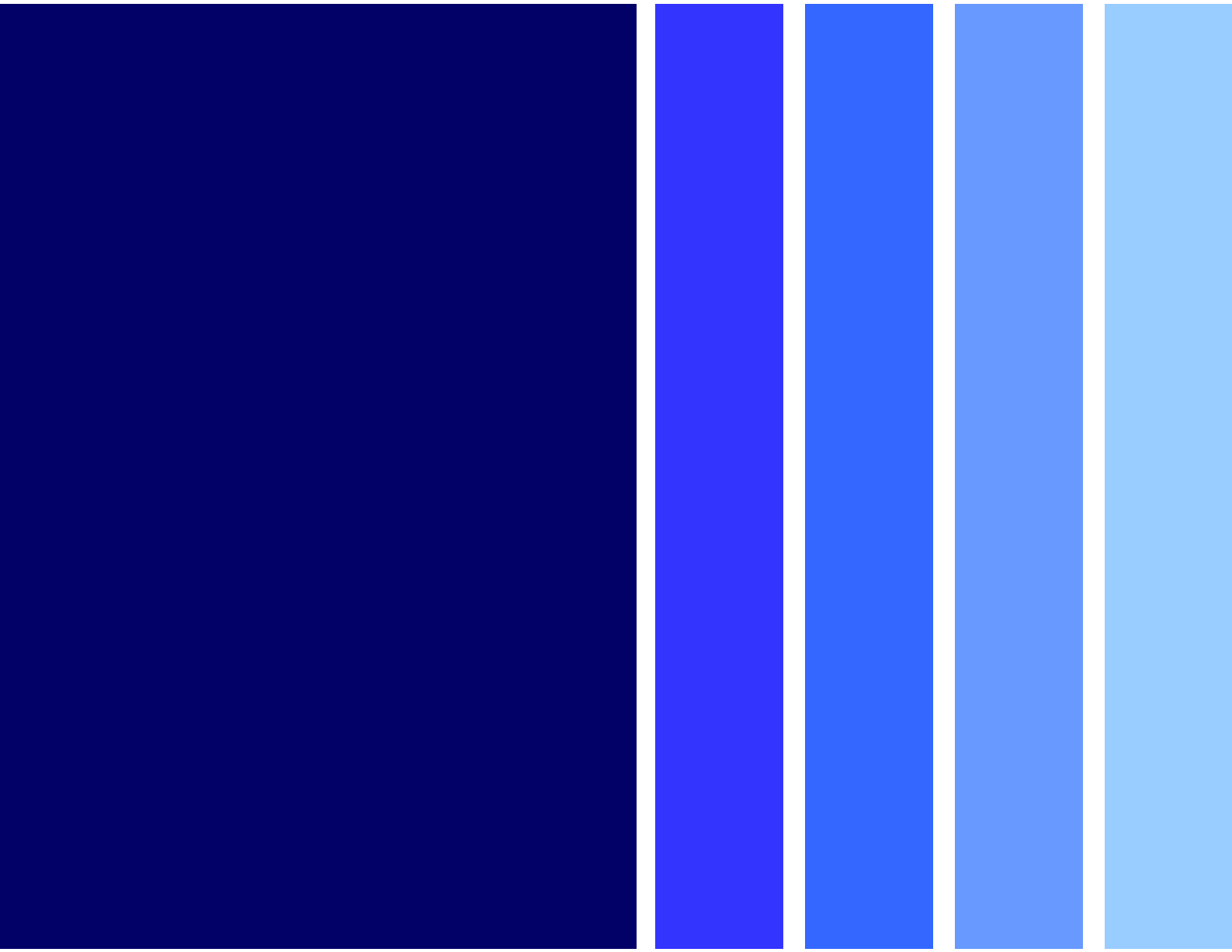
Review Report

Review of Commissioning Arrangements for Specialised Services
May 2006

An independent review requested by the Department of Health



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FOREWORD

FROM THE MINISTER OF STATE FOR HEALTH, LORD WARNER

I am delighted to welcome the independent report from the Review of Commissioning Arrangements for Specialised Services. This comprehensive report contains a significant number of challenging proposals for achieving real improvements in access to and quality of specialised services for all patients with rare conditions. We will consider the recommendations both carefully and speedily. I expect to publish our detailed response later in the Summer.

The proposed new structures and governance arrangements aim to complement the new NHS architecture and make decision-making more informed, transparent and efficient. The report also places a welcome emphasis on measuring and monitoring the health benefits for patients and looks at ways to genuinely involve patients and carers over the long term in the planning and commissioning of specialised services. This will require new levels of imagination, innovation and trust. There are many examples of good practice which we must try to make standard practice.

My sincere thanks to Sir David Carter and his dedicated Review Group for their hard work and commitment. We will take forward their recommendations in the Commissioning Framework, which we expect to publish in the Summer.

THE LORD WARNER OF BROCKLEY

FOREWORD

FROM SIR DAVID CARTER, CHAIR OF THE REVIEW

Specialised services are an important, but often complex and costly part of the portfolio of services provided by the NHS. This review examines the processes by which such services are commissioned in the NHS in England and makes recommendations aimed at improving them.

It was never our intention to provide detailed discussion of individual services or make pronouncements on which services should or should not be designated as specialised for commissioning purposes.

We have tried to define a structure for commissioning that is robust, transparent and fair, that makes optimal use of what is often a scarce resource, and that can be understood by patients, professionals and the public at large.

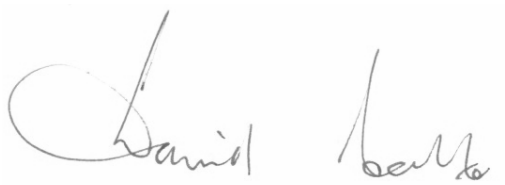
We have seen it as important that the commissioning of specialised services is not divorced from the mainstream of NHS activity and that the service and the people it serves have a sense of ownership and involvement in the decision processes.

We have placed great emphasis on service quality and the need to have a strong evidence stream on which to base difficult judgements.

The NHS is experiencing a period of unprecedented change and we have tried wherever possible to make recommendations that take account of the system reform that is now underway.

I am most grateful to the review group for bringing their knowledge and experience to bear and for their open-mindedness and hard work. We have been ably supported by an excellent project team with whom it has been a pleasure to work. We are extremely grateful to the many individuals, organisations and patient groups who met us, wrote to us, and provided invaluable insights in areas of difficulty.

I was invited to lead an independent review and at no stage have I felt constrained or subjected to any pressure. I wish to thank Lord Warner for placing his trust in us and express the hope that our work will indeed lead to significant improvements in the way in which specialised services are commissioned by the NHS in England.



PROFESSOR SIR DAVID CARTER, MD, FRCS(Ed), FRSE

EXECUTIVE SUMMARY

The primary purpose of this review is to propose improvements to commissioning arrangements for specialised services in England. The review recommends changes to structure, organisation and powers that will ensure the commissioning process is robust and fair, is understood by all, engages patients and offers optimal value for money. Realisation of the full potential of the system reforms will depend critically on providing commissioners of the future with the essential levers and tools for success.

Commissioners should be able to demonstrate that optimum health benefit is achieved from the services commissioned for their population. Specifically, an effective commissioner should:

- Safeguard access for patients to the full range of services and manage demand for scarce resources and expertise
- Stimulate supply and control the entry and exit of providers to maintain safe and high quality services
- Promote contestability and value for money

The review has considered:

- Commissioning structures and ways of working
- Commissioning levers and opportunities
- Patient and public input
- Monitoring commissioning performance
- Profile of commissioning
- Attributes of successful commissioners

Section 1 sets out the context and scope of the review.
Section 2 explains the process of consultation and the key messages from contributors.
Section 3 recommends changes to commissioning structures and improved ways of working at national and regional level.
Section 4 recommends ways to achieve strong, integrated commissioning and monitoring of health benefit.
Section 5 recommends ways to maximise the patient voice and increase patient and public input.
Section 6 recommends effective monitoring of commissioning performance.
Section 7 recommends ways to raise the profile of specialised services commissioning.
Section 8 examines the essential commissioner attributes of authority, credibility and expertise.

RECOMMENDATIONS

Recommendation 1: National Specialised Services Commissioning Group

A National Specialised Services Commissioning Group (NSSCG) should be established to coordinate specialised services commissioning across all Specialised Commissioning Groups (SCGs) where appropriate and to provide a framework within which binding commissioning decisions requiring pan SCG agreement can be made. The NSSCG should act on behalf of all Primary Care Trusts (PCTs) as represented by their SCGs and be highly influential in representing their interests with national bodies and the Department of Health (DH).

Recommendation 2: National Commissioning within the NHS

The National Specialist Commissioning Advisory Group (NSCAG), in future to be known as the National Commissioning Group (NCG), should continue national commissioning of highly specialised services and to advise Ministers on designation status. It should move from the DH to the NHS, be constituted as a subgroup of the NSSCG and be hosted by a Strategic Health Authority (SHA) on behalf of all SHAs.

Recommendation 3: Specialised Commissioning Groups

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. Each PCT in the SHA area should be required to be a member of the SCG. Each SCG should be required to be a member of the NSSCG.

Recommendation 4: Multi-Disciplinary Commissioning Teams

SCGs and the NCG should be supported by dedicated teams of commissioners - including commissioning, public health, finance, information and administrative staff - which provide sufficient capacity and expertise to support the designation programme, develop contracts and ensure compliance.

Recommendation 5: Commissioning Low and Medium Secure Mental Health Services

To maximise scarce commissioner capacity and ensure synergy, the commissioning arrangements for medium and low secure mental health services should be integrated with those for other specialised services and managed by the SCG, whilst ensuring that the focus and detailed analysis of the current forensic commissioning arrangements are not lost.

Recommendation 6: Commissioning High Secure Mental Health Services

The Department of Health (DH) and the National Oversight Group (NOG), as a matter of urgency, should seek to implement commissioning arrangements for high secure mental health services which are congruent and integrate with the NSSCG - NCG - SCG arrangements recommended in this review.

The role of NOG and its relationship to the NSSCG needs careful consideration and DH officials should be required to ensure that line of sight arrangements are clear for the commissioning and performance management of high secure mental health services.

Recommendation 7: Commissioning Screening Services

Collaborative commissioning arrangements for screening programmes should be integrated with the commissioning arrangements for specialised services.

Recommendation 8: Governance

In discharging their functions, SCGs should be constituted, within the terms of their Establishment Agreements, to enable decisions on the commissioning of specialised services to be made on behalf of the PCTs that they represent and for such decisions to be binding on all PCT members.

In discharging its functions, the NSSCG should be constituted, within the terms of its Establishment Agreement, to enable decisions on the commissioning of specialised services covering several SCGs to be made on behalf of the SCGs it represents and for such decisions to be binding on all SCG members and the PCTs they represent.

Recommendation 9: Delegated Authority

A PCT representative acting at SCG level should be given delegated authority, within the terms of the SCG Establishment Agreement, to commit the PCT that they represent to decisions relating to the commissioning of specialised services.
An SCG representative acting at the NSSCG level should be given delegated authority, within the terms of the SCG & NSSCG Establishment Agreement, to commit all PCTs that they represent to decisions relating to the commissioning of specialised services.

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.

Recommendation 11: Service Mapping to Facilitate Costing

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 Services National Definitions Set.

Recommendation 12: Annual Prioritisation Process

Each **SCG** should have an annual process for debating priorities and explicit mechanisms for eliciting and documenting the views of providers (clinical and managerial), PCT members, practice based commissioning leads, Public and Patient Involvement (PPI) representatives and commissioning teams. The agreed priorities should be set out in the SCG's annual commissioning plan. Those priorities requiring national input should be put to the NSSCG for consideration.
The **NSSCG** should have annual process for debating priorities which would be informed by the SCGs' annual prioritisation process. The agreed priorities should be set out in the NSSCG's annual plan.

Recommendation 13: Accountability

SCGs and the NCG should be expected to produce an annual commissioning plan, an annual work programme and an annual report and to disseminate these widely. The annual report should include evidence of having reviewed their commissioning arrangements against fitness for purpose/performance management criteria used by SHAs and a periodic independent survey of stakeholders' views.

Recommendation 14: Access to Patient Activity Data

SCGs and the NCG should have access to patient activity data in the national database for all services which they commission collectively.

Recommendation 15: Funding the Treatment Costs of Research

DH should urgently consider funding mechanisms for pre-trial and post-trial treatment costs that are outside national tariff in order to safeguard future research.

Recommendation 16: Horizon Scanning

The NSSCG, the NCG and SCGs need one reliable source of 'horizon scanning' and in order to avoid duplication it is recommended that information on new interventions produced by the national horizon scanning programme be made available to the NSSCG, the NCG and SCGs to support specialised services' commissioning.

Recommendation 17: Designation of Specialised Services Providers

SCGs should formally designate specific providers to provide specific specialised services. Designation should be based on a nationally agreed set of patient-centred, clinical, service, quality and financial criteria and be re-assessed every five years.
There should be strong patient and public input in the designation process.
The NCG should continue to advise Ministers on designation status for providers of highly specialised services to be commissioned on a national basis. Activity at undesignated providers should not be funded by commissioners.

Recommendation 18: Foundation Trusts

When an NHS Trust is being assessed by the DH for Foundation Trust (FT) status, the views of SCGs and the NCG should be sought with particular regard to the proposed mandatory services which are specialised services.
Where an NHS FT seeks to cease providing a mandatory service which is a specialised service, Monitor should assure itself that there has been SCG or NCG support before any decisions are made.
NHS Trusts and NHS FTs should discuss proposals for changes in specialised services provision with SCGs and the NCG at an early stage.
Where an NHS FT is planning to start a new specialised service, it should approach the relevant SCG or the NCG to seek designation.

Recommendation 19: Clinical Networks

SCGs should work closely with clinical network(s) so as to ensure that commissioning and investment plans support the delivery of integrated care.
SCGs should provide oversight and ensure coordination of clinical network plans, where the service in question has a planning population larger than a single network.

Recommendation 20: Integrated Care

PCTs should act as the focal point in ensuring a good fit between the commissioning plans and priority decisions of GP Practices and those of the SCG so as to maintain and strengthen integrated care pathways.

Recommendation 21: Patient Choice

The opportunities for patients to make choices regarding specific aspects of their care and treatment should be maximised with the proviso that choice of specialised services provider will be limited to designated providers.

Recommendation 22: Specialised Services National Definitions Set

The DH should initiate an immediate review of the Specialised Services National Definitions Set, which will be overseen by the NSSCG once established. The review should initially concentrate on developing a set of criteria for the inclusion of services in the National Definitions Set and consider priorities for changes. Decisions should be made on the future purpose and structure of the National Definitions Set and updating arrangements.

Recommendation 23: Payment by Results

There should be an agreed DH programme of work to review the development of tariffs for those specialised services that are currently not covered by Payment by Results, with the NSSCG providing major input.
Alternatives to the basic ‘episode x tariff price’ approach should be developed to cover services where patient activity and throughput is not the main determinant of cost.

Recommendation 24: National Clinical Databases

The NSSCG should consider proposals to establish and maintain national clinical databases for specific specialised services to enable commissioners and providers to monitor clinical

outcomes and performance against standards. Annual funding should be sought from the DH, as part of their programme to strengthen commissioning, with a supporting contribution from SCGs.

Recommendation 25: Audit

The NSSCG, the NCG and SCGs should ensure that regular audits of specialised service provision are undertaken and that the results are made available to commissioners to enable comparative performance to be assessed over time and between providers.

Recommendation 26: Public Information on Commissioning Arrangements

SCGs and the NCG should contribute annually to an NSSCG website giving details of their commissioning arrangements including contact details for the lead commissioner for each specialised service.

Recommendation 27: Patient and Public Involvement

SCGs and the NCG should be required to have an ongoing Patient and Public Involvement (PPI) strategy and to report progress against the strategy in their annual report.
SCGs and the NCG should have patient representation on their committee.
SCGs and the NCG should ensure strong patient and public input to the designation process.
SCGs and the NCG should routinely involve patient representatives in the annual prioritisation process and annual commissioning plans.
The NSSCG should review and compare PPI practice of SCGs and the NCG annually and publish the findings.

Recommendation 28: Consultation and Overview and Scrutiny Committee

In the interests of progressing timely, well-managed service change, the DH should advise the setting up of joint Overview and Scrutiny Committee (OSC) standing committees based on SHA boundaries.
Where the SCG has applied to an individual/joint OSC and has not received a decision within 6 months, the SCG should be free to proceed with the service change.

Recommendation 29: Performance Management

SHAs should ensure strong performance management of specialised services commissioning, ensuring that PCTs have appropriate arrangements in place for collaborative commissioning and that SCGs are working effectively. Performance management of the NSSCG and the NCG should be undertaken by one SHA acting on behalf of all SHAs.

Recommendation 30: Assessment of Commissioning Expertise

Any performance assessment of PCT commissioning by the Healthcare Commission should include the commissioning of specialised services.

Recommendation 31: Profile of Commissioning

The profile of specialised services and their commissioning arrangements needs to be raised both within and outside the NHS and should feature in national priorities and targets.
Commissioning should be given a higher profile in the career options for managers and clinicians. SHAs should ensure that career development and training programmes recognise the necessary expertise required for commissioning specialised services.

Recommendation 32: Commissioner Powers

Commissioners should have sufficient powers to be able to:

Safeguard access for patients to the full range of services and manage demand for scarce resources and expertise

Stimulate supply and control the entry and exit of providers to maintain safe and high quality services

Promote contestability and value for money.

SECTION 1: INTRODUCTION

Context

NHS Changes

1 Commissioning of health care services is the process which determines how the health care budget is used to ensure maximum health benefit. The vision for commissioning has been set out in Health reform in England: update and next steps (December 2005) and more detailed guidance was issued in January 2006 - Practice Based Commissioning: Achieving Universal Coverage and The NHS in England: the Operating Framework for 2006/07. This will be followed in the early summer by a Commissioning Framework which will set out overall policy and expectations for the development of commissioning.

2 This particular review focuses on the commissioning of *specialised* health care services. The review, which was in response to stakeholders' expressed concerns about the lack of robust and consistent commissioning arrangements across the country and the impact of NHS system reform, has taken place during a time of change to the way commissioning is organised in the NHS in England, with both Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) becoming fewer in number and consequently covering larger populations.

Specialised Services – What are They?

3 Specialised services are those services provided in relatively few specialist centres to catchment populations of more than a million people.[1] Specialised services are not provided by every hospital and will tend to be found in larger hospitals based in big towns and cities. They include services such as kidney transplantation, services for haemophilia, specialised mental health services and services for very rare cancers.

4 Patients often have a long-standing relationship with the specialist centre and have a high degree of knowledge of their condition. Patients and their families may have strong feelings of loyalty and support for a particular centre and its staff.

5 Currently 35 specialised services have been identified in more detail in the Specialised Services National Definitions Set, last published by the Department of Health (DH) in 2002 (see Appendix 1 for a list of the 35 specialised services). It is estimated that specialised services account for about 10% of total PCT expenditure on hospital services, totalling £3.48 billion in 2004/05.

6 Specialised services are high cost, low volume interventions and treatments. The risk to an individual PCT of having to fund expensive, unpredictable activity is reduced by PCTs grouping together to collectively commission such services and share financial risk.

7 Large-scale capital investment is often necessary and effective integration with other key specialties is critically important. Sometimes the specialised service has developed in an uncoordinated, piecemeal way and the number and location of specialist centres may need to be reduced to achieve provision that maximises safety/quality and geographical access.

[1] Statutory Instrument No. 2375, The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 defines specialised services as those services with planning populations of more than one million people.

8 Particular aspects of specialised services, such as the relatively small number of specialist centres and the difficulties of separately identifying activity need to be taken into account in the implementation of certain elements of NHS system reform such as 'Patient Choice' and 'Payment by Results'.

Specialised Services – How are they Commissioned?

9 Commissioning is an overall process consisting of inter-related yet distinct elements. Commissioning takes place at various different levels (from GP practice to national level) taking into account the appropriate planning population of the service and the need to make optimum use of finite commissioning capacity and skills.

10 The commissioning process is a cyclical process, which involves:

- an initial health care needs assessment
- agreed service standards and patient outcome measures
- an agreed service strategy involving providers and patient representatives in its development
- rolling out the consequent implementation and investment plans
- signing service agreements/contracts with providers
- monitoring activity and finance under these service agreements/contracts
- managing demand
- monitoring the overall health benefit (including safety, quality, process, outputs and patient outcomes)
- review whether services meet health needs

11 At its simplest, commissioning, whether of a specialised or a non-specialised service, consists of three parts – planning, procurement and monitoring of quality/patient outcomes. Compared to non-specialised services, specialised services commissioning covers a much larger planning population and geographical area, involves many more stakeholders and requires PCTs to collaborate with each other.

12 Guidance on the commissioning arrangements for specialised services was issued by the DH in March 2003. The guidance re-affirmed the need for PCTs to establish collaborative commissioning groups to coordinate the commissioning of specialised services and for SHAs to oversee and performance manage such groups. It advised that collaborative commissioning arrangements should encompass two broad groupings of specialised services, namely services for rarer conditions where the planning population is 3-6 million (commissioned by Specialised Commissioning Groups - SCGs) and services for less rare conditions where the planning population is 1-2 million (commissioned by Local Specialised Commissioning Groups - LSCGs).

13 There are currently 8 SCGs and 25 LSCGs in England; the 8 SCGs are largely coterminous with the 10 new SHA boundaries (except in the South), and the 25 LSCGs are largely coterminous with the 28 former SHA boundaries.

14 38 services for extremely rare conditions or very unusual treatments are commissioned nationally by the National Specialist Commissioning Advisory Group (NSCAG) (see Appendix 1 for the list of nationally commissioned services). The budget is held by the DH and specific providers are designated by Ministers to provide these services for a national caseload.

15 Since the guidance was published in 2003, specialised services commissioning groups have had some notable commissioning successes. In many cases they have

been able to consider service provision in more depth than individual PCTs and engage with clinicians and other members of the multi-disciplinary team providing a specific specialised service. In the main, they have set up robust collective commissioning arrangements; have successfully tackled some difficult issues around specialised service reconfiguration and rationalisation and have reduced inequity of access and maximised geographical access. There are some concerns about the current commissioning group arrangements, in particular, lack of consistency in terms of how they commission and what they commission. The Audit Commission also noted that some commissioners failed to deploy criteria which assessed service quality.

Scope of this Review

16 The review has looked at ways to improve the commissioning of specialised services to make the arrangements more robust and consistent and to ensure a good fit with the wider NHS system reform programme, the new organisational infrastructure for commissioning by the NHS and the changing role of the DH.

The terms of reference are:

- Review the current arrangements in the NHS for Specialised Commissioning Groups and Local Specialised Commissioning Groups (as established following DH guidance in 2003) and national commissioning under NSCAG, to identify strengths, weaknesses and good practice
- Assess the potential impact of NHS system reform on specialised services and treatments
- Make proposals for improvement in the commissioning of specialised services and treatments, which fit with work on implementing 'Creating a Patient-Led NHS', including what should be commissioned nationally
- Ensure that proposals keep the commissioning of specialised services in step with wider NHS reform and generate consistent arrangements across the country.

17 The report's recommendations will be taken into account in the Commissioning Framework to be published by the DH in the early summer.

SECTION 2: PROCESS OF CONSULTATION

How the Review has Worked

18 Lord Warner, Minister of State for NHS Reform asked Sir David Carter, formerly Chief Medical Officer for Scotland, to lead this independent review in October 2005. The review group, supported by a small project team, has met three times in formal session; in addition, individual members have participated in the meetings listed below. The review group membership is listed in Appendix 2.

19 Two features underpinned the work of the review:

- Identifying existing experience and good practice
- Seeking views from as wide a range of those concerned with specialised health care services as possible.

20 Existing practice, at both local and national levels, was identified in a number of ways including:

- A survey of all LSCGs' and SCGs' current commissioning arrangements for the 35 services in the Specialised Services National Definitions Set (see Appendix 3)
- In-depth interviews with specialised services commissioners
- A survey by the Audit Commission of LSCGs' and SCGs' financial arrangements
- Case studies of innovative/effective commissioning practice. (see Appendix 4)

21 Efforts to engage all possible interested parties included:

- A well attended Accelerated Policy-Making Day (APMD) in December 2005
- Workshops held by the Specialised Healthcare Alliance and the NHS Confederation
- A seminar with the Advisory Group members of the NSCAG
- Written submissions - over 140 were received from patients' groups, all parts of the NHS, professional bodies, and individual clinicians (see DH website for a list of contributors)
- Discussions with a range of people and organisations including the Healthcare Commission, Monitor, the London Teaching Hospitals Chief Executives' Group and DH officials developing system reform policies.

- Taken together, the different consultation methods have engaged all the main interests. Several very consistent themes have emerged, which are summarised briefly below; further details can be found on the APMD, the two workshops and the written submissions on the DH website: *http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningSpecialisedServices/fs/en*

What you told us - Key Themes

22 People want to see a number of improvements in the arrangements for commissioning specialised services but also recognise much that has worked well to date. There is a strong desire for consistency in key aspects of the arrangements across England, with a reasonable balance to be struck between a national framework and local flexibility.

23 Ways of working which are strongly supported include:

- Simplification and streamlining of enforceable decision-making process and commissioning processes and less bureaucracy
- More effective patient and public involvement, giving a stronger "voice" and providing clear information on who has commissioning responsibility for each specialised service across the country
- Better collaboration between the different levels of commissioner, so that patients can move easily along the pathway of treatment for their condition between the specialised and other, non-specialised parts of their treatment programme
- Close working between clinical networks and specialised services commissioners was seen as important, as was strong clinical involvement
- A consistent National Definitions Set for specialised services, regularly updated and reviewed
- A co-ordinated national approach to clinical and service standard development
- More effective monitoring of quality and health outcomes, underpinned by clinical audit and comparative datasets
- Dedicated commissioning teams, making best use of scarce expertise (which includes commissioning, finance, public health and health informatics skills), which have the capacity to build a strong and informed relationship with service providers. More investment was suggested for workforce training and development
- Integration with other PCT collaborative commissioning functions e.g. for screening programmes and specialised mental health services commissioning.

24 Commissioning structures and governance arrangements which are strongly supported include:

- The continued need to commission specialised services at particular population levels, with consistent collaborative structures country-wide
- Instituting a uniform approach to governance of specialised commissioning groups, including ways of engaging participating PCTs fully, delegating authority, making decisions faster, sharing financial risks and setting pooled budgets Effective examples were highlighted in responses
- Instituting a mechanism, perhaps a supra SCG body, for co-ordinating commissioning for the few services covering populations larger than one SCG but smaller than the nationally commissioned services
- Smart working by carrying out some functions only once - by a supra-SCG body or a lead SCG on behalf of all SCGs
- Retaining a national commissioning group for very rare conditions. International interest in the success of improving patient outcomes achieved by NSCAG was reported; this success should be maintained whilst increasing transparency and interaction with the NHS. Moving NSCAG from DH to the NHS was a suggested option
- Clearer and active performance assessment and performance management arrangements for specialised services commissioning
- Considering some form of designation of individual providers, as there is for the nationally commissioned services

25 The review was also asked to consider the impact on specialised services of certain aspects of NHS system reform. Stakeholders' comments included, in particular:

- Payment by Results and tariff setting for specialised services were of concern, as well as the difficulty of fair funding for innovatory specialised services
- Patient Choice policy needs to be developed to take into account the specific characteristics of specialised services provision
- NHS Foundation Trusts might undermine collective planning processes and the larger population perspective needed for specialised services
- The impact of these reforms on specialist hospitals and those services provided by specialist hospitals.

26 Participants at the APMD helped produce a comprehensive set of principles for specialised services commissioning. These principles are set out in the report of the APMD. (see the DH website: *http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningSpecialisedServices/fs/en)*

SECTION 3: COLLECTIVE COMMISSIONING STRUCTURES AND WAYS OF WORKING

Introduction

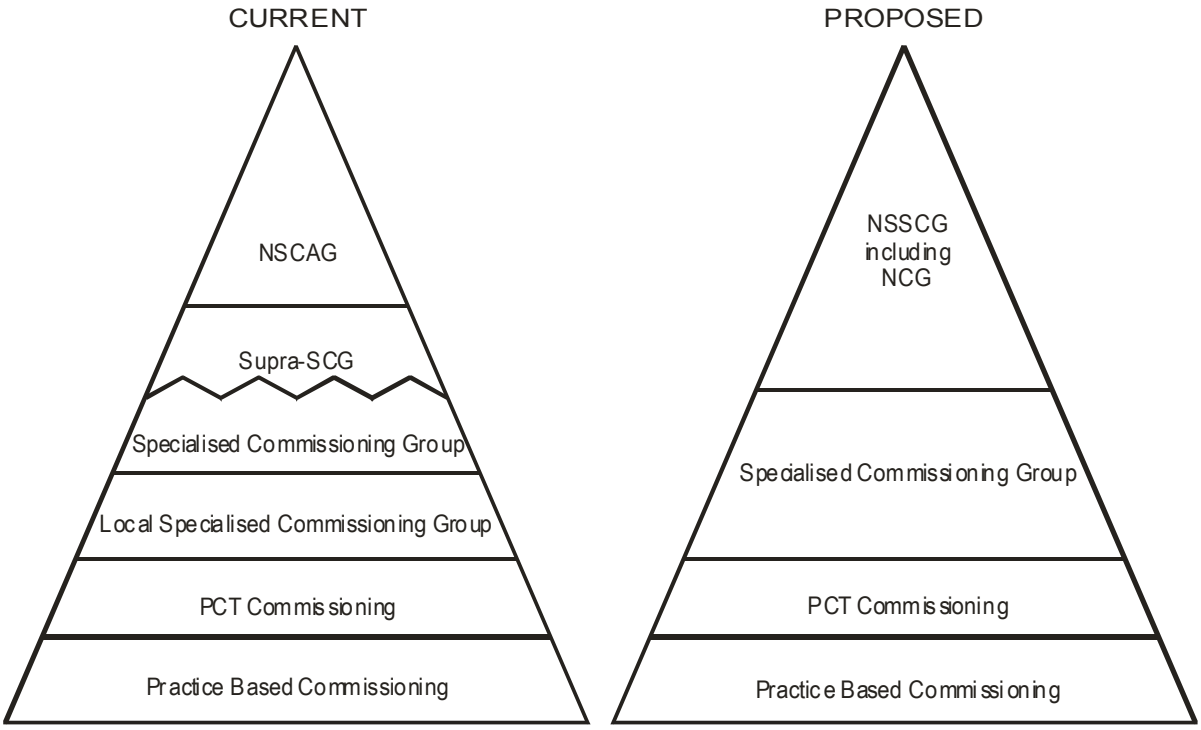
27 Stakeholders stressed the need for a simpler commissioning structure with fewer layers as well as the need to maximise scarce commissioning capacity and expertise. They also noted that future PCTs would cover larger populations and this might affect the need for collective commissioning arrangements for some of the commoner specialised services.

28 It is recommended that in future responsibility for the commissioning arrangements for specialised services should be vested with 10 SCGs, which are coterminous with the 10 SHA boundaries and act on behalf of all PCTs in the SHA area, with LSCGs becoming part of their respective SCG.

29 For some specialised services the catchment/planning population is bigger than that of the SCG or the SHA and commissioning decisions will need to be coordinated on a pan-SCG basis. To enable this to take place it is recommended that all SCGs be members of a newly established 'National Specialised Services Commissioning Group' (NSSCG).

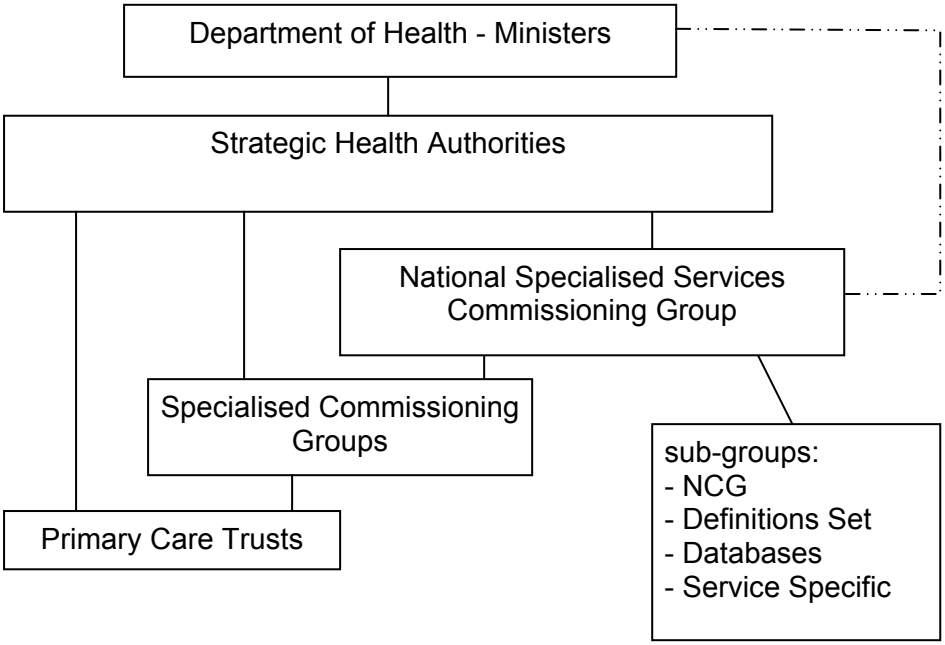
30 In addition, it is recommended that the national commissioning function, currently carried out by the DH under the auspices of NSCAG, should transfer from the DH to the NHS, become a subgroup of the NSSCG and be known as the 'National Commissioning Group' (NCG).

Figure 1: Current and Future Commissioning Levels



31 It is also recommended that the NSCAG commissioning team should transfer from the DH to the NHS and be hosted by a SHA on behalf of all SHAs. The team would continue to commission specialised services on a national basis for the National Commissioning Group and would be resourced to provide secretariat support to the National Specialised Services Commissioning Group and its sub-groups. The host SHA would have corporate responsibility for the national commissioning function and the host SHA Chief Executive would act as the responsible accounting officer.

Figure 2: Future Structure for the Commissioning of Specialised Services



National Specialised Services Commissioning Group

32 Stakeholder responses emphasised the need for commissioning arrangements that enable specialised services to be planned, procured and monitored at the appropriate level. Stakeholders expressed strong support for the creation of a supra-SCG body for those specialised services where the catchment/planning population is bigger than that of a single SCG and where commissioning decisions will need to be coordinated across SCGs.

33 It is recommended that a National Specialised Services Commissioning Group (NSSCG) be established of which all SCGs will be members. The NSSCG should provide oversight and coordination of commissioning undertaken by SCGs where the specialised service has a planning population in excess of that within each SCG area.

Recommendation 1: National Specialised Services Commissioning Group

A National Specialised Services Commissioning Group (NSSCG) should be established to coordinate specialised services commissioning across all SCGs where appropriate and to provide a framework within which binding commissioning decisions requiring pan SCG agreement can be made. The NSSCG should act on behalf of all PCTs as represented by their SCGs and be highly influential in representing their interests with national bodies and the DH.

34 The NSSCG should have responsibility for speeding up supra-SCG decision-making, using an explicit and binding decision-making process which mandates all SCG members and their constituent PCTs and which is enshrined in the NSSCG Establishment Agreement.

35 NSCAG, to be known as the National Commissioning Group (NCG), should be a formal subgroup of the NSSCG. The current NSCAG commissioning team should be resourced to provide secretariat support to NSSCG and its sub-groups as well as retaining responsibility for nationally commissioned services. This national commissioning team should be hosted by an SHA.

36 The SHA Chief Executive of the SHA hosting the national commissioning team should have corporate governance responsibility (including financial accountability) for both the NSSCG and nationally commissioned services. It may be desirable for the Chair of the 'host' SHA to also act as Chair of the NSSCG.

The NSSCG membership should include:

- Chair (host SHA Chair)
- 10 senior SCG representatives, 1 from each SCG
  (either the SCG Chair or "Director" of the SCG)
- 1 senior SHA representative
  (either from a different SHA to the Chair or from the Office of SHAs)
- 2 Medical Royal College representatives
  (nominated by the Academy of Medical Royal Colleges)
- DH representation
- Chair of NCG (NSCAG)
- 1 patient representative
  (in addition to patient representatives involved in service specific groups and sub-groups)
- Director of Public Health (SCG or SHA)
- Director of Finance (SCG or SHA)
- 1 observer from each of Wales/Scotland/Northern Ireland.

37 SCG representatives should be responsible for representing the views of all PCTs in their area and for acting as a 'conduit' between national and local level (in both directions) to ensure that issues relating to the commissioning of specialised services are properly addressed. SCG representatives should also be responsible for keeping PCTs updated on progress/performance of nationally commissioned services. The SCG representatives, the NSSCG Chair, the NCG Chair and the SHA representative should be the only voting members of the NSSCG.

38 Other members should be responsible for ensuring that the views of service providers (including clinicians), the public/patients/users/carers and other key stakeholders have been fully taken into account in developing proposals for consideration by the NSSCG; for raising issues relating to the commissioning of specialised services at national level on behalf of the organisations they represent, and for satisfying themselves that due process has been followed.

39 In addition, the presidents of the Medical Royal Colleges who are not members of the NSSCG should be invited to attend the NSSCG meetings when their specialist input would be of value.

40 The main role of the NSSCG should be to provide a forum where commissioning decisions about specialised services that span SCG/SHA boundaries can be taken. Each SCG would represent their PCTs and the results of decisions agreed by the majority of voting NSSCG members would be binding on all SCGs. The NSSCG should coordinate supra-SCG working by providing direction and impetus, brokering decisions across SCGs and monitoring the implementation of such decisions (where necessary proposing remedial action). The NSSCG would also provide a national focus for specialised services' commissioning and commissioners within the NHS.

41 The NSSCG should have overall responsibility and be accountable for the delivery of the work programme and commissioning intentions for supra-SCG services, but usually the work would be led by SCGs or an individual lead SCG. The work programme of the NSSCG should reflect a balance of priorities, being informed by commissioners, service providers and other key stakeholders. It should be recognised that in any one year, the NSSCG would only be able to focus on small number of specialised service areas. This work should be reflected in an annual work programme and annual report.

42 It is recommended that formal NSSCG sub-groups be established. Functions would include developing service standards and quality and outcome measures; supporting the development of national databases; and updating the National Definitions Set. The NSSCG should also establish a range of time-limited, service specific sub-groups to deliver its work programme. These could be led by one SCG (or shared out across SCGs) and involve commissioning, public health and finance input, service providers (clinicians and managers), patients/users/carers and other key stakeholders. Examples of such sub-groups could include the National Burn Care Group and the Pulmonary Hypertension Group. By engaging a range of stakeholders at this level, it is anticipated that local ownership and multi-disciplinary/multi-organisational involvement would be enhanced.

43 Regular progress reports from sub-groups should be presented to the NSSCG and any resulting proposed service changes, developments and/or investment decisions requiring a national approach should be identified at the earliest possible stage. This should enable SCGs to seek local views on proposals and provide for SCG representatives to put the views of their PCTs to the NSSCG and to make decisions at the NSSCG level which would be binding on all SCGs.

44 It is not envisaged that the NSSCG would actively commission specialised services and hence would not have a budget for commissioning. However, some financial support from SCGs would be required to support the NSSCG's administration costs. Proposed responsibilities of the NSCCG are set in Appendix 5.

National Commissioning Group

45 Whilst recognising the strength of current practice, stakeholders unanimously supported the move of the national commissioning function from the DH into the NHS so as to ensure better alignment with NHS processes and funding priorities. Currently, a portfolio of services for very rare conditions and unusual treatments is commissioned centrally by the DH under the auspices of NSCAG. Applications from providers to NSCAG for national commissioning status have to cover the entire national caseload which should generally be less than 400 case per year (and certainly less than 1,000) and be provided from very few providers (usually 2-4). Provision is limited to specialist centres designated by Ministers. In 2005/06, 33

services were nationally commissioned from 41 different providers with a total budget of £281m.

46 In considering where the national commissioning function might best be placed in the NHS, the review group took account of the fact that a number of options for 'hosting' the national commissioning function (such as constituting NSCAG as a Special Health Authority) had previously been considered and discounted.

47 It is therefore recommended that the national commissioning function be moved into the NHS to be hosted by a SHA on behalf of all SHAs and is constituted as a formal subgroup of the NSSCG and known as the National Commissioning Group (NCG). The NCG should continue to advise Ministers, but through the NSSCG, on whether particular specialised services should be designated and commissioned nationally, or returned from national commissioning to SCG-level commissioning. The NCG will provide a source of advice to Ministers on highly specialised services.

Recommendation 2: National Commissioning within the NHS

NSCAG, in future to be known as the National Commissioning Group (NCG), should continue nationally commissioning of highly specialised services and to advise Ministers on designation status. It should move from the DH to the NHS, be constituted as a subgroup of the NSSCG and be hosted by an SHA on behalf of all SHAs.

48 The host SHA should have corporate responsibility for the NSSCG, the NCG and the national commissioning function and the host SHA Chief Executive should act as the responsible accounting officer.

49 The former NSCAG commissioning team, currently sited in the DH, should continue to commission highly specialised services on a national basis for the NCG and should also be resourced to provide secretariat support to the NSSCG and its sub-groups. The commissioning team should be employed by the host SHA.

50 NCG would have close working arrangements and some common membership with the NSSCG. Membership of NCG would include Presidents from Medical Royal Colleges; the Chair of the Joint Consultants' Committee; the Chief Executive of the Health Technology Assessment Programme; representatives of SCGs, SHAs and DH; observers from Wales, Scotland and Northern Ireland; plus public health, finance and lay representation.

51 Changes to procedures and processes for commencing national commissioning and/or transferring commissioning responsibility from national to SCG level are needed to ensure that concerns raised by stakeholders are addressed and that the highly commended expertise and practices of NSCAG are retained.

52 It is recommended that current arrangements should continue, or be strengthened where required, to ensure:

- The publication of the criteria and the process for considering applications from providers for national commissioning
- An open and iterative process for considering services to be nationally commissioned, including a periodic invitations to the NHS to propose new applications and changes and consideration of the results of horizon scanning for emerging technology/services

- A standardised procedure for assessing new applications for services to be commissioned nationally and for transferring commissioning responsibility for an existing nationally commissioned service back to SCGs
- Transparent criteria and process for prioritising funding for service developments and cost pressures for existing nationally commissioned services
- The publication of annual commissioning intentions that are informed by a process of consultation with other commissioners
- The publication of an annual report that describes the work and achievements of the NCG so as to share good commissioning practice and the outcomes from audit and quality assurance programmes
- Development of national tariffs (where appropriate) for all nationally commissioned services within an agreed period following the commencement of national commissioning
- Establishment of a formal process for the involvement of patients and carers in the commissioning of nationally commissioned services.

Specialised Commissioning Groups

53 It is recommended that in future responsibility for the commissioning arrangements for specialised services should be vested with 10 SCGs which are coterminous with the 10 SHA boundaries and act on behalf of all PCTs in the SHA area.

54 SCGs would be free to arrange sub SCG commissioning arrangements where this could be justified by particular referral patterns and geography but the SCG would remain the sole responsible commissioning body above PCT level for the purpose of commissioning specialised services.

Recommendation 3: Specialised Commissioning Groups

Each SHA area should have a Specialised Commissioning Group (SCG) responsible for the commissioning arrangements for all specialised services as defined by the Specialised Services National Definitions Set. Each PCT in the SHA area should be required to be a member of the SCG. Each SCG should be required to be a member of the NSSCG.

Membership and Establishment

55 PCT membership of SCGs should be predominantly at PCT chief executive level (nominated deputies should be at Director level or equivalent). There should also be senior SHA input (at least at Director level) to give objectivity and ensure fairness and consistency in the interests of the population across the whole SHA area. Each PCT in the SHA area should be required to be a member of the SCG although PCTs could nominate a 'lead PCT' to represent their views at SCG meetings.

56 Membership of the SCG should reflect schemes of delegation agreed by all the PCTs within the SHA area. It should also include senior public health and finance representatives as well as commissioner representation from neighbouring areas where there are substantial patient flows to services located within the SCG boundary. Where appropriate, commissioners from Wales, Scotland and Northern Ireland should also be involved.

57 The SCG should be constituted as a joint subcommittee of each of their constituent PCTs, with delegated authority to act on behalf of their PCTs at both SCG and pan SCG level as set out in an Establishment Agreement. An illustrative list of headings

for an Establishment Agreement is noted in Appendix 6. Each SCG and their commissioning team should be hosted by one of their member PCTs.

58 The Chair of the SCG (or nominated deputy, who should be at Director level or equivalent) should normally be the SCG member for the NSSCG. They would be expected to represent the SCGs' views at the NSSCG and ensure the SCG contributed fully to the work of the NSSCG, so that the NSSCG is well informed and works in an optimally effective and efficient manner for the benefit of all SCGs.

59 Service providers (clinicians and managers) and patients (or their representatives) should have formal input to the SCG and to the development and delivery of its annual work programme

Working Arrangements

60 SCGs should be responsible for the commissioning arrangements for all specialised services within the National Definitions Set and for the commissioning of some non-specialised services where that is agreed by their constituent PCTs. SCGs might choose to discharge their responsibility for specialised services by delegating some or all commissioning functions (i.e. planning, procurement and/or performance monitoring) to another 'lead' SCG or a 'lead' PCT. In such circumstances, the SCG would remain answerable for the commissioning arrangements and ensuring that patients continue to have access to high quality and cost effective specialised services.

61 SCGs should publish annual commissioning plans and work programmes agreed by constituent PCTs. Where the commissioning of some specialised services requires a joint SCG approach this should be clearly identified in the work programme, together with details of the other SCGs involved. In such circumstances it is expected that SCGs would use their 'mandate' to commit all constituent PCTs to any decision resulting from such joint SCG work, with oversight (and arbitration, if necessary) from the NSSCG. Appendix 4 includes a case study on the London SCG arbitration agreement as an example of good practice.

62 New arrangements should build on the good practice developed by collaborative commissioning groups in establishing links and good working relationships with tertiary centres, clinical networks and patients/public. In establishing the new commissioning arrangements there will clearly be merit in retaining as much of the commissioning expertise and corporate memory as possible.

63 SHAs should be responsible for the performance management of PCTs and their collective arrangements for commissioning specialised services.

Commissioning Teams

64 The Audit Commission survey of specialised services commissioning arrangements found only 50% of LSCGs and 60% of SCGs had the appropriate staffing levels to manage specialised services.

Recommendation 4: Multi-Disciplinary Commissioning Teams

SCGs and the NCG should be supported by dedicated teams of commissioners - including commissioning, public health, finance, information and administrative staff - which provide sufficient capacity and expertise to support the designation programme, develop contracts and ensure compliance.

65 The structure and composition of the SCG commissioning team should be based on issues such as geography, number of tertiary centres (and/or service agreements/service agreements/contracts), clinical networks, number of services commissioned and the size of the budget for specialised services. The team should be headed by a director-level post or equivalent with senior commissioner, public health, finance and information input. Access to other expertise (such as communications) would be useful.

66 NHS commissioner capacity is relatively scarce; best use should be made of limited commissioning staff resources and expertise by sharing work across commissioning teams within an SCG and/or across SCGs nationally.

An example of good practice

PUBLIC HEALTH

A UK Specialised Services Public Health Network has been established across the UK. It has been operating since September 2004. It largely operates as a 'Yahoo' group but also holds a meeting twice a year. The network members are part of specialised services commissioning teams or provide substantial support to such teams (uk_ph_sc@yahoogroups.com).

This group of public health professionals is highly active as indicated by over 250 communications per month and as such, has become indispensable to those working in specialised services. The group:

- *Reduces professional isolation*
- *Enables rapid sharing of information, policies, etc, access to expertise in particular areas and joint work to take place efficiently and almost in real time dialogue*
- *Strengthens individual's work by accessing wider input*
- *Enables individuals to work on strategic goals which require collaborative effort*
- *Provides an vibrant environment for debate and developing new ideas and peer support*
- *Gives a voice to the public health group and also a means for others to gain professional opinion on relevant topics and issues*
- *Provides a vehicle for continuous professional development.*

67 Consideration should also be given to SCGs contracting in some services, where it makes economic sense to do so (e.g. data analysis) and/or where such skills are not readily available within the NHS (e.g. economic analysis).

Mental Health Services

68 The commissioning of mental health specialised services (e.g. specialised mental heath services for addiction, the deaf, eating disorder, severe learning disability, new mothers, personality disorder, etc) is already undertaken by L/SCGs.

69 With regard *to* ***medium/low secure*** mental health services, in some areas in the country these services are commissioned by the L/SCG and its commissioning team, in some areas they are commissioned separately. Stakeholders commented that these inconsistent commissioning arrangements were confusing and inefficient.

70 A 2005 DH review of commissioning and performance management of secure mental health services had reached similar conclusions. It recommended that commissioning arrangements for medium and low secure mental health services should be aligned with SCGs but noted that stakeholders wanted to retain the planning structures at "Catchment level " (i.e. same area as SCGs/new SHAs) as these had shown significant benefit.

Recommendation 5: Commissioning Low and Medium Secure Mental Health Services

To maximise scarce commissioner capacity and ensure synergy, the commissioning arrangements for medium and low secure mental health services should be integrated with those for other specialised services and managed by the SCG, whilst ensuring that the focus and detailed analysis of the current forensic commissioning arrangements are not lost.

71 When integrating commissioning teams for secure mental health services with specialised services it will be important to recognise the particular skills required for commissioning mental health services, not least an understanding of the mental health legislation and the need to carry out joint commissioning across health and social care.

72 The commissioning of ***high secure*** mental health services was the subject of the same DH review which recommended that high secure services should be commissioned on a national basis by one commissioning body which reported directly to the National Oversight Group for Secure Mental Health Services (NOG) but with the retention of the lead commissioning arrangements with the three high secure provider units to give in-depth oversight of each unit. The 2005 review also emphasised that the role of NOG should be maintained and that this should clearly be a strategic function sited within the DH - its core function being to discharge the responsibilities of the Secretary of State for Health (in section 4 of the NHS Act 1977)[2] in partnership with key stakeholders including the Home Office on behalf of the Home Secretary.

73 Following discussion within DH, it was concluded in the autumn of 2005 that any final decisions should be postponed until the review of commissioning arrangements for

[2] Section 4 of the NHS Act 1977, as amended by section 41 of the Health Act 1999, reads:
High security psychiatric services
4(1) The duty imposed on the Secretary of State by section 1 above to provide services for the purposes of the health service includes a duty to provide hospital accommodation and services for persons who are liable to be detained under the Mental Health Act 1983 and in his opinion require treatment under conditions of high security on account of their dangerous, violent or criminal propensities.

specialised services was completed. This was to ensure that there was congruence between the commissioning structures.

Recommendation 6: Commissioning High Secure Mental Health Services

The DH and the National Oversight Group (NOG), as a matter of urgency, should seek to implement commissioning arrangements for high secure mental health services which are congruent and integrate with the NSSCG - NCG - SCG arrangements recommended in this review.
The role of NOG and its relationship to the NSSCG needs careful consideration and DH officials should be required to ensure that line of sight arrangements are clear for the commissioning and performance management of high secure mental health services.

74 Where the different security levels of the forensic mental health service patient pathway are commissioned by different commissioners, it will be important to maintain an integrated commissioning approach to ensure a needs-led risk-managed service that provides timely transition of patients between high, medium and low secure services.

Screening Services

75 National screening programmes have planning populations over one million and are thus specialised services. PCTs are already required to collaborate to commission screening programmes, with arrangements approved by SHAs. L/SCGs have increasingly been involved in commissioning new screening programmes and related services such as specialist diagnostic laboratories. Rather than maintain parallel collaborative commissioning arrangements, the commissioning arrangements for relevant screening services should be consistently integrated into those for specialised services.

Recommendation 7: Commissioning Screening Services

Collaborative commissioning arrangements for screening programmes should be integrated with the commissioning arrangements for specialised services.

Binding Decision Making

Recommendation 8: Governance

In discharging their functions, SCGs should be constituted, within the terms of their Establishment Agreements, to enable decisions on the commissioning of specialised services to be made on behalf of the PCTs that they represent and for such decisions to be binding on all PCT members.

In discharging its functions, the NSSCG should be constituted, within the terms of its Establishment Agreement, to enable decisions on the commissioning of specialised services covering several SCGs to be made on behalf of the SCGs it represents and for such decisions to be binding on all SCG members and the PCTs they represent.

76 The core functions of SCGs and the NSSCG would be covered within an 'Establishment Agreement', which includes the process for decision-making, the responsibilities and accountabilities of members, rights of appeal (and to whom) and any voting mechanism. The SCG/NSSCG Establishment Agreements would not only cover the process for SCG/NSSCG decision-making, but also provide the requisite authority (mandate) for PCT/SCG representatives to make decisions at SCG/NSSCG level and set out the circumstances and conditions under which such authority would be given.

Recommendation 9: Delegated Authority

A PCT representative acting at SCG level should be given delegated authority, within the terms of the SCG Establishment Agreement, to commit the PCT that they represent to decisions relating to the commissioning of specialised services.

An SCG representative acting at the NSSCG level should be given delegated authority, within the terms of the SCG & NSSCG Establishment Agreements, to commit all PCTs that they represent to decisions relating to the commissioning of specialised services.

77 To facilitate decision-making, reasonable notice should be given of any intention by the SCG/NSSCG to make a particular decision in order that the issue can be properly debated by constituent PCTs/SCGs to gain ownership and to mandate representatives where appropriate.

78 Decisions taken by the SCG/NSSCG should be binding on all constituent members. There would be a standard appeal and/or arbitration process to resolve disputes between commissioners.

79 The NSSCG should provide regular feedback to SCGs on the impact of decisions taken on their behalf.

80 The process for making decisions and monitoring their implementation should be part of any overall performance management of specialised services commissioning.

81 Decisions by the NSSCG and SCGs should be made having taken full account of the views of all key stakeholders. Where major service change is proposed, formal consultation and the involvement of Overview and Scrutiny Committees is required.

Budgetary Arrangements

82 Stakeholders felt strongly that PCT pooled budgets for commissioning specialised services were fundamental to the maintenance of robust, long-term commissioning arrangements.

83 The Audit Commission survey of commissioners' financial arrangements found that over 50% of LSCGs already held a pooled budget on behalf of their PCTs for a range of specialised services.

84 It is recommended that there should be a consistent national approach to the development of SCG commissioning budgets for specialised services and it should be mandatory for all PCTs to contribute to such budgets.

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.

85 For those SCGs covering LSCGs, where the LSCGs already have service budgets identified for specialised services, these budgets should be aggregated to form the core of the SCG budget, subject to any changes necessary for sound financial management.

86 Where budgets do not already exist at SCG level, then some form of data collection process would be required and budgets should be determined using disaggregated provider costs (and activity), uplifted by inflation and any other agreed generic uplifts. Each PCT's share of the pooled budget should be agreed at the outset (in the absence of agreement it should be on a pro rata to baseline allocation basis). Where one or more PCTs cannot agree, the relevant SHA should take action to resolve the matter.

An example of good practice

POOLING BUDGET FOR SPECIALISED SERVICES

The principle of pooling specialised services' budgets was agreed by PCT Chief Executives within Thames Valley LSCG in 2005. Closer analysis of specialised services (as defined by the National Definition Sets) showed that some services were much more easily identified than others and it was decided that pooling should take place in two tranches.

The LSCG defined the services that should be pooled in the first tranche and coordinated a data collection process with service providers to identify the activity and costs associated with such services. Initial PCT contributions to the 'pool' are to be based on historic spend, but longer term it is expected that they will be based on capitation shares. Further work is to be undertaken in the future to extend the 'pooling' arrangements to other services.

87 It is recommended that the development of budgets be linked to the next major revision of HRGs and national tariff due in 2008/09 and the recommended review of the Specialised Services National Definitions Set and be as follows:

- All SCGs to have an initial budget for specialised services from 1 April 2007, based on an agreed minimum number of specialised services which are clearly defined, quantified and 'costed' (see Appendix 7) - for SCGs with an existing budget the aim should be to level up rather than to level down
- All SCGs to work together (through the NSSCG) and in conjunction with service providers to define (or re-define), quantify and cost all specialised services by 30 September 2007
- All SCGs to have a complete budget for all specialised services from 1 April 2008.

88 The 'budget setting' timetable should be included by SCGs in their annual commissioning plan for 2007/8 and beyond and SCGs should work with service providers (as necessary) to separately identify and cost all specialised services in line with the timetable.

Recommendation 11: Service Mapping to Facilitate Costing

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 Services National Definitions Set.

89 In the Audit Commission's view, the above recommendation is core to competent financial management and is in keeping with the recommendations set out in: 'World Class Financial Management' (Audit Commission 2005).

90 As a general rule, where providers have not made available the appropriate activity and/or cost information by the required date, then commissioners should not be expected to fund such activity.

91 For each SCG there should be an agreed approach for uplifting SCG budgets for generic cost pressures and inflation for those services that are outside national tariff. Similarly, for each SCG there should be agreed specified arrangements for managing over and under spending.

92 Specialised services are low volume interventions and treatments which are often extremely high cost. The risk to an individual PCT of having to fund such expensive, unpredictable activity is reduced by PCTs collectively commissioning these services and sharing financial risk. Currently a variety of risk management approaches are used by specialised services commissioning groups to minimise the financial risk to individual PCTs of any in-year fluctuations in activity/cost.

An example of good practice

RISK SHARING AGREEMENT

NORCOM, an LSCG covering South Yorkshire, has produced a policy to assist PCTs in determining when it is appropriate to risk share the cost of services and in calculating individual commissioner shares.

A range of criteria is taken into account when considering whether or not a risk sharing arrangement should be established. When a new risk share is proposed, a 'commissioner shares' analysis is produced showing the impact on PCTs by weighted population and by historical usage. This comparative information highlights where there are significant inequities and helps to inform the judgement about when commissioner shares need to be actioned, by exception, on a historical usage basis.

93 As part of their overall commissioning arrangements, PCTs may choose to delegate their responsibility for the commissioning of some non-specialised services that require a collaborative approach across PCTs, to a SCG. In these circumstances, the staffing resource and budgets for such non-specialised services should be accounted for separately from those for specialised services.

Annual Prioritisation Process

SCGs should have transparent and systematic processes for reviewing service and financial pressures and for determining the annual budget for each specialised service and for the prioritisation of service development funds. These processes and initial budget setting decisions should be made clear in the annual commissioning plan, with any in-year changes documented and recorded in publicly available minutes and meeting papers.

Recommendation 12: Annual Prioritisation Process

Each SCG should have an annual process for debating priorities and explicit mechanisms for eliciting and documenting the views of providers (clinical and managerial), PCT members, practice based commissioning leads, PPI representatives and commissioning teams. The agreed priorities should be set out in the SCG's annual commissioning plan. Those priorities requiring national input should be put to the NSSCG for consideration.

The NSSCG should have annual process for debating priorities which would be informed by the SCGs' annual prioritisation process. The agreed priorities should be set out in the NSSCG's annual plan.

94 It is important that the priorities for specialised services dovetail with priorities for non-specialised services. The cost pressures associated with specialised services can be considerable and these need adequate attention when commissioning priorities are being considered. In order to ensure this, it is important that the NSSCG is able to contribute to discussions that are held with the DH on NHS planning guidance.

95 In the context of specialised services commissioning and the development of performance management and performance assessment processes it will be increasingly important to be clear about the depth and focus of commissioning for each specialised service in annual commissioning plans and work programmes. This will help manage the expectations of performance managers and performance assessors as well as those of patients/carers, providers and other commissioners.

96 An agreed approach to categorising commissioning activity (e.g. re-assessment of designation status for a particular service / a full-scale service review / local standards development / clinical audit of a specific service aspect / etc) would be helpful. Appendix 8 gives four suggested categories. It would enable SCGs and the NCG to categorise their commissioning activity as set out in their annual plans and annual work programmes. This would greatly assist the Healthcare Commission in their performance assessment of commissioning across the country.

An example of good practice

SERVICE REVIEWS

Northern SCG has developed a proactive system of planning through the development of individual service collaborative commissioning strategies informed by a series of service reviews. There are currently three categories of service review, namely an initial service review, full service review and monitoring review. Each spring a workshop involving all stakeholders determines the work priorities for the following year including which services will be prioritised for review. The aim is to review all of the 35 specialised services on the national definition set list over a five-year period.

Accountability and Openness

Recommendation 13: Accountability

SCGs and the NCG should be expected to produce an annual commissioning plan, an annual work programme and an annual report and to disseminate these widely. The annual report should include evidence of having reviewed their commissioning arrangements against fitness for purpose/performance management criteria used by SHAs and a periodic independent survey of stakeholders' views.

97 SCGs should ensure an ongoing programme of quality assurance of service agreements/contracts, which will compliment the audit and outcomes development programmes coordinated by the NSSCG.

98 Regular meetings of SCGs should oversee financial performance, progress with service reviews, investment programmes and other priorities and agree, in accordance with formally agreed risk management protocols, how PCTs should share risks. Papers and minutes of SCGs (and the NSSCG) should be readily available to the public (and other key stakeholders).

99 Each SCG should have a formally agreed process for ensuring ongoing public and patient involvement.

100 There should be sufficient capacity within each SCG team to support the commissioning of specialised services for the whole area and to facilitate sustained, mature commissioning and the maintenance of long-term relationships with providers and the public.

101 SCGs should have the capacity to undertake formal consultation on major service reviews and to engage with Overview and Scrutiny Committees (OSC), where appropriate.

102 SHAs should satisfy themselves that the proposed SCG structural and commissioning team arrangements adhere to explicit criteria such as those noted in Appendix 9.

Access to Patient Activity Data

103 During the consultation process, commissioners and patients' groups expressed their frustration at the difficulties encountered by L/SCGs trying to access activity data from national databases.

104 To be effective, SCG commissioning teams need to be able to monitor patient activity for those services they collectively commission on behalf of their PCTs. Currently PCTs, as the 'Responsible Commissioner', have access to a national database holding activity information on all their patients at all NHS providers across the country. SCGs need similar access. To this end, SCGs should be allocated a specific 'organisational' codes plus authority to access the national database for patient activity data on those services they commission collectively.

Recommendation 14: Access to Patient Activity Data

SCGs and the NCG should have access to patient activity data in the national database for all services which they commission collectively.

Funding the Treatment Costs of Research

105 With the development of tariffs and disaggregation of treatment costs, it will become increasingly difficult for providers to fund the treatment costs of research (both the *pre*-trial and *post*-trial periods) for new drugs, devices and procedures.

106 There will not be a problem with treatment costs incurred *during the course of a trial* where the research is funded by partners of the NHS (such as research councils, charities and universities) because these costs have to be meet by the commissioners as set out in Health Service Guidelines HSG(97)32[3].

Recommendation 15: Funding the Treatment Costs of Research

The DH should urgently consider funding mechanisms for pre-trial and post-trial treatment costs that are outside national tariff in order to safeguard future research.

107 Specialised services commissioners should expect providers seeking to embark on research to submit the protocol to an ethics committee, in line with the Research Governance Framework. It is reasonable for commissioners to resist funding the treatment costs of other research activity that is not part of formal research funded in partnership, or any research activity that is not sponsored in accordance with the law and/or the Research Governance Framework.

108 Commissioners should expect the research protocol both to describe the treatment costs of research activity and to identify an agreed exit strategy. In line with the Helsinki Declaration, ethics committees scrutinise the plans for treatment or care of participants after their participation in a study ends.

109 It is the responsibility of clinicians and health care providers to offer the best proven treatment. After new drugs, devices and procedures have been tested in a formal

[3] Health Service Guideline (97)32, Responsibilities for meeting Patient Care Costs associated with Research & Development in the NHS, issued 29 May 1997.

research trial, there is normally a delay before trial results are written up and publicised, and before new medicines, or new uses of medicines, are licensed. During this period commissioners may decide not to fund a treatment if there is insufficient published evidence to show that it is safe and effective.

Horizon Scanning

110 It is important that three-year commissioning plans and priorities be properly informed by emerging technology - new drugs, devices and procedures. For specialised services many new interventions are expensive and their introduction needs careful planning and review.

Recommendation 16: Horizon Scanning

The NSSCG, the NCG and SCGs need one reliable source of 'horizon scanning' and in order to avoid duplication it is recommended that information on new interventions produced by the national horizon scanning programme be made available to the NSSCG, the NCG and SCGs to support specialised services' commissioning.

SECTION 4: COMMISSIONING LEVERS AND OPPORTUNITIES

Introduction

111 Commissioners of specialised services, just like commissioners for other health care services, have primary responsibility for securing the provision of services including stimulating supply and promoting contestability, through their routine dealings with providers. In doing so they will need to reflect patients' views about service provision and requirements to improve quality, increase health benefit and secure value for money.

112 Similarly commissioners and providers of specialised services also have a shared responsibility for managing demand and maintaining referral and treatment thresholds and providers are expected to respond to system incentives (such as 'Patient' Choice' and 'Payment by Results') and flex capacity in line with demand.

113 Put simply, the functions of a commissioning body are to: stimulate supply, safeguard access, manage demand, promote contestability and value for money, assure quality and maximise health benefit.

114 Specialised services commissioners have an additional role in preventing the proliferation of specialist centres to the point where there are too many centres, each treating too few patients, to provide a safe, high quality, value for money service.

115 There are currently a number of ways in which commissioners of specialised services can influence who should provide the service, to what level and under what conditions. (See paper "Commissioning Influences" on the DH website: http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningSpecialisedServices/fs/en)

116 The incentives that drive the current system are unlikely to be sufficient to ensure patient safety and drive improvements in the quality and efficiency of specialised services. Where the number of potential providers and the volume of activity are necessarily limited and services may be seen to be less 'attractive' to provide there will therefore be a greater onus on specialised services commissioners to look at other ways of influencing supply and promoting continuous improvement

Designation

117 NSCAG currently advises Ministers on which providers of highly specialised services should be 'designated' to provide services on a national basis. This is to ensure that highly specialised services are only provided in a few centres across the country. Designation means that commissioners have control over which providers are funded to provide a specialised service at any one time and treatment for patients is limited to those providers.

118 It is recommended that SCGs (and when appropriate, the NSSCG) should be given powers to designate specific providers to provide specific specialised services. There should be a robust, transparent process for selecting potential providers, run on a five yearly basis. SCGs should have the power to withdraw designation status during the five yearly period.

119 Designation of specialised service providers by SCGs would secure an appropriate concentration of clinical expertise and activity at designated centres, located to maximise geographical access. Designation would safeguard patient access to high

quality, cost effective services and prevent unsafe and/or unplanned proliferation of services.

120 Service designation would enable patients, who wish to be able to choose from a range of service providers to do so secure in the knowledge that a 'designated provider' offers a high quality, safe specialised service.

121 Designation would also make it easier to identify specialised service activity; target any national tariff supplements for such activity; assure financial viability of some relatively small and vulnerable services and plan developments and/or changes in service provision.

Recommendation 17: Designation of Specialised Services Providers

SCGs should formally designate specific providers to provide specific specialised services. Designation should be based on a nationally agreed set of patient-centred, clinical, service, quality and financial criteria and be re-assessed every five years. There should be strong patient and public input.

The NCG should continue to advise Ministers on designation status for providers of highly specialised services to be commissioned on a national basis.

Activity at undesignated providers should not be funded by commissioners.

122 The NSSCG should quickly establish a formal ongoing designation programme whereby provision of each specialised service is assessed every five years. The programme timetable should be published and all services have been through process for the first time by 2010. The period of designation will not exceed five years. It would be open for potential new providers to seek designation and for commissioners to seek expressions of interest from new providers.

123 For services currently under review, the designation process is expected to be completed relatively soon.

124 At the outset it is suggested that all current providers of specialised services, who have service agreements/contracts with specialised services commissioners, be provisionally designated.

125 To be considered for designation status each provider of a specific specialised service should be able to demonstrate that it meets agreed service standards and be able to satisfy the following criteria:

- Ability to produce monitoring data against agreed service standards and clinical outcome/patient experience measures - these may be initially agreed at a local level if no nationally agreed standards and measures exist
- Standard description of the service, which includes referral criteria/thresholds, the position of the service in a patient pathway and discharge criteria to secondary care or elsewhere, essential staff, facilities and equipment
- Disaggregated costs and activity using agreed currencies (currencies which should be subject to national agreement as part of a national collaboration)
- Agreement from clinicians and managers to partake in an ongoing national audit programme so that data collection can commence within one year of designation and audit within two years

- Existence of a patient/user group which is actively involved in shaping the delivery of the service and is represented on the commissioner designation team
- *Where national standards and measures for clinical outcome do not exist* an agreement from clinicians and managers to contribute to a national clinical initiative to develop a set of nationally agreed standards and nationally agreed clinical outcome and patient experience measures.

126 The SCG would then decide, in the light of their health needs assessment for that particular service and other considerations including value for money, which provider applicants would be designated and which would not.

127 During the course of the five year 'designation' period, commissioners might wish to review or withdrew designation status due to material changes in the way the service is provided, persistent failure to meet agreed clinical outcome and quality standards and/or the provider giving notice that they wish to cease offering the service. The outcome of service re-organisation and re-configuration strategies might also affect designation status. There should be no automatic assumption that designation status will be renewed at the end of the five-year period.

128 Designation does not mean the same as "accreditation". Accreditation is generally used to denote that an organisation has reached or maintained an agreed set of standards. No specialised service should be designated at a hospital that is not accredited, if a relevant accreditation system applies.

Foundation Trusts

128 It is important for specialised services to be concentrated in relatively few specialist centres so that each centre deals with a sufficiently large caseload to provide a safe, high quality, expert service. In this respect a balance needs to be struck between FTs responding to, often relatively local, patient demands and the wider NHS responsibility to ensure appropriate patient access to specialised services with catchment populations covering more than one FT.

129 There are real benefits in early engagement of providers (whether an NHS Trust, an FT NHS Trust or a non-NHS provider) with commissioners when there are proposals to change/cease the provision of existing specialised services or provide a new one. Similarly, commissioners should maintain an ongoing dialogue with providers so to be well informed about any change proposals.

130 SCGs, the NCG and the NSSCG will, of course, ensure that they remain conversant with NHS FT Terms of Authorisation and Annual Plans as published on the Monitor website.

Recommendation 18: Foundation Trusts

When an NHS Trust is being assessed by the DH for Foundation Trust (FT) status, the views of SCGs and the NCG should be sought with particular regard to the proposed mandatory services which are specialised services.

Where an NHS FT seeks to cease providing a mandatory service which is a specialised service, Monitor should assure itself that there has been SCG or NCG support before any decisions are made.

NHS Trusts and NHS FTs should discuss proposals for changes in specialised services provision with SCGs and the NCG at an early stage.

Where an NHS FT is planning to start a new specialised service, it should approach the relevant SCG or the NCG to seek designation.

131 Effective commissioning will depend heavily on contracts with providers which are able to deliver the commissioning objectives.

132 Within a contract, specific reporting requirements should be identified for each specialised service which measure performance against agreed criteria (e.g. service standards, referral criteria, treatment thresholds, services given, discharge criteria, adherence to the patient pathway, clinical and patient outcomes). The contract should identify sanctions which the commissioner can apply in the case of provider non-compliance; these sanctions may include non-payment, delayed payment or fines.

133 Commissioners should be able to refuse to fund activity outside contract.

134 To ensure consistency and cost effectiveness, it may be appropriate for SCGs and the NCG to have access to a central source of legal advice for commissioners regarding contractual issues.

Integrated Care and Clinical Networks

135 Stakeholders told the review that relationships between L/SCGs and various clinical networks (cancer, coronary heart disease and children's service networks being the most commonly cited) were generally good. In some instances the network manager was part of the L/SCG commissioning team. However, sometimes the relationship was quite distant and occasionally there had been confusion between the network and the L/SCG over the commissioning role.

136 There is a clear need for SCGs to forge strong links with clinical networks and provide the commissioning input to the development of specialised services within the network. SCGs also have a role to play in providing commissioning oversight and coordination of service network plans, where the service in question has a planning population larger than a single network, e.g. services for those with rare cancers.

Recommendation 19: Clinical Networks

SCGs should work closely with their clinical networks so as to ensure that commissioning and investment plans support the delivery of integrated care.

SCGs should provide oversight and ensure coordination of clinical network plans, where the service in question has a planning population larger than a single network.

137 Practice-based commissioning (PBC) excludes specialised services, but it is important for practice-based commissioning plans to be integrated with those relating to specialised services to ensure continuity of patient care and appropriate use of resources.

138 In this respect it should be recognised that PBC and the commissioning of specialised services are likely to be concentrating on opposite ends of the same patient pathways and that service development and investment needs to be appropriately targeted if best use is to be made of limited resources. Decisions taken at a practice based level to change the provision of primary and secondary care services (e.g. introduce specialist obesity clinics) may have an impact on the provision of specialised services (e.g. the need for obesity surgery) and vice versa.

Recommendation 20: Integrated Care

PCTs should act as the focal point in ensuring a good fit between the commissioning plans and priority decisions of GP Practices and those of the SCG so as to maintain and strengthen integrated care pathways.

139 Excellent commissioning practice would include agreed *service specific* commissioning strategies across the entire care pathway to provide a framework within which practice based commissioners, PCTs and specialised services commissioners can plan those services.

Patient Centred Care

140 Currently 'Choice' of service provider is offered, in the main, for those services where the GP refers the patient for an identified intervention or treatment, although patients are also being offered a choice of tertiary centre for invasive cardiology and other cardiac surgical services. Typically, a tertiary referral occurs where the patient has already been referred by their GP to a local hospital who then refers the patient on to an appropriate specialist centre which may be in the same or in a different hospital.

141 Patient centred care should be as flexible and sensitive to the patient's needs and requirements as possible and can include choice of nature of treatment, place of treatment (e.g. home, health centre, hospital, in/out patients), timing of treatment and provider of treatment. Patient centred care should drive the provision of specialised service care as much as it does for non-specialised service care. Individual specialised services frequently have very well informed active patients' groups who provide extensive information and support to patients, their relatives and carers and are involved in assessing service quality with commissioners.

142 Extending patient choice to cover specialised services requires further consideration of the impact and appropriateness of such an approach, bearing in mind the following issues:

- Specialised services are provided in a limited number of specialist centres to achieve a critical mass of cases so as to ensure a safe, high quality service is provided, expertise is developed and maintained, the scarce specialist workforce is efficiently deployed, expensive resources including equipment and facilities are best utilised, and research and medical training are supported
- Specialised services are generally part of a wider clinical service network designed to support the whole care pathway and as such are provided as part of an integrated care package. This care pathway is likely to be complex and involve primary, secondary and tertiary care as well as care from the voluntary sector, the local authority and the private sector
- Specialised services are provided at designated (formally or informally) providers recognised by commissioners as appropriate providers

- Choice of provider requires flexible capacity - due to the high cost, low volume nature of many specialised services, capacity may be (a) more constrained , (b) more difficult to create in terms of scarce expert staff and (c) costly to increase.

Recommendation 21: Patient Choice

The opportunities for patients to make choices regarding specific aspects of their care and treatment should be maximised with the proviso that choice of specialised services provider will be limited to designated providers.

143 Some preliminary work has already commenced to explore choice in relation to services organised around clinical networks and this should be developed to capture the above issues (see Appendix 10).

Specialised Services National Definitions Set

144 The existing Specialised Services National Definitions Set, published in 2002, has been widely appreciated by commissioners, providers and patients alike. However, stakeholders are unanimously agreed that it needs to be reviewed and updated. They report major variations in the breadth and depth of individual service definitions (e.g. specialised services for women's health compared with ear surgery or the extensive details on pathology sub-specialties compared with a single sentence describing blood and marrow transplantation). They want more balanced and consistent coverage and a review of which services are actually included in the National Definitions Set.

145 The Audit Commission noted in its survey of commissioners' financial arrangements that 64% of LSCGs and 40% of SCGs commissioned services were outside the National Definitions Set.

146 Many of the specialised services in the original National Definitions Set were poorly identified because specific procedure and diagnostic codes (and hence Health Resource Groupings - HRG - codes) did not exist. Fortunately, the enhanced OPCS 4.3 classification and the ongoing review of HRGs will enable specialised services activity to be better identified. In addition, annual OPCS updates are planned. A system for annually updating the codes listed in the National Definitions Set is needed. This process could also identify where coding remains inadequate and the DH needs to undertake further work.

147 Review of the National Definitions Set (both the actual services included and the detail of individual definitions) has become particularly pressing for the following reasons:

- The need to identify the actual costs of specific specialised services, and develop national tariffs or agree local pass-through payments as appropriate, so as to be able to set budgets and agree service agreement/contracts with providers
- The need to re-assess how particular services should be commissioned and by whom, given the development of PBC, larger PCTs, specialised services consortia, an increasing number of clinical networks and PCT collaborative commissioning arrangements for other services, and the importance of integrating the commissioning of different aspects of the same patient pathway

Recommendation 22: Specialised Services National Definitions Set

The DH should initiate an immediate review of the Specialised Services National Definitions Set, which will be overseen by the NSSCG once established. The review should initially concentrate on developing a set of criteria for the inclusion of services in the National Definitions Set and consider priorities for changes. Decisions should be made on the future purpose and structure of the National Definitions Set and updating arrangements.

148 Inclusion of a specialised service on the revised list should be on the basis of the service having a planning population of at least 1 million as well as meeting a set of agreed criteria. Provision needs to be made for significant new treatments and drugs to be added to the National Definitions Set.

149 A standard list of headings for the National Definitions Set and a logical process that determines the most effective currency for commissioning each service, which is linked to the development of national tariff and/or commissioning budgets, is set out in Appendix 11.

150 It should be recognised that capacity of specialised services commissioners in any one year will be limited. Inclusion in the National Definitions Set is not therefore meant to indicate that all specialised services identified will be receiving the same amount of attention from commissioners at any one time.

Payment by Results

151 Many stakeholders, both commissioners and providers, identified the application of Payment by Results and the creation of national tariffs for specialised services as an area of concern. The Audit Commission survey of commissioners' financial arrangements received similar feedback.

152 There is a need to commission specialised services on a basis which relates to payment but the nature of these services means that different approaches to currency may be required, including the possibility that one single national price is inappropriate in certain circumstances.

153 It seems likely in the short term that the majority of specialised services will remain outside national tariff. The inclusion of certain specialised services may not necessarily be in the interests of the services themselves, service providers and/or the patients that access them (see Appendix 12).

154 Some stakeholders were concerned that excluding certain specialised services from tariff might mean that, if those services within tariff went over budget, there would be less funding available to fund services outside tariff. One safeguard to protect the funding of specialised services outside tariff would be the development of SCG budgets for specialised services.

Recommendation 23: Payment by Results

There should be an agreed DH programme of work to review the development of tariffs for those specialised services that are currently not covered by Payment by Results, with the NSSCG providing major input.

Alternatives to the basic 'episode x tariff price' approach should be developed to cover services where patient activity and throughput is not the main determinant of cost.

155 Specialised services need to be separately identified and costed by each service provider as a matter of urgency so as to facilitate tariff development, set SCG budgets and enable commissioners to monitor service level agreements/contracts.

156 For some services, where they are already in tariff or where diagnostic and procedure codes already exist, this should be straightforward; for others, estimates of activity and costs (which could be refined over a period of time) may be necessary. There should, however, be an agreed programme of work to develop tariffs for specialised services that are not currently included which should be coordinated nationally and which should make use of specialised service commissioners and service providers.

157 Examples where patient activity and throughput is not the main determinant of cost include services for cystic fibrosis, neonatal / paediatric intensive care and complex burns. It is important that the future development of national tariffs for specialised services is linked to any revision and/or updating of the National Definitions Set. In this respect service standards should also be an essential element of the calculation of tariffs for specialised services as a way of securing improvements in the quality of specialised services.

158 Further work is needed to improve the sensitivity of HRGs - for example, where outpatient attendances include high cost diagnostics/interventions or multi-disciplinary staff input - and review the current tariff uplift supplement for specialised services (see Appendix 12).

Service Standards, Clinical Outcomes, Monitoring and Audit

159 The effectiveness of commissioning is directly related to three critically important drivers of quality, continuous improvement and clinical engagement:

- nationally agreed service standards
- nationally agreed patient outcome, including clinical, measures
- national clinical databases that enable monitoring and audit of clinical outcomes and service standards.

160 If the NHS is to be effective in driving improvements in quality and efficiency then there needs to be sufficient resource to support clinicians in developing standards, outcome measures and clinical databases. This is fundamentally important to sustaining clinical involvement in commissioning and to informing the availability of choice for patients.

Recommendation 24: National Clinical Databases

The NSSCG should consider proposals to establish and maintain national clinical databases for specific specialised services to enable commissioners and providers to monitor clinical outcomes and performance against standards. Annual funding should be sought from the DH, as part of their programme to strengthen commissioning, with a supporting contribution from SCGs.

161 SCGs should agree which clinical databases should be supported using a pre-determined set of criteria, which amongst other things considers the value of the database to commissioners, service providers and patients. Once a database has been established and is running satisfactorily then the costs should be incorporated into national tariff with input to the database compulsory for all providers.

162 The National Institute for Health and Clinical Excellence (NICE) has been commissioned by the DH to write commissioning guides for services for which they have developed clinical guidelines. It might be beneficial to consider asking NICE to work with specialised services commissioners to develop the implementation guidance for the health technology appraisals that relate to specialised services commissioning

163 Robust clinical audit programmes are also essential if commissioning is to be effective and system reforms are to be fully realised. Good commissioning relies on thorough and ongoing analysis, audit and review.

Recommendation 25: Audit

The NSSCG, the NCG and SCGs should ensure that regular audits of specialised service provision are undertaken and that the results are made available to commissioners to enable comparative performance to be assessed over time and between providers.

An example of good practice

AUDIT, INFORMATION AND ANALYSIS UNIT

The London Specialised Commissioning Group, on behalf of PCTs in London, Kent, Surrey and Sussex, agreed the establishment of the Audit, Information and Analysis Unit (AIAU). The work programme of the AIAU is determined by the London SCG and is integrated and aligned with the specialised services commissioning agendas for London, Kent, Surrey and Sussex.

The purpose of the AIAU is to support and enable clinicians, trust managers, commissioners, patients and the public to understand the nature and quality of specialised services across provider groups. Study recommendations aim to provide information for clinicians, trust managers and commissioners, with involvement by patients, to implement changes to:

- *Optimise the use of existing capacity*
- *Use resources more efficiently*
- *Deliver more appropriate services to patients*
- *Improve equity of access for patients and*
- *Provide safer services for patients.*

SECTION 5: PATIENT AND PUBLIC INPUT

Public Information

164 Patients' groups repeatedly stressed to the review the lack of information detailing what each SCG commissions and would like readily available information that clarifies which commissioner is responsible for commissioning each specialised service.

Recommendation 26: Public Information on Commissioning Arrangements

SCGs and the NCG should contribute annually to an NSSCG website giving details of their commissioning arrangements including contact details for the lead commissioner for each specialised service.

Patient and Public Involvement in Commissioning

165 Patients' groups emphasised the importance of the following factors when reviewing the effectiveness of the arrangements for commissioning specialised services:

- Commissioners to have in-depth knowledge of the specialised service concerned and to share this with patients' groups
- Constructive patient-centred relationships between the patient and the provider/commissioner that demonstrate mutual trust and respect and prevent the patient feeling like an "expensive commodity"
- A specialised services National Definitions Set which has consistent definitions across all services and which enables all services to be quantified, costed and monitored
- Processes in every part of the country which reflect best practice in the involvement of patients, carers and the public and engage patients in the monitoring of quality and outcomes
- Nationally agreed service standards and clinical outcome measures for each specialised service
- Equitable access to specialised services, wherever a patient resides
- Integration of services, including health and social care, along a patient pathway so that the patient journey is as seamless as possible.

166 Currently there is no consistency in the extent to which, or the way that, specialised services commissioners involve patients, carers and the public in decision-making.

167 Commissioners should seek the views of patients, carers and the public on which specialised services to commission and from where; take their advice on the development of patient-centred services and engage them in monitoring the performance of service providers. The way in which this happens should be determined locally and may take a variety of forms depending on the type of service, the catchment population and the circumstances of patients, carers and the public providing the input. Commissioners should however make every effort to elicit patients' views and take them into account in the commissioning process.

Recommendation 27: Patient and Public Involvement

SCGs and the NCG should be required to have an ongoing Patient and Public Involvement (PPI) strategy and to report progress against the strategy in their annual report.

SCGs and the NCG should have patient representation on their committee.

SCGs and the NCG should ensure strong patient and public input to the designation process.

SCGs and the NCG should routinely involve patient representatives in the annual prioritisation process and annual commissioning plans.

The NSSCG should review and compare PPI practice of the NCG and SCGs annually and publish its findings.

An example of good practice

PATIENT AND PUBLIC INVOLVEMENT

In 2003 the London SCG began an extensive process of involving patient interest groups and individuals who used specialised services in developing patient and public involvement in commissioning specialised services. The resulting strategy, Living Well, is available at *http://www.londonspecialisedcommissioning.nhs.uk/patientandpublic/index.asp*

The London SCG Patient and Public Involvement Reference Group was also established and this has led to a number of initiatives including the organization of visits to specialised service providers, providing PPI input to the Healthcare Commission's review of Foundation Trusts, developing an 'Expert Patient Programme' for renal patients and the appointment of a part time PPI Project Worker.

Consultation with Overview and Scrutiny Committees

168 An SCG's population is much larger than that covered by a Local Authority's Overview and Scrutiny Committee (OSC). Several stakeholders mentioned the problems associated with the fact that there is no formal grouping of OSCs at a higher level, such as on a Regional Government Office basis, so an SCG has to relate to several OSCs. This can be a barrier to having any kind of meaningful, ongoing relationship between the SCG and the OSCs. The difficulties are compounded when a formal joint subcommittee of OSCs is required to be established to consider an SCG proposed service change. Stakeholders reported that the process of establishing a joint OSC was lengthy and cumbersome and extended the date of the final OSC decision, resulting in planning blight and delay of necessary modernisation programmes.

169 The review supports the DH in examining ways to engender a closer, ongoing relationship between OSCs and SCGs and to improve the timeliness and robustness of the consultation process when several OSCs are involved and a joint OSC needs to be established. The creation of joint OSC standing committees should be considered. A standing committee would facilitate an ongoing relationship with specialised services commissioners and enable OSC members to become better

equipped to deal with the specifics of specialised services issues and better able to respond in an informed manner. The Centre for Public Scrutiny could advise on the best ways to deliver such arrangements. A joint OSC should also make arrangements to involve users of services (plus their families and carers etc) in the scrutiny process.

Recommendation 28: Consultation and Overview and Scrutiny Committee

In the interests of progressing timely, well-managed service change, the DH should advise the setting up of joint Overview and Scrutiny Committee (OSC) standing committees based on SHA boundaries.

Where the SCG has applied to an individual/joint OSC and has not received a decision within 6 months, the SCG should be free to proceed with the service change.

170 A PPI Resource Centre is soon to be established from which commissioners could usefully seek advice and guidance on PPI and consultation.

SECTION 6: PERFORMANCE

Performance Management

Recommendation 29: Performance Management

SHAs should ensure strong performance management of specialised services commissioning, ensuring that PCTs have appropriate arrangements in place for collaborative commissioning and that SCGs are working effectively. Performance management of the NSSCG and the NCG should be undertaken by one SHA acting on behalf of all SHAs.

171 SHAs should be represented on SCGs and provide support and guidance as well as ensuring consistent behaviour across PCTs. SHAs, through their oversight role, should take account of the cumulative impact of commissioning proposals on individual providers and facilitate transitional arrangements in conjunction with specialised services commissioning groups if necessary.

172 Performance management by SHAs should include an initial 'fitness for purpose' check of SCG and NSSCG structures and processes and an ongoing, annual review of SCG performance (this would be separate to any system introduced by the Healthcare Commission or a regulatory body).

173 The initial 'fitness for purpose' check should be aimed at ensuring that the new arrangements are consistent with national guidance and that PCTs are fully 'signed up' to them. A suggested framework for SHAs to use is set out in Appendix 9.

174 The annual review of SCG and NSSCG performance by SHAs should concentrate on both the work of the SCG/NSSCG and the engagement of PCTs (or SCGs on their behalf) in it. There may be some overlap between the issues covered by the annual review and the initial 'fitness for purpose 'check but revisiting some of the latter annually may be useful.

175 The purpose of the annual review is for the SHA to satisfy itself that the arrangements for commissioning specialised services are appropriate, effective and transparent and that national and local specialised services priorities are properly addressed.

176 The production of information comparing or benchmarking individual SCG performance will be important for strengthening commissioning nationally. A tool that could be used to assist this has been included as Appendix 13.

Performance Assessment

177 The Healthcare Commission will be important in promoting improvements to the quality of specialised services commissioning. The Healthcare Commission should have regard to an SCG's annual work programme and annual reports in guiding their performance assessments and achieving assessments that are of value to both parties. The Healthcare Commission could actively share good practice from different forms of commissioning.

Recommendation 30: Assessment of Commissioning Expertise

Any performance assessment of PCT commissioning by the Healthcare Commission should include the commissioning of specialised services.

SECTION 7: PROFILE OF SPECIALISED SERVICES COMMISSIONING

178 The profile of specialised services commissioning should be enhanced by:

- National development programmes for commissioners which specifically recognise specialised services
- Development of national commissioning standards, priorities and targets for specialised services which are monitored as part of the SHA performance management process
- Role of the NSSCG as a 'champion' for specialised services' commissioners and the commissioning process with DH, NICE, Monitor, Healthcare Commission, etc
- The publication and dissemination of:
  - annual reports by NSSCG/NCG/SCGs, which include an assessment of progress against annual work programme priorities
  - PCT annual reports, which include reference to the commissioning of specialised services and the PCT's involvement in them
  - annual NSSCG/NCG/SCG commissioning plans
  - publicly available information identifying which specialised services commissioner is responsible for the commissioning of each specialised service.

179 Improvements to specialised services commissioning in the future will depend in part on SHAs adopting a vigorous performance management role. Robust performance assessment by the Healthcare Commission will also be important.

180 NHS commissioning capacity and skills are in short supply; this is as true for specialised services commissioning as for general service commissioning. Commissioning should be given a higher profile in the career options for managers and clinicians. The need to develop and support the skill base of specialised services commissioning teams, working with providers to sustain and develop services, must be recognised within training programmes and career planning.

181 The Audit Commission survey, as well as identifying that only 50% of LSCGs and 60% of SCGs had appropriate staffing levels, also highlighted that the commissioning team would benefit from development of expertise in financial information and information analysis, greater understanding of PbR and improved clinical & public health input.

Recommendation 31: Profile of Commissioning

The profile of specialised services and their commissioning arrangements needs to be raised both within and outside the NHS and should feature in national priorities and targets.

Commissioning should be given a higher profile in the career options for managers and clinicians. SHAs should ensure that career development and training programmes recognise the necessary expertise required for commissioning specialised services.

SECTION 8: POWERFUL AND EFFECTIVE COMMISSIONERS

182 The recommendations in this report attempt to equip specialised healthcare service commissioners of the future with the essentials to be successful. Success will depend upon commissioners having the necessary *authority, credibility and expertise*. These three essential attributes are explained more fully below.

Authority

183 **Powers:** Commissioners should have the power to designate providers for a period of up to 5 years, in accordance with a transparent process and criteria. Commissioners should be able to refuse to fund activity outside contract. Within a contract, commissioners should be able to set out specific reporting requirements from each provider for each service which measure performance against agreed criteria. (These criteria could include service standards, referral criteria, treatment thresholds, services given, discharge criteria, adherence to the patient pathways, clinical and patient outcomes.)

184 **Sanctions:** Commissioners should be able to apply sanctions and to withdraw funds, refuse to pay or fine providers if they fail to honour aspects of the contract or designation. Commissioners should be able to withdraw designation status if the designation requirements are not being met or if there are serious concerns about service quality and safety which the provider has not taken sufficient or timely action to resolve. Commissioners should be able to expect provider staff, whose attitude/behaviour is of serious concern, to be removed from delivering the contract.

185 **Choices:** Commissioners should be able to choose to de-designate providers after the specified period if, as a result of inviting the market to apply for designation, other providers offer better value and to designate for less than 5 years in exceptional circumstances. Commissioners should be able to choose how many providers to designate for each service so as to promote choice for patients but maintain sufficient critical mass in each provider to ensure clinical safety, quality and value for money.

186 **Efficiency:** Commissioners should be able to test value for money and relative value annually. (This might be through national tariffs or, where they do not exist, through disaggregated activity and costs giving service specific information that can be compared nationally.)

187 **Incentives:** Commissioners should be able to provide incentives to improve provision. (This might be offering a local supplement to a provider to achieve greater capacity/improved access where it is dependent on a step change in infrastructure; by guaranteeing the security of a five year designation status if the provider needs to raise capital; by offering differential monetary incentives for differential benchmarked performance.)

Credibility

188 **Access:** Commissioners should have access to data on their population; be able to meet provider staff and patients to gain an understanding of the service opportunities and threats; and be able to visit each provider annually.

189 **Skills**: Commissioning teams should contain senior professionals in public health, finance, information, commissioning and analysis; this is a fundamental prerequisite of successful commissioning.

190 **Capacity**: Commissioning capacity should be sufficient to be able to routinely interrogate and analyse data, question providers and seek patient feedback on all aspects of delivery for each specialised service.

191 **Experience**: Commissioning expertise should be of a level to inspire trust in patients and clinicians; this is the most commonly quoted feature that distinguishes poor commissioning from good commissioning from a provider and patient perspective.

192 **Independence**: Commissioners should be able to use challenging initiatives to exert leverage and influence. (This might involve commissioning an independent survey of patient and carer views or proactively seeking new competitors to assess for designation status.)

Expertise

193 **Analysis and audit:** Commissioners should be able to independently audit and analyse provider data and to have the capacity to routinely and randomly do so; the provider will judge a commissioner's expertise on whether the commissioner can tell if the service provided is that specified in the contract.

194 **Standards**: Commissioners should be able to monitor and appraise specialised services against nationally agreed service and clinical standards, using the designation process to ensure standards are developed, where the appropriate.

195 **Comparisons:** Commissioners should be able to benchmark, compare and contrast services to lever service improvement and greater cost effectiveness.

196 **Effectiveness:** Commissioners should be able to develop nationally agreed clinical outcomes, measured through national clinical databases, for each specialised service.

Recommendation 32: Commissioner Powers

Commissioners should have sufficient powers to be able to:

- Safeguard access for patients to the full range of services and manage demand for scarce resources and expertise
- Stimulate supply and control the entry and exit of providers to maintain safe and high quality services
- Promote contestability and value for money.

Appendix 1 List of Specialised Services Commissioned by the NHS

as set out in the Specialised Services National Definitions Set (2002)

1. Specialised cancer services (adult)
2. Specialised services for blood and marrow transplantation (all ages)
3. Specialised services for haemophilia and other related bleeding disorders (all ages)
4. Specialised services for women's health (adult)
5. The assessment and provision of equipment for people with complex physical disability (all ages)
6. Specialised spinal services (adult)
7. Complex specialised rehabilitation services for brain injury and complex disability (adult)
8. Specialised neurosciences services (adult)
9. Specialised burn care services (all ages)
10. Cystic fibrosis services (all ages)
11. Renal services (adult)
12. Home parenteral nutrition services (adult)
13. Specialised cardiology and cardiac surgery (adult)
14. HIV/AIDS treatment and care (all ages)
15. Cleft lip and palate services (all ages)
16. Specialised immunology services (all ages)
17. Specialised allergy services (all ages)
18. Specialised services for infectious diseases (adult)
19. Specialised services for hepatology, hepatobiliary and pancreatic surgery (adult)
20. Medical genetic services (all ages)
21. Specialised learning disability services (adult)
22. Specialised mental health services (adult)
23. Specialised services for children
24. Specialised dermatology services (adult)
25. Specialised pathology services (all ages)
26. Specialised rheumatology services (adult)
27. Specialised endocrinology services (adult)
28. Hyperbaric oxygen treatment services (adult)
29. Specialised respiratory services (adult)
30. Specialised vascular services (adult)
31. Specialised pain management services (adult)
32. Specialised ear surgery (all ages)
33. Specialised colorectal services (adult)
34. Specialised orthopaedic services (adult)
35. Morbid obesity services (all ages)

Appendix 2

LIST OF NATIONALLY COMMISSIONED SERVICES

Services designated and funded by NSCAG as of 1 April 2006

1. Alstrom syndrome service for adults and children *****
2. Amyloidosis service (diagnostic service)
3. Bladder exstrophy service for children
4. Choriocarcinoma service
5. Complex tracheal disease service for children *****
6. Craniofacial surgery service
7. Epidermolysis bullosa service for children
8. Epidermolysis bullosa service for adults
9. Extra corporeal membrane oxygenation service for adults **#**
10. Extra corporeal membrane oxygenation service for neonates, infants and children
11. Extra corporeal membrane oxygenation / Ventricular assist devices (bridge to heart transplant) service for children
12. Heart and lung transplantation service for adults and children
13. Liver transplantation service for adults and children
14. Lysosomal storage disorders service
15. Mental health service for Deaf children and adolescents (inpatient service)
16. Ocular oncology service
17. Ophthalmic pathology service
18. Osteo odonto keratoprosthesis service *
19. Pancreas transplantation service
20. Persistent hyperinsulinaemic hypoglycaemia service for infants *****
21. Primary ciliary dyskinesia service (diagnostic service) *****
22. Primary malignant bone tumours service
23. Pseudomyxoma peritonei service
24. Pulmonary thromboendarterectomy service
25. Rare neuromuscular diseases service
26. Reconstructive surgery in adolescents for congenital malformation of the female genital tract service
27. Retinoblastoma service
28. Secure forensic mental health service for young people
29. Severe combined immunodeficiency and related disorders service
30. Severe intestinal failure service
31. Small bowel transplantation service for adults
32. Small bowel transplantation service for children
33. Specialist paediatric liver service
34. Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders **#**
35. Telemental health service for Deaf children and adolescents **#**
36. Vein of Galen malformation service for children *****
37. Ventricular assist devices (bridge to heart transplant) for adults **#**
38. Ventricular assist devices / Extra-corporeal membrane oxygenation (bridge to heart transplant) service for children

Services designated by NSCAG but not funded by NSCAG:

1. Deep brain stimulation for Parkinson's disease service
2. Pulmonary hypertension service

***** *Services designated from April 2006*
# *NSCAG services currently being independently evaluated*

Appendix 3

MEMBERS OF THE REVIEW GROUP

Chair:
Sir David Carter (Former Chief Medical Officer of Scotland)

Office of the SHAs:
Adrian Pollitt (Director)

Specialised Commissioning Group Chair:
Peter Spilsbury (Director at Birmingham SHA and chair West Midlands SCG)

Specialised Commissioning Group chief officer:
Jaki Meekings (Director of Commissioning, South SCG)

Local Specialised Commissioning Group Chair:
Caroline Taylor (Chief Executive of Croydon PCT and chair of South West London LSCG)

Local Specialised Commissioning Group chief officer:
Jon Develing (Director of Commissioning, Cheshire & Mersey LSCG)

SHA Director of Performance:
Cameron Ward, (Director of Performance, Northumberland, Tyne & Wear SHA)

Specialised services clinicians:
Dr Frances Flinter (Clinical Director of Children's Services & Genetics, Guy's and St Thomas')
Professor Sue Bailey (Registrar, Royal College of Psychiatry)

Specialised Healthcare Alliance:
John Murray (Chief Officer)

NSCAG:
Professor Rod Griffiths (Chair of NSCAG and President of Faculty of Public Health)

DH:
Dr Jane Moore (Representative for the DCMO, Healthcare Quality & Standards)
Bob Ricketts (Representative for the Director of Policy, Strategy and Business Development)

Appendix 4

SURVEY OF COLLECTIVE COMMISSIONING ARRANGEMENTS BY LOCAL SPECIALISED COMMISSIONING GROUPS (March 2006)

Table showing how many LSCGs collectively procure individual specialised services and whether there is a risk sharing arrangement in place.
Figures in bold italics identify where more than half of LSCGs are collectively procuring the indicated service

	Service	Number of LSCGs Collectively Procuring		
		Total	Yes and risk share	Yes, but no risk share
1	Specialised cancer services (adult)			
1a	***Lung***	***14***	***11***	***3***
1b	Pancreatic	10	8	2
1c	Sarcomas	10	8	2
1d	Testicular	10	8	2
1e	Young people	10	9	1
1f	Other	12	11	1
2	***Specialised services for blood and marrow transplantation (all ages)***	***17***	***16***	***1***
3	***Specialised services for haemophilia and other related bleeding disorders (all ages)***	***17***	***15***	***2***
4	***Specialised services for women's health (adult)***	***14***	***12***	***2***
5	***The assessment and provision of equipment for people with complex physical disability (all ages)***	***16***	***15***	***1***
6	***Specialised spinal services (adult)***	***17***	***14***	***3***
7	***Complex specialised rehabilitation services for brain injury and complex disability (adult)***	***17***	***16***	***1***
8	Specialised neurosciences services (adult)			
8a	***Deep brain stimulation for Parkinson's disease***	***14***	***12***	***2***
8b	Neurosurgery	12	12	0
8c	***Rehabilitation***	***13***	***12***	***1***
8d	***Stereotactic radiosurgery/therapy***	***16***	***14***	***2***
8e	Other (Spasticity Services)	8	8	0
9	***Specialised burn care services (all ages)***	***20***	***18***	***2***
10	Cystic fibrosis services (all ages)	12	11	1
11	Renal services (adult)			
11a	***Dialysis***	***17***	***14***	***3***
11b	***Transplantation***	***15***	***13***	***2***
12	Home parenteral nutrition services (adult)	6	6	0
13	Specialised cardiology and cardiac surgery (adult)			
13a	***Congenital heart disease (adult, not children)***	***14***	***13***	***1***
13b	***Implantable cardioverter defibrillator (ICD)***	***23***	***22***	***1***
13c	***Invasive cardiology (not revascularisation)***	***14***	***13***	***1***
13d	***Revascularisation (CABGs & PTCAs)***	***15***	***14***	***1***
13e	***Pulmonary hypertension***	***17***	***13***	***4***
14	***HIV/ AIDs treatment and care (all ages)***	***13***	***12***	***1***
15	***Cleft lip and palate services (all ages)***	***15***	***14***	***1***
16	Specialised immunology services (all ages)	0	0	0
16a	Primary immunodeficiency disease (PID)	6	6	0
17	Specialised allergy services (all ages)	5	4	1
18	Specialised services for infectious diseases (adult)	5	4	1
19	Specialised services for hepatology, hepatobiliary and pancreatic surgery (adults)	11	9	2
20	Medical genetic services (all ages)	6	6	0
20a	***Haemoglobinopathies (sickle cell/thalassaemia)***	***16***	***12***	***4***
21	Specialised learning disability services (adult)	5	3	2

Note: Number of LSCGs = 26. (Where an SCG commissions on behalf of its constituent LSCGs, the number of LSCGs being represented is counted. Hence London SCG = 5 LSCGs, West Midlands SCG = 4 LSCGs, Northern SCG = 1 LSCG.)

Table showing how many LSCGs collectively procure individual specialised services and whether there is a risk sharing arrangement in place. Figures in bold italics identify where more than half of LSCGs are collectively procuring the indicated service				
Service		Number of LSCGs Collectively Procuring		
		Total	Yes, and risk share	Yes, but no risk share
22	Specialised mental health services (adult)			
22a	Addiction	5	4	1
22b	Deaf	5	4	1
22c	Eating disorders	11	10	1
22d	***High secure forensic***	***17***	***12***	***5***
22e	***Medium secure forensic***	***19***	***18***	***1***
22f	***Low secure forensic***	***15***	***15***	***0***
22g	Learning disability	11	3	8
22h	Neuropsychiatry	10	5	5
22i	Perinatal psychiatric	9	8	1
22j	Personality disorders	5	4	1
22k	Specialised psychological therapies	4	3	1
22l	Treatment resistant disorders	9	3	6
22m	Other	3	3	0
23	Specialised services for children			
23a	Children/adolescent mental health services - tier 3	5	5	0
23b	***Children/adolescent mental health services - tier 4***	***16***	***16***	***0***
23c	Congenital heart disease	11	11	0
23d	***Neonatal intensive care (NICU)***	***19***	***18***	***1***
23e	***Paediatric intensive care (PICU)***	***16***	***15***	***1***
23f	Spinal cord deformities / scoliosis	5	4	1
23g	Spinal cord injuries	10	10	0
23h	Other (See Note)	12	12	0
24	Specialised dermatology services (adult)	5	4	1
25	Specialised pathology services (all ages)	5	4	1
26	Specialised rheumatology services (adult)	5	4	1
27	Specialised endocrinology services (adult)	5	4	1
28	Hyperbaric oxygen treatment services (adult)	8	8	0
29	Specialised respiratory services (adult)	10	8	2
30	Specialised vascular services (adult)	5	4	1
31	Specialised pain management services	7	6	1
32	Specialised ear surgery (all ages)		0	0
32a	Cochlear implants	11	9	2
33	Specialised colorectal services (adult)	5	4	1
34	Specialised orthopaedic services (adult)	2	4	2
35	Morbid obesity services (all ages)	11	7	4
36	Additional services:			
36a	Metabolic diseases	9	8	1
36b	***Photodynamic therapy***	***15***	***8***	***7***
36c	Other	9	9	0

Note: Number of LSCGs = 26. (Where an SCG commissions on behalf of its constituent LSCGs, the number of LSCGs being represented is counted. Hence London SCG = 5 LSCGs, West Midlands SCG = 4 LSCGs, Northern SCG = 1 LSCG.)

Appendix 5

CASE STUDIES ON SPECIALISED SERVICES COMMISSIONING

1. Arbitration (London Specialised Commissioning Group)
2. Audit (8 Local Specialised Commissioning Groups in South East England)
3. Entry / Exit of Collaboratively Commissioned Services (Scotland – National Services Advisory Group)
4. National Commissioning (National Specialist Commissioning Advisory Group)
5. Patient / Public Involvement (London Specialised Commissioning Group)
6. Prioritisation (Thames Valley Local Specialised Commissioning Group)
7. Public Health (West Midlands Specialised Commissioning Group)
8. Risk Sharing (NORCOM Local Specialised Commissioning Group)
9. Quality (West Midlands Specialised Commissioning Group)
10. Service Review (Northern Specialised Commissioning Group)

CASE STUDY 1: Dispute Resolution Process for Specialised Services Commissioning – London SCG

The formal arbitration process is in two parts:

A] For disagreements between PCTs within consortia. Each consortium has a Management Protocol which includes the decision making process for the consortium and should address most difficulties. If the consortium is unable to resolve the difficulty through its decision making process, the Chair of the Consortium formally raises the issue with the SCG's Head of Specialised Commissioning who then agrees an appropriate process for resolving the dispute with the SHA Finance representative on the SCG.

B] For disagreements between consortia and trusts. There is an escalation process which starts with PCT/Consortium and Trust Finance Directors, escalates to PCT Chief Executive Chair of Consortium and Trust Chief Executive and then to more formal processes.

Where the dispute has a value in excess of £100k, there is a two stage process, starting with a facilitated meeting with 3 commissioner representatives and 3 Trust representatives, a Director from the relevant SHA, Head of Specialised Commissioning, expert clinical advice and representation from neighbouring SCGs for pan Thames consortia.

If facilitation is not possible, an arbitration panel is established with neutral (to the dispute) membership at Chief Executive and Director level – PCTs, Trusts and SHAs, and neighbouring L/SCG representation for pan Thames consortia. Providers and Commissioners are invited to present their cases and the decision of the panel is binding on all parties.

The process for Foundation Trusts (FTs) is detailed in the FT Contract documentation.

Key Assumptions Underpinning the Process

Each consortium has a management protocol which includes the risk sharing agreement for commissioners and trusts. Most risk sharing between commissioners is based on a 3 year rolling average of activity. The Haemophilia commissioner consortium no longer risk share but pay in full as expected of Payment by Results which assumes that drugs, consumables and outpatient attendances are prescribed. HIV has a more complex arrangement where there is a 2% or 3% tolerance and a graduated contribution from commissioner and provider eg for the first 1% it is a 25%/75% contribution from commissioner/ provider; for the second 1% it is 50%/50%; for the third it is 75%/25% commissioner /provider; and for over 3% it is all paid by the commissioner.

Each LSCG has a binding decision making arrangement eg for NWL LSCG if 6 PCTs agree the decision is binding on the other 2 PCTs. There is no risk sharing for the totality of specialised budgets across PCTs but risk sharing for each consortium. If a consortium overspends then all members contribute on the basis of their percentage contribution to the baseline budget.

CASE STUDY 2: AUDIT: Audit, Information and Analysis Unit for London, Kent, Surrey, Sussex, Essex, Bedfordshire and Hertfordshire

Background

The Audit, Information and Analysis Unit (AIAU) came into being on the 1 April 2004. It is funded by 79 PCTs in London, Kent, Surrey, Sussex, Essex, Beds and Herts which between them cover 8 LSCGs.

The predecessor organisations evolved from what was the SE Thames RHA regional medical audit programme set up in 1990. As organisations merged and changed, the unit evolved. The unit initially focused on small specialty and professional group studies. In 2000 the focus was redirected towards specialised services. Funding was originally top sliced from Health Authorities by SE Thames RHA and then South Thames RHA. When PCTs came into being in South Thames they picked up the funding. North London PCTs agreed funding in 2003; Essex, Beds and Herts PCTs in 2005.

The AIAU is accountable to the London SCG and hosted by the SE London LSCG. The 2005/06 budget is £503,333, based on PCT weighted capitation (although Essex, Beds and Herts PCTs contribute a reduced level). There are 11 staff that support the work programme: eight project coordinators, one research analyst, a business coordinator and a Head of Unit.

Scope of the AIAU

The role of the AIAU is to support and enable clinicians, trust managers and commissioners, with involvement by patients and the public, to provide equitable access to quality specialised services across organisations.

The work of the AIAU is integrated and aligned with the specialised commissioning agendas' for the 8 LSCGs. The AIAU work programme is established by the London SCG and the LSCGs on the basis of recommendations made by the London Commissioning Sub Group.

The Advisory Board oversee the work of the AIAU including:

- Ensuring academic rigour of studies
- Approving study protocols prior to commencement of projects
- Ensuring that the agreed objectives of the project are met and reported at the conclusion of the study and the outcomes are implemented.

The AIAU is responsible for carrying out focused studies in specialised services. These studies may include assessments of equity of access, review of referral protocols, outcomes and baseline reviews, organisational and clinical audit studies, and development of clinical management guidelines and integrated care pathways where they do not exist. Each study includes action plans for the implementation of recommendations. In 2005/06 the work programme covered 40 studies in 11 specialised service areas as well topics relating to Public, Patient Involvement, Genitourinary Medicine and Haematology.

Work programme outcomes
The study recommendations provide information for both clinicians and commissioners, with input from patients, to implement changes to:

- Optimise the use of existing capacity
- Use resources more efficiently
- Deliver more appropriate services to patients
- Improve equity of access for patients
- Provide safer services for patients

These arrangements offer the commissioners clear quality control mechanisms to ensure high and consistent standards of care are provided for patients accessing treatment in specialised services.

CASE STUDY 3: Commissioning Services Nationally in Scotland - Service Entry and Exit Process - National Services Division - Scotland

The National Services Advisory Group (NSAG) in Scotland has developed a formal process for considering applications from NHS Boards to have services designated and funded as national specialised services (and to designate and fund national managed clinical networks).

Applications are invited from NHS Boards at least 18 months in advance of any designation and national funding taking place. There are no additional central funds for designated national services; the funding of the National Services Division (NSD) funding is derived from NHS Boards' general allocations. Decisions on designation are therefore prioritised alongside all other pressures in the healthcare system, since any funding allocated to NSD reduces the total available for local and regional services.

A standard form is used by NHS Boards to submit applications covering issues such as clinical and cost effectiveness and these are considered by NSAG using a predetermined set of criteria. Applications that meet the NSAG criteria are further considered by the NHS Board Chief Executives' Group to confirm affordability, before designation is sought from Ministers.

For NSAG to consider designation of a service there must be clear evidence that all forms of local, regional and cross-regional consortia commissioning are inappropriate and that there is a real threat to the continuing provision or development of a Scotland-wide service of proven benefit. There is an obligation on providers of national services to prepare reports, which cover both clinical and financial aspects and this must be recognised and accepted in any service application. Additional funding is not made available to meet NSD reporting requirements.

In parallel with this process NSAG also considers existing services for de-designation 17 months in advance, to provide adequate time for NHS Boards to plan alternative funding. A similar process is adopted and the NHS Board Chief Executives' Group views are again taken into account, before any Ministerial approval is sought.

CASE STUDY 4: NSCAG - National Commissioning

The National Specialist Commissioning Advisory Group (NSCAG) designates and commissions services that:

- Relate to a clearly defined group of patients
- Relate to a condition which is so rare that the national caseload is unlikely to be above 400, and would not normally exceed 1,000
- Are capable of being provided by a small number of centres, which can between them meet the needs of the national caseload
- Place a significant financial burden, when cases arise, on PCTs' funds

In addition, NSCAG only considers established services, services that are at risk in some way and services that would be able to justify their costs when set against alternative uses of NHS funds.

NSCAG operates a rigorous process to assess whether or not a service should be designated. When initial contact is made by a service or provider, the NSCAG Medical Adviser sends the potential applicant a bid proforma and a set of guidance on how this should be completed. Applicants are encouraged not to write a lengthy submission at this stage in case their service does not meet the NSCAG criteria. If the applicant wishes to pursue making a bid, the Medical Adviser visits the applicant for an informal discussion. If, after this meeting, it is clear that the service meets the NSCAG criteria, the applicant completes the bid proforma and sends this to the NSCAG Commissioning Team for consideration.

All bids for potential designation are considered at the quarterly NSCAG Advisory Group meetings where the membership includes Presidents of five Medical Royal Colleges.

An analysis of the new applications that were considered by NSCAG between June 2003 and October 2005 shows that a total of 17 applications were considered, for 14 different services. Of the 14 services considered, NSCAG recommended that eight should be designated and that six should not. Of the recommended eight, four had been considered at least once previously.

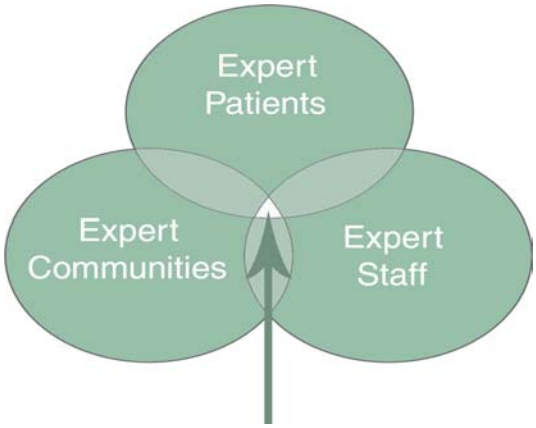
Once designation has been recommended, a submission is sent to the Minister for his consideration of the Advisory Group's recommendations. If approved, the DH Financial Issues Group then decides on how the transfer of funding from PCTs to NSCAG should be undertaken.

Concurrently, detailed discussion takes place between the proposed centres and the NSCAG Commissioning Team. This includes discussion on the costs of the service, outcome measures, activity-reporting requirements and the appropriate nature of the service level agreement.

CASE STUDY 5: Patient and Public Involvement - London SCG

Given their complex nature, specialised services have always presented a challenge for patient and public involvement. However, the London Specialised Commissioning Group (London SCG) is committed to creating a patient-led NHS and, to this end, strives for a high level of patient and public involvement in its own work, and also seeks to facilitate this within the services for which is it is responsible.

In early 2003 the London SCG began an extensive process of involving patient interest groups and individuals who used specialised services in developing patient and public involvement in London's specialised services. The resulting strategy, Living Well, was produced in March 2003. The strategy is based on the tripartite model shown below.



Shared decision taking
Influencing and improving service commissioning and delivery

The London SCG Patient and Public Involvement Reference Group (PPIRG) was established in July 2003 with 25 members. The Terms of Reference of the group are available on line at: http://www.londonspecialisedcommissioning.nhs.uk/patientandpublic/index.asp where the PPIRG's strategy and Annual Report can also be found.

The PPI Strategy includes a set of agreed principles adopted by the London SCG. These are key both to why the PPIRG exists and how it must work. The principles are:

- Patients and the public are entitled to be involved in decisions taken about care in the NHS
- There must be honesty about the scope of patient and public involvement. Patients and the public should be made aware of any constraints on their ability to influence decision-making
- The involvement of patients and the public must be embedded in the structures of the NHS and permeate all aspects of healthcare
- There is also a role for independent organisations and individuals in bringing about change, and the NHS should support this
- Patients and the public should have access to the information required to enable them to make informed decisions about their care and the planning and provision of healthcare

- Healthcare staff must be partners in the process of involving patients and the public
- The London SCG will work in partnership with other organisations with an interest in patient and public involvement, and with other NHS organisations, to achieve an effective and integrated system across London
- There must be clear, open and accountable procedures for involving patients and the public
- A wide range of individuals and groups should represent patients and the public. Therefore, strenuous efforts must be made to engage all sections of the community, especially the groups that the NHS has found traditionally "harder to reach"
- The systems for involvement should be evaluated for their effectiveness, in particular for how they involve "harder to reach" groups
- Patients and the public should have access to training and support to allow them to participate fully
- Patient and public involvement must be adequately resourced and funded.

Notable areas of achievement for PPI over 2004/2005 include:

- The London SCG PPI Reference Group met every two months. Visits were made regarding paediatric cardiology at Great Ormond Street Hospital for Children NHS Trust, hepatology at The Royal Free Hospital NHS Trust and burns care at Mid-Essex NHS Trust. The Group contributed to the Healthcare Commission's review of Foundation Trusts
- In partnership with the Commission for Patient and Public Involvement in Health (CPPIH), a well-attended and favourably evaluated training session was run about specialised commissioning for London Patient and Public Involvement Forum members
- A meeting was held with Harry Cayton, Director for Patients and the Public at the Department of Health, to discuss the London model of "Expert Patients, Expert Staff, Expert Communities"
- An Expert Patient Programme for renal patients was developed with the Renal Unit at Epsom and St Helier University Hospitals NHS Trust and other partners in S W London
- PPI Steering Groups were established specifically for HIV and haemophilia services
- A part-time PPI project worker was appointed
- Meetings were held with the Department of Health and the Centre for Public Scrutiny to establish a clear consultation pathway for proposed changes to specialised services
- A very successful half-day event about PPI in HIV services was held, with over 100 attendees.

CASE STUDY 6: Prioritisation of Investment for Cost Pressures - Thames Valley LSCG

Context
Thames Valley LSCG works for 16 PCTs. In 2005/6 the LSCG commissioning team planned and prioritised service investment for specialised services. The PCTs purchase services in 4 collaborative clusters, largely modelled on the old Health Authority boundaries. In 2006/7, 15 PCTs (i.e. all the PCTs within Thames Valley SHA area) are asking the LSCG to collectively commission on all their behalf circa £120m of health services. This covers 20 of the 35 NHS specialised services listed in the Specialised Services National Definitions Set. In 2007/8 the PCTs are planning to ask the LSCG to coordinate the collective commissioning of a further circa £100m of cancer services.

The Work Programme
The work programme for the LSCG is reviewed biannually and is dominated by national priorities and services that are struggling. The LSCG does a cost pressure review for each LDP round looking at both known activity pressures and the strategic recommendations from completed service reviews. A binding decision-making agreement enshrined in the LSCG's Establishment Agreement requires that if 70% of PCTs agree the rest must accept and fund the agreed developments/activity. Each year the cost pressures identified for the LDP are evaluated against 8 impact assessment risk categories, thus generating a relative weighting for each pressure so that some judgement can be made between relative priorities.

The Impact Assessment Risk Categories
The eight categories are: legal impact, media impact, political impact, health impact on patients, impact on government policy, evidence base for intervention, financial impact, and the patient numbers affected.
For each of these categories there are 4 definitions [A,B,C,D] of the relative risk of occurrence.
Each of these is scored .The maximum score any cost pressure could attain would be 32. The minimum would be 8. The higher the score the more ongoing pressure the PCT is likely to receive to change its policy stance.
All 8 categories are given the same weighting (although the categories could be weighted if it was felt some were more important than others) so there may be particular factors relating to one cost pressure that would make its relative priority more important than the raw score would indicate.

Prioritisation of the Pressures to which the Impact Assessment criteria are applied
In addition when the first cut LDP pressures paper is developed, cost pressures are also grouped under the following 5 areas, in score order, to ensure PCTs are reminded of why the pressures have been identified:

- Developments part funded the previous year
- Developments funded by the DH [or by soft money] that require local pick up
- National reviews resulting in cost pressures
- Service growth as a result of an increasing stock of patients or increased use of products /drugs
- Service developments to support reviews being undertaken or to maintain accreditation.

CASE STUDY 7: Public Health - West Midlands SCG

A UK Specialised Services Public Health Network has been established across the UK. It has been operating since September 2004. It largely operates as a Yahoo group but also holds a meeting twice a year. The network members are part of specialised services commissioning teams or provide substantial public health support to such teams.

This group of public health professionals is highly active as indicated by over 250 communications per month, and as such, has become indispensable to those working in specialised services.

This group of public health staff:

- dramatically reduces professional isolation
- enables rapid sharing of information, policies etc.
- enables rapid access to expertise in particular areas
- enables joint work to take place efficiently and almost in real time dialogue
- strengthens individual's work by accessing wider input
- enables individuals to work on strategic goals which require collaborative effort
- provides an vibrant environment for debate and developing new ideas
- provides peer support
- gives a voice to a professional group and also a means for others to gain professional opinion on relevant topics and issues
- provides a vehicle for continuous professional development.

CASE STUDY 8: Financial Risk Sharing - NORCOM LSCG

NORCOM is the LSCG covering all PCTs in South Yorkshire SHA plus High Peak & Dales PCT, North Eastern Derbyshire PCT, Chesterfield PCT and Bassetlaw PCT. NORCOM has produced a policy to assist PCTs in determining when it is appropriate to risk share the cost of specialised services and in calculating individual commissioner shares.

It has been agreed that when considering whether or not a risk sharing arrangement should be established, one or more of the following 4 criteria should be met:

- Where the service or treatment has low incidence and/or high cost per patient and there is likely to be small number random variation in patient numbers per PCT (e.g. Blood and Marrow Transplantation);
- There is a new service – usually a specialised service - for which initial activity levels are difficult to predict and a critical mass of investment is needed to start up and initially maintain the service (e.g. Photodynamic Therapy);
- A critical mass of service infrastructure is required to meet national standards. The designated service providers and the clinical networks they serve are nationally recognised. Immediate/urgent access is more important than equity of access (e.g. Paediatric & Neonatal Intensive Care);
- Where the commissioner is unable to influence the care pathway or activity levels through local service development or demand management in respect of a specialised service (e.g. Renal Services).

When a new risk share is proposed the commissioner shares analysis is produced showing the impact on PCTs by weighted population and by historical usage. This comparative information highlights where there are significant inequities between PCTs and helps to inform the judgement about when commissioner shares need to be actioned, by exception, on a historical usage basis.

The risk sharing portfolio is reviewed on an annual basis from two perspectives. Firstly, to review whether or not it is still appropriate for the risk share arrangement to continue and secondly, to review the methodology for calculating the commissioner shares.

CASE STUDY 9: Service Quality - West Midlands SCG

The West Midlands SCG is in the process of developing a framework for improving both service quality and the quality of its commissioning. A modified version of 'Maxwell's' criteria for quality is used to underpin the process, which complements and builds on the NHS Performance Assessment Framework.

Before any substantial piece of commissioning work is undertaken, the lead person undertakes a process of project initiation. The project initiation has three elements:

- The provision of regular 'sounding board' meetings for individuals to access at the start of and during a project
- The provision of a checklist of issues, which should be considered at the start of a project with the view to improving both the quality of commissioning and the services commissioned. In particular:
  - How can the commissioning process be improved in this area?
  - What elements of a health needs assessment are required?
  - Which of Maxwell's criteria will be addressed by the project and how?
  - Does the project aim to produce quality standards?
  - Who are the main stakeholders in this service? What is their role in the project?
  - How will quality be measures and monitored?
- Completion of a project initiation document, which facilitates the need to have a clear understanding of the exact nature and remit of the project, who/which body is the main sponsor of this project as well as develop an outline plan.

The process aims to provide:

- a means to clarify why a piece of work is being undertaken, its aims and objectives, and produce a timetabled outline plan for the project
- an opportunity to consider quality aspects – including how commissioning can be improved and how service quality can be improved including what sort of service standards should be developed
- a means to access the full range of expertise and experience of the members of the commissioning team or identify a skills gap
- a vehicle for taking soundings, support and advice on change management issues faced during a project
- a vehicle for training and personal development within the team
- a vehicle for evaluating a project on completion and sharing lessons learnt.

In addition to this West Midlands SCG has introduced critical incidence management into commissioning issues and a review process by which major problems that have arisen are analysed and lessons learnt are drawn up and addressed in a systematic way.

CASE STUDY 10: Service Reviews – Northern SCG

Context

Northern SCG covers a population of around 3 million, within 2 Strategic Health Authorities (and part of a third SHA), and 19 Primary Care Organisations (PCO) grouped into 4 Local Collaborative Commissioning Groups (LCCGs). There is a dedicated specialised commissioning team, NORSCORE (Northern Specialised Commissioning Core Team) which manages and implements specialised collaborative commissioning across the participating PCOs in the Northern SCG area. NORSCORE comprises of a team of 8 plus the Head of Northern Specialised Commissioning (who is in turn responsible to the Northern SCG) – a senior commissioner and 2 commissioners for policy and planning work; a procurement and performance manager for service agreements and monitoring; a finance manager and a finance and activity analyst; a senior manager (priority services) and an administrator.

Service Planning

At a stakeholder workshop in the spring of 2004, the SCG was asked to deliver a proactive system of planning through the development of individual service collaborative commissioning strategies informed by a series of service reviews.

There are currently three categories of service review:

- **Initial Service Review**
  The initial service review is primarily a stock take and service safety check, usually undertaken where no previous review has been carried out or where the last review was conducted a considerable time ago and the services concerned may have materially changed.

- **Full Service Review**
  A decision to embark on a full service review, for which there is a standard template, usually follows consideration of the findings from the Initial Service Review. It is intended to be both rigorous and robust as it will inform the strategic direction of the service for the future (three to five years) along with any possible developments. It therefore builds upon the initial service review work but includes, in addition, a health needs assessment and future service configuration options. The steering group responsible for conducting the review is established as a formal time-limited sub-committee of the Northern SCG, with representation drawn from provider clinicians and managers, commissioners, public and patient representatives, as well as any other appropriate stakeholders.

- **Monitoring Review**
  Monitoring reviews are undertaken to check on progress where investment in services has already taken place, or where very specific aspects of a service require consideration. The purpose of such reviews is to enable the Northern SCG to decide the extent of any further action or work that is required.

Each spring, a workshop involving all stakeholders determines the work priorities for the following year including which services will be prioritised for review. The aim is to review all of the 35 specialised services on the Specialised Services National Definitions Set over a five year period. The workshop gives all participants an opportunity to raise issues and providers are encouraged to produce briefing papers to assist the debate and decision making. New NICE guidelines and National Service Framework requirements also routinely tend to become priorities.

Commissioning Strategy

If appropriate, the conclusions reached by a Full Service Review are translated into a Commissioning Strategy which is intended to be mutually coherent and affordable within commissioners longer term resource prospects. The strategies are developed on a broad brush basis and include the major areas for change, the broad process and timescale for making the changes and the associated financial strategy.

Once in place, the collaborative commissioning strategy provides a framework against which any individual proposals for developments or re-engineering of the service can be assessed. This encourages dialogue between commissioners and service providers about specific proposals and tends to mitigate against unsolicited bids for funding. The Northern SCG also normally makes full financial disaggregation of the relevant service a precondition to considering proposals to encourage the setting up of joint procurement arrangements through NORSCORE administered service agreements.

To date, NORSCORE has completed 49 service reviews and strategies, comprising; 3 Commissioning Strategies, 4 full service reviews, 23 initial service reviews and 19 monitoring reviews, as detailed in the table below. Work is currently being undertaken relating to service reviews in paediatric nephrology, paediatric oncology, haemophilia services, viral hepatitis, hepatology, neurosciences (including neurology, neurosurgery, neuro-rehabilitation, and neuro-diagnostics).

3 COMMISSIONING STRATEGIES	
No.	**Service Definition**
11	Renal
22	Mental Health Services – Services for the Deaf
22	Mental Health Services – Forensic

4 FULL REVIEWS	
No.	**Service Definition**
11	Renal Services
22	Medium & Low Secure Adult Mental Health Forensic Services
23	Child Sexual Abuse Services
23	Neonatal Intensive Care Services

23 INITIAL REVIEWS	
No.	**Service Definition**
1	Specialised Cancer Services for Adults
4	Infertility Services
4	Gynae Anomalies
6	Spinal Surgery : Tees Valley
7	Rehabilitation for Brain Injury and Complex Physical Disabilities
8	Neurosciences
10	Cystic Fibrosis
12	Home Parenteral Nutrition
13	Adult Congenital Heart Disease
17	Allergy (All Ages)
18	Infectious Diseases
19	Hepatology
22	Mental Health Services Gender Dysphoria
22	Mental Health Services for Deaf People
22	Mental Health Services Eating Disorders
23	Paediatric Oncology
23	Child & Adolescent Mental Health Services
23	Nephrology
24	Dermatology (Adult)
28	Hyperbaric Oxygen Treatment
29	Respiratory
33	Colorectal
1	PET CT

19 MONITORING REVIEWS	
No.	**Service Definition**
6	Spinal Injury
13	Cardiothoracic transplants, Cardiac electrophysiology, surgery, invasive cardiology
14	HIV/AIDS (Adults)
14	Paediatric HIV/AIDS
15	Cleft Lip & Palate Services
16	Clinical Immunology
20	Genetics
23	Paediatric Cardiology
23	Paediatric Gastroenterology
23	Paediatric Immunology
23	Paediatric Nephrology
23	Paediatric Intensive Care
25	Specialised Pathology
29b	Sleep Disorders
35	Morbid Obesity
9	Burns Care Services
N/D *	Lysosomal Storage Disorders
13	Pulmonary Hypertension
9	Burns

N/D* = No national definition

Decision making

As a formal sub-committee of the 19 PCOs, the Northern SCG has delegated powers to make binding decisions on specialised service issues affecting all the PCO members, subject to certain conditions and requirements (such as giving individual PCOs at least 30 days to consider potential financial commitments and to make representations before any binding joint decisions are made). If any service development funding is required, it is considered through an annual investment prioritisation process conducted by the Northern SCG. Whilst decisions taken by the Northern SCG are binding on its constituent PCOs, there is an expectation that decisions should normally be reached by consensus. If necessary, decisions can be put to a vote based on unified weighted capitation shares. The decision to support collaboratively is carried if 75% or more of the eligible votes are cast in favour. If not carried, the proposal lapses in terms of a collaborative commissioning decision and individual PCOs must then make their own interim arrangements until such time as acceptable alternative proposals can be agreed.

Appendix 6

PROPOSED RESPONSIBILITIES OF THE NATIONAL SPECIALISED SERVICES COMMISSIONING GROUP

The responsibilities of the NSSCG would include:

Commissioning:

- Coordinating by agreement of members the commissioning of specialised services that require a pan SCG commissioning approach and, where appropriate, nominating a lead SCG to act as the commissioner
- Monitoring the implementation of NSSCG decisions, ensuring that any agreed investment in specialised services is forthcoming and where appropriate arbitrating on commissioning decisions requiring pan SCG collaboration
- Providing advice to Ministers on specialised services that could be commissioned (and designated) nationally and/or transferred from national to SCG level commissioning and agreeing the timing and financial arrangements necessary to support such changes in commissioning responsibility
- Providing oversight of the commissioning process for those services agreed by Ministers to be nationally commissioned by the national commissioning team
- Being transparent and accountable to PCTs for the functions carried out for the populations for whom PCTs commission all other services
- Adhering to the principle of subsidiarity - only doing at a national or SCG level that which can clearly and explicitly be justified on grounds of efficiency and effectiveness in order to avoid unnecessary duplication
- Co-ordinating national capacity reviews.

Influencing:

- Ensuring that all national policy making is fully informed about the impact and implications for specialised services and commissioning
- Building a strong relationship with NICE and influencing the timetable and priorities for NICE health technology appraisals, reviews of interventional procedures and guidelines to promote smooth implementation and sound financial management
- Building a strong relationship with the Healthcare Commission and Monitor to ensure that policy and practice associated with standards, inspection and Foundation Trusts takes appropriate consideration of specialised services commissioning
- Ensuring mutually supportive relationships with the National Clinical Directors, Director of R and D, CMO and policy leads within the DH, so that the interests and concerns of specialised services commissioning are taken into account in a timely and constructive way
- Facilitating commissioning input to the development of national tariffs for specialised services

Coordinating, Developing & Facilitating (i.e. only doing things once):

- Developing outcome measures for specialised services and promoting their use by SCGs, the NCG and the NSSCG

- Working with the DH, Medical Royal Colleges and medical associations/societies and others to develop national clinical databases for monitoring, audit and bench marking performance against agreed clinical standards
- Developing and maintaining the Specialised Services National Definitions Set
- Establishing an ongoing national programme of clinical audit of specialised services using the expertise and participation of SCGs and the NCG
- Coordinating the NHS commissioning input into work with the DH Choice team on the extension of Choice to specialised services.
- Optimising the use of scarce commissioning expertise to promote excellence in commissioning and to minimise the number of commissioners that providers have to relate to
- Coordinating the development of an annual work programme of specialised service priorities, which require a pan SCG or national commissioning approach
- Promoting good practice by disseminating initiatives of specific SCGs that may be of interest to all SCGs and by working with SHAs on the development of performance management criteria for specialised services that can be consistently applied across the country
- Acting as an exemplar for sustaining a robust but flexible approach to patient and public involvement

Appendix 7

MODEL ESTABLISHMENT AGREEMENT FOR A SPECIALISED COMMISSIONING GROUP

The summary below covers the suggested main clauses that would be included in an Establishment Agreement.

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1. Introduction

- SCG is joint sub committee of PCT members
- PCT members list
- collective decisions re planning, procurement and monitoring of specialised services provided for populations greater than one million and/or as listed in the National Specialised Services Definitions Set
- excludes services nationally by the 'National Commissioning Group'
- covers non specialised services with the agreement of members
- links with the SHA and the Workforce Development Confederation
- agrees and monitors service agreements/contracts with providers on behalf of members

2. Functions of the SCG

- plans (including needs assessment), procures (including performance management of the service agreement/contract), monitors (quality and patient outcomes)
- designates providers to ensure maximum access but minimisation of unsafe proliferation of specialist centres
- manages the pooled budget from PCT members' allocations
- undertakes specialised service reviews
- manages the introduction of new services/drugs/technologies and develops risk sharing arrangements
- oversees implementation of NICE/other national guidance and standards
- co-ordinates specialised services commissioning approach to common providers of service within the SCG area and elsewhere
- manages 'Non-Contract activity' on behalf of members
- provides input to clinical networks, local commissioning groups/fora, co-ordinates service development plans with practice-based commissioners/PCTs
- develops and monitors service agreements/contracts, ensuring equity of access, highest clinical standards and value for money
- represents the SCG at the NSSCG, mandated to commit members to decisions made by NSSCG (and other pan SCG fora)
- provides 'lead' commissioner function for pan SCG services as required

3. Principles upon which the SCG is based

- SCG decisions binding on all members
- NSSCG decisions binding on all members
- reducing inequalities in access to and the delivery of services
- sharing skills, knowledge and/or appropriate resources
- utilising funds to commission services and support management costs in a transparent, cost effective way
- minimising financial risk to members of high cost/unplanned activity

- working in partnership with clinicians, providers and service users to plan, review and develop services
- maintaining close working links with providers, clinical networks, other commissioners
- arbitrating between members in case of disputes

4. Accountability of the SCG

SCG Level

- joint PCT sub committee
- PCT reps delegated to make decisions on their PCT's behalf at the SCG
- sufficient time for PCTs reps to consult their PCT prior to SCG decisions
- voting arrangements
- PCTs bound by decisions of the SCG
- PCTs' Standing Financial Instructions (SFI) and Standing Orders (SO) empower PCTs reps to commit resources
- frequency of meetings
- chair
- SCG commissioning team employed by the host PCT

Pan SCG Level

- SCG rep delegated to make decisions on their SCG's behalf at the NSSCG
- sufficient time for SCG rep to consult their PCTs prior to NSSCG decisions
- SCG bound by decisions of the NSSCG
- PCTs' Standing Financial Instructions and Standing Orders empower PCTs reps to commit resources

5. Membership of the SCG Meetings

- PCT members and deputies, quorum, SHA/provider/PPI reps
- administration of meetings
- decisions, voting,
- delegation
- sub-groups
- SCG role at NSSCG

6. Services Covered

- services covered

7. SHA role

- SHA oversight and performance management responsibilities

8. Funding Arrangements

- PCTs' contributions to SCG budget
- inflation and cost pressures
- new services
- in-year changes and over/under performance

9. Commissioning of Services

- range of possible providers (NHS Trust/FT/Private and Independent Sector/etc)
- member PCTs agree principles/functions of the SCG to act collaboratively to commission so as to:
  - approve range of SCG commissioned services
  - maintain transparent close working with member PCTs
  - designate providers

    - obtain best value (clinical/cost effectiveness, patient/carer views)
    - ensure Patient Choice requirements are met
    - agree/manage risk sharing
    - plan demand/financial needs
    - agree service specification/standards to include referral/discharge/other protocols
    - negotiate service agreements/contracts and variations, agree provider subcontracting arrangements
    - set the budget, manage in-year adjustments with providers and subsequent PCTs' adjustments
    - monitor provider performance – activity/finance/waiting times/agreed specification and standards/etc
    - carry out reviews as required
    - establish links/reporting arrangements with other collective commissioners - local, regional and national
- PCT members delegate their commissioning functions to SCG, SCG commissioning team commissions on the SCG's behalf
- SCG Chair/Director of SCG commissioning team signs service agreements/contracts on behalf of host PCT and as agent for all member PCTs in accordance with delegated financial limits set out in host PCT's SFI
- Host PCT collects subscriptions from member PCTs and pays providers on behalf of member PCTs as per service agreements/contracts
- SCG provides member PCTs with quarterly/annual summary for each service agreement/contact of finance/activity by planned/actual/forecast by total/individual PCT plus effect on risk-sharing arrangements
- SCG provides member PCTs with annual review of each service agreement/contact
- SCG provides member PCT with proposed annual costed commissioning plan for consultation prior to final agreement
- SCG will approve determine which services will be commissioned, from which providers
- Each PCT remains responsible for exercising its statutory duties/functions for its population and its patients
- Each PCT is responsible for payment of its agreed subscription and agree in-year and/or end of year adjustments

10. SCG Conduct of Business

- establish service review and implementation groups with specified delegated authority to achieve specified aims
- agree working relationship to other groups e.g. clinical networks, other commissioners
- establish a structure for co-ordination of commissioning
- agree a commissioning plan
- agree annual work programme and monitor progress
- agree and fund support structure to be provided by host PCT
- undertake annual review, present annual report to SCG and member PCTs
- SCG commissioning team to support SCG and member PCTs and commission service on their behalf

11. SCG Commissioning Team and Funding

- SCG commissioning team commission services on behalf of SCG
- SCG commissioning team employed by the host PCT
- SCG commissioning team lead by senior officer accountable to the Chair of the SCG

- SCG commissioning team may act as lead commissioner behalf of some /all SCGs
- SCG commissioning team be funded by PCT members

12. Service Providers and Clinicians Involvement

13. User Involvement

14. Facilitation and Arbitration

between SCG and providers; between SCG and member PCT(s)

- facilitation process
- arbitration process

15. Communication

- communicator role of PCT members
- communicator role of SCG commissioning team
- minutes of SCG meetings
- SCG annual report

Appendix 8

PROPOSED SPECIALISED SERVICES TO BE INCLUDED IN A SPECIALISED COMMISSIONING GROUP BUDGET

It is suggested that SCG budgets for 1 April 2007 should as a minimum cover the services in the table. Around half the L/SCGs currently have some form of collective commissioning arrangement for the services listed below.

Services for:

Blood & Marrow Transplants
Burns
Cardiac (Revascularisation, Implantable Cardioverter Defibrillators, Invasive Cardiology, Congenital Heart Disease)
Child & Adolescent Mental Health (tier 4)
Cleft Lip & Palate
Cochlear Implants
Cystic Fibrosis
Deep Brain Stimulation for Parkinson's Disease
Forensic Mental Health (medium/low secure)
Haemaglobinopathies
Haemophilia
Hepatology/Hepatobilliary & Pancreatic surgery
HIV/AIDS
Morbid Obesity
Neonatal Intensive Care
Neurohabilitation
Neurosurgery
Paediatric Intensive Care
Photodynamic Therapy for Age Related Macular Degeneration
Pulmonary Hypertension
Rare Cancers
Renal (Dialysis, Transplants)
Spinal Cord Injuries
Spinal Cord Deformities
Stereotactic Radiosurgery (Gamma Knife)

Appendix 9

CRITERIA FOR PRIORITISING THE ANNUAL WORK PROGRAMME OF A SPECIALISED COMMISSIONING GROUP

When considering the services for in-depth attention each year, SCGs should briefly review each service against the following:

- Vulnerability due to lack of succession planning, loss of staff, etc
- Increasing population need/demand (e.g. an increase in the number of new patients and / or survivors, increased use of drugs / products causing pressure on budgets and / or services)
- Services needing a review of designation status
- Serious risks to access due to provider constraints, changes or known intentions
- Concerns about clinical governance or clinical outcomes
- Inequity of access
- Major financial risks and the need to establish or review collaborative risk sharing arrangements or undertake a service review
- Ongoing work as lead SCG for the NSSCG on developing clinical outcomes or standards for a specific specialised service in collaboration with providers
- High risk service due to legal, media, political, government policy, evidence base, health impact or financial factors.

It is proposed that four broad categories should be used to help describe the focus of commissioning for each specialised service within the annual work programme.

The categories are:

- **Service Designation** – to include (i) the work to initially designate (including some health needs assessment; agreeing service standards/service specification and commissioner requirements; collaborative work with providers on standards, outcome measures and reporting requirements) (ii) thereafter to review designation status

- **Service Review** –to include (i) any or all aspects of strategic planning or a major service review which may include a review of the health needs assessment and service standards/service specification and providers and (ii) include implementation of the recommendations of the review

- **Developing Contestability and Benchmarking** – to include (i) the national work commissioners may be doing, overseen by the NSSCG, to work with providers to develop national service standards or outcome measures or tariffs (ii) the local work to test the adequacy and quality of services (e.g. stakeholder surveys or patient experience surveys or in-depth collaborative audits)

- **Routine Contract Management** – to include (i) monitoring of data associated with activity, finance and quality (and liaison with the procurers, if not the SCG) (ii) risk management, including management of over and under spending (iii) ongoing maintenance of high performing risk sharing consortia.

Within these four categories commissioners may be focusing on only some elements at any one time.

Appendix 10

MODEL FITNESS FOR PURPOSE FRAMEWORK FOR SPECIALISED COMMISSIONING GROUPS

Effective arrangements for the planning and commissioning of specialised services are essential in order to ensure that patients receive fair access to clinically effective, high quality services and that maximum benefit is obtained from the use of NHS resources.

Commissioning involves the whole process of needs assessment, strategic planning, purchasing (including funding, putting in place service agreements/contracts, and monitoring) and evaluation.

***(name)* Strategic Health Authority**	***(name)* Specialised Commissioning Group**

Dimensions	Criteria	Achievement (Y/N/P)*	Evidence of Achievement	Plans to reach full achievement
1. Engagement	PCTs work together to ensure that specialised services are commissioned effectively and documented agreements specify how (Establishment Agreement and Service Agreement).			
	Stakeholders, including providers and the public, are involved in SCG commissioning on a meaningful, long-term basis (e.g. by participating in collaborative commissioning advisory and service review groups).			
	The SHA is represented on the SCG and commissioning consortia as appropriate and provides support and expertise as well as ensuring consistent behaviour across PCTs.			
2. Structure	The remit, powers and rules of engagement of the SCG are agreed by the member PCTs and documented.			
	The decisions of the SCG are binding on all PCT members.			

Dimensions	Criteria	Achievement (Y/N/P)*	Evidence of Achievement	Plans to reach full achievement
	The SCG establishes a dedicated team(s) of commissioners (public health advisers and commissioning, finance, information and administrative staff) to support the collaborative commissioning function and to facilitate sustained, mature commissioning and the maintenance of long-term relationships with providers and the public. There are formal arrangements for obtaining clinical advice, economic analysis, public / patient advice and audit.			
	The SCG commissioning function ensures best use of scarce expertise to ensure knowledgeable commissioning and promote contestability and comparisons. (Most services will be commissioned by a team covering the whole SCG area for the specific service. For a few services, where there are strong local networks already established, local commissioning teams may be appropriate.)			
	The capacity of the SCG commissioning team is sufficient to carry out the full commissioning cycle (strategic planning, funding, specifying, procuring, monitoring, quality assurance, audit of outcomes).			
	There is an agreement in place between PCTs to share the cost of the dedicated SCG commissioning team.			
	Commissioners ensure that any commissioning arrangements support managed clinical networks and integrated care pathways.			

Dimensions	Criteria	Achievement (Y/N/P)*	Evidence of Achievement	Plans to reach full achievement
3. Joint Working	The SCGs collaborates with other SCGs where a specialised service has a planning population greater than 6 million (i.e. there should be fewer than 9/10 specialist centres in the country for that particular specialised service).			
	The SCG representatives at the NSSCG represent the views of constituent PCTs but make decisions in the interest of the population of England and the NHS.			
4. Strategy	The SCG has an annual work plan containing national and local priorities, which is owned by constituent PCTs and other key stakeholders.			
	The SCG contributes effectively to the work programme of the NSSCG.			
	The SCG's PCTs incorporate specialised services in their Local Delivery and Workforce Development Plans to ensure a coherent approach to commissioning and workforce planning at local level.			
	The SHA, in its oversight role, takes account of the cumulative impact of commissioning proposals on individual NHS trusts and facilitates transitional arrangements with the SCG if necessary.			
5. Delivery	The SCG ensures the commissioning process is transparent; and providers and the public are clear who is the lead commissioner for each specialised service at any one time.			
	The SCG commissioning arrangements focus on monitoring agreed service-specific standards, clinical outcomes and patient experience, and delivering service improvements.			

Dimensions	Criteria	Achievement (Y/N/P)*	Evidence of Achievement	Plans to reach full achievement
	Arrangements exist for considering providers' proposals for the introduction of new specialised services, research, innovation and service developments.			
6. Effectiveness	The SCG has a commissioning structure and process that ensures the provision of effective specialised services to meet patient need and respond to changes in services, technology and systems.			
	The SCG develops: • service specifications encompassing referral guidelines, access criteria, treatment protocols, service standards, outcome measures, NICE appraisals/guidelines, etc • agreed datasets and a process for monitoring activity, clinical practice, clinical outcome and patient experience.			
	The SCG accesses specialist advice for rare and complex conditions.			
	The SCG carries out clinical and capacity risk assessments			
7. Implementation	Every PCT maintains a close interest in collective considerations around new investment and service development proposals as well as in any proposals to move services from one provider to another.			
	PCT resources are allocated to implement SCG decisions, through the LDP process.			
	All PCTs honour the resource implications of SCG decisions.			
8. Financial Management	The SCG holds a budget for commissioning all specialised services derived from constituent PCT resource allocations.			

Dimensions	Criteria	Achievement (Y/N/P)*	Evidence of Achievement	Plans to reach full achievement
	The SCG develops risk-sharing mechanisms that cover all services and PCTs.			
	The SCG has appropriate structures and processes in place to manage and account for expenditure on behalf of PCTs.			
	The SCG has an agreed, transparent process for determining the SCG budget and for uplifting it for inflation and other generic cost pressures on an annual basis.			
	Arrangements are in place to minimise the financial risk to individual PCTs of any in-year fluctuations in activity/costs and to deal with over or under-spends at the year-end.			
	There are formal agreements for the introduction of new services, drugs and technologies.			
9. Monitoring	The implementation of SCG decisions is monitored and reported on including evaluation of the clinical benefits and costs of agreed service developments and changes.			
	The SCG and associated service-specific consortia report regularly to PCT boards and produce an annual report for wide circulation.			
	PCTs refer to the commissioning of specialised services in their Annual Reports.			

Appendix 11

PATIENT CHOICE AND SPECIALISED SERVICES

It is proposed that any extension of the 'Choice' options should be underpinned by the following principles:

- Choice should be available as far as is possible to patients who require specialised services
- Choice may be by provider, type of treatment, location (home / hospital), time period, health personnel, etc
- Choice in terms of access to a range of specialist centres may be constrained due to the limited number of providers of specialised services
- Choice may be constrained where the specialist care is delivered as part of a clinical / service network and the integrity of the care pathway would lead to less safe, poorer quality services if specialist care is sought from outside that network
- Choice points within the care pathway should be identified to maximise patient choice whilst minimising disruption of integrated network-delivered care that could lead to less safe, poor quality services.
- To exercise choice of specialised service provider or treatment type, patients should have access to understandable, accessible information.
- Additional resources (time and money) will be required to support the patient in making choices; in particular, additional staff time to: inform patients and discuss choices, research and provide information materials, liaise with other providers, etc
- Patients' groups should be actively included by providers and commissioners in the process of supporting patients in the exercise of choice.

Appendix 12

SPECIALISED SERVICES NATIONAL DEFINITIONS SET

A standard list of headings for the National Definitions Set are suggested below and a logical process that determines the most effective currency for commissioning each service which is linked to the development of national tariff and/or commissioning budgets.

The process might include the following sequential stages:

population served > needs assessment > service purpose > nationally agreed service model > critical mass for a safe and economically viable service > nationally agreed service standards and clinical outcome measures > nationally agreed diagnostic and procedure codes > nationally agreed currency (e.g. one patient year or three levels of complexity) > nationally agreed denominator (e.g. one patient, 5 or 10 or x episodes in a 6 month period) > comparisons of activity and costs to be used to inform the tariff setting > agreed activity and cost > national tariff or national definition of a service to be benchmarked.

Currency options might include:

- a procedure or intervention
- treatment for a year (if a long term disorder, possibly banded for complexity)
- individual care programmes banded for cost (including a range of interventions or episodes of care)
- standardised integrated care pathway
- as part of a cluster of services but with activity separated
- as a specialty with an estimated proportionate workload in different categories and activity reports that distinguish these
- as a clinical network but with the activity for each specialised service identified
- patient registers involving active patient management.

Appendix 13

PAYMENT BY RESULTS AND SPECIALISED SERVICES

Services that could be considered for exclusion from tariff include those where:

- There are a variety of acceptable service models with differing costs which could not easily be accommodated within tariff (e.g. paediatric rheumatology)
- The volume of activity at each of the specialist centres is very low (and likely to be subject to annual fluctuation) and/or the volume of activity nationally is small and the management effort required to develop tariff would not be cost effective
- There are acceptable reasons for paying differential prices to assure patient access, quality of outcome and service availability
- The variable cost element of the service is high and subject to fluctuation (eg haemophilia services).

Alternatives to the basic 'episode x tariff' price approach might include:

- An indicative model tariff
- An annual payment per patient, 'banded' to reflect different intensities and types of service input
- An average cost (or range of cost) per service (or services, if they are provided by the same clinical teams in a number of service providers), resulting from some form of national benchmarking.

A tariff based system needs to:

- Properly reflect the cost of providing specialised services
- Ensure that tertiary service providers are not financially disadvantaged
- Support the introduction of new services (or service models), drugs, devices and procedures
- Reward quality and encourage innovation
- Drive efficiency and cost reduction

Appendix 14

MODEL TOOL FOR BENCHMARKING THE PERFORMANCE OF SPECIALISED COMMISSIONING GROUPS

(*name*) Strategic Health Authority	**(*name*) Specialised Commissioning Group**

MILESTONE TRENDS – MONITORING OVER 3 YEARS				
Measures	**Year 1**	**Year 2**	**Year 3**	**Comments**
1. Budgets a) Separate budgets exist for each specialised service on the national definitions set b) Risk sharing agreements exist for all small volume, high cost services.				100% are expected by April 2008 (% of services = the measure) PCT collaborative risk sharing (% of services).
2. Monthly activity data by PCT by service by provider, routinely circulated with comment.				% of services for which this exists.
3. Clinical quality standards are monitored – at least 2 per service, at least quarterly.				% of services for which this exists.
4. Clinical outcomes or patient experience are measured for each service.				% of services for which this exists (nationally agreed outcomes are the aim.)
5. Reviews of designation of services a) the number of services for which a review has been completed in the last 5 years b) the number due to start in the next year.				A review is expected every 5 years for each service. Specificity of the services being reviewed needs sharing across SCGs by the NSSCG.
6. Benchmarking - the numbers of services for which activity, costs and quality are being benchmarked.				State which services and with which providers. % of services each year.
7. Survey of stakeholders' views and concerns re the quality of commissioning. a) what/ when/ with what outcome/ shared with whom b) key actions on survey findings.				This should be an independent survey, and every 3 years, covering providers, PCTs, PPI, OCSs etc. with the results shared openly.
8. Contribution to NSSCG work programme a) SCG is leading on what? b) SCG is contributing to what?				Specific milestones to be tabulated and performance managed by the SHA.
9. Financial management of over and underspends to achieve a balanced outturn annually rating: 1 poor, 2 average, 3 good.				Budget of SCG to be in balance annually.
10. Disputes needing arbitration a) numbers b) result c) learning.				Each dispute is written up to capture the learning.

Appendix 15

GLOSSARY

AIAU	Audit, Information and Analysis Unit
AIDS	Acquired Immunodeficiency Syndrome
AMD	Age-related Macular Degeneration
CMO	Chief Medical Officer
DCMO	Deputy Chief Medical Officer
DH	Department of Health
ECMO	Extracorporeal Membrane Oxygenation
FT	Foundation Trust
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HRG	Healthcare Resource Grouping
HSG	Health Service Guidelines
LSCG	Local Specialised Commissioning Group
L/SCG	Local Specialised Commissioning Groups and / or Specialised Commissioning Groups
NCG	National Commissioning Group
NHS	National Health Service
NICE	National Institute for Health & Clinical Excellence
NOG	National Oversight Group for High Secure Mental Health Services
NSCAG	National Specialist Commissioning Advisory Group
NSSCG	National Specialised Services Commissioning Group
OPCS	List of the classification of surgical operations and procedures as prepared by the Office of National Statistics (formerly the Office for Population Censuses and Surveys)
OSC	Overview and Scrutiny Committee
PBC	Practice Based Commissioning
PbR	Payment by Results
PCT	Primary Care Trust
PPI	Patient and Public Involvement
SCG	Specialised Commissioning Group
SHA	Strategic Health Authority
VADs	Ventricular Assist Devices
VFM	Value for Money

Appendix 16

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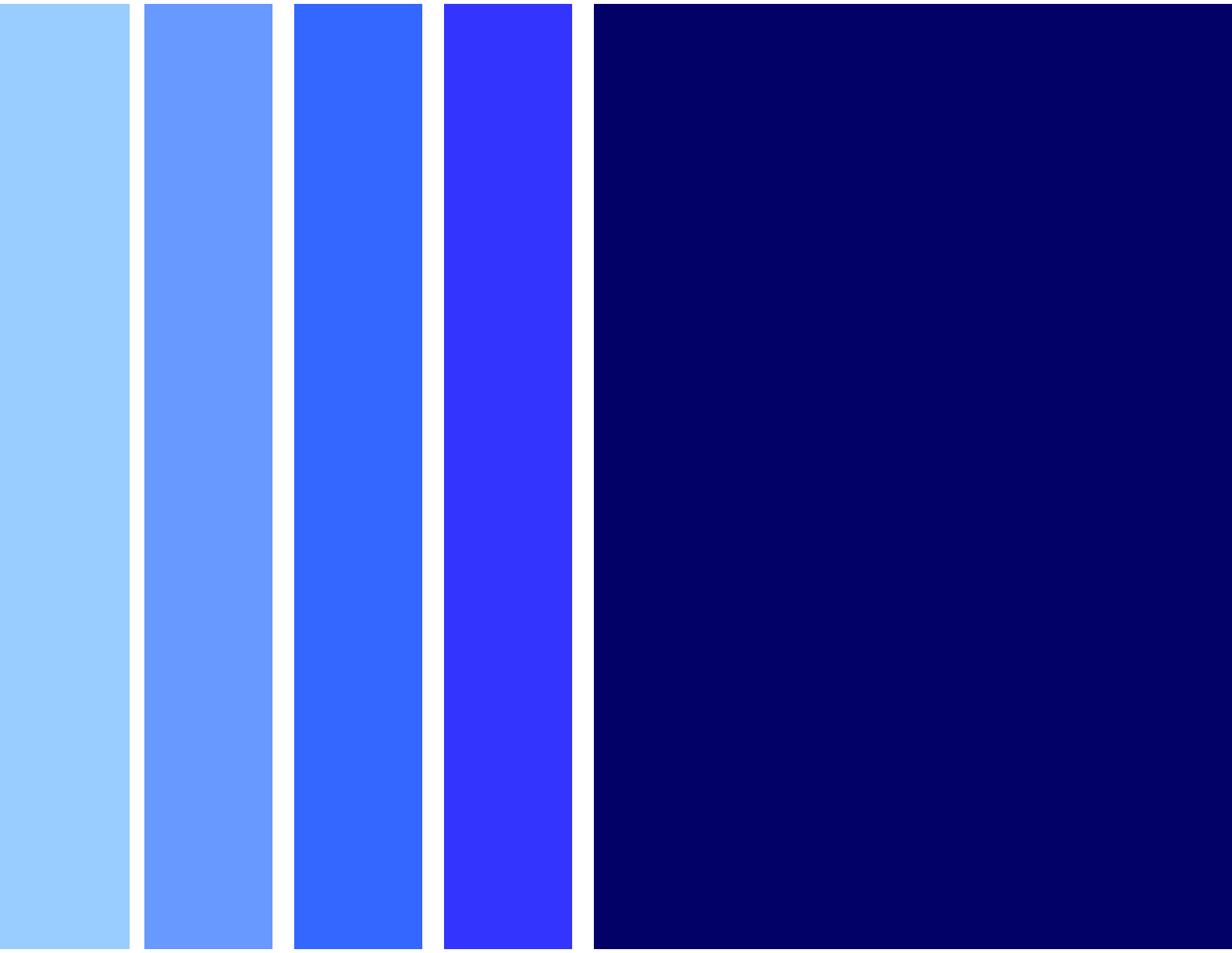

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