



## ***Specialised Healthcare Alliance***

### **SUMMARY REPORT**

#### **Specialised Health Services in England**

##### **Introduction and methodology**

In the autumn of 2003, the Specialised Healthcare Alliance commissioned the Policy Analysis Centre to conduct a study into the commissioning of specialised services within the NHS following the devolution of responsibility to the 302 Primary Care Trusts in England.

Specialised commissioning has been codified by the Department of Health in the form of a Specialised Services National Definition Set<sup>1</sup> covering 35 services. Guidance on Commissioning Arrangements for Specialised Services was published in March 2003 and fleshed out by Background Notes in July. These two documents outline PCTs responsibilities for establishing collaborative commissioning groups for specialised services and make SHAs responsible for their oversight and performance management.

The survey was carried out between November 2003 and January 2004. Questionnaires were issued to all PCTs and SHAs. Replies covered 98 PCTs but only two SHAs. This was supplemented by a series of nine in-depth interviews with lead PCTs, SHAs and Specialised Commissioning Groups throughout England.

##### **Key Findings**

###### **1. Overview**

It is important to recognise that the new arrangements for specialised commissioning in England are at an early stage of development. The devolution of budgets to PCTs has been disruptive and PCTs are clearly under severe pressure to achieve financial balance from their baseline resource allocations. Nevertheless, the survey found evidence that systems for PCT collaboration in many areas are being improved and developed with an emerging focus on quality. The fact that specialised commissioning is being done in different ways in different parts of the country is not necessarily bad but may have implications for equity of treatment. The results of the survey should also be interpreted with caution since respondents seem likely to have been drawn from those PCTs which have made most progress in the field.

###### **2. Adherence to Guidance and Background Notes**

In many areas PCTs have not yet met their responsibilities as outlined in the guidance:

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<sup>1</sup> <http://www.dh.gov.uk/PolicyandGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/fs/en>

## 2.1 Collaboration

**Guidance: “PCTs are expected to work together to ensure that specialised services are commissioned effectively”**

The extent of collaboration is variable. Many services included in the Definitions Set are commissioned by individual PCTs. Nevertheless, the situation appears from the interview data to be an improvement on the past. The researchers heard several times of initial concerns at *Shifting the Balance*, which were subsequently allayed.

Where consortia exist they are often based on the old health authority boundaries, and those that endeavour to accommodate referral patterns do so with considerable difficulty due to problems with data and the development of risk-sharing arrangements. In addition, they appear vulnerable to changes in personnel.

### Are you in a collaborative consortium?

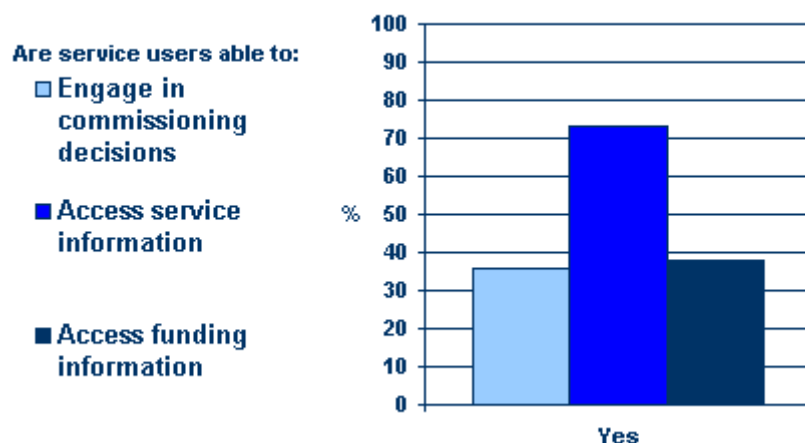
Percentage	Yes	No
HIV	59	17
Haemophilia	71	10
Renal	59	29
Rheumatology	20	49
Hepatology	34	34

## 2.2 Transparency and openness

**Guidance: “The commissioning process needs to be transparent so that providers and the public are clear who is commissioning any given specialised service for them at any one time.”**

The process is currently complex and opaque. The report showed there are no mechanisms for stakeholders to fund or generate information and no means of comparing the situation locally or nationally. The DH has no directory or map of activity in specialised commissioning.

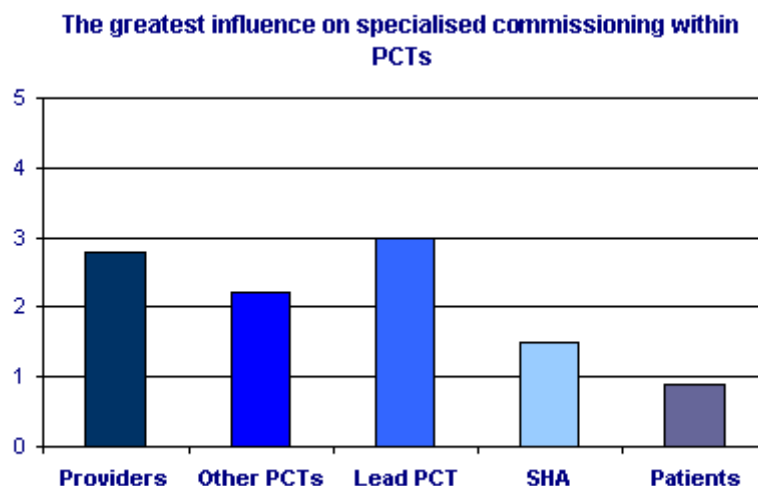
Patient engagement was poor with just over a third of PCTs reporting that users were involved in commissioning decisions.



### 2.3 Monitoring

**Guidance:** “PCTs are responsible for establishing collaborative commissioning groups for specialised services, as identified in the Specialised Services National Definition Sets, and SHAs are responsible for the oversight and performance management of these groups.”

At present SHA oversight is minimal, with PCTs claiming that the influence of SHAs was considerably less than the influence of service providers and other PCTs. PCTs were asked to rate the influence of different groups on specialised commissioning with a rating from 1 to 5 with 5 being very influential:



### 2.4 Data

**Guidance:** “Commissioning groups should ensure that there are agreed datasets and a process for monitoring activity, clinical practice and outcomes”

Commissioning groups' access to reliable data and information, even for the basic task of monitoring activity, is highly problematic. These problems worsen when it comes to data relating to patient flows beyond a group's boundaries. Where a commissioning group actually holds a pooled budget and procures services on behalf of PCTs they inevitably have some contract information, but where the commissioning group just plans and negotiates with providers, contract data rests with the individual PCTs.

### 2.5 Risk Sharing

**Guidance:** “Commissioning groups should ensure that clinical and financial risk assessments have been carried out for individual specialised services and service specific commissioning consortia and risk-sharing mechanisms are in place where appropriate”.

The use of risk sharing arrangements appears to vary across the country. In some cases these arrangements are extensive, principally where there are pooled funds vested in a commissioning group. In these situations the risk sharing system can either be direct and explicit through a specific risk-share scheme, or indirect through the calculation of contributions to the pool, or the way in which those funds are used to “develop services equitably”. The incentive to share risk will vary from PCT to PCT and condition to condition.

### 2.6 Clinical Networks

**Guidance:** “Commissioners should take account of the fact that specialised services are usually part of a continuum of care and need to ensure that any commissioning arrangements support managed clinical networks”

37 per cent of respondents rated their collaborative commissioning system's support of clinical networks as being good or very good. However, when lead PCTs were excluded this figure fell to 27 percent. In both groups the majority rated performance as average.

The role of HA Directors of Public Health in ensuring the quality of care and the support of clinical networks has been missed. Nevertheless, despite these practical difficulties, a renewed focus on quality in specialised commissioning was a persistent theme, particularly amongst the longer-established groups.

On the basis of limited evidence the research suggests, unsurprisingly, that networks are supported where they have a degree of national priority and targets, e.g. cancer, paediatric, renal and cardiac revascularisation.

### **3. Budgets**

There is concern that a combination of budgetary pressures and the low profile of specialised commissioning could make it increasingly vulnerable:

#### **3.1 PCT Financial Pressures**

Budget deficits within a large number of PCTs and local health economies mean that PCTs are under enormous financial pressure. The survey indicates that on average the specialised commissioning budget appears to account for 10 per cent of a PCT's acute commissioning budget.

The survey data show that PCTs expect an average of 11% growth in their spending on specialised services in 2004/5, yet would prefer growth to be capped at half this level. It is important to note that the vast majority of the survey replies were from PCTs that act as leads for specialised commissioning, and which might therefore have a particularly strong commitment.

In most cases budgets and contracts for Tier 1 services remain with each PCT, perhaps with a lead PCT or SCG conducting the negotiations with providers on their behalf. For Tier 2 services where funds are held by an SCG, a variety of means for calculating contributions is used, often varying from one specific service to another.

#### **3.2 Earmarked Allocations**

Special allocations that would previously have been ring-fenced for the specific services for which they were intended are now incorporated into PCT baselines. Although there is rarely central intervention, one commentator described as a *"halfway house"*, the Department of Health statement on the formerly ringfenced funds for HIV treatment and care, that: *"PCTs and GUM services must demonstrate to their SHA that this additional funding has been used as intended"*. The approaches taken to these sums seemed to vary across the commissioning groups.

#### **3.3 Targets**

The need for commissioning consortia to maintain PCT support for current and new investment in specialised services is made more difficult by the absence of these services from the targets that determine PCT star ratings or the Priorities and Planning Guidance. The absence of specialised services both from the most important national policy documents and reports, which is inevitably reflected in local delivery plans and annual reports, was of widespread concern to those involved.

It is evident that, even within budgets for specialised commissioning, it is essential for commissioning groups to allocate funds in line with PCTs' management priorities. This is essential in situations of majority decision-making, where even the worst-off PCT must buy-in to the commissioning decisions of colleagues in the collaboration. There is no longer an NHS Regional Office to bring pressure to bear, so PCT chief executives need to be convinced.

## **Conclusion and recommendations**

The survey results suggest that the collaborative arrangements established last year are still under-developed but could work, given time and commitment.

Inevitably there are areas of concern that need to be addressed, as the new mechanisms of NHS commissioning settle down. Additionally, the further changes that are afoot, including the implementation of Funding Flows and the creation of Foundation Trusts, both bring the risk of renewed difficulties for specialised services, as well as potential benefits.

As a result of the findings of this research the Specialised Healthcare Alliance is calling for:

### **1. A DH map of who is responsible for what in specialised commissioning around the country**

The report shows that there is very little public information on specialised services. There is currently no mechanism for stakeholders to find or gather information on the subject, and no means of comparing the situation, locally or nationally. A DH map would be of considerable and widespread value.

### **2. More consideration to be given to specialised commissioning in the early stages of policy making**

The low profile of specialised services is problematic and overlooks the importance of these services to the NHS, in both clinical and financial terms.

### **3. Move away from narrow target focus**

Interviews revealed how little targets related to specialised services, and how much harder this made the task of convincing PCT managers to make the necessary investments of time and money. We urge the Healthcare Commission to consider this evidence in its review of targets and to recognise the importance of specialised services in measuring the performance of Trusts.

### **4. Improved data collection**

The new environment is complex. In a few areas, for some services, a collaborative group holds a delegated budget with which it directly procures specialised services, and operates a formal risk sharing mechanism. In most cases, the budgets and contracts remain with the PCTs. Whatever the arrangement, each PCT receives data on its own patients. The lack of pooled information for collaborative commissioning groups and Strategic Health Authorities severely hinders informed planning.

### **5. SHAs to fulfil their assigned role in monitoring and managing performance**

Several interviewees stressed that they are beginning to move from mere "bean counting" with a focus on activity and costs to a new focus on quality. Performance is likely to be highly variable without the engagement of SHAs as envisaged in the Guidance.

### **6. Improved patient involvement**

Patient involvement seems especially poor in specialised commissioning. Greater transparency will be a necessary first step in engaging service users.