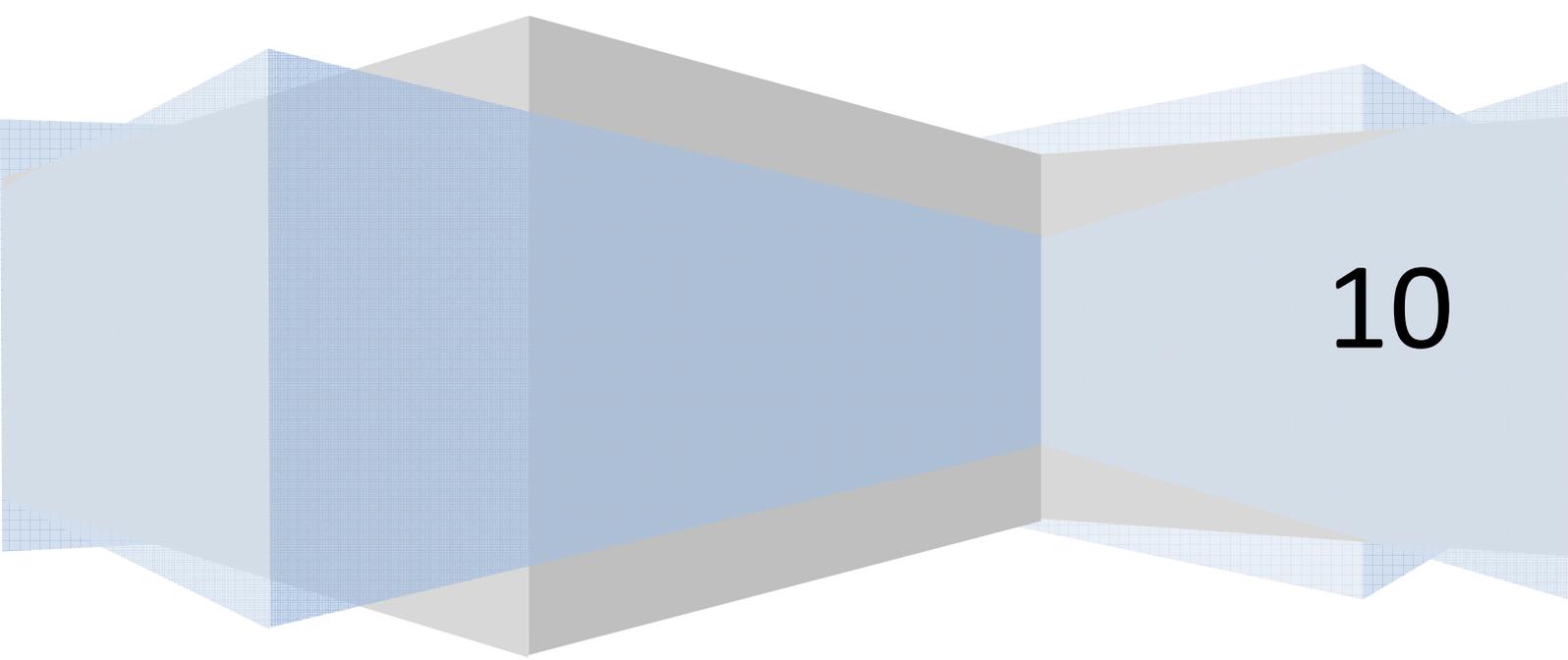


SCG Group Survey

February 2010



10

INTRODUCTION

This report summarises replies received from regional Strategic Health Authorities (SHAs) and Specialised Commissioning Groups (SCGs) in response to a short questionnaire distributed in August 2009 with a view to informing the Health Select Committee's inquiry into commissioning. A further question on the way in which SCGs pool budgets was sent out at the end of November. Although the information contained in the report is interesting and serves to highlight various strengths and weaknesses, its value for comparative purposes is limited by the different nature of many of the replies. Specialised commissioners have also pointed out that the policy environment is constantly changing with initiatives such as Quality Innovation Productivity and Prevention (QIPP) throwing up new challenges.

SCG abbreviations

EM – East Midlands

EoE – East of England

NE – North East

NW – North West

SC – South Central

SEC – South East Coast

SW – South West

WM – West Midlands

YH – Yorkshire and Humber

SGC Functions	
Q1	How many services from the National Definitions Set has your SCG fully commissioned in 2008 and in 2009?*
Summary of findings:	<p>Carter Recommendation 3: Specialised Commissioning Groups <i>“Each SHA area should have a SCG responsible for the commissioning arrangements for all specialised services as defined by the Specialised Services National Definitions Set”</i></p> <p>DH Operating Framework 2007/08 <i>Key milestone: “SCGs to collectively commission a minimum of 10 specialised services; by 2008/09 SCGs to collectively commission most specialised services for their populations.</i></p> <p>Responses to this question confused commissioning of particular services with full commissioning of the 35 service definitions within the National Definition Set, each of which might comprise several services. The results are therefore difficult to interpret but show that, despite significant progress, SCGs generally remain well short of the objectives laid down in the Carter report and subsequent DH Operating Framework.</p> <p>To provide additional information and for purposes of comparison, we have included in italics for each SCG a summary of their responses to a survey conducted in April 2008 by the NSCG.</p>
EoE	<p>EoE SCG presented costs associated with 34 of the 35 national definition set and estimates that it commissions at least 90 per cent of related spend across the region.</p> <p><i>From the April 2008 exercise EoE had planned to fully commission 10 services and partially commission 23 of the 35 nationally defined services.</i></p>
EM	<p>The EMSCG commissions 27 of the 35 national definition set. Discussions are taking place as to how this will be extended from 2010/11 onwards.</p> <p><i>In their April 2008 response they had planned to fully commission 17 and partially commission 13 of the nationally defined services.</i></p>
London	<p>The SCG plans, procures and performance manages 23 services but does not clarify where services sit within the NDS.</p> <p><i>In their April 2008 response they had planned to fully commission 9 and partially commission 10 of the 35 nationally defined services.</i></p>
NE	<p>The North East SCG fully commissioned ten specialised services, and partially commissioned (where the service is not procured by NESCG) eight specialised services.</p> <p><i>This is close to their response from April 2008 where they had planned to fully commission 11 and partially commission 10 nationally defined services.</i></p>
NW	<p>The North West SCG fully commissioned 17 and partially commissioned 41 of the (86) individual services associated with the 35 categories in the National Definition Set. It plans to fully commission 22 and partially commission 44 out of 81 in 2009/10.</p>

	<p><i>This is a similar position to that reported in April 2008, when they had planned to fully commission one and partially commission 24 nationally defined services, bearing in mind that some service categories comprise several components eg there are 8 services within the Children's definition of which NW fully commissioned 7.</i></p>
SC	<p>The South Central SCG fully commissioned 19 and partially commissioned 18 of the (86) individual services associated with the NDS for 2009/10.</p> <p><i>In April 2008, they had planned to fully commission 8 services and partially commission 13 in 2008/09.</i></p>
SEC	<p>14 individual services are fully commissioned across 8 PCTs, 3 services are fully commissioned across most SEC PCTs, and 9 services are partially commissioned. 6 out of 35 national definitions are fully commissioned and 11 are partially commissioned. By 2010/11 15 national definitions are expected to be fully commissioned.</p> <p><i>In April 2008 they suggested that 14 services would be fully commissioned by the SCG and 20 services partially commissioned in 2008/09.</i></p>
WM	<p>WM SCG reported 28 specialised services fully commissioned across all PCTs/8 fully commissioned for some localities only in 2008. 28 fully commissioned across all PCTs/8 fully commissioned for some localities only in 2009.</p> <p><i>In April 2008, WM planned to fully commission 10 service definitions and partially commission 7.</i></p>
SW	<p>2008/09 – Burns, Neonatal, Paediatric Intensive Care, Medium Secure and Personality Disorder, Spinal cord injury, Blood and Marrow Transplantation, Stereotactic Radiosurgery, PET CT, Renal transplantation, Deep Brain Stimulation, Pulmonary Hypertension, Cleft Lip and Palate, HIV-AIDs. Total £147m.</p> <p>2009/10 – All specialised services apart from Child and Adolescent Mental Health, some rare cancers that are difficult to count, equipment for complex physical disability, cardiology e.g. revascularisation and ICDs and cardiac surgery. Total £450m</p> <p><i>In April 2008, SW was involved in planning for all specialised services but only planning to fully commission 6 national definitions and partially commission another 6 out of 35.</i></p>
YH	<p>Y&H SCG (Yorkshire and the Humber) Specialised Commissioning Group agreed a 3 year phased transfer of responsibilities for commissioning specialised services from PCTs (Primary Care Trusts) to SCG.</p> <p>Year 1 was in 2008/09 when the first tranche of services transferred concentrating on those provided by Y&H NHS Providers. We estimate total expenditure on specialised services to be £600m and in 2009/10 we are commissioning £550m.</p> <p><i>In April 2008, YH had planned to fully commission 8 nationally defined services and partially commission 14.</i></p>
Q2	How many services commissioned in 2009 have been fully mapped and costed?
Summary of findings:	<p>Carter Recommendation 11: Service Mapping to Facilitate Costing</p> <p><i>“By the beginning of the financial year 2008/09 SCGs should have defined (or re-defined), quantified and costed all specialised services included in the Specialised</i></p>

	<p><i>Services National Definitions Set”</i></p> <p>Most SCGs suggested that mapping was taking places, although some or all of their services could not show associated costings.</p> <p>PbR tariff, local prices and historical costs were mentioned as means of costing.</p> <p>In some SCGs, particular services were prioritised for mapping and costing in 09/10, but several planned on fully mapping and costing all services going forward.</p>
EoE	All the services contracted for by the EoE SCG and priced by either PBR or local prices
EM	East Midlands attached a budget template but it was difficult to decipher how services were mapped and costed.
London	PbR tariff is used where available, there is an annual review of costs for HIV, remainder based on historical costs/funding
NE	Ten
NW	A project is being undertaken which will map out more services in 2009/10.
SC	Sixteen, including DBS/stereotactic radiosurgery & neurosurgery as 3 separate services
SEC	Twenty
WM	The key piece of work in 2009 has focused around amendment to the commissioning algorithm from specialty based to HRG based (for inpatient PBR activity) in 2009 which will ensure all of these services are mapped and costed
SW	<p>2008/09 None of these services were formally designated in 2008-09 but processes were in place to support burns designation which is still in progress</p> <p>2009/10 All new commissioning has been supported by a full stock take of activity and costs to establish commissioning baselines. Bariatric surgery has been designated during 2009-10</p> <p>Commissioning is supported by full stock take of all activity and costs from providers in order to set commissioning baselines.</p>
YH	<i>YH attached a document outlining what services were mapped or planned to be mapped. 21 specialised services were mapped in 2008 and 25 more are planned to be mapped for 2009/10. YH did not attach costs associated with services.</i>

SCG Meetings

Q3	How many PCT Chief Executives attended at each of the last two meetings?
Summary of findings:	<p>Carter Recommendation 3: Specialised Commissioning Groups “ PCT membership of SCGs should be predominantly at PCT chief executive level (nominated deputies should be at director level or equivalent)”</p> <p>The involvement of chief executives in SCGs is highly variable with Establishment Agreements allowing for lesser representation than envisaged by Carter in many cases. The danger is that the commitment of PCTs will be compromised.</p>
EoE	<p>19/3/09 Meeting was attended by 8 PCT Chief Executives, 6 Director Delegates 26/6/09 Meeting was attended by 10 PCT Chief Executives, 3 Director Delegates, 1 absentee</p>
EM	<p>We have 2 PCT Chief Executives on the Board, although each PCT Board has had a detailed discussion as to who their delegated representative should be. The EM SCG is an agenda item on all East Midlands Management Board meetings (chaired by Dr. Barbara Hakin – CE of the SHA). All East Midlands PCTs and the executive team from the SHA are present at these meetings</p>
London	<p>PCT Chief Executive membership of SCG Board is the Chair, Caroline Taylor and 1 PCT Chief Executive from each of the 5 sectors. The June and July meetings were attended by 5 Chief Executives</p>
NE	<p>Four of the six Chief Executives attended both the March and June 2009 meetings of the NESCG. Chief Executives can send deputies, and the NESCG is quorate when three PCO representatives are in attendance</p>
NW	<p>One – Leigh Griffin as Chair, but PCT Chief Executives (who are members) have nominated representatives as defined within the terms of the Establishment Agreement</p>
SC	<p>April – 2 of the Chief Executives unable to attend sent delegated representatives August – 2 of the Chief Executives unable to attend sent delegated representatives – the Chief Executives unable to attend were not the same each time.</p>
SEC	<p>2 out of 7</p>
WM	<p>WMSCG has 5 PCT CEO representing the 17 PCTs on its’ Board as agreed through the establishment agreement. June 2009 -4 out of 5 [due to annual leave deputy in attendance]. March 2009- 3 out of 5 [apologies due to urgent meeting]</p>
SW	<p>CEO representation at SCG :</p> <p>June09 – 6 Chief Executives out of 14 – of the remaining PCTs, 3 were represented at Director level and 3 at Associate Director level; 12 PCTs were represented in all.</p> <p>March09 – 10 Chief Executives out of 14 – of the remaining PCTs, 3 were represented at Director level and 1 at Associate Director level</p>
YH	<p>Number of Chief Executives attending SCG meetings is variable. Last two meetings, June – 3 and July – 6. Not all PCTs have nominated PCT Chief Executive Officers as the representatives; for some it is Directors of Commissioning</p>

Q4	Who represented the SHA and at what level?
Summary of findings:	<p>Carter Recommendation 3: Specialised Commissioning Groups In respect of membership: “There should also be senior SHA input (at least at Director level).”</p> <p>Carter Recommendation 29: Performance Management “SHAs should be represented on SCGs and provide support and guidance, ensuring consistent behaviour across PCTs.”</p> <p>Seven of the ten SCGs gave a named representative from the SHA who attended SCG meetings (all at Director or in one case Associate Director level)</p> <p>NHS London is not a member of the London SCG. SHA representation in the North East and North West has been minimal but is expected to improve.</p>
EoE	On both occasions the SHA was represented by Dr. Paul Watson, Director of Commissioning and Deputy Chief Executive
EM	Avril Johns – Director of System Reform has the SHA lead for specialised services. Dawn Atkinson, her deputy, sits on the SCG Board
London	SHA is not a member of SCG
NE	The SHA receives copies of agendas, papers and an invite to attend meetings. Specialised commissioning is part of the job description of one of the strategic heads at the SHA. However due to staff secondment and maternity leave the SHA has not recently been represented at meetings. This will be rectified when new people are in post
NW	There has been no regular representation from the SHA for 2008/09. In 2009/10, an Assistant Director of Finance has attended
SC	SHA representation was the Director of Finance & Performance for both meetings
SEC	SHA is represented by Dave Morgan, Director of Commissioning & System Development (Interim)
WM	Eamonn Kelly, Director of Commissioning NHS West Midlands
SW	The Strategic Health Authority is normally represented by Mr Bill Shields Director of Finance and Performance but he did not attend the last two meetings
YH	The SHA (Strategic Health Authority) representative is Helen Dowdy who is the Associate Director of Strategy

SGC Finance	
Q5	What increase in expenditure, if any, would you expect the SCG to be asking for next year for services in the National Definitions Set (excluding those which are nationally commissioned)?
Summary of findings:	<p>Survey responses ranged from “no automatic presumption” to “Too early to say” to exact percentage increases of between 2 and 6%.</p> <p>Overall funding increases are also affected by the movement of services into (or out of) the SCG, making comparisons problematic.</p>
EoE	There is no automatic presumption of an increase in funding
EM	The SCG management team are currently evaluating the full SCG spend of around £600m. It will be following this that any detail regarding business cases for next year will be considered. The SCG commissions all chemotherapy for the East Midlands and clearly this combined with the commissioning of NICE TAGs and drugs excluded from tariff results in substantial increases in funding year on year
London	Too early to say
NE	Apart from pre-commitments, the only increase in expenditure anticipated in 2010/11 will be planned increases in activity where the contract is subject to either a local tariff or PbR
NW	It is too early in the financial year to indicate the level of expenditure being sought next year. There will be some variance due to the transfer of responsibilities to SCG from PCTs where all services within a Definition Set are not yet commissioned by SCG or due to the transfer out of services no longer part of the National Definition Set. Work to clarify this for 2010/11 is being developed.
SC	2%
SEC	<p>Excluding tertiary contracts, (which hold a mixture of specialised and non specialised services), and the ambulance contract that the SCG currently manages on behalf of PCTs, the SCG currently manages resources of £120m, specifically attributable to Specialised Services National Definition Set (SSNDS)</p> <p>The Carter Report suggested expenditure on this area of service delivery should be around 10% of hospital acute care expenditure. PCTs spend approximately 50-55% of their total resource in this area.</p> <p>Therefore the SSEC SCG should be aiming to manage approximately £354m across NHS SEC, i.e. £6.46bn (Total NHS SEC x 55% x 10% = £3354m)</p> <p>Over the past two financial years the SCG managed budget for specialised services has increased by £13.4m: £3m in 07/08 to 08/09 and £10.4m 08/09 to 09/10.</p> <p>The SCG would look to continue to refine service mapping, based upon the SSNDS revisions, and to create pooling budgetary arrangements for these services and move forwards towards full carter compliance (i.e. £354m). Whilst the current gap is £234m* we would not expect to increase by this much over a single year. The bulk of the gap will sit within general contractual arrangements and should be reasonably</p>

	<p>identifiable and transferable and this will need to be facilitated over a planned period.</p> <p>*Note this sum is contained partially in tertiary contracts that the SCG holds in its portfolio, it is planned to devolve these to PCTs by October 2009, with the SCG continuing to be the lead SEC commissioner with single specialty providers, e.g. Great Ormond Street and the Royal Brompton only.</p> <p>Incrementally we would probably look to increase by a similar amount as 08/09 to 09/10 to reflect the transfer of specialised service budgets to the SCG and the priorities identified in the SCG Operating Plan/Strategic Commissioning Plan. We should be able to quantify this in more detail over the coming contracting round.</p>
WM	SHA planning assumption is 4%
SW	Expected growth in 2010/11 – It is difficult to be specific at this point. For 2009-10 activity was funded at outturn for service already within the portfolio together with a development programme for priority services. In 2010/11 it is expected that the SCG will have agreed a medium term plan which will involve specific actions to control cost pressures in existing services together with robust prioritisation in relation to service improvements which are likely to be funded from service redesign and other commissioning processes that will improve the quality and cost effectiveness of our commissioning
YH	The SCG developed a 5 year financial and commissioning plan starting in 2008/2009 which is currently being refreshed. The expectation is that the current spend of £550million will increase to £600million however this will be finalised during the contracting round for 2010/2011 in early 2010
Q6	What efficiency savings have been identified by the SCG for those services?
Summary of findings:	Although approaches vary, SCGs appear to be seeking efficiency savings in much the same way as the wider NHS.
EoE	The EoE SCG will be undertaking financial projections in line with guidance from the Department of Health
EM	The PCTs and the SHAs have not set a target efficiency saving but the SCG management team have identified a saving target of 5%. It is their view that efficiency and productivity targets are just as much an issue for specialised services as for other services
London	Too early to say
NE	None as yet. Still awaiting the outcome of national discussions
NW	The SCG requires services to make efficiency savings in line with national expectations such as those set out linked to inflationary uplifts and those required in PbR. In addition, the SCG continues to seek best value through the way it commissions services and to ensure value for money for existing services and for new services, e.g. through tendering for services and systems management arrangements.
SC	2%
SEC	Efficiency savings are implicit in the tariff uplift of 3.0% for 2009/10. Efficiency gains are arising from pooled budgets by reviewing currencies and prices, and standardising exclusions to contracts, e.g. within spinal injuries consortium.

	Standardisation through agreed policies and eligibility criteria, e.g. Pulmonary Hypertension drugs and Morbid Obesity Surgery. Where the SCG is a part of wider commissioning consortia, where purchasing power can lead to greater efficiencies, e.g. procurement of blood products for haemophilia patients
WM	<p>In 2009/10 procurement framework for secure services and CAHMS Tier 4 identified £ 2.9million savings in the first year</p> <p>5 point programme established relating to efficiency programme presented to June SCG 2009 for next year. It includes:</p> <ul style="list-style-type: none"> • Housekeeping –review of all expenditure within healthcare contracts, network costs etc • Backroom functions –support for databases to obtain VFM • Procurement –options for procurement of services including third party providers of healthcare products and drugs commissioned . • Service redesign and innovation –home delivery of drugs/products eg home chemotherapy, factor products .Review of discharge /LOS of complex cases for paediatrics ,neuro-rehabilitation • Policy-engagement in national payments by results on issues such as which services should go into national tariff next and the level of medical devices and drugs now excluded from national tariff
SW	Efficiency savings – in 2008-09 savings of £2m were achieved through re-commissioning mental health and learning disability placements in order to secure better quality, better value for money services
YH	The expectation is that the spend on SCG services will have the same efficiency savings target applied as other services i.e. likely to be around 3.5%. In addition efficiency savings will be looked at across new/changes in services. However, as is the nature of specialised services, for a number of specialised services the SCG has little or no influence on the pathway or the actual spend e.g. Forensic services where the spend, particularly on high secure, is determined largely by the courts or Specialised Burn Care as the incidence of serious burns is unpredictable and is urgent. This will make it more difficult to achieve efficiency savings

SGC Performance Management

Q7	Please provide a copy of a performance report to illustrate how the SHA performance manages the SCG
Summary of findings:	<p>Carter Recommendation 29: Performance Management “SHAs should ensure strong performance management of specialised services commissioning, ensuring that... SCGs are working effectively”</p> <p>Responses suggest that SHA performance management is in many cases weak. A situation which should perhaps be viewed in conjunction with the current decision to omit SCGs from mandatory assessment under World Class Specialised Commissioning.</p>
EoE	<p>The SHA holds regular (quarterly) accountability meetings with EoE SCG Director and Chair. The Accountability Meeting is based on the delivery of the EoE SCG Work Programme that is agreed at the beginning of each year. Prior to the meeting an agenda is agreed and the EoE SCG produces an exception report against the work programme. The content of the meeting will include discussion of exceptions within the work programme, key pieces of service commissioning work, development of the EoE SCG team and World Class Commissioning, contract negotiations (at the x of the year and contract and financial management)</p>
EM	None received
London	NHS London’s performance management approach to the SCG is currently in development
NE	<p>There is no regular performance report since the management of the SCG has been delegated to the North of Tyne Commissioning Cluster on behalf of the wider SHA. The receipt of papers and minutes of the meetings allows the SHA to keep track. The SCG chair reports by exception to the NHS management board north east which meets monthly and comprises PCT chief executives and the SHA chief executive and executive directors. On the whole SCG arrangements function very well and it has not been necessary to institute onerous performance management arrangements. If the situation changed it would be easy to escalate to a more rigorous process</p>
NW	Nil return
SC	<i>SC attached documents outlining their reporting mechanism to the SHA and other documents outlining demand management and potential savings</i>
SEC	The SCG has a detailed performance framework with the SHA assessing the position in relation to engagement, structure, joint working, strategy, delivery, effectiveness, implementation, financial management and monitoring
WM	<i>WM attached a reporting framework outlining the dimensions and criteria of the particular area of work; whether they had achieved their goal; what evidence existed of that achievement and what plans were in place to reach full achievement.</i>
SW	<p>There is not a single mechanism for performance management the following arrangements are in place:</p> <ul style="list-style-type: none"> • Director and Director of Finance both meet monthly with the SHA Director of Finance • Director of Finance is a member of SHA Director of Finance forums • Director is a member of Directors of Strategic Development Group

	<ul style="list-style-type: none"> • Informal monthly performance review meeting in place • Formal performance management meeting now starting to reflect change in portfolio • Procurement and Performance Management Group meets monthly with PCTs formally reviewing the position (report enclosed) • Regular reports of performance to main SCG based on the reports at Procurement and Performance Management Group
YH	<p>Aspects of performance management include:</p> <ul style="list-style-type: none"> • A senior member of staff at the SHA will attend the formal meetings of the SCG Board – to help make connections between key pieces of work and to ensure relevant SHA staff are briefed as necessary. Chris Welsh, Rosamond Roughton or Helen Dowdy will fulfil this role. • Helen Dowdy will meet regularly with Cathy Edwards and Amanda Forrest to ensure regional programmes of work are understood and effectively coordinated across the SHA, SCG and PCT Collaborative. • The SHA will review the SCG’s annual work plan and ensure connections are made within the SHA • SCG will report into the Strategic Commissioning Board on approaches to and the conduct of, key areas of region wide work. There will be a requirement for the SCG to notify the SCB of this type of work. • The SHA’s SCAP will apply to any reconfiguration implications arising from the SCG work programme. • SCG will ensure attendance at Y&H Directors of Performance meetings • The SHA will agree with the SCG an annual accountability agreement and in year performance monitoring arrangements • The SHA will hold annual (and mid-year if appropriate) reviews with the SCG in accordance with existing arrangements • The SHA and NHS Barnsley will agree an annual Service Level Agreement for the provision of Contract Management and Clinical Guardian services to NHS Yorkshire and the Humber in relation to the E16 Renal Service North Independent Sector contract.

SCG Achievements	
Q8	Please provide specific examples of how your SCG has improved services for patients
Summary of findings:	All SCGs reported improvement in services for patients. Examples relating to smaller patient populations were largely absent.
EoE	<ul style="list-style-type: none"> • IVF Policy – standardisation of policy across EoE in line with NICE guidance – 3 cycles • Morbid Obesity – standardisation of policy across EoE and the development of a pilot to improve access to surgery • Neonatal Intensive Care – commissioning of a 24/7 retrieval service • Neonatal Intensive Care – approval and implementation of Essex neonatal intensive care service configuration and network arrangements • Renal – approval of strategy to provide an additional 20% capacity for haemodialysis across EoE Mental Health – review of medium secure capacity and improvement in standards
EM	<p>Improving services for patients:</p> <p>Equity of Access</p> <ul style="list-style-type: none"> • Children’s Cancer Services – Development of an Integrated Centre of Excellence jointly led by Nottingham University Hospitals and University Hospitals of Leicester. The new improved service will ensure that patients receive the right care in the right place according to their needs. Improved partnership working with local DGH’s will ensure that patients receive equitable care, regardless of where they live • Individual Funding Policy – On behalf of NHS East Midlands, EMSCG’s Clinical Priorities Advisory Group introduced a Individual Funding and Top Up Policy which ensure that all requests for individual funding in the East Midlands are considered using a standardised process, ensuring consistency of approach and equity of access • Trans-cranial Doppler - The EMSCG Secured investment to improve access to the TCT screening service for children in 2009/10 which will improve access across the region. A clinical haemoglobinopathy network has been established to inform development of regional services <p>Clinical Excellence</p> <ul style="list-style-type: none"> • Trans Aortic Valve Insertion (TAVI) - EMSCG played a central role in developing a national commissioning strategy for TAVI with expert clinicians, NICE and the Department of Health. The strategy included a commitment to undertake a national clinical research programme into the long term benefits of TAVI, through the TAVI collaborative research group, and to explore its cost-effectiveness alongside open heart surgery. New investment funded 70 patients for TAVI in the East Midlands in 2009/10. • ABOI Transplantation - A new technique for allowing a kidney to be transplanted into an ABO (blood group) incompatible donor has been commissioned by EMSCG. Additional investment secured in 2009/10 will

	<p>enable nine eligible patients across the region to receive a kidney transplant using this innovative new technique. This will support the transplant programmes already in place across the region.</p> <p>Designating Services Around the Patient</p> <ul style="list-style-type: none"> • Neonatal Intensive Care - EMSCG has undertaken an extensive designation process for Neonatal Intensive Care for the East Midlands which will conclude in November 09. Our approach has been to ensure that we put in a responsive, flexible NIC system to address the needs of mothers and babies across the region. Clinical thresholds have been developed for all units which will allow maximum flexibility across the whole system. This will enable units to support each other at peak times thus maximising our precious resources and ensure that as many as possible mothers and babies are cared for as close to home as possible and limit the number of babies going out of our regional networks. • Paediatric HIV Services - EMSCG are reviewing the provision of HIV services against the national designation standards. We are working with our clinical teams across the region to implement an effective hub and spoke model of care to ensure that patients receive the expert levels of care they require throughout their care pathway. <p>Other achievements:</p> <ul style="list-style-type: none"> • Clinical Priorities Advisory Group (CPAG) - In 2007 EMSCG established its Clinical Priorities Advisory Group (CPAG). The key objectives of CPAG are to oversee policy development and to make recommendations regarding investment and disinvestment in specialised treatments. Decisions about investment/disinvestment are made using the defined CPAG principles ensuring that access to new therapies is reviewed in a systematic process that ensures equity of access, reduced clinical variation and increased value for money. In 2008/09 CPAG developed four key treatment policies, including; “In Vitro Fertilisation (IVF) / Intracytoplasmic Sperm Injection (ICSI)”, ensuring that access to treatments is both equitable and timely. CPAG works closely with clinical networks, i.e. EM Cancer Network in order to develop funding priority criteria for cancer treatments including; Non small cell lung cancer, colorectal cancer and renal cell cancer • Development of Clinical Networks - EMSCG hosts two of the key clinical networks in the East Midlands. New appointments to network managers for both the Burns and Renal networks have been made and are accountable through the EMSCG management structure. Both networks have clinical leads in place, who together with the network managers have developed collaborative working between our clinical teams in order to create environments where we can continuously drive service improvements for renal and burns patients across the East Midlands. • Quality Framework - Developing and delivering high quality specialised services across the health economy, is a high priority for EMSCG. In 2009 we introduced our quality framework which describes our approach to quality and how we are working with our providers and PCT’s to develop systems and process to measure quality in our specialised services. Working collaboratively,
--	---

	<p>we have established a wide range of national and local quality indicators including, clinical effectiveness, patient safety and experience measures. Collection of this information is helping us to benchmark service providers and to support them to improve services and increase patient satisfaction</p> <ul style="list-style-type: none"> • Engaging Patients and the Public -In June 2008 EMSCG, in collaboration with the Tribal Group, created strategies for Patient and Public Engagement and Communication. These are in the process of implementation and are being embedded in the work programme. EMSCG is committed to ensuring that high quality patient and public involvement and effective internal and external communication is evident throughout the commissioning cycle. As an example we have undertaken extensive involvement and engagement with our children’s cancer families throughout the development of our new improved integrated cancer service. We have worked at a 1 – 1 level with parents and children in order to understand what is important to them and as far as possible to ensure that the service meets their expectations and aspirations. We are currently working on specific pieces of service improvement work as a direct result of parent/patient involvement • In addition, Expert Patient Panels have been established as part of the development of perinatal mental health services and are proving to be an excellent way of engaging directly with service users in the development of services
London	<p>Haemophilia Services - Total numbers have increased year on year. Over the 5 year period 2004/05 to 2008/09 numbers of patients on active treatment have increased from 994 to 1352 an increase of 36%. There is a clear downward trend in the average cost per patient from 2006/07 as a result of savings achieved through the national contract and other local initiatives such as the Clinical Advisory Group.</p> <ul style="list-style-type: none"> • Data Quality: Contracts require provider trusts to provide accurate and complete data to commissioners and the national hemophilia database within agreed timescales. Communicating the benefit of good monitoring data and how commissioners use this information is regarded as the better method of improving data returns. The consortium agreed a range of service quality measures including an annual review for all patients, ensuring patients on home treatment return completed treatment sheets and referral of all high cost treatments for pre-authorisation through the Clinical Advisory Group • Service Quality: There Outcomes and patient satisfaction measures have been developed in consultation with clinicians and patients and trusts are expected to develop monitoring systems during this year. Additionally the London SCG has secured national support for use of consistent outcome measures so we will be able to benchmark outcomes of care nationally. The Treatment Policy Sub Group developed a rolling programme of clinical audits the first of which started in January 2009 on compliance with agreed clinical practice on care for children with hemophilia. Trusts are required to provide an annual self assessment on achievement of quality measures • Commissioning Quality: During 2008/09, the consortium continued the strategic review of services and developed a new model of care with north and south London networks for adult and paediatric care. We believe the new model is sustainable, will improve patient outcomes and ensure accessibility to out of hours care for all. Cost per case has reduced over the last two years,

	<p>with a significant decrease over the past year due to both an increase in the numbers of patients and the lower cost of clotting factor. The consortium continues to deliver savings through the national contract estimated at £7m a year. Additionally, robust management of clinical guidelines and high cost patients has contributed to the overall downward trend.</p> <ul style="list-style-type: none"> • Priorities: During 2009/10 we will be engaging with patients on the proposed model of care and Trusts will be asked for expressions of interest with a view to awarding new contracts the following year. We will also be working with London Ambulance Service to develop a protocol for patients with haemophilia who have suffered trauma to ensure people receive the right treatment at the right centre. At a national level we will be developing model documentation for designation of haemophilia services across the country to ensure services are providing consistent quality of care and standards of treatment. <p>HIV Services - Numbers of patients known to the HIV service have been increasing year on year as shown in Figure 3. Despite this the average cost per case has reduced since 2005/06 in response to the introduction of a local tariff and maximum prices from 2006/07</p> <ul style="list-style-type: none"> • Service Quality: The HIV Audit and Outcomes Group, with the support of the London Health Protection Agency developed outcome measures for service quality • Commissioning Quality: Introduction of a local tariff and ceiling prices in 2006/07 has stabilised the average cost per patient, despite the rising proportion of patients on ARV drug therapy (78% in 2008/09) and the increasing number of patients on high cost ARV drugs who are resistant to standard ARV combinations. • Priorities: The 2009/10 Quality Improvement Programmes will build on the outcomes measurements (monitored by the London Health Protection Agency through SOPHID data) and require development in Patient Engagement activities from the 2008/09 baseline. The consortium will review the current outcome measures to ensure that 2010/11 CQUINs are used to drive continuous improvement in care. We will also progress the HIV service review in the context of Healthcare for London and likely service designation in 2010/11. <p>Specialised Neuro-Rehabilitation Services - In 2008/09, care for 690 patients was commissioned by the consortium at a cost of £16.141m against a budget of £15.594m. The over-performance was within the agreed additional PCT funding to manage the 18 week transfer into specialised neuro-rehabilitation.</p> <ul style="list-style-type: none"> • Data Quality: The patient level full minimum data set, which is submitted each time a patient is discharged, transferred elsewhere for further rehabilitation or when a patient dies, incorporates a range of complexity and outcome scales/measures that are designed to help understand the effectiveness of the resources used, dispensed treatment programmes and pathways. Activity data is submitted monthly. During 2008/09, 8 of 9 centres consistently submitted the required information to the agreed timescale. The 2008/09
--	--

	<p>contract included penalty clauses, which were not invoked as the consortium has worked proactively with providers to optimise data submission and performance.</p> <ul style="list-style-type: none"> • Commissioning Quality: There has been an appreciable reduction in the average cost per patient during 2008/09 by comparison with the previous year, due to reduced average length of stay across the nine centres to 13 weeks (as opposed to stays of up to 52 weeks – and sometimes up to 32 months – before the consortium’s establishment) and minimisation of delayed discharges through a rigorous management protocol that includes a trim point at day 14, following which funding responsibility transfers to the PCT if the patient has not been discharged. Additionally the leverage of a single commissioner has resulted in preferential contractual bed day unit prices lower than the rate charged to PCTs purchasing on a cost per case basis; lower inflation uplifts compared to those applied to spot placements by individual PCTs; funding of surplus activity at marginal rate rather than full cost (an advantage over cost per case, spot purchasing by PCTs); a better average daily price of £366 compared to the 2007/8 national reference cost of £389 and compared to prices in the range of £514-£750 charged by two similar units • Service Quality: We closely monitor the key actions needed to ensure that most rehabilitation programmes are completed within the timescales set by the multi-disciplinary teams to achieve prompt patient discharge. The 2008/9 average access response was 8 weeks. Specialised neuro-rehabilitation at the nine centres is delivered to the benchmarks set out in the service specification as well as the performance and quality measures set out in individual contracts, which include access response times, complaints and PPE. The consortium also continually strives to benchmark performance against the quality requirements in the National Service Framework for Long Term Neurological Conditions
NE	<ul style="list-style-type: none"> • NE SCG agreed to fund the treatment of the first eye of patients with age related macular degeneration, six months ahead of the publication of the revised NICE guidance • Home renal dialysis – implementation of regional policy and local tariff which is beginning to show an increase in home dialysis • Outreach services, including Washington renal satellite, primary care based neurology clinics and clinical immunology outreach service at Teeside • Reconfiguration of communication aids service which both improved the delivery of the service but also re-invested £130K back into the service to increase the availability of communication aids equipment
NW	<p>In a number of areas, the Team has developed and implemented detailed service specifications setting out standards expected which are then monitored. Commissioning of services also aims to commission the most appropriate service to meet needs, as close to home as possible and within the context of a clear care pathway. Particular examples of work by the Team include:</p> <p>Secure and Specialised Services:</p> <ul style="list-style-type: none"> • Three new dialysis units opened as part of the independent sector treatment programme to expand access to haemodialysis across Cheshire and Merseyside; • New five-year Strategic Frameworks for Kidney Care were published for each

	<p>of the three North West zones;</p> <ul style="list-style-type: none"> • Major procurement exercise led to the announcement of new contracts for bariatric services in Cumbria and Lancashire and Greater Manchester, again providing access to surgery closer to home; • Launch of new primary angioplasty service in Liverpool – clinically proven as the most effective treatment for heart attacks; • Establishment of North West Tertiary Children’s Strategy Group – placing children and their families at the centre of the commissioning agenda; • Development of a low secure service specification, setting out the expected standards for such services; • Procurement of an additional 56 secure beds; • Agreement of a contract for 24 tertiary inpatient beds for patients with eating disorders. <p>Public Health:</p> <ul style="list-style-type: none"> • Development of a statement on exceptionality for PCTs to help them consider individual funding requests; • Contributing to the development of service specifications (ACHD, bariatric surgery); • Carried out work on a prioritised list of pre-NICE cancer drugs for the North West to address the recommendation in the North West Cancer Plan regarding equity of access to treatments. <p>Corporate:</p> <ul style="list-style-type: none"> • Development of the World Class Commissioning evidence base, which informed the NWSCG’s participation in the DH pilot; • Raised public awareness of specialised services via the media; • Produced, in conjunction with patients, regular newsletters for those on dialysis; • Engaged with PCT Non-Executive Directors across the North West to ensure they understand the particular issues associated with specialised services
SC	<ul style="list-style-type: none"> • Public engagement process as part of revising the criteria for access to IVF across South Central • The work of Forensic Mental Health caseworkers to place and follow up patients in secure facilities • Engaging with FESC partner (Framework for procuring external support for commissioners). This contract was signed in February (2009). The contractor, UnitedHealthUK, have developed plans to use nursing expertise to triage referrals so that patients are sent to the most appropriate and suitable facility, so that the best outcomes are obtained
SEC	<ul style="list-style-type: none"> • PET CT – Commissioned services to meet 800 pmp, as set out in DH framework • IVF – full review undertaken, including demand and capacity review. New policy developed to ensure equity across SEC. Agreement to fully commission from 2010/11 SEC-wide with pooled budgets. Tendering exercise about to commence to standardise provision, quality and value for money • Burns – Supported the development of a clinical network, across London and South East, which has given a comprehensive review of use of national money to ensure improved quality, by meeting national standards • Cystic Fibrosis – Full needs assessments for adult services undertaken.

	<p>Detailed service specifications being developed to be incorporated into 2010/11 contracts, improving quality</p> <ul style="list-style-type: none"> • Renal – Significant increases in renal dialysis capacity in place, with demand and capacity plan to identify areas under provision. Plans being developed to address these capacity gaps, in collaboration with the local PCTs. EOP tendering exercise carried out by renal providers in collaboration with the lead commissioner and efficiencies delivered as a result • Mental Health – Review of medium secure units with regard to security audits, marked improvement on follow up audit
WM	<ul style="list-style-type: none"> • Implementation of primary PCI for patients in Black Country – HSJ Highly Commended Award 2008 [WCC Category]. • Procurement framework for secure mental health and CAMHS Tier 4. Implemented in 2009 ensuring consistent quality standards, specification for services across 80% of independent sector units in England – HSJ finalist in WCC Category 2009. • Neonatal Surgery specification developed for dedicated service in West Midlands. • Annual Report for 2008/09 details a comprehensive range of other deliverables for patients
SW	<p>The following relate to 2008-09:</p> <ul style="list-style-type: none"> • Neuromuscular Services – The South West Specialised Commissioning Group reviewed services within the South West for adults and children and comparing them to best practice standards and service models elsewhere. As a result a Neuromuscular Service Development Strategy was developed, consulted upon widely and approved. This will lead to £2m investment in new services and the establishment of a Clinical Network to support further improvements to patient care • Mental health – the South West Specialised Commissioning Group reviewed all individual, specialised, mental health placements, outside of our main service providers in order to better understand where these patients are being cared for and the nature of the services they receive, and how these are commissioned. Following the review the SCG undertook a procurement process to secure services according to a service specification targeted at the needs of the patient groups identified. The process has established expected quality standards for patient care, mechanisms for performance management, streamlined contractual processes, released savings of £2million and will provide valuable information for longer term strategic planning within the South West • Patient and Public Engagement – The South West Specialised Commissioning Group has developed a very inclusive approach to engaging with patients and the public. During 2008-09 we developed an approach to service specific stakeholder days which shares information about services and gathers views and opinions about that service and specialised health care in general which is then formally analysed and written up as an appendix to service development plans. For large development processes we often have several stakeholder days in different parts of the South West to ensure maximum opportunity for

	<p>access. At stakeholder days, attendees can register to be on our database for invite to future events and can complete questionnaires on line via our website. In addition, we have established a formal policy for managing large service improvement programmes that involve all of our PCTs and their Health Overview and Scrutiny Committees</p> <p>Other areas of significant development related to our governance structures and increasing the capacity of the team</p>
YH	<p>The key achievements in 2008/09 include increasing the range of commissioned services to £550m with effect from 1st April 2009, development of the service designation process, producing a range of commissioning policies, developing prioritisation and decision making processes to support the introduction of new treatments, developing a patient and public engagement strategy and implementing the SCG website.</p> <p>Over the last year the Specialised Commissioning Team has been working closely with clinicians on the implementation of a new integrated Paediatric Critical Care Transport service. The combined service will replace the existing ad hoc children’s services and the existing services for neonates which has limited hours of service and geographical coverage. The service will operate 24 hours a day, 7 days a week and have a team of dedicated staff. There will be approximately 2000 transfers a year. The new service will commence on a phased basis between November and April 2010.</p> <p>During 2008/09 there has been a focus on improving morbid obesity surgery services. Working through the designation process we are now assured that all the current providers meet all the core standards. There has also been a full analysis of the morbid obesity surgery market which identified that there is a need to increase availability and choice of providers. A formal tendering exercise has enabled two additional service providers to offer this care.</p> <p>Other services which have received interim designation, in the last year, include: principal treatment centres for HIV (adults); principal treatment centres for children and young people with cancer; pancreatic services; stereotactic radiosurgery; and cochlear implants.</p> <p>Implementation of a new region wide clinical network for renal services, with dedicated clinical leadership time will enable rapid sharing of good practice across the region and facilitate the delivery of the renal services strategy.</p> <p>One of the key priorities for the SCG is a review of vascular services. This feeds into the regions strategy for improving health and wellbeing. During 2008/09 the SCG carried out the diagnostic phase of the review to understand current patient flows and service standards. This information will inform the designation of specialist vascular centres in 2009/10.</p> <p>The “Involvement for Improvement” Project has attracted a lot of interest both regionally and nationally. The project has focussed on involving service users and staff, in low secure mental health services, in directly influencing the service model and service standards.</p>

SCG Challenges	
Q9	What are the 3 major challenges your SCG faces in the next 12 months?
Summary of findings:	World Class Commissioning was the biggest common denominator, though its application to SCGs is currently optional. The financial climate also understandably bulks large.
EoE	<ol style="list-style-type: none"> 1. Development of an overarching strategy for the next 5 years, incorporating improved commissioning efficiency and service innovation 2. Major renal consultation and procurement 3. Improved and enhanced management capability for the team, incorporating further improvement towards World Class Commissioning Capability
EM	<ol style="list-style-type: none"> 1. Putting robust processes in place to ensure that routine benchmarking of a range of specialised services are core to commissioning activity 2. Ensuring that SCG staff remain part of mainstream commissioning development and as such that the SCG is subject to the same scrutiny as part of world class commissioning as PCTs 3. Using the dynamics brought about by the economic downturn to engage clinicians in discussions around efficiency and productivity ensuring that clinical quality and improved outcomes are core to the commissioning agenda
London	<ol style="list-style-type: none"> 1. The financial climate 2. Consolidation of the SCG as a single team 3. Delivering world class commissioning
NE	<ol style="list-style-type: none"> 1. Designation of specialised services 2. Implementation of world class commissioning 3. Activity and financial pressures
NW	<ol style="list-style-type: none"> 1. Financial outlook 2. Understanding the PCT local plans and their effect on pathways into and out of specialised services 3. Influencing PCT measures to manage demand
SC	<ol style="list-style-type: none"> 1. Strategic planning for the next 3 years to cope with the economic downturn and the reduction in NHS funding 2. Changing the mindset from expecting the traditional levels of growth in the specialised services world 3. Consolidating and growing the Specialised Commissioning brand across the country as other models of collaborative commissioning emerge
SEC	<ol style="list-style-type: none"> 1. Developing a prioritisation framework to support SCG world class commissioning and ensuring that areas with the greatest need/demonstrable inequalities in access to provision are given focus 2. Demonstrating value for money for PCT stakeholders in terms of services commissioned and demonstrating added value of a centralised SCG team supporting the collaborative commissioning of rare and specialised services on behalf of constituent PCTs 3. Increasing the SCG portfolio and pooled budgets to reflect the revised National Specialised Services Definition Set and to ensure sufficient resources across the SCG to support designation, in line with PCT procurement rules and

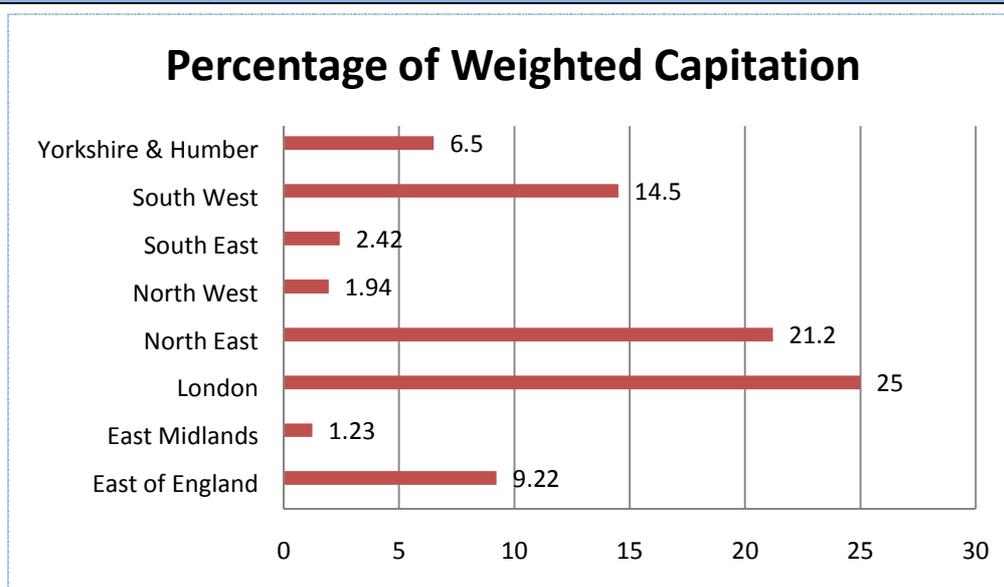
	competition and contestability guidance
WM	<ol style="list-style-type: none"> 1. Financial challenge – economic climate. Need to ensure delivering high quality, innovation whilst reducing costs. 2. Management of introduction of new technology/drugs [need to prioritise/engage public on decision making]. 3. Development of specialised tertiary paediatric strategy to maintain sustainable high quality, safe services [including key workforce issues to maintain viability]
SW	<ol style="list-style-type: none"> 1. Team capacity to drive commissioning programmes, maintain financial balance and achieve World Class Commissioning 2. Financial sustainability – challenging period ahead with plenty of potential for the future but time scales for delivery very short
	<ol style="list-style-type: none"> 1. Driving up productivity and efficiency in all services 2. World Class Commissioning assurance 3. Supporting service development/change in a financially challenging environment – in particular responding to NICE guidance

SCG Risk Sharing

Q10 What percentage of the services you commission are funded by a budget pooled on the basis of:

- A. Weighted Capitation**
- B. 3 Year Rolling Average**
- C. Actual Cost per PCT**

Summary Graph Representation:



Carter Recommendation 10: SCG Pooled Budget

“To develop robust, long-term commissioning arrangements and manage financial risk, each SCG should have a budget pooled from PCT allocations to cover both the cost of specialised services that it commissions on behalf of PCTs and its management costs.”

Operating Framework 2008/09

“We expect SCGs to create pooled budgets and to commission the majority of specialised services on their patch this year, extending this to all specialised services in 2009.10.

This additional question was put to SCGs in November 2009 and has elicited seven replies to date. These demonstrate little progress towards weighted capitation since the Alliance’s previous survey at the end of 2007.

EoE	<p>A. 63m (9.22%)</p> <p>Of our £683m budget, £63m is risk shared, the balance is managed on actual cost and usage by each PCT, but is fully managed by the SCG</p>
EM	<p>A. 7.2m (1.23%)</p> <p>B. 61.18m (10.48%)</p> <p>C. 515.2m (88.28%)</p>

London	<p>A. 25%</p> <p>B. 40%</p> <p>C. 4%</p> <p>In addition, London pools some 26% by other means such as last year's cost, historic block cost and recharging to PCT with 2% unknown. Total spend in 2009/10 is £756m, of which £246m is HIV, which has recently been removed from the National Definition Set.</p>
NE	<p>A. 32.4m (21.2%)</p> <p>B. 98.3m (64.3%) – 5 year average</p> <p>C. 11.1m (7.3%)</p>
NW	<p>A. 18.6m (1.94%)</p> <p>B. 381.3m (39.55%)</p> <p>C. 550.8m (57.14%)</p>
SC	None received
SEC	<p>A. 3.9m (2.42%)</p> <p>B. 97.2m (59.7)</p> <p>C. 61.7m (37.9%)</p>
WM	None received
SW	<p>A. 65m (14.4%) – relates exclusively to mental health and learning disability</p> <p>B. 31m (6.9%) – ditto</p> <p>C. 354m (78.7%)</p>
YH	<p>A. 6.5%</p> <p>B. 11.97%</p> <p>C. 79.36%</p>