Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 25th July, 2006

PROPOSALS FOR COMMISSIONING ARRANGEMENTS IN LONDON AND LAS RESPONSE

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For noting

3. Summary

Attached are two papers: the London PCTs' proposals *"London: Commissioning for Health"* and the LAS response to the paper

Although the proposals include greater co-ordination of commissioning and better business support to the process, they are a little disappointing from the LAS point of view as they suggest that commissioning of the LAS is likely to continue in much the same way as now.

This means that the opportunity may be lost to make radical changes to the provision of urgent and emergency care in London.

The LAS response makes this point and sets out the arguments for more central, strategic commissioning of urgent care services.

4. Recommendation

THAT the Trust Board note the attached papers

NHS
Londonwide PCTs

London: Commissioning for Health

Developing world-class commissioning to improve the health of Londoners

June 2006

London: Commissioning for Health

Contents

1 Executive Summary

London PCTs have agreed to strengthen their commissioning functions to improve the health of Londoners and reduce health inequalities in the capital. We will do so by developing key elements of the commissioning process, as outlined below. Taken together, they constitute a newly developed **London Commissioning Model.**

- **Effective local partnership arrangements between PCTs and London Boroughs,** developed through Local Area Agreements and focused on improving the health and wellbeing of local people

- **Enhanced strategic commissioning roles of PCT Boards and Professional Executive Committees,** with the voice of patients and the public increasingly influencing strategic commissioning plans, and PCTs fulfilling their responsibilities as the local NHS body accountable to their populations for improvements in health and service delivery

- **Strong primary care and practice based commissioning arrangements**, to raise standards of primary care services across the capital, with front line clinicians driving improvements in services to meet local needs and ensuring appropriate use of NHS resources to maximise health improvement

- **A first class commissioning business process** to provide a high quality, consistent approach to commissioning in London

- **More effective pan PCT and lead commissioning arrangements, underpinned by a newly developed Duty of Partnership**, with a London wide Commissioning Group and 5 Local Commissioning Groups established to bring PCTs together where appropriate to plan and commission services collaboratively. Lead commissioning arrangements will be further developed to streamline the relationships between the 31 London PCTs and service providers. It is proposed that Local Commissioning Groups align with existing 'Turnberg' sectors, based on current acute and tertiary care patient flows[1]. The Local Commissioning Groups will also work across sector boundaries when required.

- **A highly performing Commissioning Business Service** developed across London to provide PCTs with a range of expertise and skills to support them in their commissioning functions

  This paper outlines proposals for the development of this London Commissioning Model to deliver a world class commissioning process across London.

[1] We have carried out a brief analysis to confirm that this is sensible, and details are available from the project group.

1 London PCTs recognise the need to strengthen commissioning to drive improvements in health and service delivery in line with *Commissioning a Patient led NHS*, the White Paper*, Our Health, Our Care, Our Say,* and the need to address the current critical financial and capacity challenges in London. The retention of borough- based PCTs with their local knowledge and local relationships, combined with strengthened and more effective collaborative commissioning arrangements provides a unique opportunity to achieve significant improvements in the range and quality of health services in London. PCTs need to make a step change in their commissioning capacity and capability to secure greater leverage with service providers, and to ensure their Fitness for Purpose as effective commissioners.

2 The model we propose will be cost-neutral or better across London, but individual PCTs will need to make commitments to invest if necessary, given the differing levels of current investment. We will prepare a business case for the development of the Commissioning Business Service (CBS) early in the implementation programme, and ask PCT Boards to approve it. Within the business case there will be a baseline assessment of current costs and outcomes, which will include all costs associated with commissioning, including network support. The business case will seek to achieve significant reductions in transaction costs across London, as well as supporting the development of stronger and more effective commissioning of all services.

3 The approach to the development of the Commissioning Business Service will be iterative, and there will be opportunities for discussion between PCTs and Practice-based Commissioners, Local Authorities and the SHA about the range of services that the CBS will provide.

4 The establishment of the London and Local Commissioning Groups, together with the Commissioning Business Service will support PCTs to deliver more effective commissioning by achieving collective impact where it is required. Commissioners in the new model will be expected to apply consistent quality and efficiency standards in commissioning at all levels, from London wide specialised services to the commissioning of primary care and joint commissioning with Local Authorities, in all cases recognising the fundamental importance of the patient care pathway.

5 Our key principles are:

- **Addressing Health Inequalities and improving Londoners' Health**
  London's communities are highly diverse and the commissioning model must be able to respond to that. It will support wider work to tackle health inequalities and social exclusion

- **Focusing on Patient Pathways, Quality and Choice**
  We should ensure that our commissioning is innovative, based on best practice and led by patient needs and expectations.
- **Spending Londoners' money well, and reducing bureaucracy by doing it once**
  Londoners should expect PCTs to commission services which are responsive to their individual and collective needs, are effective, deliver value for money and are affordable
- **Commissioning on integrated basis with Local Authorities**
  Local partnerships and services built up since the introduction of PCTs should be strengthened and supported, not replaced, by collaborative arrangements in local sectors and across London
- **Developing new markets**
  New primary care contracts and the impact of the White Paper make it imperative that PCTs work together to manage the market and develop new providers from both traditional and new sectors. Working together will give the scale and leverage required to work effectively both in these new markets and with existing providers, including Foundation Trusts.
- **Focusing on specific challenges – for example mental health, TB, prison health**
  The new model will be introduced with an agreed prospective programme of work where London has specific challenges to address

6 We have developed this model on the approach agreed in January 2006. The proposals build on:

- The London wide collaborative commissioning arrangements developed for 2006/07, including publication of pan London commissioning intentions and the implementation of lead commissioning arrangements;
- A review of commissioning business process models carried out by Matrix[2];
- Publication of the White Paper *Our Health, Our Care, Our Say;*
- The Department of Health confirmation of PCT functions issued in early May;
- The recommendations of the Warner review of specialised services commissioning, which has recently been published;
- The PCT Fitness for Purpose programme, which sets out key assessment criteria for effective commissioning.
- Our understanding of the requirements of the DH 'Commissioning Framework' due to be issued in July

7 Section 2 describes the **specific aims** of London PCTs in commissioning services to improve health, reduce health inequalities and improve the experience of patients.

[2] The matrix document (*a Unified Commissioning Model for London / a strategic overview)* is available from the project group.

8 Sections 3 to 6 ('Developing Our Commissioning Capability') set out the **key elements** of the proposed London Commissioning Model, consistent with the PCT **Fitness for Purpose Assessment Framework**. The model delivers effective commissioning across strategic planning, care pathway management, provider management, monitoring and remediation activities. The Matrix review of international commissioning models (undertaken as part of this commissioning workstream) indicates that these proposals will be consistent with best practice in the international context.

9 Section 7 sets out proposals for a **Duty of Partnership** between London PCTs to ensure that our collaborative commissioning arrangements are effective. The Duty of Partnership is not a complex set of rules or mechanisms – it supports and enables PCTs to commission collaboratively to maximise their position in the health market and achieve their organisational objectives. Also included are the proposed Terms of Reference for the Local and the London Commissioning Groups. The proposed timetable for implementation of these proposals is as follows:

- PCT Boards' approval of these proposals by August
- Discussions with stakeholders and partners during July to September to ensure wide involvement in the development of the model;
- Establishment of the London and Local Commissioning Groups by October 2006 to lead the 2007/08 commissioning business process
- Development of a costed Commissioning Business Service (CBS) specification and proposed implementation plan by the end of October 2006;
- A review of commissioning skills by October 2006;
- Review and evaluation of proposals in place by March 2007 to ensure that the introduction of the new model is properly tested against our objectives.

2 Our Commissioning Aims

10 Our commissioning challenge is to make the best use for our communities of the £10 billion that the NHS invests each year in London, to achieve significant improvements in the health of Londoners and to improve the quality of the patient experience. Our new London Commissioning model will need to ensure delivery of these key aims and to do so, it will need to respond to the following challenges.

11 **Meeting the needs of our Population**

London's current resident population of 7.4 million is highly mobile, **with 20-40% p.a**. **turnover on GP lists**. London is ethnically diverse – almost **40% of people are from an ethnic minority**, with over 90 different ethnic groups and 300 different languages spoken. **Three hundred thousand Londoners** arrived here from overseas in the last 5 years, and the population is increasing more rapidly than in any other city – by 2016 we anticipate over 800,000 more London residents, the equivalent of a city the size of Leeds. We are also responsible for commissioning services for the estimated **1 million daily commuters** to London and the **13.1 million tourists coming every year.**

12 London is **relatively young -** 27% of people are aged between 20 and 34 years compared with 20% in England as a whole. Many are living in poor housing - 60% of England's homeless households in temporary accommodation are in London. Many are living in poverty - **41% of children in London live in households below the poverty line.** There are profound inequalities within and between boroughs: Tower Hamlets, Hackney and Islington are in the **10 most deprived local authorities** in England, whereas others are amongst the best off.

13 Improving Health and Reducing Health Inequalities

Average life expectancy in London is similar to the national figure, but the average masks significant differences across London. Kensington and Chelsea has the highest life expectancy in England, but as you travel by Underground on the Jubilee line from Westminster to Canning Town, **each of the 8 stops represents nearly a year's drop in life expectancy**. Similarly, the infant mortality rate varies considerably across London despite London having a similar rate to England (5.4 and 5.2 per 1000 live births respectively). The rate in Southwark (8.1) is 2 and half times that in nearby Wandsworth (3.2).

14 Premature deaths from circulatory diseases are higher in London (103 as against 97 per 100,000 in England), with a **2.5 times difference between the London boroughs with the lowest and highest rates** (Bromley 66, Tower Hamlets 161). Perhaps more worryingly, mortality

is falling more slowly than in England in some of the areas with the highest rates, implying that inequalities may well widen.

15 Whilst *on average* health in London does not compare too badly with the UK, some health problems are particularly profound. For example **incidence of TB is over two and a half times the national average and up to seven times higher** in some boroughs**; nearly half of new cases of HIV** are resident in London; rates of other sexually transmitted disease are substantially higher than elsewhere, as is the prevalence of drug use; one in four adult drug users live in London. The prevalence of mental illness is higher than elsewhere, particularly psychotic disorders**: the rate of compulsory admissions is twice that of any of any other region**.

16 To deliver improved health and reduced health inequalities, we need to emphasise preventing ill health, ensuring early intervention, and managing chronic diseases. The White Paper '*Our Health, Our care, Our say*: *a new direction for community services*' emphasises the need over time for growth in health spending to be directed more towards preventative, primary, community and social care. In addition it underlines the importance of stronger joint local commissioning between PCTs and local government, and improved joint working between the NHS, local government and the voluntary sector; with the need for the patient's voice to be central to commissioning decisions.

17 Local borough-based PCTs, working with Local Authorities, have the central role in strategic planning to meet health needs. The approach should be population-based, taking as its starting points the determinants of health, health status and the current performance of health promoting and health service interventions to improve health and reduce inequalities.

18 A commissioning strategy on this model needs to assess where investment will have most **impact** in terms of health improvement and reducing health inequalities. We propose an approach to commissioning which does this, and which makes those aims the key drivers for investment decisions.

19 **Restoring financial stability and review strategic configuration** - PCTs' responsibilities for strategic commissioning mean that they must ensure that their commissioning plans meet the needs of their local communities, and are also consistent with the health resources available. Overcapacity and duplication exist in some parts of the system. Restoring financial balance in London will require hard choices and imaginative proposals about whether the current service configuration can be sustained. PCTs will need to take the lead in this process through the commissioning decisions that they make.

20 **Reducing variations in performance and cost across all services -** Reviews of performance and cost across London providers consistently

reveal significant differences. PCTs will need to contest these variations from best practice and financial prudence, to ensure that equity in standards and cost are achieved. We must also recognise that there is significant variation in the present capacity and capability of PCTs as commissioners, and recognise the value of collaborative working in achieving the full benefit of scarce skills and abilities across London.

21 **Stimulating the market and developing choice.** We must ensure the greater involvement of primary care professionals, the public and of patients in redesigning care pathways. The Practice Based Commissioning and Choice initiatives will lead to exciting and innovative ways of working in which PCTs will have the critical role, working closely with health providers, both existing and new to the market, to create, manage and modify services in response to these fundamental initiatives. Key to this will be the further expansion of plurality in NHS provision, with the role of the voluntary and independent sector market developing further to meet specific needs in London.

3 London PCTs – Developing Our Commissioning Capability

22 This section outlines the roles of PCTs, their local partners and clinicians in developing more effective commissioning arrangements as outlined in the first 3 elements of the proposed London Commissioning Model (see Executive Summary). These are as follows:

- Effective local partnership arrangements between London PCTs and the London Boroughs, focused on improving the health and wellbeing of local populations
- Enhanced strategic commissioning roles of PCT Boards and Professional Executive Committees (PECs)
- Strong primary care and practice-based commissioning arrangements

For each of the elements we look at how they will fit within the proposed London commissioning model, and the nature of agreements required between partners.

Effective local partnership arrangements

Partnership Arrangements with Local Authorities

23 PCTs are the leaders of the local NHS, and work in partnership with Local Authorities to improve the health and healthcare of the communities they serve. PCTs discharge this responsibility in a variety of ways, but remain the accountable body for health improvement and healthcare services in their area. The specific benefits of the decision to retain borough based PCTs need to be embodied in our models of **joint commissioning**, and the commissioning and providing relationships between PCTs and their Borough partners will be enhanced and developed through this model.

24 In line with the *White Paper* and the *Every Child Matters* agenda, there must be a joint process between PCTs and Local Authorities to agree appropriate commissioning arrangements for the following services in order to deliver agreed strategic health outcomes for their population

- Mental health
- Learning disabilities
- Physical disabilities
- Drugs and alcohol
- Older people
- Children and young people
- HIV/AIDS

25 The relationship between the proposed new Londonwide structures, the PCTs and their partners will need to be developed with Local

Authority colleagues early in the development process. We will ensure that the work of the Commissioning Business Service helps to add consistency and value not only to NHS commissioning but also to the wider range of services commissioned by and with Local Authority partners, including third sector providers.

26 This, and the present direction of travel towards joint appointment of Public Health professionals, will improve the ability of PCTs and their local partners to work together in tackling social exclusion and improving health. This will require integrated approaches at local level, focused within boroughs, reflected in Local Area Agreements and in integrated approaches to commissioning and providing local services across traditional organisational boundaries.

27 This whole system approach is crucial to meeting the strategic commissioning aims outlined in section 2, supports care pathway management in commissioning and extends the care which be provided outside the hospital setting, enabling commissioners to rebalance the health and social care system.

Enhanced Commissioning Roles of PCT Boards and Professional Executive Committees

28 **Individual PCTs are the local centre of accountability for NHS Services** – ensuring that their commissioning plans meet the needs of their local communities, achieve improvements in health and service provision and are delivered within available financial resources. *Commissioning a Patient-led NHS* places patients and the public at the centre of the commissioning process; and the development of Practice-based Commissioning will strengthen local clinical engagement.

29 PCTs will find new ways to involve patients and the public in these enhanced commissioning structures, and the implementation programme for the new commissioning model will ensure that there is a Londonwide as well as local process for ensuring real engagement with Londoners.

30 Many PCTs in London are currently reviewing their corporate structures to ensure that they will meet their requirements both in terms of financial balance and Fitness for Purpose. This means that there will be:

- A clearer division between commissioning and providing roles at all levels within PCTs;
- Strengthened PEC structures to enhance the role of the PEC as the clinical commissioning arm of the PCT, and to ensure that the PCT priorities and strategic commissioning framework have broad clinical support;

- A clearer role for PCT Boards in ensuring that commissioning is effective and outcome focused.

Primary care and Practice-based Commissioning

The commissioning of Primary Care

31 PCTs have been facing major changes in their commissioning and provider roles as a result of *Commissioning a Patient-led NHS,* and although there is no longer an obligation on PCTs to divest themselves of all provider functions, there must now be a clear, formal separation within the PCT between commissioning and service management functions[3]. This of course will have a specific impact on the *commissioning* of primary care, where traditionally the knowledge and skills in PCTs have been found in service development and provision, rather than in commissioning. It will be absolutely critical to the development of services in primary and community care, in line with the White Paper, that the commissioning of these services embraces the same standards of quality, effectiveness and value for money as it does for Acute, Mental Health and Foundation Trusts.

32 The London PCTs are working together to define excellence in the commissioning of primary care and what changes PCTs need to make to improve the quality of primary care consistently across London The responsibility for commissioning Primary Medical Services, of course, has not been devolved to practices and is fully retained at PCT level.

33 Given that the performance management of contracts in primary and community care must be as robust as it is elsewhere, this is an area where a collective approach will be particularly helpful in ensuring that local performance management structures, whilst recognising particular local issues, are consistent with objective quality standards.

34 The workstream will deliver a commissioning framework, a skill set, and the options for the level at which the commissioning of primary care can be carried out. This framework will be consistent with the structures described here, whilst recognising the different issues in the commissioning of primary care contractors.

35 The framework will pick up how we tackle issues such as entry to and exit from the market, the PCT role in supporting practices, the statutory requirements of contracts, service specifications and the approach to pricing. We will define the significant levers for change, and set out an approach to performance management (including the recommended indicators) consistently across London.

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[3] *Our Health our Care Our Say, January 2006, para 7.90*

36 Some significant issues that have emerged so far include:

- Contestability
- How to address the question of the optimum size of primary care providers;
- The involvement of patients at this critical level;
- The balance between commissioning and managing a national contract;
- The commissioning of self-care.

37 All of these issues must be considered across the whole range of primary care providers – the commissioning of primary care must not be seen as just being about GPs, and is about all the Family Health Service (FHS) practitioners - GPs, dentists, pharmacists, and optometrists. The different contract arrangements across the range of FHS services will need to be effectively managed, but throughout all of this we need to be really explicit about commissioning for improved outcomes and care pathway management. Quality and access need to improve and there need to be more consistently high quality services available for Londoners.

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38 This approach will also apply to directly provided (community) services, and we will need to use the new collaborative commissioning structures to make sure that there is a wide spectrum of provision based on patient needs and the building of capacity, rather than on purely historic models of care. This will develop more integrated services across the NHS and social care, build capacity in the voluntary and third sector providers and develop interfaces between primary care and hospital care, using practice-based commissioning to build (and manage) new care pathways that are patient rather than provider focused.

Strong practice based commissioning arrangements

39 Practices that participate in Practice-based Commissioning are allocated an indicative budget and are given the opportunity to redesign services to better meet the needs of their patients. However, responsibility for contracting for services is retained by PCTs.

The aim of **practice-based commissioning** is to improve the health of local people and improve health services, and Practice-based Commissioning will work only if it is directly driven by clinicians. The new commissioning model must avoid the risks of:

- Setting up collaborative structures that do not have the flexibility and capacity to respond to local clinical issues – the ‘lowest common denominator’ error,
- Allowing the new structures to lead rather than follow the intentions and requirements of the PCTs’ service change strategies.

40 Similarly, PCTs will have to ensure that their own PBC groups are linked into these service change strategies, and that the relationships between the PBC groups, the PCT and the collaborative structures are absolutely clear.

41 Practice based commissioning may also become the **key driver of change towards a preventive commissioning strategy**, and this must be recognised in how the new model is shaped – particularly in the delivery of accurate, timely and systematic data analysis and commissioning information.

42 We must recognise that Practice-based Commissioning is a **key element of the system reform programme** currently being implemented across the NHS. It is a key mechanism for delivering more care outside of hospital. Elements of the framework for this form of commissioning will need to be consistent across PCTs, and one aim of the pan-PCT commissioning proposals is to ensure that there are mechanisms in place to deliver this consistency where required.

43 Implementing PBC successfully is a major challenge for PCTs. We have to ensure that practice based commissioners operate within a coherent service framework and support delivery of national priorities. However, practices must also have the power and ability to make local changes to improve services. Practice-based Commissioning has the potential to unlock innovation in primary care if the commissioners are given the support and freedom to act. The challenge for PCTs is to develop a strategic framework within which practice based commissioners can be given flexibility to develop local service solutions.

44 PCTs in London have encouraged GP practices to work together in commissioning clusters, and the majority of practices have now agreed to work together with neighbouring practices in local groups. However, while many services will appropriately be shaped at this type of 'cluster' level, the individual practice remains the building block for Practice-based Commissioning. Where possible, individual practices will be given the opportunity to use PBC to improve services for their patients.

45 Practice-based commissioning will therefore be supported and not led by the three new structures proposed here, and practice commissioners must be closely involved in the early stages of establishing the Local Commissioning Groups and setting out the detailed functions of the Commissioning Business service. **The relationship between the CBS and local PBC groups will be a key indicator of the ability of the model to deliver true patient-led NHS care**.

4 A first class Commissioning Business Process

46 We want to ensure that we have a consistent and clear definition of commissioning activities carried out by PCTs and practice based commissioners, working collaboratively with each other and with Local Authorities We therefore propose that London PCTs adopt the Commissioning Business Model set out in the *Fitness for Purpose* review. This will help us to be clear that 'commissioning' covers a wide range of activities undertaken at various levels – from practice, or Borough to pan- London and even national levels for highly specialised services.

47 This Commissioning Business Model is outlined below – illustrating the cycle of commissioning activities required. We will develop this model further over the coming months to produce a consistent annual commissioning cycle to align these various activities appropriately, so that London PCTs are best placed to maximise their commissioning leverage and meet the challenges outlined earlier. This will be complemented by the Fitness for Purpose review process, which will help PCTs to identify and plan for their development needs to perform an enhanced commissioning role.

48 The proposed Commissioning Business Service (CBS) will support the range of commissioning activities and levels of commissioning within the London Commissioning model. The proposed functions of the Commissioning Business Service are set out in section 6 of this paper.

49 The Commissioning Business Process incorporates the following key components:

- Strategic planning
- Care pathway management
- Provider management
- Monitoring

Each of these components is outlined below.

Strategic Planning

50 The strategic planning role of PCTs is critical to ensuring that PCT commissioning plans meet the needs of their local communities, achieve improvements in health and service provision and are delivered within available financial resources. Strategic planning activities include assessing the needs of the population by review of a range of health indicators and service metrics and securing the views of service users and local people to inform future priorities. PCTs will

work closely with Local Authorities to align their commissioning plans and resources, where appropriate.

The PCT's strategic planning role will also involve clinicians – including PbC commissioners – to ensure that there is a unified 'commissioner' strategic approach in place. PECs will also play a key role in providing PCT Boards with strategic clinical commissioning input.

51 PCT strategic plans will need to articulate the health and service outcomes to be achieved for the benefit of local populations over a medium to long term basis, recognising that measures to reduce health inequalities will require a focused and sustained strategic approach. Strategic plans will be developed jointly with Local Authority partners, based on agreed outcomes to be achieved in improving the health and wellbeing of local people.

52 PCTs will implement their strategic commissioning intentions by developing 'operational' plans, which will detail the PCT's key commissioning plans and priorities over the following 1 – 3 year business cycle. These operational plans will be known as the PCT's Commissioning Prospectuses, and will be produced and widely consulted on by PCTs on an annual basis. These prospectuses (informed by systematic feedback from patients, carers, and GPs) will provide a powerful vehicle for the voice of patients and local communities.

53 London wide priorities will be agreed by the London PCTs and the SHA, and will be incorporated into all PCT prospectuses; they will feed into the annual London wide commissioning intentions.

Care Pathway Management

54 Over the next 2-3 years, the NHS commissioning process will develop further, underpinned by the effective implementation of Practice based Commissioning, the roll out of Payment by Results across all services (with the potential unbundling of some tariffs for 2007/08), the Choice agenda and Foundation Trusts.

55 Practice-based commissioners will increasingly take the lead for the development of new care pathways, which will deliver improvements in the quality of the patient experience, improved health outcomes and more cost effective use of NHS resources. These new care pathways will be consistent with the direction of travel in the White Paper and jointly planned and commissioned with social care -developing more services close to where people live, and ensuring high quality specialised services to support these local arrangements.

56 We will need to ensure that care pathway management across London is consistent, so that commissioners and providers can ensure the following:

- Delivery of the 18 week waiting time target by 2008, including the key role that diagnostics will play in reducing waits within current patient pathways;
- Effective referral management from primary care to hospital services – to ensure the management of appropriate referrals and thereby the effective utilisation of hospital resources
- Effective care for people with long term health conditions – to significantly reduce the level of unplanned admissions to hospital
- An integrated urgent care system which is responsible to the needs of individuals and communities at a local level.

57 New care pathways will articulate the patient 'journey' across primary, secondary and tertiary care – they will place patients at the centre of the commissioning process to ensure that these key requirements can be met.

Provider Management

58 PCTs will bring together their annual plans (as detailed in the Commissioning Prospectus and PbC care pathway plans) into service and activity requirements, which in turn will feed into the contracts to be negotiated with NHS and Foundation Trusts.

59 The Commissioning Business Service (when fully developed) will provide PCTs with a range of information on the performance of providers which will inform priorities for commissioning, for example, services that are poorly performing or not meeting population needs are likely to be subject to a service review/ development of a service specification and procurement process. The CBS will support PCTs to work with providers to assure the quality of services and improve standards.

60 The CBS will provide expertise in contract development and negotiation, supporting the lead commissioner arrangements which will be further developed to provide a single commissioner/ provider relationship for Acute Hospital Trusts in London. These lead commissioner relationships will also be developed for Mental Health NHS Trusts for 2007/08. Lead commissioning arrangements for mental health services will reflect the context of joint commissioning relationships and section 31 arrangements in place between PCTs and Local Authorities Further discussions will be held with Local Authority colleagues and Mental Health Trusts to agree the model of lead commissioning .

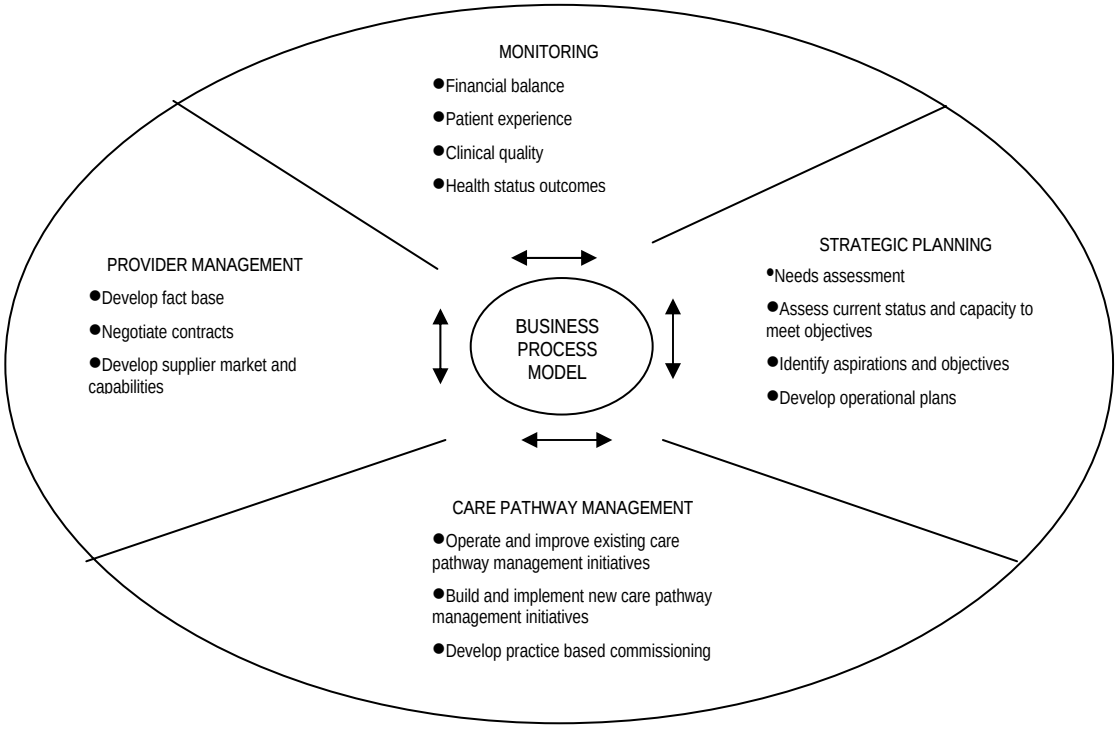
61 The CBS will also provide a role in supporting PCTs, Practice- based commissioners and Local Authorities to develop new markets to meet local needs.

Monitoring

62 PCTs will strengthen their monitoring of providers to ensure that agreed contracts deliver the outcomes prescribed in service specifications. This will include activity and financial monitoring, taking remedial measures where needed to ensure that contracts are fulfilled according to agreed plans.

63 In addition, the quality of services, patient experience and health outcomes will increasingly be monitored on a regular and systematic basis by the lead commissioner, supported by information and expertise secured from the Commissioning Business Service. The contract agreed between commissioners and providers will identify remedial measures to be taken, should the contract underperform on quality and performance indicators.

64 These monitoring indicators will be reviewed with providers as part of the ongoing contract review process and will feed into the future commissioning plans of PCTs.



Diagrammatic representation of the four main commissioning functions

5 Pan- PCT and lead commissioning arrangements

65 This section sets out our basic organisational proposals (the 'building blocks') for Londonwide commissioning arrangements, as follows:

- The role of the London Commissioning Group and the SHA;
- The role of the Local Commissioning Groups
- Lead Commissioning arrangements
- Performance management, scrutiny and overview, fitness for purpose and financial stewardship.

The London Commissioning Group

66 The London PCTs have agreed that they will be more effective in discharging their key responsibilities by establishing more effective collaborative commissioning arrangements. However, a variety of different approaches to collaborative commissioning currently exists across London. Different approaches are also in place for clinical networks and the degree to which they are co-ordinated on a sector and London basis**.**

67 We therefore propose that a Londonwide Commissioning Group be established, with the following terms of Reference:

- Oversee the London wide commissioning process, and ensure that there is "fit " between local plans;
- Undertake an annual 'horizon scanning' process to identify prospective commissioning priorities, with input from all London PCTs to form the basis of annual London wide Commissioning Intentions;
- Market manage on a London wide basis, where appropriate, and ensure that a comprehensive range of patient services exists within reasonable access of all Londoners;
- Stimulate the market on a London wide basis where necessary to align capacity and resources.
- Take the lead for specialised commissioning activities on a London wide basis, as set out in the recommendations of the Warner Review.

68 The London Commissioning Group will also help support the relationship of commissioners with the London SHA, but this will not

intervene in the normal relationship between PCTs and the SHA, and its role will be limited to the commissioning agenda.

69 Membership of the London Commissioning Group will be representative of the Local Commissioning Groups (see next section, paragraph 69 onwards), and the SHA. The London Commissioning Group will co-opt members (from, for example, the Commissioning Business Service and the Specialised Commissioning Group) or invite external attendance on specific issues.

Local Commissioning Groups

70 PCTs are the **strategic planners** and leaders of the local NHS, as well as relationship managers**,** meeting the health needs of their populations through their commissioning and contractual arrangements and within the context of Foundation Trusts, Payment by Results, Independent Sector providers, joint commissioning arrangements, practice based commissioning and primary care commissioning. Our proposals recognise these responsibilities, and will strengthen support for PCTs in meeting their responsibilities rather than attempting to dilute them.

71 It is proposed to strengthen lead and collaborative commissioning arrangements by establishing **Local Commissioning Groups.** These groups will comprise at least the Chief Executives of a group of PCTs, under an explicit duty of partnership, to agree on shared commissioning arrangements for their populations. The presence of Chief Executives will give the Group the appropriate level of representation, but the Local Commissioning Groups will clearly need to have appropriate input from clinicians and others. Discussions will be held with Local Authority colleagues to agree appropriate pan-borough partnership arrangements. The terms of reference of these Groups and the Duty of Partnership itself are set out in section 7, and there is a descriptive list of the Local Commissioning Groups' range of responsibilities at the end of this section.

72 A key indicator of the success of the commissioning model will be its ability to sustain successful performance across **all levels and elements** of the system. This will mean applying the model not just to the acute, mental health and joint commissioning areas, but also to Practice-based Commissioning and to primary care commissioning, where the issues of collaboration between PCTs are somewhat different. With the milestones set out in the recent White Paper giving a new focus on care outside hospital these are increasingly critical areas, and we have referred already to the need for London's approach to include strong and effective **primary care and Practice-based Commissioning arrangements**

73 For acute services, analysis of patient flows[4] shows that in the main patients seek their care from a relatively limited group of service providers, and initially this will form the basis for the London commissioning sub structure arrangement. At present the data indicates that acute flows still reflect the five 'Turnberg' sectors, and it is therefore sensible to propose that there be five cluster commissioning groups, but it is equally important to recognise that flexibility will be required as the system is established, to reflect new pathways that commissioners will create.

74 The Local Commissioning Groups will ensure that there will be a consistent model for joint working arrangements in each sector, rather than a multitude of different models, and these joint working arrangements will build on the best features of the structure currently in place for specialised commissioning – i.e. a structure that operates at both sector and London wide levels.

An example of how the new London model could operate, drawn from Cardiology Services.

A multi-PCT Local Commissioning Group, following a debate initiated by local clinicians, requests and receives information from the Commissioning Business Service highlighting capacity, performance and cost variation across cardiology services in the 6 acute trusts in the area.

The Local Commissioning Group agrees the need for a service review and draws up a specification agreed with the PECs and Boards stipulating the involvement of the CHD network and PbC commissioners in the review which is commissioned from the Business Service.

The outcome is a proposed service rationalisation across the 6 hospital sites, an agreed care pathway and the development of a Network Heart Attack Centre.

The proposal is discussed by the Local Commissioning Group and remitted to PCT Boards for decision.

75 Specialised commissioning itself will be integrated within these new arrangements and not function separately, either at Local or London Commissioning group levels**.** Each sector currently has a Local Specialised Commissioning Group and there is a London wide Specialised Commissioning Group, which brings together the lead PCT Chief Executives and Directors of Specialised Commissioning in each sector with representatives from the SHAs and NHS Trusts to manage the specialised commissioning agenda on a London wide basis. There

[4] A summary analysis of 2004/05 patient flows is available from the project group

are also a number of pan London and wider specialised services commissioning consortia currently in place which are based on pooled commissioning resources, agreed risk sharing arrangements and collective service agreement/ contractual agreements with Foundation and NHS Trusts. This model is consistent with the findings of Lord Warner's review, and will align with the proposed Local and London Commissioning Groups.

76 **Networks** have developed considerable commissioning expertise essential to establishing the PCT collaborative commissioning arrangements. However, arrangements vary between networks and the staff working for these networks is spread between commissioning and providing organisations. We will need to scope the networks, map out their services and staff, and identify their current funding, and then agree a process and timetable for transition. They will be accountable to the PCT, but it is noted in the descriptions following that 'provider' networks will also have a role, and that role needs to be clarified and defined; it will become a matter for providers rather than commissioners to support these organisations.

77 The overall responsibilities of the Local Commissioning Groups are summarised in the boxes below;

Local Commissioning group responsibilities

Strengthening Lead Commissioning - given the changes and constraints which influenced the 2005/06 commissioning round the Lead Commissioning arrangements proposed and adopted by the London Directors of Commissioning were an important advance and the proposals contained in this document aim to build upon and strengthen this.

Provider Management – ensuring that the range and quality of acute hospital services provided meet population needs (but ensuring local contestability) / reviewing strategic cases for service investment and reconfiguration – market management can take place at a number of levels;

Network management – commissioning clinical networks to deliver on agreed objectives, with clinical networks being accountable to the Commissioning Group – this approach would ensure that there is a clear commissioning rather than provider development role for clinical networks; and the provider network role itself will need to be clarified, with providers themselves taking this responsibility.

Specialised Commissioning – collaborative commissioning for those specialised services needing a planning population of 1 million or less will be undertaken by the Local Commissioning Groups. The Local Commissioning Group will also lead the collaborative commissioning of specialised services, through commissioning consortia or other arrangements, for services needing a planning population of more than 1 million. These commissioning consortia may be London wide, or larger.

Care Pathway management – ensuring consistency and 'fit' in the building and implementation of new care pathway initiatives at PBC, PCT and sector level.

Practice-based Commissioning – agreeing common ground rules where appropriate.

Contract planning – agreeing the aggregated activity, financial and performance requirements to be included in contracts (which might be negotiated by or with the extended support of the Londonwide commissioning business service). This would entail PCTs agreeing the level of financial resources available to feed into the contract planning and negotiating processes/ parameters for variances from resource plans and risk share arrangements

Risk share arrangements and risk management – these will be developed separately, and will emerge appropriately as lead commissioning arrangements are developed.

Contract compliance – receiving regular reports on contract compliance to assess performance against plans and agree action plans where required.

Workforce and skills development – ensuring co-ordinated development and building on the expertise available at PCT Director level across London.

Lead Commissioning

78 In January 2006, PCTs across London (through the Londonwide Directors of Commissioning Group) agreed collaborative arrangements for commissioning in the current round - 2006/07. The PCTs agreed to abide by a set of common rules and business processes, set out in:

- 2006/07 London planning guidelines (issued by SHAs)
- London wide commissioning - Primary Care Trust commissioning intentions 2006-07
- London PCTs Lead Commissioner arrangements.

Lead commissioning in this context means '*the delegation of a PCT's contract negotiation responsibilities with an Acute Trust to a team led by the Trust's host PCT*', with the leading PCT team responsible for developing a clear and specific set of objectives and priorities from those contributed by all PCT commissioners and those contained within London wide commissioning intentions. Once negotiated, all PCTs abide by the final SLA agreed by the host-led team.

79 The 2006/07 planning guidelines included requirements for sector-wide PCT management and co-ordination arrangements to oversee:

- Consolidation of strategic commissioning plans by provider;
- Review of standard documentation;
- Consistency of approach to lead commissioning and practice-based commissioning

80 PCTs reflected these requirements in their Commissioning Intentions, a document developed for the Londonwide PCT directors of Commissioning, and sponsored by PCT Chief Executives from each sector, which set out the strategic context for commissioning, and some underpinning principles. The latter included commitments, for example, that all Service Level Agreements and Contracts should:

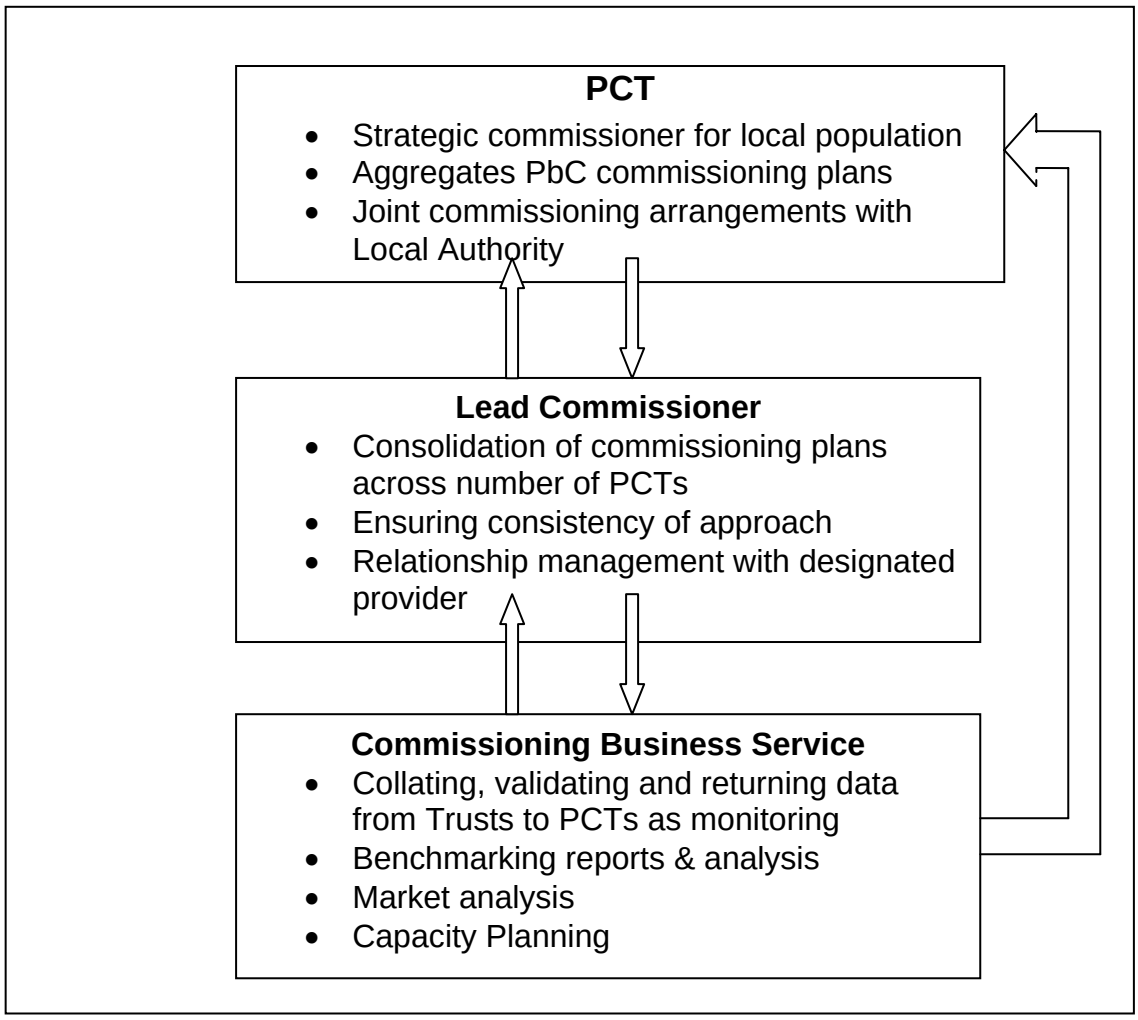
- Reflect the principles of key policy initiatives including Payment by Results (PbR), PbC, Choice, Plurality, the roll out of Foundation Trust (FT) status and the development of Integrated Service Improvement Programmes;
- Manage imperfections in the health market and individual policy areas in a fair and practical manner, in order to ensure organisations are able to fulfil their statutory responsibilities, including the achievement of key performance targets, financial balance and long term sustainability.
- Support the development of more effective strategic commissioning for services best planned for larger populations and the managed introduction of new technologies.
- Support the development of high quality services that are convenient for people to use, making use of best practice models of care and cost effective design and delivery.
- Support improved public involvement in the design, development delivery and performance management of health and healthcare services to local populations.
- Recognise the responsibility of the Trusts to provide evidence that activity has taken place which is payable by the PCT; and the need for PCTs to manage demand for services with the support of service providers

81 The Commissioning Intentions also set out key priorities for acute commissioning, and were a first stage of commitment by PCTs to the development of lead commissioning arrangements across London. They were accompanied by management arrangements, and

agreements on the respective responsibilities of lead and supporting commissioner PCTs.

82 The proposal in this document is that we adopt and improve on these arrangements through the Local Commissioning Groups and the London Commissioning Group, but strengthen their supporting infrastructure through the Commissioning Business Service. We also propose that lead commissioning arrangements are extended to (for example) Mental Health Trusts, and have set out below how these relationships would look under the new arrangements.

Flowchart of Relationships between PCT, Lead Commissioner & CBS



83 The current lead commissioner arrangements as established for the 2006/07 commissioning round are listed in Appendix A

.**Performance management, scrutiny and overview**

84 **Performance Management.** It is important to be clear that the proposed London Commissioning Group will not substitute for the

London SHA's Performance Management function, although it may be a forum for discussion on performance. We assume that the SHA will continue to work directly with PCTs, as the 'local headquarters of the NHS', The SHA would have an arbitration role in disputes resolution between members of Local Commissioning Groups.

85 **Overview and Scrutiny.** PCTs will maintain their existing relationships with Borough Overview and Scrutiny Committees. In the event that collective arrangements for scrutiny across a number of Local Authorities are needed in relation to service changes affecting populations greater than that of one single borough, discussion will be held with the Local Authorities involved to agree appropriate arrangements.

86 **Financial Stewardship.** There is no proposal in either the collaborative arrangements described here or in the Duty of Partnership for any change in the PCTs' accountability for their own financial balance, or for their effective local use of resources. In the immediate development of the Duty of Partnership and the creation of Local Commissioning Groups and the Commissioning Business Service, we will take careful note of the McKinsey standards for Governance Assessment, and ensure that the model is in line with the standards for financial governance

6 A highly performing commissioning business service

87 A London wide commissioning business service will be established to bring together expertise and knowledge better to support PCTs in their commissioning role. This proposed model of functions draws from similar arrangements being developed in Manchester and Birmingham.

88 The key functions of the proposed London Commissioning Business Support Service (CBS) must support the four main commissioning tasks:

Strategic Planning	A local activity supported by the Commissioning Business Service and then potentially aggregated to a sector or London level;
Monitoring:	The CBS has a supporting role in combining local intelligence to provide Londonwide coverage and analysis;
Care Pathway Management	Developed on a local basis and then shared or rolled out more widely
Provider Management	Using local intelligence aligned with wide information – for example benchmarking data.

89 **The Commissioning Business Service will be accountable directly to PCTs,** and will not form a separate 'commissioning' organisation. PCTs will performance manage the CBS, possibly through the London Commissioning Group.

90 PCTs will need to resource the CBS, and we will produce a business case by October 2006, setting out how its functions will be linked to and integrated with –

- Information 'hubs' across London, including new PCT/PBC information systems;
- Londonwide Public Health functions;
- Development of clinical efficiency benchmarks through other strands of the Londonwide work programme

91 Our outline implementation programme recognises that there will need to be a comprehensive review of existing support arrangements, before the service specification can be tested with commissioners and stakeholders, and this is therefore a preliminary set of functions. We are clear however that the correct specification will bring improvements in quality and reductions in transaction costs

92 The development of the CBS will necessarily be iterative, and by listing out commissioning support functions here, we do not imply that all of

them will be carried out by the CBS in the first phase of its development. The Public Health workstream will be working in parallel to develop the panLondon and PCT Public Health functions, and we will need to co-ordinate how these and the CBS will work together most effectively. We will concentrate in the initial implementation programme on aggregating where possible those functions that can bring early gains to the lead commissioning process, and there will be a process of agreement and amendment as the service specification is drawn up

93 Public health and service intelligence, strategic analysis and market management support

- Public health intelligence to support value added commissioning approach, clinical engagement; including 'horizon scanning' systems and policy/clinical development reporting and updating; workshops/seminars and commissioner guidance publications
- Public health led needs assessment, critical appraisal of effectiveness and cost effectiveness, health economics, independent clinical advice, best practice in care pathway management;
- Information - to include data cleaning, analysis and handling, health determinants, health needs, health service activity, quality and outcomes data, statistics
- Effectiveness and quality analysis, utilisation analysis;
- Capacity analysis, modelling of future demand and patient flows including analytical systems for population risk stratification
- Performance reporting
- Provider and market intelligence/analysis, including input and response to major capital investment appraisal on appropriate aggregation scales

94 Service specifications, standards of clinical effectiveness, quality assurance The role of the CBS here is to support and provide expertise to PCTs, not to take from the PCT the authority or responsibility for the management of care pathways. The supporting role as far as Practice-based Commissioning is concerned will centre on the development and dissemination of the evidence base and of best practice; and the CBS role in the development of community services will be similarly based. The CBS will clearly have a role in the operational delivery of Healthcare Commission standards and policy.

- Utilisation management
- Network accreditation and liaison
- Standards specification
- Expertise in specialised/tertiary services
- Benchmarking
- Key quality assurance processes inc primary care support
- Support for service analysis/pathways

- Expertise to support local development of evidence based services at PCT, Borough, practice and PBC levels
- Development of service specifications in contracts reflecting agreed protocols and care pathways, including Practice-based Commissioning service plans
- Specification of quality standards in contracts together with legally robust incentives/penalties structures
- Contract negotiation and competitive tendering support
- Hold and develop PbR understanding and expertise including in relation to tariff unbundling and fitting PbR to service redesign

95 **Contracting support and management** There will not be a 'big-bang' approach to the Londonwide development of data and information resources, but the CBS will rapidly develop central analysis functions where they do not exist or are in short supply locally, and will procure and provide advice and technical support where it makes sense to 'do it once' across London. Support to local services where these remain the best option will be generic (training, validation, etc)

- Utilisation/capacity planning;
- Contracting;
- Back-office information systems and data-processing;
- Audit and analyse PBR claims and ensure robust application of Assurance System locally;
- Clearing house for data dispute resolution;
- Production of contract monitoring reports;
- Local negotiation support services;
- Support for Practice-based Commissioning consortia;
- PbR audit ;
- Obtain/provide legal advice;
- Receipt, validation and triggering payment of provider bills in line with contract terms (in conjunction with national system), including SUS deadlines;
- Maintenance of Directory of Services.

96 The **central delivery** of these functions will:

- Develop and deliver a high quality analytical specification that can be used as a basis for prioritisation by all commissioning bodies (i.e. identify the scope for improvement for different market segments);
- Accelerate innovation in commissioning capability;
- Reduce duplication and costs; and
- Free commissioning time to focus upon tackling strategic challenges.

97 The Commissioning Business Service will support the development of the commissioning Prospectus, which will be a key driver at three specific levels – practice based commissioning, PCT and London-wide, and will be a signal to the market about how commissioners intend to

shape services during the next 1-3 years. The combination of Londonwide and more local sector-based activity offers us flexibility for the future, and can evolve over time as commissioners' needs develop.

98 As part of the development of the business case for the CBS, we will undertake an appraisal to confirm which of the functions outlined above should be delivered **once** across London, and which might be best delivered more locally in support of PCT cluster arrangements. Criteria for this appraisal will include:

- Scope of intelligence/ analysis needed – i.e. local or London wide
- Best use of scarce resources
- Ensuring close client relationships with the London PCTs

99 Information systems across London will be the key enabler of the CBS, and the Matrix review[5] (section on *Strategic commissioning information requirements*) contains an analysis of the type and levels of information that need to be generated by the commissioning business service. The business case will also need to indicate how diverse information standards and mechanisms across Trusts, PCTs and the SHAs will be integrated, and give an appropriate timescale is for this integration. It will also review the feasibility of bringing NHS information and analysis more closely aligned with that of Local Authorities, in line with the recommendations of the White Paper.

100 Proposals on the **size, skill mix, organisation and cost** of the commissioning support service will be set out in the business case. This will also include an analysis of funding currently available to PCTs eg current clinical networks, specialised commissioning and modernisation resources, which could be redesigned to support its costs. The Commissioning Business Service will require staff with very specific skills, and there will need to be an analysis (and stocktake) of where these skills can be found in the existing system.

[5] Available from the project group.

7 The Duty of Partnership

"It is the duty of Strategic Health Authorities, Special Health Authorities, Primary Care, NHS and Foundation Trusts to cooperate with each other in exercising their functions." Section 26 Health Act 1999

101 PCTs in London have strongly articulated that the retention of borough-based PCTs is essential to maintain and strengthen local commissioning partnerships, improve health and reduce health inequalities. But London PCTs also recognise that they need to work collaboratively to strengthen Londonwide commissioning arrangements.

102 PCT Governance as defined by the Audit Commission - *Governing the NHS,* DH 2003 - sets out the system and processes by which health bodies lead, direct, and control their functions in order to achieve organisational objectives. An organisational duty placed upon PCTs is to commission effectively within an increasingly difficult and diverse market. The Duty of Partnership means that where this is appropriate, PCTs should commission collaboratively to maximise their position in the health and social care market and therefore achieve their organisational objectives.

103 Each PCT Board is asked to approve formally the remit of the Local and London Commissioning Groups and confirm its intent to act in partnership. The Commissioning Groups will consist of PCT Chief Executives as a minimum, with SHA representation on the London Commissioning Group. In addition to PCT CEO involvement, the London and the Local Commissioning Groups will secure appropriate clinical, expert Director and partner engagement. A dispute resolution procedure is therefore included with the Terms of Reference set out below, which will ultimately be performance managed by the London SHA. This section and the following sections will be issued with this paper as a formal recommendation for adoption by PCT Boards in June/July 2006.

Terms of Reference for London and Local Commissioning Groups

London Commissioning Group

104 We propose that a Londonwide Commissioning Group be established, with the following terms of Reference:

- Oversee the London wide commissioning process, and ensure that there is "fit " between local plans;
- Undertake an annual 'horizon scanning' process to identify prospective commissioning priorities, with input from all London PCTs to form the basis of annual London wide Commissioning Intentions;
- Market manage on a London wide basis, where appropriate, and ensure that a comprehensive range of patient services exists within reasonable access of all Londoners;
- Stimulate the market on a London wide basis where necessary to align capacity and resources.
- Take the lead for specialised commissioning activities on a London wide basis, as set out in the recommendations of the Warner Review.

105 Membership

- Each Local Commissioning Group will nominate a Chief Executive representative onto the London Commissioning Group
- To ensure that the strategic development of services in London and London wide commissioning plans are aligned and consistent the SHA will nominate its representative
- The Group will elect a Chair
- The Group will co-opt members or invite external attendance on specific issues
- The Group will secure public health, finance and information support

Local Commissioning Groups

106 We propose that Local Commissioning Groups be established, with the following terms of reference:

- Manage the lead commissioning of the 2007/08 Commissioning round, supported by the Business Service, with acute services as a priority, but with commissioning progressively rolled out to

all other services including mental health, specialised and primary care commissioning.

- Implement and monitor the progress of negotiations across its geographical area and undertake joint action where appropriate

- Through representation on the London Commissioning Group, performance manage the Commissioning Business Service.

- Oversee the role and performance of commissioning clinical networks , and liaise with provider networks

- **'**Market manage' through planning and provider stimulation to meet the needs of the local population, where gaps in service provision or market failures are identified. In this respect the Local Commissioning Groups will work with Practice Based Commissioning Consortia in addressing the provider management of new or revised Patient Pathways.

107 Membership

- Each constituent PCT Chief Executive will be a member. Each Group will also determine appropriate clinical and technical membership.
- The Group will elect its Chair
- The Group will co-opt members or invite external attendance on specific issues

108 **Meetings**

- The Local Commissioning Groups will meet monthly
- The London Commissioning Group will meet monthly

109 **Administrative Arrangements**

- The London CBS will provide administrative support to both London and Local Groups

110 **Accountability**

London Commissioning Group

- The Group will be accountable to the London PCTs within the performance management framework of the London SHA.

Local Commissioning Group

- The Group will be accountable to its constituent PCTs. Copies of the minutes of all meetings will be supplied to each PCT, and the Group shall produce an annual report of its activities for submission to each PCT Board.

111 **Dispute Resolution Procedure**

- These procedures are designed to provide a clear and easily understood set of rules for dispute resolution and reaching agreement amongst the PCT members of the Local and London Commissioning Groups.

- PCTs by agreeing to the "Duty of Partnership" and the establishment of the Commissioning Groups agree to adhere to these procedures and the collaborative approach which underpins it.

- Disputes and issues requiring agreement will be categorised under three headings: **collective procurement**, **service development** (e.g. the cardiology example referred to in section 5 above); and **major service reconfiguration** as defined by the policy to be agreed by the London Commissioning Group and PCTs.

- Disputes involving issues about **collective procurement** will normally be resolved by a 75% majority. Procurement consortia will need to determine the detailed implementation of this arrangement as it applies to the scope and size of the consortia portfolios. These majority agreements already operate within the specialised services consortia that have been in place across London PCTs for some time. Any new procurement consortium will agree its financial and decision making arrangements at inception, consistent with arrangements already in place.

112 **Pan PCT Agreements**

- Groups will decide in advance of considering a specific piece of joint work around **service development** or **service reconfiguration** a process for decision making and how they intend to deal with a failure to agree. This will involve agreement to the prospective service review and sign off at the end of the process by the sponsoring PCT Boards.

- Disagreements will be subject to mediation within the Group, conducted by the Chair, but if at the end of the review PCTs cannot agree on their recommendations, then the SHA would be asked to facilitate reaching a decision.

- The SHA's performance management responsibility remains and complements these arrangements.

LONDON: COMMISSIONING FOR HEALTH

Appendix A Lead Commissioners for London Trusts, 2006/07

Lead PCT	Acute Trust
Barnet PCT	Royal Free Hampstead NHS Trust
Barnet PCT	Royal National Orthopaedic Hospital NHS Trust
Bexley Care Trust	Queen Mary's Sidcup NHS Trust
Brent PCT	North West London Hospitals NHS Trust
Bromley PCT	Bromley Hospitals NHS Trust (Princess Royal University Hospital)
Camden PCT	University College London Hospitals NHS Trust
City & Hackney PCT	Homerton University Hospital NHS Trust
Croydon PCT	Mayday Healthcare NHS Trust
Ealing PCT	Ealing Hospital NHS Trust
Enfield PCT	Barnet and Chase Farm Hospitals NHS Trust
Greenwich PCT	Queen Elizabeth Hospitals NHS Trust
Hammersmith & Fulham PCT	Hammersmith Hospitals NHS Trust (including Ravenscourt Park Hospital)
Haringey PCT	North Middlesex University Hospitals NHS Trst
Havering PCT	Barking, Havering & Redbridge Hospitals NHS Trust
Hillingdon PCT	HEMS
Hillingdon PCT	Hillingdon Hospital NHS Trust
Islington PCT	Moorfields Eye Hospital NHS Trust
Islington PCT	The Whittington Hospital NHS Trust
Kensington & Chelsea PCT	Royal Brompton and Harefield NHS Trust

Lead PCT	Acute Trust
Kensingon & Chelsea PCT	Chelsea & Westminster Healthcare NHS Trust
Kingston PCT	Kingston Hospital NHS Trust
Lambeth PCT	Guys and St Thomas NHS Trust
Lewisham PCT	Lewisham Hospital NHS Trust
Newham PCT	Newham University Hospitals NHS Trust
Richmond & Twickenham PCT	London Ambulance Service NHS Trust
Southwark PCT	Kings College Hospital NHS Trust
Specialist Commissioning Haringey PCT	Great Ormon Street Hospital for Children NHS Trust
Sutton & Merton PCT	Epsom & St Helier University Hospitals NHS Trust
Sutton & Merton PCT	Royal Marsden NHS Trust
Tower Hamlets PCT	Barts and The London NHS Trust
Waltham Forest PCT	Whipps Cross University Hospital NHS Trust
Wandsworth PCT	St Georges Healthcare NHS Trust
Westminster PCT	St Marys Hospital NHS Trust

LONDON AMBULANCE SERVICE NHS TRUST

Response to 'London – Commissioning for Health – Developing World-Class Commissioning to Improve the Health of Londoners'

The London Ambulance Service (LAS) has been asked by the Primary Care Trust (PCT) Chief Executives for comments and opinions on their proposals for London-wide commissioning. Our response is set out below.

The Strategic Agenda for the LAS

The LAS' new 7-year strategic plan will make the Service of 2013 radically different from the one of today and will create an organisation capable of delivering significant benefits for the whole health care system in London. Benefits expected to be delivered include:

- A reduction of around 200,000 in the number of patients referred to A&E
- More "treat and discharge"
- Provision of appropriate care in a more cost-effective way than in the current system
- Increased use of alternative care pathways both for urgent and emergency patients
- A cohort of flexible emergency/unscheduled care professionals able to work in a variety of care settings including Minor Injuries Units (MIUs), Walk In Centres (WICs) and out of hours primary care.

Current Commissioning Arrangements

The LAS is the only pan-London NHS Trust.

In this context it is extremely disappointing that no specific attention is paid to the commissioning arrangements for the LAS. In fact the only mention of the LAS is in the Appendix to the document!

The current commissioning arrangements consist of a group formed of one representative from each of the 5 old Strategic Health Authority (SHA) areas, one Lead Commissioner from Richmond and Twickenham PCT and one representative from the Trust's previous lead SHA, South West London.

Sub-group commissioning meetings are held for one afternoon each month with Chief Executive level meetings held twice a year. The commissioning meeting usually comprises a performance review, an update on clinical developments and, towards the end of the year, an increased focus on the following year's funding.

The Key Proposals Impacting the LAS

Structure

The proposals include the formation of a ‘London Commissioning Group’ with 5 ‘Local Commissioning Groups’.

The London Commissioning Group would take a strategic role overseeing the London-wide commissioning process and this would include taking the lead on specialised commissioning activities. This does not include the LAS which does not fit into the ‘high cost, low volume’ definition of ‘specialised services’.

The 5 Local Commissioning Groups would be formed (in alignment with the old SHA sectors) for the purpose of strengthening lead and collaborative commissioning arrangements. Their role would include monitoring performance against plans, commissioning clinical networks, ensuring consistency and ‘fit’ of new care pathway initiatives and agreeing activity levels across the sector.

The Commissioning Business Service

The proposals advocate the establishment of a London-wide Commissioning Business Service (CBS) to provide PCTs with a range of expertise and skills to support them in their commissioning functions.

This Service, accountable to PCTs, would be a provider of information, data and analysis across the London health economy, including quality and outcomes data, effectiveness and quality analysis, capacity analysis, provider and market intelligence, benchmarking information, dissemination of best practice information and advice on service and standards specifications, support on contract negotiation and competitive tendering and audit and analysis of Payment by Results (PbR) claims.

Our response to these proposals

Structure

The Ambulance Service is not referred to in the proposals but our understanding from the paper is that a similar commissioning arrangement is being recommended as currently exists for the LAS with representatives from each sector (from each Local Commissioning Group under the new arrangements) forming a consortium with a lead commissioner.

Although PCTs have been positive about LAS local developments, they are not of a size to influence successfully broader, more strategic change of the sort being undertaken by the LAS as proposed under the 7 year plan. Our management structure has 3 Assistant Directors of Operations responsible for performance and for working with local PCT commissioning groups. This enables local issues to be addressed at a local level. What is required for the LAS is a commissioning arrangement which focuses on strategic London-wide

issues and which is able to influence London-wide change to realise benefits the LAS can provide.

For each PCT, the LAS represents a very small element of its annual investment. Those currently charged with commissioning LAS services on behalf of other PCTs in their SHA area, whilst supportive of change, are not able to give this element of their work the attention it requires.

For a Service undergoing significant change, the speed of decision-making is crucial. A sector-based lead-commissioning group, required to consult individual PCTs on significant changes, does not support the speed of change required for the LAS to deliver the benefits of its strategic plan.

With our commissioning arrangements being sector-based and without dedicated commissioning resource, our most forward-thinking developments have been provider-led. We are now bypassing emergency departments to take patients with myocardial infarction directly to one of nine units in London that we know are best suited to provide primary coronary interventions such as angioplasty. We hope to do the same for stroke patients in due course.

Developments such as these have a direct impact on demand and income in other parts of the health economy. We have discussed with our commissioners how we can ensure our developments in patient care link-in with overall commissioning intentions and have asked for their assistance in influencing further such developments but the lack of London-wide influence restricts the effectiveness of this process.

Some of the commissioners who attend from PCTs have an acute sector focus. Some PCTs have sent individuals who have a brief for older people's care or long term conditions. This has provided a refreshing range of perspectives, but does not seem to have led to a coherent, whole systems approach to commissioning ambulance services as part of urgent care generally. The CEO meetings have been presented with and welcomed this perspective, but it not clear that this has led to any strategic focus on commissioning ambulance care as part of broader imperatives and objectives in healthcare development.

Indeed, it is probable that single-organisation commissioning can never bring about systemic change, since what is required is a shift in resources between organisations that simply cannot be achieved by incremental and silo-based commissioning.

Further, the cost savings the LAS expects to deliver to the London health economy are dependent on costs being extracted from elsewhere in the system and innovative, local PbR-type funding arrangements being developed through the commissioning process. This requires in-depth understanding of the LAS, strong financial skills and a significant time investment in working jointly to develop such arrangements.

Even with the creation of the CBS, designed to free commissioning time to focus on strategic challenges, we do not feel these challenges can be met without dedicated commissioning arrangements.

The most innovative and progressive developments in Ambulance Services recently have occurred where there is one commissioning lead. The PCTs commissioning East Anglian Ambulance Service (now part of East of England Ambulance Trust) appointed one full-time commissioner for the Service, empowered to make decisions on their behalf and with the time to invest in understanding and analysing the Service. As result, the Service has already developed Out of Hours (OOH) services, Community Responders and Community Paramedics. Essex Ambulance Service (also now part of East of England) was commissioned by only one PCT and has been able to develop an innovative PbR-based funding arrangement. This has resulted in a quicker process of agreeing funding as well as better alignment of purchaser and provider incentives.

Our 7 year plan will details for our future workforce requirements. The LAS always has and will continue to train the majority of its own frontline staff both in terms of initial training and continuing training and development. Funding for this comprehensive training school provision is currently within the baseline funding for the Trust and therefore needs to be considered when commissioning agreements are made. This internal requirement will continue and indeed increase as we expand and change the workforce skill mix to meet future requirements. Unlike other NHS Trusts, central funding provision for operational staff training such as NMET does not apply to the LAS and previous allocations of NPET funding is now minimal.

The commissioning proposals seem to be silent on the topic of how links will be made between workforce plans and commissioning. But this is as important as the need to take a whole systems approach to urgent care development as a whole.

<u>The Commissioning Business Service</u>

We welcome the development of this new Service, particularly the opportunities for more joined up procurement and the overall savings in the health economy it should help identify.

It is important that the CBS consults the LAS on its reviews of capacity and cost-savings in the London health economy. Cost-savings are often assessed without reference to the impact on the LAS. For example, the closure of an A&E department or the opportunity for us to have parking bays and facilities at a new Walk In Centre have a significant impact on our cost-base and on our performance in that area.

It is also important to the LAS that the CBS supports the development of ‘themes’ in line with the vision of the new London SHA, for example, reviewing Unscheduled Care as a whole, rather than simply benchmarking acute trusts

against other acute trusts and looking for capacity and opportunities within the same tier of providers.

We also welcome the CBS' role in advising on service and standard specifications and would particularly welcome this being extended to cover the specifications for the purchase of Patient Transport Services (PTS) by PCTs and acute providers. We understand that the task of London PCTs commissioning PTS has to date been considered too large to tackle with existing PCT capacity. However, in the current market, there is no consistency of provision and little quality assurance. Where contracts are awarded to commercial providers, there is no standard specification and 'overspill' costs (e.g. of services not covered by a commercial provider or work 'upgraded' to urgent) will be incurred by the purchaser and the LAS.

Our recommendations

1. A full-time commissioning post be created, dedicated to the LAS. This would alleviate some of the issues outlined above and enable the LAS to prepare for more significant change in the future. This post would need to control some of the PCT A&E capacity related funding to effectively lead and drive system change.

2. The CBS consults the LAS on the impact of proposed changes in London and focuses on a 'theme' basis (e.g. Unscheduled Care) as well as on tiers of individual providers.

3. That commissioning is not organisation-focussed but focuses instead on areas of care such as urgent/unscheduled care in acute and primary care as well as ambulance services and that the appropriate integration is gained with workforce planning and workforce development funding.

4. The CBS includes PTS in its work regarding contract specifications to ensure that the perceived benefits of lower-cost provision are realised.

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