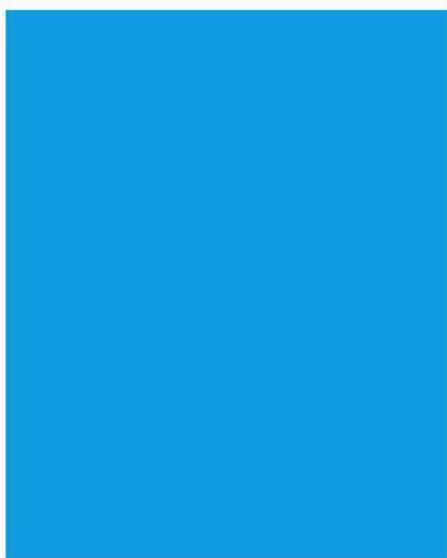


**Securing equity and  
excellence in  
commissioning  
specialised services**



# ***Securing equity and excellence in commissioning specialised services***

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**Prepared by the Specialised Services Commissioning Transition Team**

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## Foreword

We are delighted to launch and publish the Operating Model on “*Securing Equity & Excellence in Commissioning Specialised Services*”.

Since the publication of the White Paper ‘Equity and excellence: liberating the NHS’ by the Department of Health in July 2010, we have had an exciting opportunity to review the specialised commissioning function and transfer this into the new national system and into the structure of the NHS Commissioning Board. We have utilised this opportunity to realise many of the strategic recommendations outlined in Sir David Carter’s 2006 review of specialised commissioning.

The Operating Model outlined in this document provides a national commissioning structure that will ensure we commission specialised services that provide access to a consistent range of high quality services for patients across England based on the best clinical advice and evidence that deliver outcomes that matter to patients.

The process of engaging clinical experts, commissioning, public health knowledge and patient voices has taken place through 60 clinical reference groups covering the full range of specialised service patient pathways. This is a model that we aim to replicate and develop through this Operating Model, ensuring that as we move forward we are basing our work on real knowledge, expertise and experiences.

It is of high importance that we continue to innovate, consolidate the design of the new commissioning system and work with key strategic partners, in order to continuously improve the quality of care for patients and carers. And we must deliver this within our available resources.

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## Introduction

1. From 1st April 2013, the NHS Commissioning Board (NHS CB) will be established with an overarching role to ensure the NHS delivers better outcomes for patients within its available resources and upholds and promotes the NHS Constitution. The Department of Health (DH) will hold the NHS CB to account, and set its objectives, through the annual publication of the Mandate. An assessment against the following four factors will determine whether the NHS CB will be responsible for the commissioning of a prescribed specialised service:
  - the number of individuals who require provision of service
  - the cost of providing the service or facility
  - the number of persons able to provide the service or facility
  - the financial implications for Clinical Commissioning Groups (CCGs) if they were required to commission the service or facility themselves.

**The Four Factors determine whether the NHS Commissioning Board commissions a service as a prescribed specialised service**

2. Specialised services have a key role to play and are provided in relatively few specialist centres. These services treat either rare conditions or those that need a specialised team working together at a centre. The conditions treated range from long-term conditions, such as renal (kidney services), specific mental health problems and neonatal services, to rarer conditions such as uncommon cancers, burn care, medical genetics, specialised services for children and cardiac surgery.
3. These services can be expensive to provide and some may be described as high cost/low volume services. Specialised services account for approximately 10% of the total NHS budget and spend circa £11.8 billion per annum.
4. The NHS CB is charged to design the commissioning of specialised services in line with the direction set out by Sir David Carter's 2006 independent review of commissioning arrangements [[Report](#)]. The ambition of the NHS CB is to help achieve equity and excellence in the provision of specialised care and treatment through ensuring excellent commissioning which:
  - is patient centred and outcome based. The patient must be placed at the centre of planning and delivery and commissioners, working with providers, must deliver improved outcomes for them across each of the five domains of the 2013/14 NHS Outcomes Framework

- is fair, consistent throughout the country and ensures that patients have equal access to services regardless of their location
  - improves productivity and efficiency.
5. This ambition is accelerated by:
- the changes to commissioning arrangements allowing a single national commissioning structure and process to be formed
  - an approach to ensure the continued visibility of specialised commissioning and a focus on rarity in highly specialised services
  - a focus on making engagement with and understanding patients and carers a priority
  - designing a clinically led system developing national strategies for services which are then locally delivered
  - the opportunity to manage new innovations and the introduction of technologies in a systematic way.
6. A national consistent and coherent approach to specialised commissioning has been developed which builds on universal support. To date there has been wide variation in how each region discharges its commissioning responsibilities. This has resulted in inconsistencies in the management of the commissioning cycle e.g. budget setting, contract negotiation, performance management and the development and application of service specifications, commissioning policies and quality standards. It has also resulted in duplication of activities and functions such as horizon scanning for new treatments.
7. A consistent approach to central planning that is delivered locally will help tackle these variations and take positive steps towards raising standards of care for all patients receiving treatment for rare and specialised conditions with equity across the country.
8. The NHS CB will work with a range of stakeholders at a national level to determine the outcomes expected for specialised services. This will be achieved through the development of clinical strategies set out within five National Programmes of Care (PoC) which group together the prescribed specialised services.<sup>1</sup> These strategies will enable service to be commissioned based on clear evidence and ensure they are cost effective and patient focused. The PoCs span three portfolios covering acute, highly specialised and mental health services.
9. The NHS CB will work through the PoCs to develop nationally agreed frameworks that identify clear and consistent strategies and standards of care. National service-specific Clinical Reference Groups (CRGs) will design the PoCs with wide and expert engagement.
10. To ensure local decisions about services are made as close to the patients as possible, ten Local Area Teams (LATs) of the NHS CB will take on the responsibility across

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<sup>1</sup>N.B Programmes of Care detailed in paragraph 43

England to contract and deliver the frameworks with local providers. The NHS CB will also work in partnership with Clinical Commissioning Groups (CCGs) and other local stakeholders to ensure the whole patient pathway is as locally responsive as possible in meeting patients' needs.

11. Achieving the right balance between national consistency and local delivery through contracting will be vital. Therefore, the regional role of the NHS CB will be important to ensure this balance is maintained. A large number of specialised services span a wide catchment population of over one million people, therefore having a level of co-ordination and oversight across the four regions to ensure equity is delivered is an important role for the NHS CB.
12. The NHS CB will ensure that wide stakeholder engagement and patient participation are central to how we work. We will work hard to ensure that all our commissioning processes are underpinned by the real involvement of people who use the services.
13. The purpose of this document is to outline the new arrangements for commissioning specialised services across England and how they will improve outcomes for patients whilst reducing inconsistency and duplication in the system. It outlines the services that the NHS CB will be responsible for commissioning and the programme of work which will manage the process of transition to the new system.
14. This is an ambitious programme of change that will for the first time allow clinicians, patients and partners to see a level of consistency in the what, how and where of commissioning .

## Specialised commissioning in context

15. Specialised services in England have been commissioned by ten separate, regionally based, Specialised Commissioning Groups (SCGs) and a National Specialised Commissioning Team (NSCT) that is responsible for commissioning highly specialised services. To date, the London Strategic Health Authority (SHA) has hosted national specialised services on behalf of all SHAs. These were fully established in 2007/8 following the review of specialised commissioning arrangements led by Sir David Carter.
16. The regional teams have evolved and currently operate in different ways according to the particular agreements and arrangements with their constituent Primary Care Trusts (PCTs) who collaborated together to host this function.
17. This has resulted in commissioning variation and differential access to services with different service standards and specifications for services across SCGs (sometimes with the same provider). Whilst the existing Specialised Services National Definition Set (SSNDS) provided a collection of 34 service definitions its application has been inconsistent.
18. Without a national strategy, decisions were taken locally. Contractual arrangements differed with some PCTs holding separate SCG contracts and others incorporating the activity through PCT contracts.
19. From 1<sup>st</sup> April 2013, these arrangements will end and the NHS CB will be responsible for the commissioning of specialised services. The main drivers for change are identified as:
  - **Direction of travel:** the NHS reforms provide an opportunity and responsibility to design the commissioning of specialised services in line with the direction set out by Sir David Carter and his review
  - **National consistency based on national direction:** national clinical and commissioning leadership, planning and co-ordination are essential to achieve consistency in the delivery of commissioning functions and to minimise duplication
  - **Improved quality and value for money:** current arrangements do not provide sufficient rigour in financial planning and control; they do not always ensure equity of access to services or consistency in the design and application of quality standards.
  - **Outcome based commissioning:** the NHS Outcomes Framework places a clear responsibility on commissioners to ensure that services deliver improved outcomes for patients across each of the five domains.
20. As highlighted earlier a number of these drivers for change were identified in the 2006 review of specialised commissioning led by Sir David Carter. The table below

summarises the key recommendations in Sir David Carter's report and the NHS CB's response:

<b>Carter Report</b>	<b>NHS CB Response</b>
Each SHA area should have an SCG responsible for the commissioning of all specialised services as defined by the SSNDS	The NHS CB will be directly responsible for the national commissioning arrangements for a prescribed list of specialised services across England. Ten LATs will be responsible for the contracting of specialised services with national strategy development and regional co-ordination within the NHS CB.
SCGs should formally designate specific providers to provide specific specialised services. Designation should be based on a nationally agreed set of patient-centred clinical, service, quality and financial criteria.	The NHS CB will contract with providers against a single national set of service specifications, standards, policies and quality measures.
The Department of Health (DH) will initiate an immediate review of the Specialised Services National Definitions Set (SSNDS). The review should initially concentrate on developing a set of criteria for the inclusion of services in the SSNDS and consider priorities for changes.	The DH led a review through a Clinical Advisory Group (CAG) made up of GPs and hospital doctors to agree the recommended prescribed list of services to be commissioned by the NHS CB from 2013. All prescribed services have been assessed against the four key principles identified in paragraph 1 of this document.
SCGs and the NCG ( <i>since renamed the NSCT</i> ) should have access to patient activity data in the national database for all services which they commission collectively.	NHS CB has developed a single identification tool to identify all activity across England, which will be used by all providers.
A need for one reliable source of horizon scanning to avoid duplication.	NHS CB will have systems and process in place to ensure one national way of evaluating evidence and effectiveness for new interventions and treatments.
SCGs and the NCG ( <i>now the NSCT</i> ) should have an on-going Patient and Public Involvement Strategy	NHS CB is committed to strong patient and public engagement in all aspects of its work.

21. Sir David Carter's review aimed to ensure that specialised commissioning was not separate from mainstream NHS activity, was robust, transparent and fair, made the optimal use of resources and could be understood by patients, professionals and the public. The NHS CB shares this ambition and hopes to bring about the national transparency and equity that the review strived to achieve.

## Defining Specialised Services for the NHS CB

22. To date all of the specialised commissioning teams are commissioning services as set out in the SSNDS but not all regions commission all the services and in some regions PCTs take a more active role in the commissioning work. The definitions for the services are also interpreted differently across the country.
23. To address this challenge, during 2011 the Department of Health (DH) established a working group known as the Clinical Advisory Group (CAG) to test out the services in the last two editions of the SSNDS (versions 2 and 3) against the four factors which determine whether or not the NHS CB will be responsible for the commissioning of a prescribed specialised service. The CAG did not consider the 60 highly specialised services commissioned by the NSCT as these are, by definition, rare and provided in few centres. The CAG was made up of clinical leads in specialist centres and a number of GPs from across the country.

**CAG – is the Clinical Advisory Group that provides clinical advice to the Department of Health**

24. The group concluded that the SSNDS forms a solid basis upon which to decide the specialised services that the NHS CB should commission. However, it also advised that the current mixture of commissioning arrangements, and in some cases ambiguity over the actual service descriptions in the definition set, meant that more work should be carried out before they are transferred to the NHS CB.
25. The DH has accepted the [\[Report\]](#) recommendations of the advisory group and has consulted with the NHS CB on the regulations that will define which services the NHS CB will commission from 1<sup>st</sup> April 2013. These regulations are expected to be laid before Parliament in November 2012.
26. The final list of prescribed services and the detailed descriptions of the services that have been developed will be available in a separate manual. The manual will include details of how the activity will be identified through a single Identification Tool. It will include appropriate technical information - including drugs and devices - where necessary. All providers contracting for specialised services with the NHS CB will use the Identification Tool consistently.
27. In order to prepare for the transfer of responsibilities all ten SCGs agreed to move a small number of services into SCG contract portfolios during 2012/13. These were services that met the 4 factors in the NHS Act. This allowed a careful transition of services during 2012/13 prior to all services recommended by the CAG and defined in the regulations moving to the NHS CB for direct commissioning in 2013/14.

## Developing a National Approach to Standardising Services

28. A key part of the transition to a single Operating Model is the production of a unified or converged single national service specification and supporting documentation - such as clinical policies - for each service area. Thirty-four specialised service areas were defined in the SSNDS and therefore for the future within the regulations and within each definition set are a number of service lines. Altogether approximately 130 services require distinct service specifications.

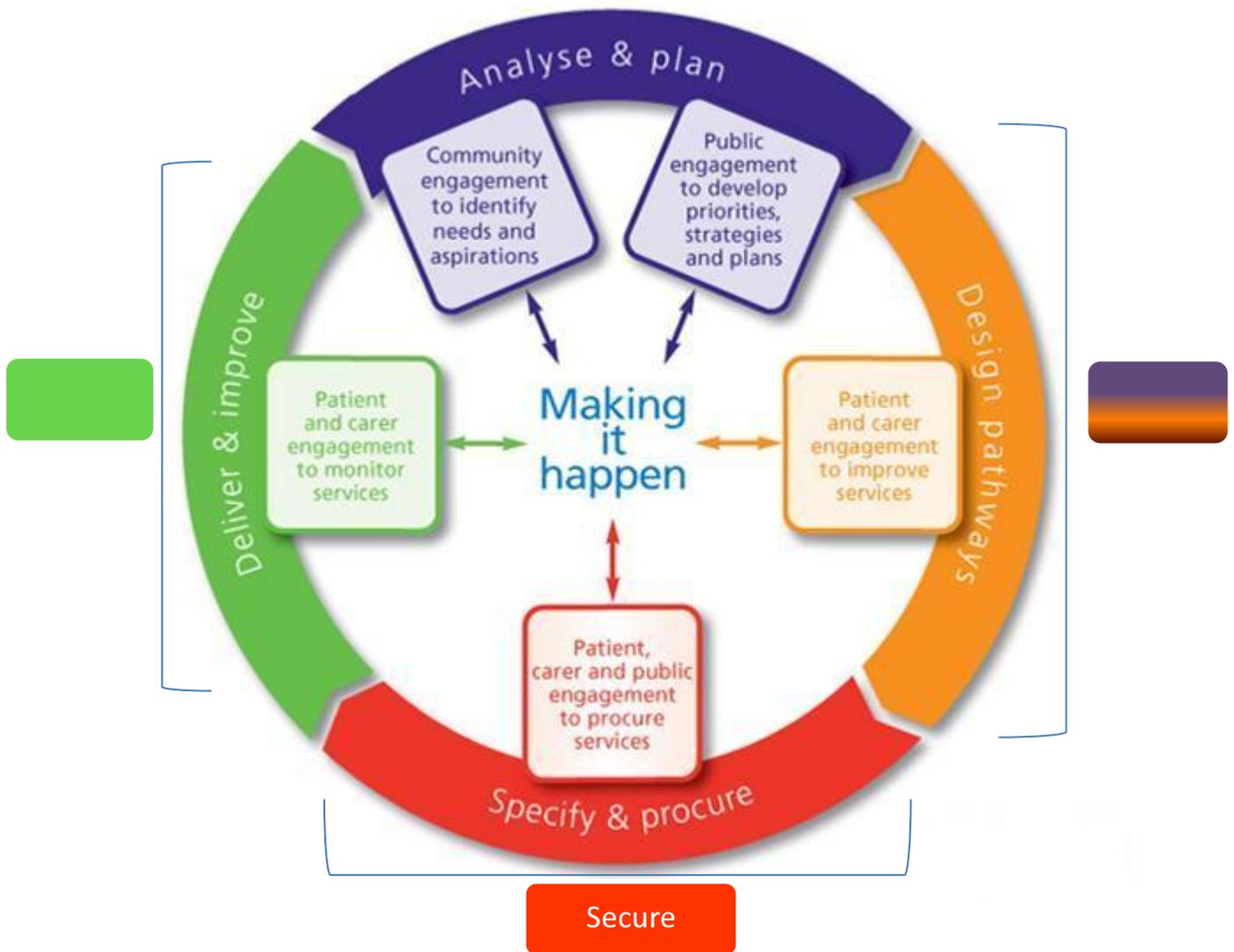
**There are more than 130 services that make up all the prescribed specialised services**

29. A contract service specification is a clear description of what a service is and the acceptable standards that need to be in place for delivery. They will include outcome measures and quality standards. The specifications that are being consulted on will not have a financial inflationary effect as they are what a provider of a reasonable service should be providing.
30. Below this service specification, a number of individual service policies are required to bring about a consistent approach to either accessing services or receiving specific treatments for certain conditions based on sound clinical evidence.

## Defining the Direct Commissioning Functions undertaken by the NHS CB

31. The NHS CB will be responsible for the needs assessment, strategic planning, procurement (contracting), monitoring and evaluation of the performance of an agreed set of prescribed services delivered by providers of specialised healthcare. The overall process is encapsulated within the commissioning cycle. The following functions form part of this cycle:
- **Planning** – setting priorities and a strategic direction for services based on an assessment of the health needs of our populations, developing plans for services: which meet national standards and local ambitions, ensuring that patients, carers and the public are involved in the process, alongside other key stakeholders. This will include the design of pathways involving patients and carers to improve services
  - **Specify and procure** – the method by which services are secured and agreed with providers using a contract that puts the strategic plans into action locally.

- **Deliver and improve** – The way in which the performance of the contract is monitored and where necessary challenged. To use this process to gather intelligence to design and plan and continuously improve services in the future.



32. The NHS CB will facilitate delivery through nationally developed frameworks and strategies for services, managing relationships with providers through contracts, strong clinical leadership and patient engagement.

### Specific Functions and Activities

33. **The Cancer Drug Fund.** The NHS CB will be responsible for the oversight and management of the Cancer Drug Fund which was established in November 2010 to enable individual patients to receive clinically recommended treatments they have been unable to access. For 2013/14 there will be a single national approach delivered via the four regions.

34. **Management of Individual Funding Requests (IFRs).** The NHS CB will also be responsible for the management of applications for funding specific individual patients for specialised service treatments which fall outside of nationally agreed service specifications and policies. For 2013/14 there will be a single national approach delivered via the four regions.
35. **Oversight and Performance Management of High Secure Hospitals and Services.** Due to the nature and complexity of the risk of the management of high secure services the NHS CB will be responsible directly to the Secretary of State for Health for the oversight and performance of these services. High secure services are designated within three NHS Trusts to provide high security psychiatric care services to meet the needs of adults with a mental illness, learning disability or a personality disorder who also require care in conditions of maximum security.
36. **Safe and Sustainable Programme.** There is a bespoke programme of work currently led by the NSCT on behalf of PCTs which is responsible for the Safe and Sustainable programme of work to review the following specialised children's surgical services:
- **paediatric congenital heart surgery** - This is a programme of work that is currently underway to reconfigure services following the decision made in July 2012 by a Joint Committee of PCTs across England.
  - **paediatric neurosurgery services** - This is a review of how we deliver neurological services to children in England.
- The responsibility for this programme of work will transfer to the NHS CB.
37. **Safeguarding Rarity and Highly Specialised Services.** One of the key functions of the NHS CB is the ongoing guardianship and oversight of services with a clear and transparent application process for proactively commissioning low volume/rare disease services and new technologies. It will be important for the NHS CB to retain a proactive approach to service proposals for low volume services or rare diseases.

## The Approach

38. This document sets out a clear guide for the organisation and development of the NHS CB and its stakeholders over the coming few months. The key areas taken into account are:

## Design Principles

39. The main principles guiding the design and development of the Operating Model were co-produced between SCG staff and key stakeholders and are summarised below:
- **Patient centred and outcome based.** The model must place patients at the centre of planning and delivery and must deliver improved outcomes across each of the five domains.

- **Equity and consistency.** Commissioning arrangements must be fair and consistent throughout the country, ensuring that patients have equal access to services, regardless of their location.
- **What can be done once should be done once.** The model should minimise unnecessary duplication of commissioning functions and activities.
- **Nationally planned, locally responsive.** A nationally consistent planning framework that minimises ‘regionalisation’ whilst retaining the capacity to recognise and respond to local population needs. The national role is in defining the ‘what’, the local function is delivering the ‘how’.
- **Quality outcome commissioning.** Must ensure delivery of clinical and experiential quality in line with expected outcomes.
- **Design out complexity and ambiguity.** Must identify explicit lines of accountability and responsibility and enable clear lines of sight to be maintained. Each part of the system should be charged with doing what it is best placed to carry out to support transparency and accountability.
- **One way of working.** Actively promote shared planning, ownership and responsibility for the commissioning of specialised services.

## NHS Outcomes Framework

40. The Operating Model has been developed with consideration of how specialised commissioning will contribute to the delivery of the five domains of the 2013/14 NHS Outcomes Framework:
- preventing people from dying prematurely
  - enhancing quality of life for people with long term conditions
  - helping people to recover following episodes of ill health or following injury
  - ensuring that people have a positive experience of care
  - treating and caring for people in a safe environment and protecting them from avoidable harm.
41. This will be achieved through the development of clinical strategies which will enable commissioning decisions to be evidenced, cost effective and patient focused, whilst meeting patients’ needs in an equitable manner. These strategies will be set out through well-constructed and managed National Programmes of Care (PoCs). The Clinical Reference Groups (CRGs) are clustered into National PoCs that bring together clinical areas in a common theme. Tested during the transition year, five PoCs have been defined. Specialised services are split between these programmes. The programmes will manage an array of service specific projects in a consistent manner. The project work will align to the commissioning products, or to one of the five outcome domains:
- Internal medicine - digestion, renal, hepatobiliary, and circulatory system

- Cancer and blood - infection, cancer, immunity and haematology
- Trauma - traumatic Injury, orthopaedics, head and neck, and rehabilitation
- Women and Children - women and children, congenital and inherited diseases
- Mental Health

## **Clinical Engagement**

42. Clinical engagement is vital to successful commissioning and the new operating model gives the opportunity for all aspects of the commissioning process to be supported by robust integrated clinical engagement. The clinical engagement and leadership model described on page 22 describes how this will happen at every part of the commissioning system.
43. Clinical advice to specialised commissioning needs to be service specific and therefore the development of national programmes of care (described earlier in this document) will be essential to ensure that we have a clear service specific focus.
44. In taking this work forward Public Health England has an important role to play with all the public health healthcare advice coming to the NHS CB from Public Health England. Each local area team will have dedicated public health healthcare advice and this will form a national network to support both the generation of clinical policies and specifications and will also ensure that LATs have clinical advice to commissioning. There will also be a lead national post for highly specialised services to ensure that we build and retain a very clear focus on rarity. Together this public health team will ensure that we have a clear population view of health needs for specialised services and that this informs our prioritisation processes.
45. During transition Clinical Reference Groups (CRGs) were established which brought together a range of service speciality experts – patients, clinicians, public health experts and a broad range of commissioners. There are currently 60 CRGs and they have produced the first ever national specifications and policies for a number of different clinical areas. These CRGs are currently being reviewed and we will be using the learning from the last year of transition to re shape them in such a way that we can ensure integration with LATs and CCGs.

## **Patient Engagement and Involvement**

46. A core function of the NHS CB is to champion the effective involvement of patients and carers and in making decisions about and managing their own care. This includes shared decision-making about treatment, and choice of provider wherever possible.
47. There is also a role for the NHS CB to promote collective engagement by patients, carers and the public in decisions affecting health services in their area.

48. The business model must ensure that the needs of patients, carers and the public are at the heart of the way NHS services are commissioned and delivered. Their experience and feedback must be used to improve the quality of NHS services.
49. Patient involvement and engagement must encompass the whole portfolio of specialised services, from those where the emphasis will be on local or regional engagement, to those services which have an extremely small caseload, (i.e. less than 500 people nationally). This will support the fundamental principle of the protection of rarity.
50. The system must also ensure accountability to the public for the use of taxpayers' money. This will be fulfilled by providing evidence that resources have been used cost-effectively to provide equitable, high quality treatment and care, which reduces health inequalities and improves outcomes.
51. In addition to the engagement of individual patients, carers and members of the public, it will be essential to work with a wide range of national and local stakeholders, including patient organisations and umbrella groups such as HealthWatch, health and wellbeing boards, Health Overview and Scrutiny Committees and the Care Quality Commission (CQC).
52. Patient and Public Engagement (PPE) is not a discrete function and embraces all aspects of the NHS CB's work. Effective delivery will require an integrated approach across many of the functions of the NHS CB. This will require strong and influential leadership.

## **Financial Issues**

53. Historically, specialised services have been funded on a subscriptions basis by local PCTs. A consistent financial strategy for the management of resources has not been in place to secure value for money in the commissioning of specialised services. One consequence of this has been variation in local prices across the country for some services and a lack of equity and consistency in commissioning decisions.
54. The NHS CB will set a finite resource envelope for specialised services. Locally the NHS CB LATs will commission all national specialised activity from providers in their area.
55. A financial assurance programme has been established to identify and validate the financial envelope to transfer to the NHS CB. Specialised services will have to be delivered within the resource envelope available which will require a more robust financial management approach than has perhaps previously been the case.
56. A financial strategy is being developed which will allow prioritisation of service developments against a consistent prioritisation framework to ensure that effective commissioning decisions are being made. In order to ensure that value for money and the resources available are optimised, the opportunities of commissioning by one

organisation in terms of pricing and procurement are actively being pursued and risk management strategies established.

## **The single operating model**

### **The scope of specialised services**

57. The previous section described the scope of the NHS CB's specialised commissioning responsibilities and the approach taken to designing the operating model for getting the system working from 1st April 2013.
58. This section describes the detailed Operating Model, including how it will operate and the roles of other organisations, such as commissioning support services, Public Health England, CCGs and networks.

### **The national, regional and local relationship across the NHS CB**

#### **National role**

59. The national specialised commissioning function will sit within the Operations Directorate of the NHS CB. This central function although led by Operations Directorate will be carried out by all directorates of the NHS CB with particularly close links to the Medical and Nursing Directorates. A small cross directorate leadership team will work across the NHS CB to set the pace of convergence so that we move from the current system to a single function.
60. The NHS CB will prioritise what will be commissioned against nationally constructed health needs assessment. There will be clear links to the joint strategic needs assessments of clinical commissioning groups and health wellbeing boards so that service decisions around specialised services are contextualised with those of local populations.
61. Clear national standards and eligibility policies will be created for access to specialised services. Developing these standards and specifications will draw upon the clinical and service expertise in the medical and nursing directorates and the expert views of patients, staff working in services and those engaged in delivering the contracting through the local area teams.
62. All parts of the NHS CB need to work in a fully co-ordinated way across the patient pathway to commission specialised services, ensuring local contracting activity informs national strategy and vice versa. The NHS CB's clinical directorates, both Medical and Nursing, will provide the conduit for professional and clinical leadership. They will ensure that objectives relating to securing outcomes, improvements and safeguarding quality will be reflected in all senior nursing and medical director roles at NHS CB central, regional and local levels.

## **Regional**

63. The four regions of the NHS CB will focus on turning 'strategy to reality'. They will be the regional delivery mechanisms for the national strategic direction. It is important that any variations are managed and handled appropriately rather than setting new strategic directions.
64. The regional Programme of Care function will have both a national and regional role. It will work with the national programme of care leads to form a small team with national and local reach. It will be a key resource to provide support and advice on individual clinical service areas through CRGs. Additionally it will provide support to LATs with specific service issues at their provider interface.
65. There will also be a regional link to the Strategic Clinical Networks and Clinical Senates, which will help shape the local vision for the clinical services.
66. The regional function will ensure the NHS CB delivers the large-scale clinical transformation required to improve standards and ensure there is a focused dialogue across LATs and providers to achieve this.
67. It will also ensure all innovation and good practice is cemented into delivery across the patch as consistently and efficiently as possible.
68. Specialised service provision does tend to cover a wider population base than CCGs. One of the key roles of the region is to ensure it is supporting the LATs by providing specific skills and advice on complex issues around contract negotiations and provider relationship management.
69. In summary, the regional role is to work with the national team to develop policy and strategy whilst leading the regional implementation and delivery of strategy, health improvement through the Outcomes Framework and performance at regional level.

## **Local area teams**

70. There will be 27 LATs across England which will all have the same core functions; Primary Care, Public Health and local relationship management including CCG development and assurance, and quality and safety.
71. There will however be a variation around the discharge of direct commissioning responsibilities. Ten of the 27 LATs will lead locally on specialised services contracting across England. These are:
  - Cumbria, Northumberland, Tyne and Wear
  - South Yorkshire and Bassetlaw
  - Cheshire, Warrington and Wirral
  - East Anglia
  - Leicestershire and Lincolnshire

- Birmingham and Black Country
- Bristol, North Somerset and South Gloucestershire
- Wessex
- Surrey and Sussex
- London <sup>2</sup>

72. The core function of the LAT leading on specialised services is operational delivery and contracting. There is an explicit difference between commissioning and contracting within the Operating Model - all commissioning (i.e. setting priorities and strategic direction) is done nationally; all contracting and the prime focus for local relationship management with providers is through the named ten LATs.
73. The local function is delivering the 'how', with the implementation of national strategy and policy through provider contracts. The 'how' is as equally important as the 'what' as at every part of the system patients, public, clinicians and other key stakeholders need to see how the system will work.
74. Each of the ten LATs will hold a single NHS CB contract with providers in their area for all agreed service provision for specialised services (including Highly Specialised). They will contract for all of the population across England with those providers.
75. This is very different to arrangements to date where PCTs commissioned and contracted just for the geographical catchment population. It will mean, for example, that London will be contracting with all London providers for all activity for all of the population across the country for patients that are treated in these facilities.
76. The LATs will hold the local knowledge ensuring that local expertise on services and providers is maintained and shared to ensure robust market management of the provider landscape. Crucially, they will ensure the integration across the patient pathway at a local level with CCGs and other commissioning bodies.
77. One of the more specific functions which will be undertaken at a regional level (led by one of the LATs) is the management of the Cancer Drug Fund. The overall administration of the fund and the processing of applications will be undertaken by a small team.
78. In a similar manner, the management of the Individual Funding Requests for treatment of patients will also be managed on a regional basis (through a lead LAT).
79. The majority of the staff resources in specialised services will be located within the ten LATs, including a significant role for contractors or supplier managers. The contracting function and team within each LAT will require multi-disciplinary teams (including contractors, finance and information support).

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<sup>2</sup>London will have an integrated regional/LAT operating model.

80. To improve the contracting process and achieve economies of scale, LATs will be provided with nationally developed contract products such as service specifications, service policies, quality standards, and CQUINs (Commissioning for Quality and Innovation). LATs will also receive a handbook of clinically developed schemes and examples of best practice which will identify further opportunities to increase productivity and efficiency.

### **Highly Specialised Services - Operating Arrangements**

81. The operational design of the NHS CB fundamentally changes the way in which highly specialised services are commissioned. Importantly, it builds an explicit focus on highly specialised services and rarity through nationally co-ordinated programmes of care that have active relationships with service providers, including facilitating joint clinical audit meetings across the service on an annual basis. The programmes will integrate across all specialised services.
82. The Operations Directorate will also have a national lead for highly specialised services to ensure there is clear focus on these rare services and national oversight is maintained (working closely with the Medical Directorate).
83. All highly specialised services will be part of a single contract held with each provider managed through the ten LATs leading specialised services. There will no longer be separate contracts for these services and this will ensure LATs can maintain a picture of the whole provider for specialised services, whilst the programmes of care and national lead maintain the oversight of the services.
84. On-going guardianship and oversight of services will be through a formal advisory mechanism within the NHS CB. This is currently being developed.
85. Highly specialised drugs and technologies will be evaluated through NICE in the future.

### **High Secure Services - Operating Arrangements**

86. The three LATs that will host the three high secure hospital contracts, will have an additional role with the oversight and performance management of these hospitals, reporting nationally in order to provide assurance to the NHS CB. The NHS CB will be expected to fulfil its commissioning role outlined in the high secure commissioning directions, and provide assurance to Ministers on a regular basis.

### **Focus on Innovation**

87. **Specialised Service Commissioning Innovation Fund (SSCIF).** The NHS CB has established a fund to rapidly test and evaluate innovations that have the potential to deliver high impact changes for specialised services throughout the NHS. This will make innovations available to NHS patients much earlier than is currently possible.

88. The SSCIF will use an application and assessment process to identify innovations that have the potential to deliver high impact changes. This will be open to healthcare staff, manufacturers, clinicians, researchers, patient groups and commissioners,
89. The SSCIF will invest in the evaluation of innovations to generate a better understanding of their relative value and create an evidence base for use in national commissioning decisions. This will result in rapid, widespread adoption of proven innovations in the NHS, meaning that patients will have earlier access to innovative care and value for money to the NHS will improve whilst supporting the UK economy.

### **Patient Focus**

90. A strong patient focus will be retained and built upon across all aspects of specialised commissioning. This will be achieved via formal Patient and Public Engagement (PPE) processes and through on-going engagement with patients and carers, as part of the strategic planning and local delivery functions. PoCs will place a strong emphasis on patient involvement in designing strategies and policies.
91. For engagement with users of specialised services the NHS CB will demonstrate and describe its commitment to engage with the full range of patients and patient groups using different methodologies, in different locations and at different times. It will demonstrate how the NHS CB will support capacity building with individuals and organisations to ensure that there is on-going engagement with informed, trained and resourced patients and patient groups.
92. In addition to any generic service user engagement groups or process, the NHS CB will look to involve groups specific to specialised services to ensure that the voice of the patient is not lost.

### **Links with clinical commissioning groups**

93. Clinical Commissioning Groups (CCGs) will be responsible for the commissioning of health services to meet all reasonable requirements for their patients with the exception of directly commissioned services undertaken by the NHS CB (primary care, specialised services, offender health and military health).
94. Improving patient care means providing a seamless service with planning across the whole pathway and across commissioners. Therefore it will be vitally important for the NHS CB to engage locally with CCGs to manage the interface between services for patients and also to manage providers collaboratively.

### **Clinical Engagement and Leadership in the new model**

95. The reach of clinical advice for specialised commissioning will span all parts of the NHS CB from a discrete national co-ordinating team within the lead clinical directorates of Medical and Nursing, across the regions and into the local area teams. The cascade of clinical information and advice for specialised services will be from the Deputy Medical

Director - National Clinical Director for Specialised Services - Regional Medical Director  
 – Local Area Team Medical Director – Provider Medical Director.

Deputy Medical Director	<ul style="list-style-type: none"> <li>• Responsible for specialised services within the Medical Directorate of the NHS CB</li> <li>• Enables communication between the primary and tertiary care system</li> </ul>
National Clinical Director Specialised Services	<ul style="list-style-type: none"> <li>• Holds clinical and commissioning knowledge across specialised services to advise the NHS CB</li> <li>• Secures service specific advice from Clinical Reference Groups that cover all specialised services</li> <li>• Leads 3 portfolios: Acute; Highly Specialised; Mental Health and through them 5 National Programmes of Care. These will form the national components of commissioning and strategic planning.</li> <li>• Manages a small national Clinical Effectiveness Team to procure high quality information that will support the development of commissioning policy</li> </ul>
Regional Medical/Nurse Director	<ul style="list-style-type: none"> <li>• Leads service change that spans more than one local area and provides advice on the risks and benefits of change</li> <li>• Secures service specific advice from the National Clinical Director</li> <li>• Integrates with the 5 National Programmes of Care working with regional programme managers for each programme to shape the national components of commissioning and strategic planning</li> </ul>
Local Area Team (Specialised Services) Medical/Nurse Director	<ul style="list-style-type: none"> <li>• Establishes strong lines of communication with local area providers and the Clinical Senates</li> <li>• With a Public Health Consultant holds the detailed knowledge of the local population and their needs and access to services</li> <li>• By exception develops time limited derogation from the national service specifications where local providers or populations require</li> <li>• Secures local service specific advice from the LAT service member on the national CRG</li> </ul>

96. A devolved clinical leadership model has been successfully tested during this transition year to support the direct commissioning function of the NHS CB, preparation of a national service strategy and the development of service specifications. The model will

proactively provide specialised clinical advice. Clinical Reference Groups (CRGs) covering all prescribed specialised services will draw membership from each of the geographies covered by the ten specialised commissioning LATs.

97. Clinical leadership will be supported by a portfolio and programme management team that spans the clinical directorates of the NHS CB nationally (Medical and Nursing Directorates) and the Operations Directorate regionally. This will integrate the matrix working across the NHS CB Directorates at its multiple levels. Three portfolios will cover Mental Health, Acute and Highly Specialised Services. Five National Programmes of Care will span nationally and to the regions (Internal Medicine, Cancer & Blood, Trauma, Women & Children, and Mental Health). Closing the loop the members of the national CRGs are drawn from each of the ten specialised commissioning LATs.
98. Public Health Consultants provided by Public Health England (PHE) will be embedded within each of the specialised commissioning LATs to work closely with both the LAT Medical and Nursing Directors. They will build on the understanding of local population needs for specialised services, their access to services and integration across pathways of care. A component of their role will be to support the development of national 'components coordinated through the Programmes of Care. Nationally the Highly Specialised Portfolio will secure clinical advice from a Public Health Lead and the Clinical Effectiveness Team will have dedicated clinical leadership to define and secure the highest quality commissioning information.
99. Clinical advice related to drugs used in specialised services will be co-ordinated nationally by a Specialised Commissioning Pharmacist in the Clinical Effectiveness Team, collaborating with a pharmacist within each of the specialised commissioning LATs.
100. The Domain Directors of the Medical and Nursing Directorates will secure their work stream objectives in relation to specialised services through the National Programmes of Care. All work within the programmes will be defined in terms of the linkages with the five domains recognising that the patient experience and safety domains cover all five Programmes of Care. Patient safety and experience in specialised services will integrate with the work of the Nursing Director at the Local Area and Regional Teams.
101. The national CRGs will be inclusive of all healthcare professionals related to the particular service area. Clinical advice from the wider clinical community - such as medical, nursing, allied healthcare professionals, health care scientists - will be secured through the CRG membership.

## Impact of the new Operating Model

102. The impact of the new model will be to bring about a level of national and local consistency in both the planning and delivery of services for patients across the country. An example of this is shown in the table below:

Now	NHS CB future arrangements
Sickle Cell and Thalassaemia (haemoglobinopathies) not commissioned by all SCGs	All ten LATs will contract for Sickle Cell and Thalassaemia services for the country
Transcranial Doppler scanning in children with haemaglobinopathies helps to identify those children at high risk of childhood strokes but is not routinely commissioned as part of core service standards	Where technology is shown to assist in delivering improved health outcomes it will be nationally evaluated and then incorporated into national service specifications.
No national specification for the service	National minimum specification for paediatric Sickle Cell and Thalassaemia. This will have core standards and core outcome measures.
No single source of clinical advice	National clinical advice will come through a National Programme of Care and an expert clinical reference group

## Other Support Activities

103. The arrangements for commissioning support are developing as described in “Developing Commissioning Support; Towards Service Excellence”, February 2012.
104. The NHS CB has identified the functions and activities it requires both at scale and locally, and is currently working through more detailed specifications to ensure these are finalised and Commissioning Support Units (CSU) arrangements agreed

## Public Health

105. NHS Public Health England (PHE) will be responsible for the provision of bespoke public health support and advice to the NHS CB, with regard to specialised commissioning. This will be provided at all levels of the NHS CB ensuring there is leadership and support for the Programmes of Care alongside local support to the LATs.

## Clinical Networks

106. The NHS CB has set out its plan for a small number of national networks to improve health services for specific patient groups or conditions.

107. Strategic clinical networks hosted and funded by the NHS CB, will be condition-specific and include patient groups where improvements can be made through an integrated, whole system approach. These networks will help local commissioners of NHS care to reduce unwarranted variation in services and encourage innovation.
108. The areas chosen for the first strategic clinical networks are:
  - Cancer
  - Cardiovascular disease (including cardiac, stroke, diabetes and renal disease)
  - Maternity and children's services
  - Mental health, dementia and neurological conditions
109. Specialised commissioning has traditionally harnessed the strength of networks to achieve improvement to the patient pathway across geographical boundaries. The new strategic networks will provide vital support activity to embed change and innovation, reducing unwarranted variation in services for the benefits of patients across the country.
110. For some services such as burns care, critical care, neonatal and trauma care, operational delivery networks have brought providers and commissioner together to co-ordinate patient pathways and ensure access to specialist resources and expertise. These arrangements will play a vital role in shaping future services and full details will be published shortly.

## **Strategic Relationships**

111. Specialised care for patients spans a wide number of services and hospitals across England. This requires the NHS CB to build excellent strategic relationships with many different organisations and bodies to enable the best possible quality of care to be commissioned.

## **Next Steps**

112. The NHS CB will set out further information in due course about the detailed operating structure for specialised commissioning. This will provide more specific guidance on the processes and ways in which the Operating Model will be implemented. This will include common operating procedures and guidance, including contract management
113. During the next three to six months, the NHS CB will build upon the Model and the transition plan to transfer the function fully by 1st April 2013.

114. Work will continue to transfer the services to the NHS CB and to ensure that the full list of prescribed services will be able to be commissioned by the NHS CB from 1st April 2013.

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