall policy and expectations for the development of commissioning.

## What are specialised services?

Specialised services are those with low patient numbers but which need a critical mass of patients to make treatment centres cost effective. Particular challenges for these services include training specialist staff, supporting high quality research programmes and making the best use of scarce resources such as expertise, 'high tech' equipment and donated organs. Specialised services are subject to different commissioning arrangements than other NHS services.

There are currently 35 specialised services recognised in the Specialised Services National Definitions Set (last reviewed by Department of Health in 2002) that are provided in specialist centres to catchment populations of more than a million people. They include services such as kidney transplantation, haemophilia services, specialised mental health services and services for very rare cancers. In 2004 approximately 10% of total PCT expenditure was on specialised services.

## Current commissioning arrangements

At its simplest, commissioning is a three stage process involving planning, procurement and monitoring. But within these stages there a number of activities:

- assessment of health needs
- agreed standards and outcome measures

- agreed service strategy developed with the involvement of providers and patients
- implementation of commissioning strategy and agreeing contracts with providers
- activity and financial monitoring, and monitoring health benefit
- managing demand and supply
- reviewing whether services meet health needs.

Specialised commissioning involves large population groups and, therefore, involves many stakeholders. Guidance published by DH in 2003 advised PCTs to collaborate to coordinate specialised commissioning, and for SHAs to oversee and performance manage the collaborative arrangements. There are currently 25 local specialist commissioning groups (LSCGs) that plan for population groups of one to two million. A further eight specialist commissioning groups (SCGs) plan services for rarer conditions, serving populations of three to six million. The eight SCGs are largely coterminous with SHA boundaries (though there are ten SHAs) and the LSCGs are largely coterminous with the 28 former SHA boundaries. There is also a National Specialist Commissioning Advisory Group (NSCAG) that commissions services for 38 extremely rare conditions.

Since the DH guidance was published in 2003, specialist commissioning has had some success, especially in relation to the reconfiguration of services and improving geographical access. However, concerns about lack of consistency in how and what is commissioned and the patchy application of quality criteria were important considerations in the review.

## **The findings of the Review**

The review identifies existing experience and good practice, and sought the views of those involved with specialist commissioning. A number of key themes emerged. There was a need for greater consistency in standards, less bureaucracy and better collaboration between commissioners to streamline patient pathways. This would enable greater patient and public involvement in specialist commissioning by aligning structures more closely with SHAs. There was also demand for more guidance and examples of good practice to ensure that all could learn lessons from the best. The relationship between SCGs, LSCGs and NSCAG is complex and requires adjusting to ensure that specialist commissioning takes place at the most appropriate and effective level.

The Review considered the impact on specialist services of certain aspects of NHS reform. Stakeholders identified the following issues:

- payment by results and tariff setting for specialist services was causing concern
- patient choice policy needs to take into account the particular characteristics of specialised services
- NHS Foundation Trusts could undermine the collective planning processes and the larger population perspective needed for specialised services.

The review cautioned that the negative impact of these reforms on specialist facilities and the knock-on effects to NHS trusts that provide them must be considered at both national and regional level.

## **Collective commissioning structures**

### **A simpler, flatter structure**

Section 3 of the report recommends new commissioning structures that are simpler and have fewer layers. The Review recommends that 10 SCGs, which are coterminous with SHAs, should have the responsibility for commissioning arrangements for specialised services. The existing LSCGs should become part of their respective SCG. A new National Specialised Services Commissioning Group (NSSCG) should be formed with membership from each of the SCGs to deal with commissioning decisions for specialised services for which the catchment area is bigger than that of the SCG or SHA (referred to in the report as "supra-SCG services"). Other members of the NSSCG should include:

- two Medical College representatives
- DH representation
- one patient representative
- the Director of Public Health from an SCG or SHA
- the Director of Finance from an SCG or SHA
- one observer each from Wales, Scotland and Northern Ireland.

It is also recommended that the national commissioning function currently undertaken by the NSCAG under the auspices of the DH should be transferred to the NHS as a subgroup of the NSSCG and be renamed the National Commissioning Group (NCG).

The NSSCG should be hosted by an SHA, with the Chief Executive of the host SHA having corporate governance and financial responsibility for both the NSSCG and all nationally commissioned services. It is also recommended that the Chair of the host SHA act as Chair of the NSSCG.

SCG representatives to the NSSCG should be responsible for representing the views of all the PCTs in their area, and for keeping PCTs updated on progress of nationally commissioned services.

### **Functions for the NSSCG**

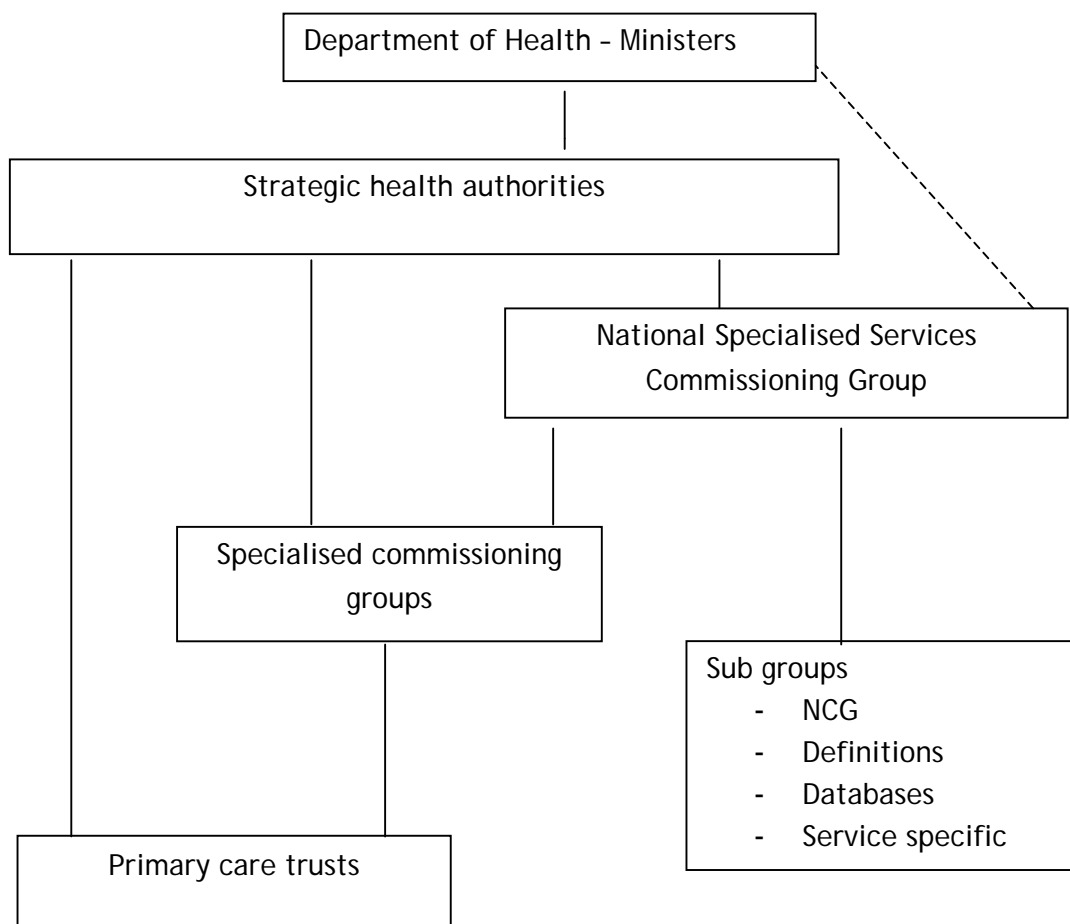
The NSSCG should provide a forum where commissioning decisions regarding supra-SCG services are taken. The decisions of the NSSCG would be binding on all SCGs. The NSSCG will have its own work programme though it is likely that most of its work would be led by a lead SCG or group of SCGs. It will also produce an annual report. The review identifies the need for sub-groups to consider:

- developing service standards and quality and outcome measures
- supporting the development of national data bases for particular conditions and services
- updating the National Definitions Set

The sub-groups would include input from commissioning, finance, public health and patient and public involvement. It is envisaged that the subgroups would report to the NSSCG so that SCGs are able to report back to PCTs on developments and recommendations.

The NSSCG would not commission specialised services itself - this would be delegated to a lead SCG - but it will need some financial support from SCGs to cover administration costs.

### Proposed structure for the commissioning of specialised services



### Specialised Commissioning Groups

The SHA and all PCTs in its area would be represented on the SCG, though they would be able to nominate a 'lead' PCT to represent their views at meetings. The SCG should be constituted as a joint subcommittee of each of the constituent PCTs, with delegated authority to act on its behalf. Each SCG and its commissioning team should be hosted by one of the member PCTs. The Chair of the SCG would

also normally be the SCG's representative on the NSSCG. Service providers and patients should also have input to the SCG (further details given on page 6).

The SCGs would be responsible for the commissioning arrangements for all specialised services included in the National Definitions Set. When preparing annual commissioning plans, an SCG may choose to delegate commissioning functions to another 'lead' SCG or a 'lead' PCT. The new arrangements should build on existing good practice and retain as much of the commissioning expertise as possible. SHAs should performance manage the SCGs through their general performance management of the constituent PCTs.

### **Commissioning teams**

An Audit Commission survey of LSCGs and SCGs found serious understaffing was common. The review recommends that staffing levels that should take into consideration geography, the number of specialist providers, clinical networks, the level of services commissioned and the budget for specialised services. Furthermore, they should be headed by someone at Director level. Since commissioning capacity is scarce, work should be shared across commissioning teams within an SCG and/or across SCGs nationally.

### **Budgetary arrangements**

The review recommends that each SCG should have a budget pooled from PCT allocations to cover both the cost of specialised services that it commissions and its management and administrative costs. Some areas already have budgets allocated for some specialist services. In other areas, they will need to be set up. Each PCT's share of the pooled budget should be agreed at the outset. If agreement cannot be reached the SHA should act to resolve the dispute. All SCGs should have an agreed initial budget by April 2007, based on a clearly defined, costed and quantified set of specialised services. By April 2008, all SCGs should have agreed a complete budget.

SCGs should not be expected to fund services or treatments if the provider has not submitted information on activity levels and costs. It is important to remember that specialised services are low in volume but high in cost.

### **Accountability and openness**

SCGs and the NCG should produce an annual commissioning plan, an annual work programme and an annual report that is clear and easily accessible to all stakeholders, including patients and the public. Papers and minutes of SCGs and the NSSCG should also be readily available to the public. In addition each SCG should have a formally agreed process for ongoing patient and public involvement, including formal consultations on major service reviews. Engagement with overview and scrutiny committees is specifically mentioned.

### **Commissioning levers and opportunities**

Section 4 considers the role of specialised commissioning in balancing supply and demand.

### **Designated providers**

A key function of commissioners of specialised services is to ensure that development of specialist centres does not outstrip demand for services, with the result that each centre is treating too few patients and not, therefore, representing value for money. It is recommended that SCGs have the power to designate specific providers to provide specific specialist services on a five-yearly basis - though SCGs should have the power to withdraw designated status within the five-year period of performance standards are not met. Designation would ensure safe, high quality and cost-effective services. It would also provide some measure of financial viability of specialised services, which may be highly vulnerable to changes in activity. Activity at undesignated providers should not be funded by commissioners (see section on patient centred care below).

There should be a national programme for reviewing designated specialised service providers but at the outset, all current providers with contracts should become designated providers. The review process will be a rolling programme but the first cycle of review of all designated providers should be complete by 2010.

### **Foundation Trusts**

The need to concentrate specialised services in a few specialist centres may be undermined by the activities of Foundation Trusts, which may wish to respond to local demands for such services to be locally available. Foundation Trusts that currently provide specialised services may wish to cease providing them because of the relatively low volume of activity. It is recommended therefore, that in considering NHS trusts for foundation status, the DH seek the views of SCGs and the NCG. Their views should also be sought where Foundation Trusts proposes to stop providing specialised services.

### **Patient-centred care**

The review emphasises that patient-centred care allows the patient to choose the time, place and provider of treatment but it should not drive the provision of specialised services to the extent that it does for non-specialised care. This is in order to guard against the unnecessary proliferation of specialist providers and to provide existing specialist centres with some measure of financial stability. Therefore, the opportunities for patients to make choices regarding specialised services should be limited to designated providers.

### **Specialised Services National Definitions Set (SSNDS)**

The SSNDS has not been reconsidered since 2002 and this is a major concern for many of the stakeholders that took part in the review. The review supports the

view of stakeholders that a revision of the SSNDS should be initiated immediately. It would be overseen by the NSSCG (once it is established). There is a pressing need for a set of criteria of the inclusion of services in the SSNDS and for it to be regularly updated.

### **Payment by results**

Many stakeholders felt that the application of payment by results was problematic in relation to specialised services - in particular it may not be appropriate to set one national price for each treatment. Currently, most specialised services are not included in the National Tariff and the review recommends that the DH should work closely with the NSSCG to oversee the development of tariffs for such services.

### **Service standards, clinical outcomes, monitoring and audit**

Effective commissioning is underpinned by:

- nationally agreed service standards
- nationally agreed patient outcomes
- national clinical databases that enable monitoring and audit of clinical outcomes and service standards

The review recommends that the NSSCG should consider establishing clinical databases for specialised services so that commissioners and providers can monitor outcomes and performance against national standards. The costs of doing this should be met by DH with a contribution from SCGs. The review recommends that the NSSCG, the NCG and SCGs ensure regular clinical audits of specialised service provision and that commissioners have access to the results so that they are able to compare performance between providers and over time.

### **Patient and public involvement**

Section 5 addresses patient and public involvement in specialised commissioning. Stakeholders to the review were concerned about the lack of publicly available information about specialised services, how they are commissioned and how patients and the public are involved in the process. To address this, the review recommends that there should be a website in which all SCGs and the NCG give details of their commissioning arrangements.

The review found a high level of inconsistency in the extent to which patients, carers and the public were involved in decisions relating to specialised services. It is entirely appropriate that the ways in which commissioners involve patients and public may vary according to the type of services, the population group, the geography of the area and the patient groups providing input. However, every effort should be made to ensure their views are part of the commissioning process. The review recommends that SCGs and the NCG should be required to develop a patient and public involvement strategy and report on its progress as part of their annual reports. Furthermore, SCGs and the NCG should have patient

representation and there should be a high degree of patient and public involvement in the designation process, the annual prioritisation process and in developing annual commissioning plans.

### **Consultation with overview and scrutiny committees**

The fact that there are 150 health overview and scrutiny committees and only 10 SCGs makes meaningful engagement with OSCs on specialised commissioning problematic. A number of stakeholders found arrangements for setting up joint OSCs cumbersome and time consuming, leading to delays in implementing changes to specialised commissioning. The review recommends that the DH should advise OSCs to establish standing joint OSCs based on SHA boundaries. It further recommends that both individual and joint OSCs should have a time limit of six months to respond to SCG consultations. If they have not responded within this period, SCGs should be free to proceed with service changes. The review suggests that both the CfPS and the new National PPI Resource Centre may have a role in developing solutions. CfPS is already engaged with specialist commissioning around Burn Care Services and further advice about joint health OSCs is in the CfPS guide to joint committees published in November 2004.

## **Performance**

### **Performance management**

SHAs should be responsible for performance managing PCT arrangements for specialised services commissioning. Performance management of the NSSCG and the NCG should be undertaken by a 'lead' SHA. Performance management by SHAs should include an initial 'fitness for purpose' check of SCG and NSSCG structures and processes and annual reviews of SCG performance. The annual review of SCGs and the NSSCG should focus on the extent to which they have achieved their work programme and the extent of PCT involvement.

### **Performance assessment**

The Healthcare Commission will play an important role in promoting improvements to specialised services commissioning and they will consider an SCG's work programme and annual report in their performance assessments of PCTs. The Audit Commission is well placed to identify and disseminate good practice.

## **The profile of specialised services commissioning**

Commissioning capacity must increase for it to be effective in ensuring safe, accessible and cost effective services that meet the needs of the population of the SHA. Currently, specialised services and their commissioning arrangements have a fairly low profile both within the NHS and amongst key stakeholders such as patients, the public and health OSCs. In part, this is because it does not feature in national priorities and targets. Although the profile of commissioning in general is

rising, it is still not widely seen as a career choice for either managers or clinicians.

## **Powerful and effective commissioners**

The review recommends that commissioners should have powers to safeguard patients' access to the full range of services, while managing demand to make best use of scarce resources. They should also have powers to stimulate supply and control, entry and exit of providers to ensure that the designated providers maintain an adequate supply of safe, effective and high quality services.

## **Conclusion**

The review has given a comprehensive and considered assessment of the current arrangements for commissioning specialised services and has, rightly, concluded that the current arrangements are not fit for purpose. The recommendation that LSCGs are incorporated into SCGs that are themselves coterminous with SHA boundaries is rational and removes an unnecessary layer. The review also considers the potential implications of the government's change agenda on the viability of specialised services and identifies that commissioners have an important role to play in managing both provision and supply. Nevertheless, it will be important for both the government and the DH to take heed of the review's findings on payment by results, patient choice, the roll out of the national tariff and the proliferation of Foundation Trusts and their possible destabilising effects on specialised services.

The need to involve patients and the public in commissioning specialised services is an underpinning and welcome theme of the review. The examples of good practice in relation to patient and public involvement are useful and deserve to be widely disseminated. CfPS welcomes the consideration of the role of OSCs in commissioning specialised services as a positive and constructive step towards a more transparent and democratically accountable approach. That said, the review could have been more inclusive in relation to OSCs. The tone of the document is that consultation with OSCs is merely a bureaucratic hoop to be jumped through and amounts to little more than a "rubber stamping" of specialised commissioning plans. We would have preferred a more inclusive approach that explicitly valued to contribution of OSCs in developing specialised commissioning plans. The review's view that the proposed 10 SCGs will find it difficult to engage individual OSCs is well made and OSCs should consider setting up standing joint committees based on SHA boundaries.

Lord Warner has indicated that it is likely that the government will implement all of the recommendations of the review. We do not yet know the timetable for implementation.

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