

SPECIALIST SERVICES: IS THEIR FUTURE SECURE?

An advisory report from the Academy of Medical Royal Colleges

1. Background

The Academy of Royal Medical Colleges established a working group (see Appendix 1) to consider the impact of *Shifting the Balance of Power* on the commissioning of specialist services. This was in response to discussions at Academy meetings that raised issues about the impact of new structural changes on the delivery of specialist services and the definition of just what these were. Particular concerns were raised about the learning curves and capacities of Primary Care Trusts (PCTs) as well as their relationships with Strategic Health Authorities (StHAs) and clinical networks. A particular tension anticipated is that between promoting managed clinical networks and devolution of commissioning to PCTs. This paper reviews the existing situation and lays out key elements which members of the Academy believe should underpin future developments.

2. Findings

The following issues have been identified:

- Care needs to be patient centred, not hospital or PCT centred – i.e. it needs to address the question of what is the best way of ensuring that the needs of the patients, (with both common and rare) needs can be met when care pathways cross several boundaries.
- PCTs are not just about general practice – particularly with their commissioning role. However, there is variable understanding of the specialist services agenda and it is too early to say whether some of the arrangements being put into place will be robust enough to cope with the financial pressures and service aspirations. There is particular concern about the possibility of individual PCTs wishing to pull out of funding specialist services in order to fund local initiatives.
- As an example of the type of problem envisaged, money put into the base line budget for implementing the cancer plan has not reached cancer services administered by Health Authorities. Funds were going into other areas, often to support Trust infrastructures. Cancer service clinicians report increased problems in getting PCTs to accept carefully worked out priorities, raising the question of conflict between PCTs and cancer networks. In addition, surgery is omitted from the cancer plans and has a specialist component. Procedures are needed to

ensure cancer network priorities can be funded and are inclusive of all specialist services

- Proposals for specialist pathology services need to reflect the current work of the pathology modernisation programme. It is envisaged that managed networks will develop between services to ensure population based coverage which will depend on resources available and range of tests requested rather than on PCT boundaries. The definition of specialist tests will require regular updating – which raises the question of the role and involvement of PCTs .
- The balance of decision making between PCTs and StHAs needs to be in favour of supporting policies across larger geographical areas for less common conditions. A systemwide group to advise PCTs not only on the list of specialist services but also general services which could be shared should be established if not already in existence. The Royal College of Physicians (RCP) felt particularly strongly that any service crossing PCT boundaries could face problems securing funding. Examples of such are chest medicine and diabetes. There is some early evidence suggesting that PCTs are not funding appropriate numbers of consultants in some of these specialties.
- The Association of Directors of Public Health *E-Group* highlighted the variability of arrangements across the country. For example, the Regional Specialist Commissioning Group (RSCG) for West Midlands will remain with a specialist services consortia within the StHAs whereas in others, public health skills now in PCTs will be used to support groups of PCTs with the commissioning process. The skills built up by public health specialists should not be lost through reorganisation.
- There is a problem providing adequate levels of staff to maintain quality of care in services which are low volume but high cost. This includes the difficulty of giving adequate experience to clinical staff, especially those in training
- The model of the outreaching 'Expert Team' needs to be developed rather to prevent fragmented, duplicated services which do not have the same expertise or ability to provide 24 hr cover or treat complex cases. The model from North Trent (Appendix 2) is one possible solution.
- There is continuing confusion about the nature of the 75:25 % split for PCT: Central funding. Just who gets what for what?
- The principle that children with conditions defined as specialist should be managed by specialist led networks of doctors, nurses and other staff is a priority which needs to be established.

Many of the above findings confirm the uncertainty about how specialist services will be delivered by the NHS. To some extent they have been addressed by the proposals for specialist service commissioning which were laid out by John Hutton in a speech to the APPG. [appendix 3] in March. Many practical problems do however remain unanswered. In addition, other issues that need to be addressed are how to :

- Decrease geographical variability by taking a national strategic overview
- Develop innovative practice and disseminate good solutions as effectively as possible.
- Meet centrally imposed standards whilst responding to local need.

3. Proposals for the current, transitional period

In summary, the proposals set out by the DOH for the following year or so are as follows:

- PCTs will form commissioning consortia and StHAs are to ensure that consortia arrangements are working smoothly. Expected boundaries will be those of StHAs. Lead PCTs will be identified to lead for specific areas
- PCTs have been asked to maintain stability by honouring arrangements previously negotiated by RSCGs
- RSCGs are to continue for a further year to help PCTs develop the capacity to commission specialist services
- RSCGs are to identify commissioning staff who deal with specialised services and secure their employment in PCTs

In addition, a group is being set up within the Department of Health to make proposals for future arrangements and it is assumed that NSCAG will continue its role during the review.

During this period, the Academy is concerned about

- the maintenance of specialist services and standards of patient care and
- the provision of proper training (including research opportunities) for clinical staff.

Members recognise that the relationship between the StHAs and their constituent PCTs is key, but have concerns that the nature of many specialist services will require StHAs to work together. Members support the key role to be played by StHAs in determining strategy and performance management and would not wish to see this diminished. The model of lead PCT with commissioning responsibilities for a

collaboration of PCTs is supported as long as there is no diminution of quality of patient care and training opportunities.

5. Preferred Model for the Longer Term

The key elements of the model that members of the Academy would wish to see are:

1. The publication of an explicit, agreed list of designated specialist services which reflects the patients' needs and their care pathways together with a framework defining national standards for their delivery. These are needed to guide PCTs in earmarking funding streams for conditions which may be rare in their population .
2. It is important to recognise the complexity of specialist service commissioning. In particular, maintaining standards of care and encouraging innovation whilst at the same time supporting the spirit of Shifting the Balance of Power in allowing local choice by frontline clinicians may be difficult to achieve.
3. Lead PCTs should be identified for appropriate populations by epidemiology, recognising that such a policy may cross StHA and even regional boundaries.
4. The Academy encourages the active shaping of specialist services by StHAs, and their role in monitoring service delivery by PCTs .They will need to work closely with clinical networks and Workforce Development Confederations.
5. Regional Specialist Commissioning Groups should be reconstituted to reflect the changed boundaries and the increased commissioning role of PCTs, the performance management role of StHAs . They should have adequate and appropriate engagement of clinicians from Acute and other Trusts.
6. The National Specialist Commissioning Advisory Group should continue to have responsibility for small very specialist services, with the list regularly reviewed with input from the Colleges via the Academy. The work and approach of NSCAG needs to be compatible with that for specialist services.
7. The proposed review of specialist services by the DoH would benefit from Academy representation because of the range of specialty interests it can canvass.
8. Specialist services need to be reviewed by the DoH (HSC regions) on a regular basis to ensure equitable access/provision across the population, with results published and available to the public.
9. It is imperative to consider the interface with universities and research communities during the shaping of services.

10. Initiatives are required to increase awareness of the public and of primary care managers and clinicians about the epidemiology, need, effective treatments, research directions/innovations and cost of providing care for specialist treatments. There also need to be links to the NICE programme.

6. Conclusion

The Academy strongly support the above recommendations and are anxious to be engaged in further discussions. Its particular concerns remain the need to maintain services for conditions which need to be provided to larger populations by specialist teams. Services need to guarantee the quality of patient care whilst simultaneously allowing the training of specialists and the promotion of innovation and research. The Academy is also very pleased that the JCC, having considered this paper, strongly supports its recommendations.

Appendix 1

Membership of the working group.

Chairman: Sian Griffiths

Members: George Alberti, David Hall, David Haslam, Dan Ash

Appendix 2

MEETING NOTE – MS CATH EDWARDS, CEO OF NORCOM: 10th May 2002.

NORCOM is the North Trent commissioning network. It began as a collaborative between 13 commissioners to provide a single voice for the commissioning of complex services such as renal disease and also had a voice in capital projects. It now includes 13 PCTs. It functions as a sub-committee of each PCT and the Minutes go to the Board of each PCT. 1 PCT (Barnsley) acts as lead PCT for the consortium and employs the staff.

NORCOM commissions specialised services; supports the development and functioning of clinical networks; and also has an administrative function. It negotiates collective purchases with other major centres (e.g. London hospitals) and with other providers such as in seaside towns.

It is uncertain how this will work for commissioning over larger areas and how NORCOM will take this over from Regional groups. It will be important to harmonise services that are provided over large areas but the mechanism has not yet been developed.

An important issue is the split in large centres between tertiary care and the secondary care provided for local residents. These large centres tend to have higher costs than DGHs for similar cases. It would be helpful to commission secondary and tertiary care separately but this is very difficult because data are inadequate.

The system works well because CEOs of trusts and provider units collaborate and meet regularly in formal session. Funding agreements are developed with the trusts which are binding on the members of the consortium.

The networks work well for cancer and are developing for cardiac services, adult critical care, histopathology, vascular surgery and are developing for neonatal care and oral, maxillo facial and ENT surgery. Network meetings are chaired by a CEO. There is a network co-ordinator who is generic rather than dedicated to one specialty. In the cancer system which is based on multi-disciplinary teams, there are agreements as to which cases are treated where. There is a lead clinician and a lead nurse – the sessions for these are included in the budget of the consortium. Every case is reviewed by a panel, often using a videoconference set-up – these meetings are often held at lunchtime and involve (for example) surgeons, oncologist, histopathologist, radiologist and network co-coordinator.

The cost of this whole exercise is under £500,000 pa. This covers some 11 staff and includes the support costs for the networks.

I asked about out of hours and emergency cover as the responsibility for this will pass to PCTs. Various organisations may be contracted to provide this – there would be an accreditation system. Advice to consult with CEO of Barnsley DGH, Jan Sobieraj, or CEO Barnsley PCT Ailsa Clare.

Summary This was a useful meeting. The NORCOM model looks workable and is regarded as a model of good practice by other areas. It would need to collaborate with other similar bodies for regional planning but this should be feasible.

David Hall, May 13th 2002.

Appendix 3

Speech to a joint meeting of the All Party Parliamentary Groups

on 21 March 2002

Thank you for inviting me today to speak to you about Primary Care Organisations and the Commissioning of Specialised Services. We need to see this relationship in the context of our vision for the NHS and the steps we are putting in place to achieve that vision.

INTRODUCTION

Shifting the Balance of Power: The Next Steps (issued in January) sets out the major changes needed to achieve our vision.

The Next Steps will:

- empower front line staff to use their skills and knowledge to develop innovative services - with more say in how services are delivered and resources are allocated
- empower patients to become informed and active partners in their care - involving them in the design, delivery and development of local services
- change the NHS culture and structure by devolving power and decision-making to frontline staff and PCTs - led by clinicians and local people, and by building clinical networks across organisations

Shifting the Balance of Power is radical. Behaviour needs to change as well as organisation with a greater focus on team working and on enabling and supporting people and less on hierarchy and control.

Changing long established behaviours and ways of working requires support and development programmes for individuals and organisations at every level.

THE NEW STRUCTURE

- PCTs will be given new powers and control over resources to shape and commission services
- 95 health authorities will be replaced by 28 Strategic Health Authorities, each covering 1.5 million people
- the Department's direct role in management will be reduced and its eight regional offices abolished

Primary Care Trusts

The strengthening and development of Primary Care Trusts (PCTs) is central to *Shifting the Balance of Power*. Primary care staff are uniquely placed to have an overview of services in their community and in hospitals.

The main roles of PCTs are to:

- improve the health of the community
- secure the provision of high quality services
- integrate health and social care locally

These roles will be enhanced from around October 2002 when, subject to legislation, PCTs become responsible for the delivery of the vast majority of current Health Authority functions.

By 2004, again subject to legislation, PCTs will have 75% of the total NHS budget allocated to them for decision making.

To succeed, PCTs will need to:

- learn to involve patients and the public as well as their own general practices and partners
- learn to manage the co-ordination of all the agencies who deliver local health care, taking the responsibility for creating strong local partnerships
- work collaboratively with other PCTs, StHAs and NHS Trusts as well as Local Authorities

PCTs will be responsible for planning and securing the provision of the totality of care and services that their population needs, including services that cover populations larger than a single PCT such as specialised services, emergency ambulance and patient transport services and population screening programmes.

For such services PCTs will need to work together and commission collaboratively.

NHS Trusts

Although the statutory functions of NHS Trusts will not change following Shifting the Balance of Power, they will be deeply affected by these changes.

NHS Trusts will need to:

- work ever more closely in partnership with PCTs and other local partners
- review their systems and provide greater devolution to clinical teams and front line staff
- increase the involvement of patients and the public

Strategic Health Authorities

All NHS organisations locally – PCTs and NHS Trusts – will become part of a single structure and be held to account through the StHA. This will facilitate working together and encourage a whole system approach.

The three key functions of a Strategic Health Authority will be to:

- create a coherent strategic framework

- agree annual performance agreements and performance management
- build capacity and support performance improvement

The Department of Health

As responsibility is devolved to the frontline, the Department of Health will need to change the way it works and its relationship with the NHS.

- the Department needs to do only those things that only it can do
- Intervention should only occur where necessary

SPECIALISED SERVICES

What is a specialised service?

Specialised services are those services where:

- patient numbers are small
- a critical mass of patients is needed in each centre
- there are relatively few centres offering treatment
- there is not a specialist centre in every local hospital

By concentrating specialised services in a few centres we can be sure we:

- achieve the best outcomes and maintain clinical competence
- sustain the training of specialist staff
- support high quality research programmes
- ensure services are cost effective
- make the best use of scarce resources (including expertise, high tech equipment, donor organs)

What constitutes good commissioning?

Effective commissioning arrangements ensure the *right* patient is offered the *right* treatment by the *right* provider in the *right* place

- The *right* patient is ensured by having proper patient selection criteria and referral guidelines.
- The *right* treatment is ensured by offering evidence-based medicine which is clinically effective and cost effective.
- The *right* provider is ensured by having agreed universal standards against which centres are monitored.
- The *right* place is ensured by maximising geographical access without unnecessary duplication of centres.

Commissioning produces the best results when everyone is involved in the process: the commissioner, the provider and the users.

What has been happening to the commissioning of specialised services over the last 3 years?

- during 1999 HAs formed themselves into 8 Regional Specialised Commissioning Groups (RSCGs)
- RSCGs have been responsible for the effective working of commissioning arrangements for specialised services in their region
- good progress has been made with delivery of some real improvements in the strategic planning, procurement and monitoring of specialised services
- genuine partnerships have been formed between commissioners, people who use the services and people who provide the services
- specialised service commissioner/provider networks, similar to cancer networks, are a model that has worked well
- HAs have agreed commissioning arrangements to cope with the financial risk involved in high cost degree /low volume services - most commonly by agreeing a financial risk-sharing arrangement

What are the lessons learned about commissioning specialised services in the last 3 years?

We have learned that:

- commissioners can work together successfully in a group to plan and fund specialised services covering populations larger than any one individual member of the group
- this more systematic approach enables fairer access to clinically effective, high standard services
- this approach is more efficient and encourages intelligent commissioning - by sharing out the work in the group so that one HA is the lead for one specialised service and another HA is the lead for another, each has time to become knowledgeable about individual specialised services

We have absorbed this learning. And we have made sure that PCT-led commissioning of specialised services is based on the same principle of collectivity as characterised by HAs working together under the umbrella of RSCGs.

PCTS AND COMMISSIONING SPECIALISED SERVICES

In 2002/03:

- PCTs will be responsible for identifying the health needs of all parts of the community they serve and for securing services for them
- this includes the commissioning of specialised services for the appropriate planning population, which will always cover several PCTs
- PCTs will be expected to collaborate with neighbouring PCTs to commission services and work as part of consortia
- the shape of these consortia will differ for particular specialised services - for one service, the consortium might work within the boundaries of the

local StHA; others may be larger and cover several StHAs - it all depends on the referral patterns for that particular specialised service

- the decisions made by consortia will be binding on all member PCTs
- every PCT will need to maintain a close interest in the work being done to invest in services or support new developments – and in any proposals to move services from one provider to another

Real improvements in specialised services will only happen where all the interested groups work together on a shared agenda and collaborate to tackle common problems

The role of the StHA and DofHSC

- the StHAs will ensure that each PCT has appropriate arrangements in place for commissioning specialised services and that consortia are working effectively
- StHAs will be represented on commissioning consortia
- StHAs will provide support and experience as well as ensuring consistency across PCTs
- StHA will resolve disputes between PCTs or between a PCT and a provider within its own boundaries
- Directors of Health and Social Care will facilitate agreements, and if necessary determine disputes that cross StHA boundaries

Developing new specialised services

- developing new specialised services is particularly complex because of the inter-dependence between caring for patients and the demands of research, education and training of small numbers of very skilled staff
- changes in best practice occur rapidly in specialised services, often driven by new technologies
- providers and PCTs will need to establish mechanisms to test whether proposed service developments actually bring clinical benefits and are cost-effective

Securing stability – the role of RSCGs

- it is important that specialised services are not damaged by the changes going on around them
- we need to adopt a pragmatic approach and maintain those commissioning arrangements that work well
- to ensure stability in the forthcoming year current consortia arrangements will be continued with all PCTs honouring existing financial commitments and existing programme of reviews
- we have pledged that Regional Specialised Commissioning Groups will continue to exist for a further year at least
- RSCGs are charged with the responsibility of ensuring that a planned transition to successor arrangements takes place and developing PCT capacity to commission specialised services

- the membership of RSCGs is currently being altered to include PCTs representatives

Maintaining commissioner expertise

- to avoid the loss of skilled and experienced commissioning staff we have charged RSCGs with the responsibility of ensuring that these staff continue in their existing roles wherever possible
- **I am pleased to hear reports that commissioning staff are currently being employed by PCTs, often in small teams housed in one of the PCTs**

Safeguarding regional commissioning arrangements

- in 2002/03 RSCGs will be responsible for maintaining commissioning arrangements for those highly specialised services covering populations larger than several StHAs
- over the next 6 months we will be reviewing commissioning arrangements, including those for regional type specialised services, with a view to issuing guidance in the Autumn
- **very highly specialised services, currently commissioned by the National Specialist Commissioning Advisory Group (NSCAG), will continue to be nationally commissioned**

HIV/AIDS services

- HIV/AIDS treatment covered by specialised commissioning arrangements for 2002/03, and PCTs have been told to honour existing arrangements, both financial and otherwise
- implementation of the targets in the Sexual Health & HIV Strategy will shape services for the future
- monitoring of service delivery will continue through the AIDS (Control) Act 1987, amended in the light of the Strategy and StBOP, and through the NHS performance management framework
- we are already monitoring the progress of Regional Specialised Commissioning Groups in data requested by 31 March 2002
- we have asked for summary reports on baseline sexual health and HIV data, by 31 March 2002, to inform implementation of the strategy
- we have asked each authority for a named contact for sexual health from April 2002, so as to enhance information quality and continuity of services during transition to StBOP
- we are exploring the role of the new StHAs in the overall monitoring of specialised services for HIV in the future
- we will expect PCTs to work in consortia to deliver services across PCT boundaries
- the DPH within each PCT (a key post for HIV prevention and service delivery) will be responsible for ensuring that core public health functions are co-ordinated and delivered at a local level although budgets are being mainstreamed from April 2002, authorities are aware of their target shares of the former ringfenced funding for 2002, and the skewed distribution of HIV in England will be accounted for in future

CONCLUSION

In summary:

- **To ensure PCTs work together to commission specialised services we have asked PCTs to form commissioning consortia and StHAs will ensure these consortia arrangements are working smoothly.**
- **To maintain stability we have asked PCTs to honour existing agreements negotiated by Regional Specialised Commissioning Groups.**
- **To support PCTs we have asked RSCG to continue for a further year to help PCTs develop capacity to commission specialised services.**
- **To ensure continuity we have asked RSCGs to identify commissioning staff who deal with specialised services and secure employment in PCTs.**

To conclude:

I am pleased to tell you that a January survey of RSCGs showed that they were making good progress in developing successor arrangements with PCTs. And RSCGs also report that PCTs are showing a willingness to grapple with the issues of commissioning specialised services and work together.

I can report that at this very moment RSCGs and PCTs are preparing for the April 2002 changes:

- **HA members of RSCGs are being replaced by PCT members**
- **PCT collective commissioning arrangements based on StHA boundaries are being set up**
- **within these collectives lead PCTs are being identified for particular specialised services**
- **commissioning staff are being employed by PCTs, often in small teams housed in one of the PCTs**

Finally, in conclusion I would like to reassure you that:

- we have learned from the success of specialised services commissioning over the last three years and
- we have built these lessons in the new process for PCT led commissioning

Over the next 6 months we will be conducting a detailed monitoring exercise on the workings of the devolved commissioning arrangements with a view to issuing guidance in the Autumn