Specialised Healthcare Alliance

SURVEY OF NEW SPECIALISED COMMISSIONING ARRANGEMENTS

Summary

This survey was conducted by the Specialised Healthcare Alliance in the autumn of 2007 to assess early progress in implementing certain aspects of the Carter recommendations on specialised commissioning, as adopted by Ministers in July 2006. The results show that a good start has been made but that much remains to be done in relation to the number of services collaboratively commissioned, the pooling of budgets and public and patient involvement.

The Alliance looks forward to maintaining and strengthening its links with Specialised Commissioning Groups and others as they seek to deliver on this key component of World Class Commissioning.

Background

Specialised services are officially recognised by the Department of Health as those services requiring planning populations of over 1 million. An attempt was made to establish those services that should be regarded as specialised with the publication of the National Definitions Set.

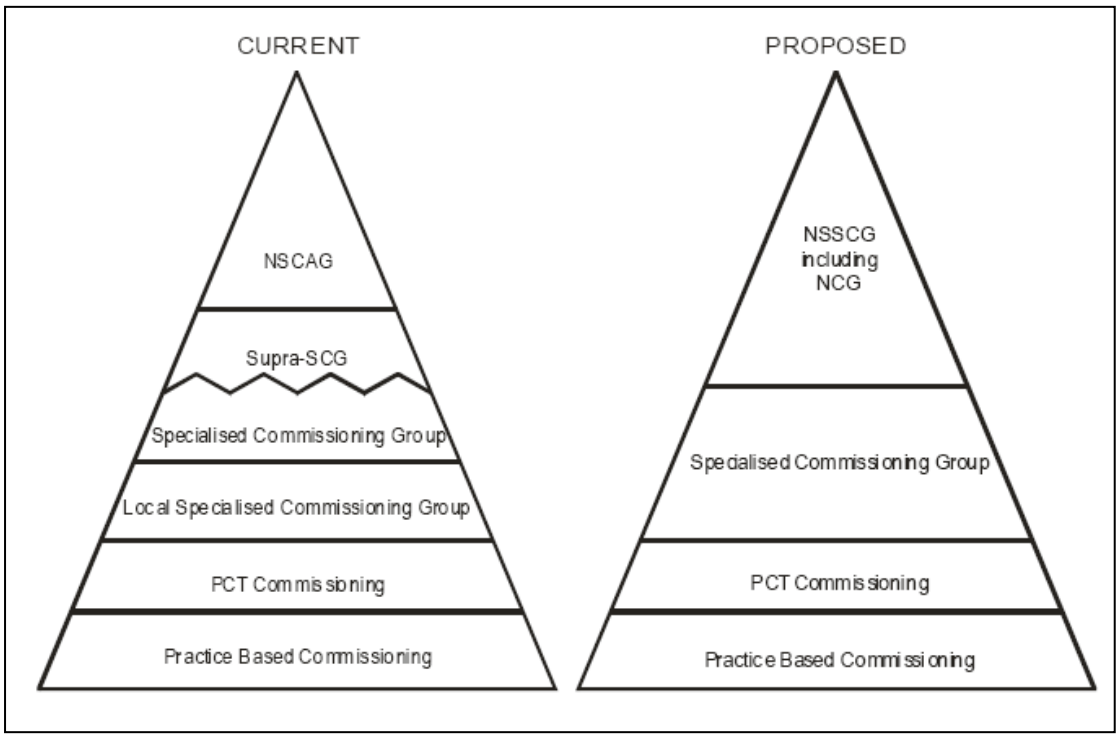
As part of the Government's strategy to shift the balance of power within the NHS, budgets and responsibility for specialised commissioning were devolved to Primary Care Trusts in April 2003.

Guidance encouraged PCTs to work together in collaborative commissioning groups, with Strategic Health Authorities being asked to monitor performance. Collaborative commissioning arrangements were expected to encompass two broad groupings of specialised services: those with planning populations of 3-6 million (level 2) and those with planning populations of around 1-2 million (level 1).

These arrangements were never implemented in full and there was a great deal of geographic variation in the structure and standards of commissioning arrangements for specialised services.

Carter Review

As a result of sustained lobbying activity, Lord Warner agreed to establish a review of specialised commissioning arrangements in October 2005. This was chaired by Lord Carter and the final report was published in May 2006. It contained a number of recommendations regarding the commissioning



structure for specialised services, performance management of specialised commissioning, review of the National Definition Set and the profile given to specialised services, all of which were strongly supported by the SHCA.

Specialised Commissioning Arrangements

Most of the recommendations of the Carter review were adopted by the DH in the new Commissioning Framework published in July 2006. Key elements of the new arrangements include:

- A National Specialised Services Commissioning Group (NSSCG now known as NSCG) to co-ordinate specialised services commissioning and make national decisions, where appropriate;

- The National Specialist Commissioning Advisory Group (NSCAG) to continue commissioning services for extremely rare conditions or very unusual treatments nationally and to advise Ministers on national provider designation status, but but from within the NHS andrenamed the National Commissioning Group (NCG);

- Each SHA area to have a Specialised Commissioning Group (SCG) responsible for the commissioning arrangements for all specialised services. SHAs are responsible for the performance management of these groups;

- All PCTs required to be a member of the SCG with SCG decisions binding on PCT members;

- SCGs tol be funded from a budget pooled from PCT allocations to cover the cost of specialised services commissioned on behalf of its PCTs and the SCG commissioning team costs.

- SCGs to designate specific providers to provide individual specialised services.

Implementation of the new arrangements

When considering the results of the survey and the current position in terms of the new arrangements it is important to consider that different geographic areas had very different historical arrangements and levels of preparedness for implementing the new arrangements. In some areas comparable arrangements had been in place for some time, in others there was no tradition of collaborative commissioning while in some parts of the country well established collaborative arrangements had to undergo substantial reform to fulfil the Carter criteria.

The Specialised Healthcare Alliance has been heartened by the effort and enthusiasm with which the new arrangements have been adopted and the priority that has been afforded to this project by PCTs. In general progress has been extremely positive and whilst more remains to be achieved, the Alliance is confident that commissioners are dedicated to making this happen.

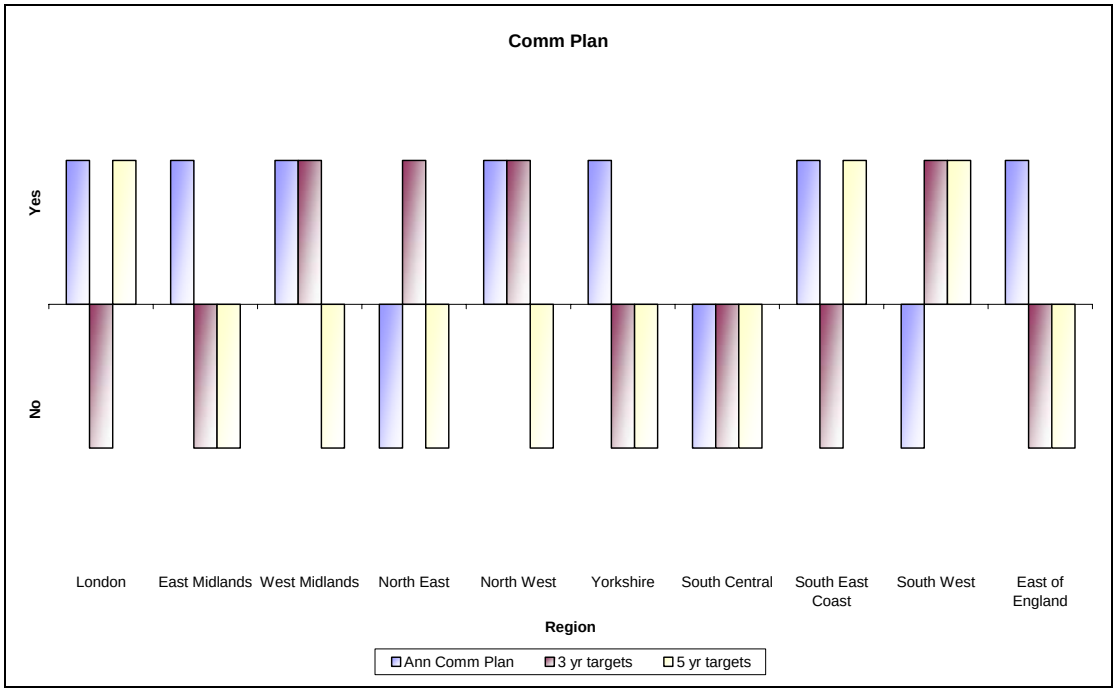
Commissioning Groups

All ten Specialised Commissioning Groups are now established and all are supported by a dedicated team of commissioners. The National Specialised Services Commissioning Group (NSCG) has established a challenging work programme for the coming year and the National Commissioning Group (NCG – formally NSCAG) has moved from the Department of Health to the NHS.

In most cases SCGs have established annual Commissioning Plans with three year targets. As can be seen from the following chart in some cases SCGs

have established three year targets but these are not contained within a formal annual workplan at this stage.

Chart 1: Does the SCG have an annual commissioning plan? Does this have 3 yr and 5 yr targets?

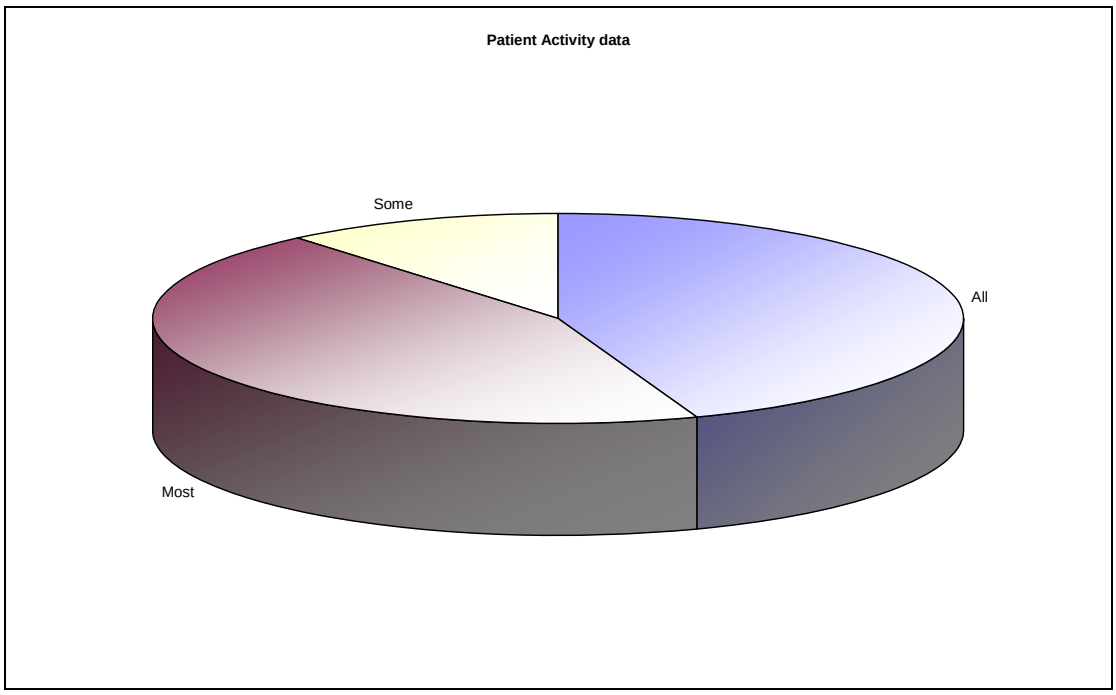


Specialised Commissioning Groups have developed formal processes to determine the view of clinicians, providers and PCTs when developing their Commissioning Plans. Unfortunately, only three SCGs had a formal process to garner the views of patients. In most cases this reflected poorly established patient involvement across the board – something all SCGs recognised and intend to rectify in the coming year (see later section).

Data

Access to patient activity data had been a real problem under the old arrangements so it was positive to see that almost half the SCGs had access to all patient data. However, six groups were still in the position where they were only able to access the data for most or some of the services they commission directly. This is clearly a problem which is understood to be receiving urgent attention at national level.

Chart 2 Was the SCG able to access patient data for the services it commissioned directly?

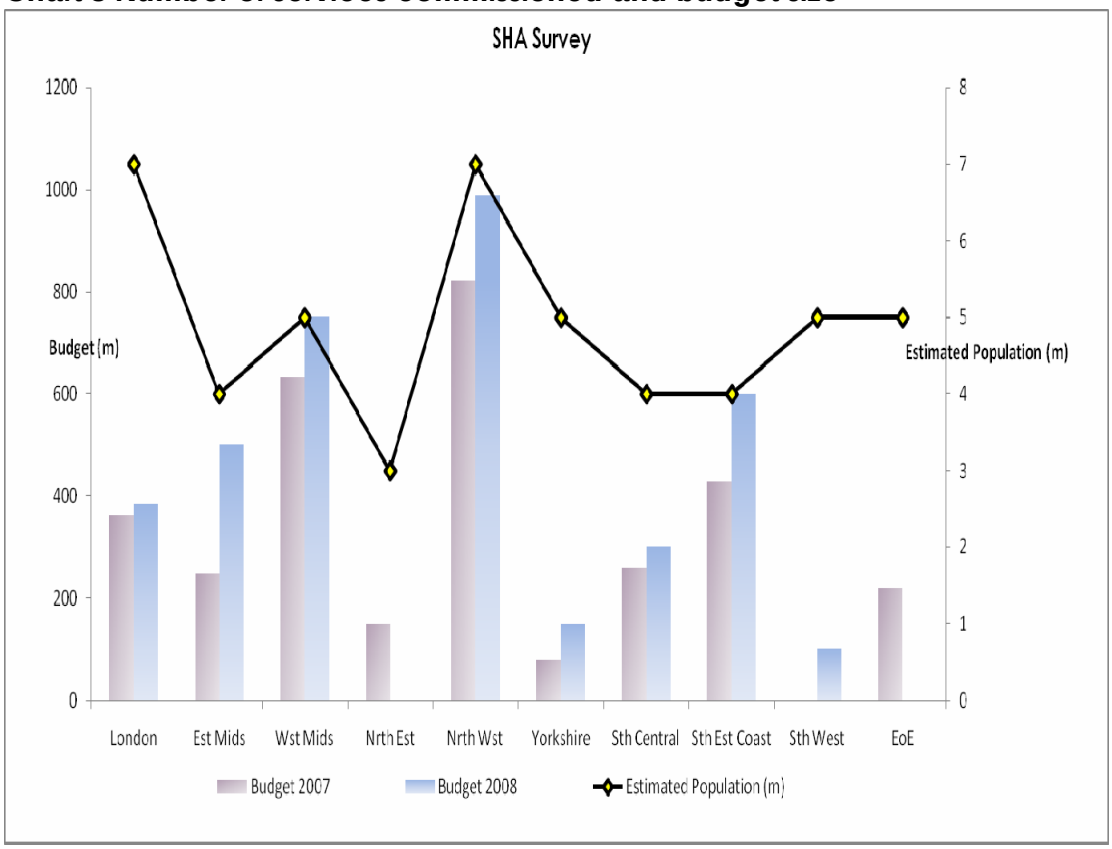


Pooled budgets

Only one commissioning group had not yet established a pooled budget for the services it commissions directly. However, work to establish this is in train and a substantial pooled budget covering a minimum of ten services will be established by April 1st 2008. Currently, budgets for all groups are pooled on a mixed basis. The SHCA would like to see groups move towards budgets pooled on the basis of weighted capitation as soon as possible.

The following chart indicates the budget size and number of services commissioned by each SCG. As is clear there is a large variation in the number of services commissioned collaboratively and the size of the SCG budgets. Once again, this data should be viewed with the caveat that commissioning groups came from very different baselines and budget size/number of services commissioned are not necessarily indicative of overall activity. In some cases SCGs partially commission a significantly higher number of services. However, this data has not been included on the following chart. All groups expect an increase in budget size and to commission at least 10 services collaboratively by 2008.

Chart 3 Number of services commissioned and budget size



NB in many cases figures for 2008 are estimates only

Patient Involvement

All SCGs recognise that patient involvement in commissioning is poor and work is in train to improve this.

Four SCGs now have websites which will prove a useful means of updating patients, clinicians, providers and other stakeholders about the activities of the SCG. Three more SCGs will have established sites by Spring 2008 and we are hopeful that the remaining SCGs will follow suit.

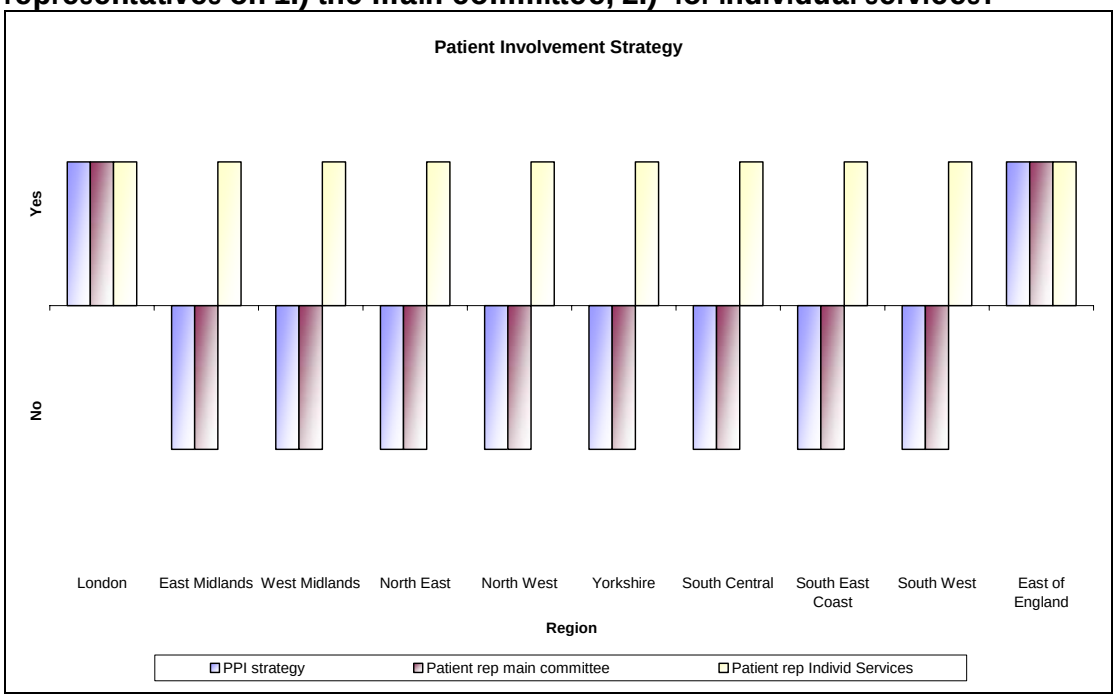
The SHCA views the establishment of websites as an important element in establishing the openness and accountability of SCGs. Of the four SCGs with websites three already publish papers on the sites and we would encourage the others to follow suit.

South East Coast SCG website

Only two SCGs currently have a PPI strategy in place. However, in many cases SCGs are in the midst of developing this and all SCGs indicated that they expect to have an established PPI strategy by 2008.

As the following chart indicates, the absence of a formal PPI strategy does not mean that the SCG has no patient involvement. In all cases patient or lay representatives are involved in the commissioning of individual services. The SHCA would like to see this involvement replicated on the main committee of the SCG – which only two SCGs have achieved to date. In only one case are the SCG meetings open to the public (one other SCG has some open meetings) another factor the SHCA believes would add to the accessibility of SCGs. We will be watching the development of PPI strategies with interest and hope to liaise with the SCGs as these are implemented.

Chart 4 Does the SCG have a PPI strategy? Are there patient/lay representatives on 1.) the main committee, 2.) for individual services?



SHA Oversight

This survey was sent to SHAs who are responsible for monitoring the effectiveness and performance of the new SCGs.

It appears to be indicative of the priority that SHAs have assigned to this role that in all cases the individual within the SHA responsible for performance managing the SCG was at director level. In addition, in all but two cases a representative from the SHA regularly attends SCG meetings. The SHCA believes that a high level of involvement and support from SHAs has been and will remain critical in ensuring commissioners make good progress with implementing the Carter requirements.

Conclusion

Commissioning within the NHS is often subject to criticism. It is therefore important to recognise progress and the SHCA is encouraged by the start which has been made across the country in implementing the Carter recommendations on specialised commissioning.

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Clearly, these arrangements are very new with some SCGs having only recently signed their establishment agreements and there were very different levels of preparedness in terms of adopting the new arrangements. However, in all cases, the principles of Carter appear to have been accepted with real progress made in 2007 and ambitious but achievable plans for 2008.

The SHCA hopes that PCTs will continue to support the SCGs that commission these important services for vulnerable patients on their behalf. We believe that SCGs form an important element of world class commissioning and that many contain examples of best practice which should be shared with the wider NHS.

The SHCA believes that the interconnectedness of the NHS is one of its greatest strengths and, historically, has facilitated the delivery of universal healthcare at a much lower cost than comparable systems in other parts of the world. The commissioning framework provides a valuable opportunity to adopt a holistic approach to services from practice through to tertiary level and we hope the progress to date in implementing this will be recognised and continue to be supported.

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Appendix 1 Questionnaire

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SURVEY OF NEW SPECIALISED COMMISSIONING ARRANGEMENTS

1. Is the SCG supported by a dedicated team of commissioners?

Yes ☐ **No** ☐

2. Does the SCG produce an annual commissioning plan?

Yes ☐ **No** ☐

Does this have targets for:

3 years	**Yes**	☐	**No**	☐
5 years	**Yes**	☐	**No**	☐

3. As part of developing the annual commissioning plan has the SCG developed formal processes for determining the view of:

Patients	**Yes**	☐	**No**	☐
Clinicians	**Yes**	☐	**No**	☐
Providers	**Yes**	☐	**No**	☐
PCTs	**Yes**	☐	**No**	☐

4. Does the SCG have access to patient activity data for services they commission directly?

All services	☐
Most services	☐
Some services	☐
None	☐

5. Does the SCG have a pooled budget for services they commission directly?

Yes ☐ **No** ☐

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On what basis is this pooled?

Weighted capitation ☐

3 yr rolling average ☐

Mixture ☐

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6. What is the size of the SCG budget (£m) for:

2007/08 _____

2008/09 _____

7. How many services are/will be commissioned by the SCG in:

2007/08 _____

2008/09 _____

8. Does the SCG have a website or webpage?

Yes ☐ **No** ☐

If not, when will this be established

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9. Are SCG meeting papers published on the website?

Yes ☐ **No** ☐

10. Has the SCG established a PPI strategy?

Yes ☐ **No** ☐

If not, when will this be established

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11. Does the SCG have patient/lay representation?

On its main committee **Yes** ☐ **No** ☐

For individual services **Yes** ☐ **No** ☐

12. Are SCG meetings open to the public?

Yes ☐ **No** ☐

13. Who is the lead responsible for performance managing the SCG within the SHA?

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14. Does a representative from the SHA regularly attend SCG meetings?

Yes ☐ **No** ☐

15. What areas are/will be assessed as part of the SHA performance management of the SCG:

Effectiveness of performance ☐

Effective use of available resources ☐

Other (please provide details) ☐

_____

_____

_____

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Appendix 2 Summary of results of Survey

		London	Est Mids	Wst Mids	Nrth Est	Nrth Wst	Yorkshire	Sth Central	Sth Est Coast	Sth West	EoE
1	**Dedicated team**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
2	**Ann Comm Plan**	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	Yes
	3 yr targets		No	Yes	Yes	Yes	No	No	No	Yes	No
	5 yr targets	Yes	No	No	No	No	No	No	Yes	Yes	No
3	**Process to determine view of:**										
	Patients	Yes	No	No	No	No	No	No	Yes	Yes	Yes
	Clinicians	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Providers	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	PCTs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4	**Patient Activity data**	Some	All	All	All	Some	Some	Some	Most	Some	All
5	**Pooled budget**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
	Basis Pooled		Mixture	Mixture	Mixture	Mixture	Mixture	Mixture	Mixture	Mixture	Mixture
6	**Budget Size**										
	2007	364	250	634	150	823	80	260	430	220	
	2008	383	500	750		990 est	150	300	600est	100	
7	**Number services**										
	2007	21		36	30	18	5 (19 partial)	1	17 (50 partial)	51	
	2008			37	35	20	25 (20 partial)	10	25	10	More
8	**Website**	Yes	No	Yes	No	Yes	No	No	Yes	No	No
	When established?		Apr-08				2008		Dec	2008/09	
9	**Publication papers**	No	No	Yes	No	Yes	No	No	Yes	No	No
10	**PPI strategy**	Yes	No	No	No	No	No	No	No	No	Yes

	When?		2008/2009	2008/09	In train	Dec-07	2008	2008	2008/09	2008	
11											
11	**Patient rep**										
	Main committee	Yes	No	No	No	No	No	No	No	No	Yes
	Individ Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12											
12	**SCG public Meetings**	No Dir of finance and Performance	No Deputy Ch Exec	No Dir Comm	No Dir Public Health	Yes Dir Comm	No Dir Comm	No **Director of Strategy and Reform**	No Head Perf	both Dir finance & perf	No Dir Comm
13	**SHA rep**										
14											
14	**SHA attend meetings**	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
15											
15	**SHA Assessment:**										
	Effectiveness Perf	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Use of resources		Yes	Yes Carter	Yes Carter	Yes Carter	Fitness for purpose	Yes Yes	Yes Carter	Yes	Yes Fitness for Purpose