



THE ROYAL BOROUGH OF  
KENSINGTON  
AND CHELSEA

Report of the Health Scrutiny Committee

## **Priorities for Health**

A review of NHS Kensington and Chelsea's  
priorities in the context of the current financial  
climate

*May 2010*

## FOREWORD

At the Health Scrutiny Committee (HSC) meeting on 28 January 2010, the Terms of Reference for the review of the NHS Kensington and Chelsea (the "PCT") priorities were agreed (Appendix 1). This review builds on the work carried out in a previous "Review of Kensington and Chelsea Primary Care Trust's Commissioning Priorities"<sup>1</sup>.



*Cllr Christopher  
Buckmaster,  
Committee Chairman*

This HSC review is carried out in order to ensure an RBKC input into the Primary Care Trust (PCT)'s strategic thinking, and to assist the PCT to plan more effectively for a possible future financial challenge. This report draws attention to two potential threats: (1) The poor state of public sector finance and (2) The PCT currently receives an allocation which is around 20% higher than the capitation target.

We believe that Kensington and Chelsea residents should have world-class quality NHS services. To achieve this, we believe the commissioning of services has to be increasingly smart in the challenging financial climate ahead. The review broadly supports and welcomes the priorities of the PCT, as set out in its Commissioning Strategy, in particular the 10 priority outcomes (paragraph 4.8) and its current commissioning intentions (paragraph 4.11).

In order to respond more helpfully to the Terms of Reference, this review sets the position of the PCT in the context of developments elsewhere for the NHS in London. It is hoped that it might also be seen as a useful introduction to the PCT and its operations for those Members who are less familiar with the NHS.

It highlights that, as the PCT's commissioning priorities were founded in the previous political environment, their success was dependent on there being no significant change in the direction of health policy after the general election. However, we now have a Conservative-Liberal Democrat coalition government. The challenge posed by

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<sup>1</sup> The "Review of Kensington and Chelsea PCT's Commissioning Priorities" report was published in June 2008 and available on the Internet at:  
<http://www.rbkc.gov.uk/councilanddemocracy/howwemakedecisions/scrutinycommittees/idoc.ashx?docid=5a9120e4-877a-41bb-8f50-cb52ddcd613e&version=-1>

commissioning a higher proportion of healthcare from primary and community services than from secondary services will be difficult - this is highlighted by the Audit Commission's finding that all the 6.5% national increase in PCT funding in 2008-09 was swallowed up by acute trusts (paragraph 5.54).

The report makes a number of recommendations, but also can aid the understanding of decision-making at NHS Kensington and Chelsea.

I would like to give my thanks to all the members of the "Review of the PCT Priorities for Health" Sub-group (listed in Appendix 1) and NHS Kensington and Chelsea for being fully involved in aiding the HSC's work on this review. In particular I'd like to thank Andreas Lambrianou (PCT Non-Executive Director) for his input and Henry Bewley (Health Policy Officer) for his work in pulling it all together.

A handwritten signature in black ink, appearing to read 'Chris Buckmaster', written in a cursive style.

Councillor Christopher Buckmaster  
*Chairman, Health Scrutiny Committee*  
*Royal Borough of Kensington and Chelsea*

*May 2010*

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## **1. RECOMMENDATIONS**

- 1.1 The 15 recommendations made throughout this document are reproduced here for ease of reference:

### **FOR NHS KENSINGTON AND CHELSEA**

- a. The HSC believes the PCT has been sensible to model for both a 0% and a 1.2% per annum allocation reduction over 2011-14. However, there is much uncertainty on finance in the future. The allocations of monies to NHS Kensington and Chelsea in the coming years could be further affected downwards for two reasons: (1) The poor state of public sector finance and (2) The PCT has been receiving a larger allocation relative to the centrally perceived need - and we believe the NHS could drive a more aggressive pace of change to move PCTs towards capitation targets than that planned for by NHS Kensington and Chelsea. The PCT should be prepared for this worse than the "worst-case scenario"<sup>2</sup>, as set out in the Commissioning Strategy<sup>3</sup>. The HSC hopes this will not happen. However it would be precautionary to plan, well in advance and together with partners, for the very worst possible situation that could affect the PCT's finances. The HSC suggests it would be prudent to examine the potential for a more pessimistic financial outlook than those currently being considered. The PCT will be more able to stay ahead of any spending pressures, and avoid panic or false economies, if it has built for itself a (net) savings plan for future years.
- b. See below.
- c. The PCT will need to continue to embed into its work the concept of prevention and the promotion of staying healthy.
- d. The HSC recommends that, in taking forward the Joint Strategic Needs Assessment (JSNA), more consideration is needed on how the information gathered is best used and integrated into decision-making. The main part of the work should not just be about data collection, but about information that can be used to help plan services and actions in the future. The JSNA could be

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<sup>2</sup> The PCT has modelled the scenario of a 1.2% reduction in allocation per annum in revenue allocation. However, this assumes 2.5% average NHS allocation growth.

<sup>3</sup> NHS Kensington and Chelsea's "Commissioning Strategy 2010-2015": <http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.2CSP260110.pdf>

improved as an interactive internet tool by linking it to other data sets that are themselves updated. This will minimise the need for officer time and effort.

- e. The PCT needs to ensure that its plans for polysystems are fully compatible with those of its surrounding PCTs. For example, plans for a polysystem based at St Charles should take due consideration of services based at St Mary's and Hammersmith hospitals; and any potential for a polyclinic at the Charing Cross Hospital site will need to be co-ordinated with the plans for Earls Court.
- f. The PCT should monitor closely the levels of demand for the new services, to ensure their performance matches that planned for changes in the movement of patients. The PCT needs to evaluate the changes in patient flow from hospital to community settings, to know that patient outcomes have improved.
- g. The PCT should move quickly to a position where it can commission the best provider from a plurality of providers, to optimise the provision of each of its community service lines.
- h. The PCT should examine the scope for increasing provider competition in the provision of mental health services – in particular, options for service line management.
- i. The HSC recommends that the PCT and the Council carry out further work to consider areas where they can jointly improve commissioning for Kensington and Chelsea residents.
- j. The HSC recommends that the PCT and the Council carry out further work to consider areas where they can share services and save costs.
- k. The respective functions of the pan-London and the sector-wide commissioning partnerships will need to be clearly distinct to ensure that relationships are complementary.
- l. See below.
- m. The PCT should take due consideration of the potential for a different political approach to healthcare reconfiguration in London, including polyclinics, that could arise from the new Conservative-Liberal Democrat coalition government.

- n. All investment in activities that is not evidence-based should be re-examined before being resourced.
- o. If it is necessary for the PCT to make substantive savings, it should investigate the potential for making savings in each of the following areas: PCT re-negotiate GP and provider arm contracts; increase the productivity of the least well-performing GPs; stop or reduce elective procedures that are ineffective; explore the use of alternatives, in order to reduce routine referrals to outpatient appointments; reduce variability in outpatient referrals; review how much of nurses' time is spent with patients, in order to increase nurses' patient-facing time; increase clinical productivity; increase the rate of patients treated as day cases; reduce any variation in prescribing; reduce unnecessary spending on supplies; better joint working with Council and/or other PCTs; and not wasting NHS space.

#### **FOR LOCAL ACUTE PROVIDER TRUSTS**

- b. Local NHS organisations can minimise the potential for direct conflict with neighbouring trusts by being clear and transparent in their plans and actions. Imperial College Healthcare NHS Trust and Chelsea and Westminster Foundation Trust will need to continue to work in partnership with the local health and social care community. We recommend that the Foundation Trust and Imperial College Healthcare NHS Trust work towards some type of charter for collaboration.
- l. The HSC supports Imperial College Healthcare NHS Trust in its endeavours to co-locate services optimally to give the best patient outcomes, working towards NHS London's vision for a Major Acute Hospital. The original Healthcare for London proposal was for the local hyper-acute stroke centre to be based alongside the major trauma centre.

## **2. FUTURE FINANCIAL CHALLENGE AND THE PCT'S BUDGET**

- 2.1 NHS Kensington and Chelsea endeavours to deliver high-quality NHS services to residents and patients in the borough.
- 2.2 The PCT has a stable financial base, has delivered a surplus for each of the last three years, and has a good understanding of its own finances.
- 2.3 Don Richards (Interim Finance Director, NHS Kensington & Chelsea) spoke to the Sub-group on 12 February 2010 about PCT future anticipated spend. He informed the Sub-group that the PCT had constructed its future plans on the "NHS London Base Case" (i.e. 2.5% cash increase over 2011-14). They have also modelled for both a 0% and a 1.2% per annum allocation reduction over 2011-14 as possible scenarios. The 0% allocation is used as the base case in the Commissioning Strategy. The Sub-group heard that the PCT can maintain its investment programme with reasonable contingencies under a 0% allocation increase scenario, but will have to cut non-core investments and contingencies by 33% (£15m) over 4 years should the 1.2% per annum revenue allocation reduction scenario materialize. The PCT believes capital investment can be maintained under both scenarios, but additional revenue savings would need to be found for 2012-14 under the 1.2% per annum revenue allocation reduction scenario.
- 2.4 However, the PCT needs to be fully realistic about the future state of public finances in their planning assumptions. There are two big potential issues: (1) The poor state of public sector finance and (2) The PCT currently receives an allocation which is around 20% higher than the capitation target.

### **The poor state of public sector finance**

- 2.5 For the next few years it is likely to be very tough financially for the NHS. Although the actual impact on the NHS of addressing the deficit in public finance is unknown, the poor state of government finance should be a concern to all in the public sector. On 24 March 2010, the previous Chancellor, Alistair Darling, warned of the "toughest for decades" spending cuts after the general election.<sup>4</sup>

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<sup>4</sup> LocalGov: Budget 2010: Spending cuts will be 'toughest for decades'  
<http://www.localgov.co.uk/index.cfm?method=news.detail&id=87521>

2.6 The King's Fund report, "How cold will it be? Prospects for NHS Funding 2011-2017"<sup>5</sup> has said that the prospects for future NHS funding look bleak, although there is no consensus about just how cold the financial climate will be. The NHS Confederation report "Dealing with the downturn"<sup>6</sup> suggests that healthcare faces the biggest challenge in its history because of the recession and expected spending cuts after 2011. In the five years from 2011 they forecast the impact of the recession, allied to rising costs, means it is likely that the NHS will face a real-terms shortfall of £15bn. The previous Secretary of State for Health, Andy Burnham, told the King's Fund (18 September 2009) that the NHS will have to find ways of saving between £15-20 billion by 2014<sup>7</sup>. A confidential report commissioned from the management consultancy firm McKinsey and Company (but reported in the Health Service Journal<sup>8</sup>) explored what this might mean in practice. This is sober reading, as it is an analysis of where NHS organisations may be able to find savings (see Section 6.17). Following on from this, the Operating Framework stated that £15bn to £20bn needs to be generated by 2013-14 from existing resources in order to keep pace with system pressures. The Budget 2010 stated, "the NHS will deliver annual efficiency savings of £15 to 20 billion by 2013-14".<sup>9</sup> The Conservative and Liberal Democrat Coalition Agreement sets out that they have agreed there will be a significantly accelerated reduction in the structural deficit over the course of a Parliament, with the main burden of deficit reduction borne by reduced spending rather than increased taxes. However it also states that they "agree that funding for the NHS should increase in real terms in each year of the parliament, while recognising the impact this decision would have on other departments".<sup>10</sup> The

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<sup>5</sup> The King's Fund report "How cold will it be? Prospects for NHS Funding 2011-2017" [http://www.kingsfund.org.uk/research/publications/how\\_cold\\_will\\_it\\_be.html](http://www.kingsfund.org.uk/research/publications/how_cold_will_it_be.html)

<sup>6</sup> NHS Confederation report "Dealing with the downturn": <http://www.nhsconfed.org/OurWork/latestnews/Pages/NHSfacesits%E2%80%98biggest-everchallenge%E2%80%99,saysConfederation.aspx>

<sup>7</sup> Reported in the Telegraph article "NHS told to find ways of saving £20 billion": <http://www.telegraph.co.uk/news/newstopics/politics/labour/6208651/NHS-told-to-find-ways-of-saving-20-billion.html>

<sup>8</sup> Health Service Journal article "DH is told 137,000 NHS posts must go in next five years": <http://www.hsj.co.uk/5005782.article>

<sup>9</sup> Paragraph 6.14 "Budget 2010: Securing the recovery": [http://www.hm-treasury.gov.uk/d/budget2010\\_chapter6.pdf](http://www.hm-treasury.gov.uk/d/budget2010_chapter6.pdf)

<sup>10</sup> HSJ: NHS budget will increase in real terms, coalition document confirms (12 May, 2010) <http://www.hsj.co.uk/news/finance/nhs-budget-will-increase-in-real-terms-coalition-document-confirms/5014614.article?referrer=RSS>

new Secretary of State for Health, Andrew Lansley, has confirmed that the planned efficiency savings of around 3 per cent a year needed to achieve £20bn of savings would still need to happen. He has said, "We may need to do more, because of increases in demand." In the recent past, the NHS's spending had gone up in real terms by 4.2 per cent a year. He added, "We know we cannot possibly do that in the next few years."<sup>11</sup> There will be pressure to keep any rises in monies low - they will be lower than the NHS has received in recent years, while health needs will continue to rise at a faster rate.

- 2.7 The think-tank Reform's report, "Fewer hospitals, more competition"<sup>12</sup> (March 2010) says, "The NHS should not be immune from the drive to reduce public spending." The looming public spending cuts will be more profound than any experienced in modern times, the head of the spending watchdog warned as he labelled political promises to protect schools and the NHS "insane".<sup>13</sup> The King's Fund report, "Windmill 2009"<sup>14</sup>, said that if the NHS is to continue to deliver quality while reducing costs, politicians and NHS leaders must be honest about the scale of the financial challenges ahead, and engage health care staff and the public in their proposals.
- 2.8 The NHS Confederation report, "Rising to the challenge: health priorities for the Government and the NHS (11 March 2010)"<sup>15</sup>, paints a stark picture of the challenges the incoming Government faces in the management of the health service. It argues that the demands of a spending squeeze combined with lifestyle factors, the UK's ageing population and the increasing cost of healthcare, mean that the NHS is facing one of the most difficult moments in its history.

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<sup>11</sup> HSJ: Lansley promises real-terms NHS budget increases and greater say for clinicians over reconfiguration (13 May 2010)

<http://www.hsj.co.uk/news/finance/lansley-promises-real-terms-nhs-budget-increases-and-greater-say-for-clinicians-over-reconfiguration/5014651.article>

<sup>12</sup> Reform report, "Fewer hospitals, more competition" (March 2010):

<http://www.reform.co.uk/Research/ResearchArticles/tabid/82/smId/378/ArticleID/1147/reftab/161/t/Fewer%20hospitals%20more%20competition/Default.aspx>

<sup>13</sup> Guardian (21/1/10): Promises to spare NHS and schools from cuts 'insane' says audit chief <http://www.guardian.co.uk/society/2010/jan/21/nhs-schools-cuts>

<sup>14</sup> King's Fund report, "Windmill 2009" (December 2009):

[http://kingsfund.chn.com/a/hBLINaIB7R\\$KDB73zq9C0TyCvKu/windmill](http://kingsfund.chn.com/a/hBLINaIB7R$KDB73zq9C0TyCvKu/windmill)

<sup>15</sup> NHS Confederation report, "Rising to the challenge: health priorities for the Government and the NHS (11 March 2010)":

<http://www.nhsconfed.org/Publications/reports/Pages/health-priorities-for-government.aspx>

### **Challenges and priorities for the NHS** <sup>16</sup>

The NHS has made significant progress in delivering improved and high-quality healthcare over the past decade, but there is much more to do.

- The NHS cannot and should not wait for government action to respond to the financial challenge.
- A rigorous approach to rooting out inefficiencies in the system, reducing costs and redesigning services is needed.
- There must be a continuing focus on the things that matter to patients: quality of outcomes; patient experience; and safety.
- Perhaps the biggest challenge and greatest imperative is to ensure the NHS is working effectively to improve the health of the whole population and reduce health inequalities.

### **Kensington and Chelsea Primary Care Trust Revenue Allocations** <sup>17</sup>

2.9 In 2010-11 there will be an average 5.5% increase in PCT allocations (only 5.14% in the case of NHS Kensington and Chelsea): 1% of this is to be kept back as a surplus and a further 2% should be allocated to "non-recurrent" spending to enable changes to services – for example, one-off costs to set up new services, redeploying or retraining staff or even redundancy. 2010/11 will be the last year of growth in NHS funding for some time.

<b>Kensington and Chelsea Primary Care Trust Revenue Allocations</b>		
	<b>£</b>	<b>% rise</b>
2009-10	337,424,000	5.23
2010-11	354,773,000	5.14

### **New national weighted capitation funding**

<sup>16</sup> Taken from page 3 of the NHS Confederation report, "Rising to the challenge: health priorities for the Government and the NHS".

<sup>17</sup> The allocation applies a weighting to the population (a figure of 184,218 was used in 2010) to account for the population's needs for healthcare relative to that of other PCTs. The need is informed by the age distribution and additional need over and above that relating to age. Information on how this is calculated is found in "Resource Allocation: Weighted Capitation Formula (Sixth Edition)":

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091849](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091849)

- 2.10 In December 2008, the new national weighted capitation funding formula was published by the Department of Health (DH). This gave revised capitation targets for PCTs and showed the distance from capitation for all PCTs. According to this formula, NHS Kensington and Chelsea receives an allocation which is around 20% higher than the capitation target for the PCT. While the pace of change towards capitation has historically been very gradual, this large over-capitation may result in the PCT receiving funding below the worst case scenario modelled in their Commissioning Strategy<sup>18</sup>. The pace of change policy has only been set out up to 2010-11 (minimum growth is 5.1% in 2010-11).<sup>19</sup>
- 2.11 The Marmot Review, "Fair Society, Healthy Lives"<sup>20</sup> (February 2010) advocated the reduction of health inequalities, and all political parties have affirmed a commitment to tackling health inequalities. We note that the Liberal Democrat manifesto said: "poorer areas are less well served by the NHS, contributing to widening health inequalities."<sup>21</sup> Whilst the draft Conservative Party manifesto stated that in government the party would "make sure the NHS is funded on the basis of clinical need . . . allocate resources to different parts of the country and make access to the NHS more equal."<sup>22</sup>
- 2.12 The money available in the future could be lower than even the PCT's "worst case" modelling.<sup>23</sup> Under any "worse than the worst-case scenario", the PCT would be facing significant deficits. A radical review of all non-essential spend would need to be carried out and the PCT would have to consider cuts in those services currently provided which are not deemed as core PCT services.

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<sup>18</sup> NHS Kensington and Chelsea "Commissioning Strategy 2010-2015": <http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.2CSP260110.pdf>

<sup>19</sup> Department of Health (2008) NHS Operating Framework exposition booklet: [http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH\\_091850](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_091850)

<sup>20</sup> Marmot Review report - 'Fair Society, Healthy Lives': <http://www.idea.gov.uk/idk/core/page.do?pageId=16908107>

<sup>21</sup> The Liberal Democrat manifesto (2010) is available at: [http://www.libdems.org.uk/our\\_manifesto.aspx](http://www.libdems.org.uk/our_manifesto.aspx)

<sup>22</sup> Draft Conservative Party manifesto (2010): [http://www.conservatives.com/News/News\\_stories/2010/01/Cameron\\_launches\\_age\\_nda\\_for\\_the\\_NHS.aspx](http://www.conservatives.com/News/News_stories/2010/01/Cameron_launches_age_nda_for_the_NHS.aspx)

<sup>23</sup> The PCT has modelled the scenario of a 1.2% reduction in allocation per annum in revenue allocation. However, this assumes 2.5% average NHS allocation growth.

## Capital

2.13 PCTs no longer receive formula-based allocations for the capital programme. Instead they need to submit their proposals to the Strategic Health Authority (NHS London) for decision. The NHS Operating Framework for 2010-11 says capital expenditure will be reduced in coming years.

### Summary Capital Schedule 2010/11<sup>24</sup>

	<b>£000</b>
St Charles Development	3,538
Polysystem Development - North	1,000
Polysystem Development – South and Central	1,750
C&W Urgent Care Centre	1299
GP Premises	335
IM&T	928
Capital Grants (Dental)	500
Other	461
<b>Total</b>	<b>9,811</b>

### Funded By

	<b>£000</b>
Revenue to Capital	5,000
Strategic Capital Bid	4,811
<b>Total</b>	<b>9,811</b>

2.14 If there is a significant reduction in the level of additional investment available to it, the PCT has said that it may require “a scaling back of the capital schemes”. “Priority would be given to those schemes which are critical to the delivery of polysystems and moving care to lower cost settings and the PCT would explore any opportunities for land sales to increase the funding available, although there is limited scope for this within our estates portfolio.” (Section 4.11.1, Commissioning Strategy 2010-2015<sup>25</sup>). The PCT's Interim Finance Director confirmed to the Sub-group on 12 February 2010 that the PCT held some potentially surplus land adjacent to the Princess Louise site and at World's End.

## Scale of the financial challenge

<sup>24</sup> Taken from Don Richard's presentation to the Sub-group on 12 February 2010.

<sup>25</sup> NHS Kensington and Chelsea's "Commissioning Strategy 2010-2015": <http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.2CSP260110.pdf>

- 2.15 The scale of the potential financial challenge is such that NHS Kensington and Chelsea needs to consider a more gloomy future to avoid a “bust” after the “boom”. Hard decisions need to be considered. If decisions are not prepared for in the short-term, knee-jerk processes could have a worse long-term impact on the quality of care. We must avoid the classic reactions such as the use of 'across the board' cuts, or arbitrary decision-making.

*Recommendation (a): The HSC believes the PCT has been sensible to model for both a 0% and a 1.2% per annum allocation reduction over 2011-14. However, there is much uncertainty on finance in the future. The allocations of monies to NHS Kensington and Chelsea in the coming years could be further affected downwards for two reasons: (1) The poor state of public sector finance and (2) The PCT has been receiving a larger allocation relative to the centrally perceived need - and we believe the NHS could drive a more aggressive pace of change to move PCTs towards capitation target than that planned for by NHS Kensington and Chelsea. The PCT should be prepared for this worse than the "worst-case scenario"<sup>26</sup>, as set out in the Commissioning Strategy<sup>27</sup>. The HSC hopes this will not happen. However it would be precautionary to plan, well in advance and together with partners, for the very worst possible situation that could affect the PCT's finances. The HSC suggests it would be prudent to examine the potential for a more pessimistic financial outlook than those currently being considered. The PCT will be more able to stay ahead of any spending pressures, and avoid panic or false economies, if it has built for itself a (net) savings plan for future years.*

### **Increased competition for scarce resources**

- 2.16 Another outcome of the downturn which we need to work hard to avoid is that each individual local NHS organisation starts to make decisions in its own best interests, rather than in the interests of the patients and the NHS as a whole. One mechanism to try to avoid this is strong collaboration in the decision-making between clinical and managerial professionals and organisations.

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<sup>26</sup> The PCT has modelled the scenario of a 1.2% reduction in allocation per annum in revenue allocation. However, this assumes 2.5% average NHS allocation growth.

<sup>27</sup> NHS Kensington and Chelsea's "Commissioning Strategy 2010-2015": <http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.2CSP260110.pdf>

- 2.17 The change to the level of resources going to provider services is likely to change the relationships between providers - they are likely to become less co-operative and more competitive. The PCT and North West London Partnership will need to be able to manage a more competitive landscape to ensure that the emerging market provides the best outcomes for the residents of Kensington and Chelsea and North-West London.
- 2.18 The Sub-group believes that the PCT can offer leadership to the local health economy to make the best of a difficult situation. NHS Kensington and Chelsea is well-placed to act to minimise disputes between local NHS organisations.

*Recommendation (b): Local NHS organisations can minimise the potential for direct conflict with neighbouring trusts by being clear and transparent in their plans and actions. Imperial College Healthcare NHS Trust and Chelsea and Westminster Foundation Trust will need to continue to work in partnership with the local health and social care community. We recommend that the Foundation Trust and Imperial College Healthcare NHS Trust work towards some type of charter for collaboration.*

### **Managing the market**

- 2.19 Mr Lambrianou, a Non-Executive member of the PCT Board, informed the Sub-group of the PCT's increasing role in "managing the market". The PCT approved a Market Management Strategy<sup>28</sup> on 23 March 2010. This sets out how NHS Kensington and Chelsea has and intends to: promote competition in the local market; stimulate growth and development in the market; and ensure that investment is maximised in terms of quality and productivity over the next 5 years. Mr Lambrianou referred to measures being taken by the PCT to achieve the necessary blend of personnel and expertise in this area.

## **3. NHS KENSINGTON AND CHELSEA – PRIMARY CARE TRUST**

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<sup>28</sup> NHS Kensington and Chelsea "Market Management Strategy" was agreed by the PCT Board on 23 March 2010: [http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.2MarketManagementStrategyv8.1\\_103015.pdf](http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.2MarketManagementStrategyv8.1_103015.pdf)

- 3.1 The primary role of the PCT is to secure the best possible services for the population, whether these are provided directly (in-house) or procured within their resources from another provider. In order to achieve this, the PCT must work closely with primary care practices, Central London Community Healthcare, secondary care providers in the public and private sector, and the local authority, as well as patients and the public. Kensington and Chelsea PCT priorities are set out in the next section.
- 3.2 NHS Kensington and Chelsea (the Primary Care Trust) is a free-standing body, performance-managed by the Strategic Health Authority. It is the lead organisation in assessing need, planning and securing all health services, and improving health in the area.
- 3.3 NHS Kensington and Chelsea has to:
- Secure high-quality, safe services;
  - Improve health and reduce inequalities;
  - Manage financial balance and risk;
  - Improve public involvement;
  - Improve co-ordination with social services;
  - Improve commissioning and effective use of resources.
- 3.4 Functions include:
- Commissioning (there is information on each of the areas of commissioned services in section 5);
  - Primary care development;
  - Public health and health improvement;
  - Emergency planning;
  - Public and patient engagement;
  - Corporate management;
  - Financial management.

### **Efficiencies and good value**

- 3.5 Ultimately the PCT has discretion over its entire budget, but in practice until there is an evidenced reason to change patterns of service, the bulk of the budget is based on the previous year's patterns of referral, and existing services.

3.6 The PCT, as the commissioner of healthcare, needs to get value for money. It needs to ensure that it is investing in good quality services, and decommissioning where appropriate. Outcomes have to be monitored and reviewed. The principal ways in which the PCT ensures efficiency in the commissioning process are:-

- Constant monitoring of the financial position - The PCT monitors its financial position every month in order to ensure that targets are being met, or mitigating actions put in place where there are variances against the budget.
- Benchmarking - The PCT checks its spend and results against other PCTs' spending. The PCT can be compared to a comparison group to analyse programme budget spend data, using the Audit Commission's "Value for Money Profile Tools".<sup>29</sup> Also the NHS reports each year on "Programme Budgeting" by PCT, comparing each PCT to an appropriate peer group. This information is freely available on the Internet under the title 'PCT Spend and Outcome factsheets and Tool (SPOT)'. For example: The SPOT for 2008/09<sup>30</sup> shows Kensington and Chelsea PCT's highest spend areas, excluding programme 23 (Other), are: £285 per head per year on Mental Health; £139 on Infectious Diseases; and £88 on Circulation. Kensington and Chelsea PCT has outlier(s)<sup>31</sup> on spend area(s): Infectious Diseases, Mental Health, Neurological, Vision, Circulation, Respiratory System, Dental, Gastrointestinal System, and on outcome area(s): Infectious Diseases, Cancers & Tumours, Vision, Genito Urinary System, Neonates.
- Programme budgeting - PCT commissioners look at costs across Kensington and Chelsea and compare spend with other PCTs. This newly introduced system requires information to be submitted to the Department of Health (DH).
- Best use of patient-reported outcome measures (PROMS) - The King's Fund report, "Getting the most out of PROMS: putting health outcomes at the heart of NHS decision-making (11 March 2010)"<sup>32</sup> examines how PCTs can strengthen their

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<sup>29</sup> The Audit Commission's "Value for Money Profile Tools": <http://vfm.audit-commission.gov.uk/RenderReport.aspx>

<sup>30</sup> The full "Spend and Outcome Factsheet 2008/09 for Kensington and Chelsea PCT" is available at: [http://yhpho.org.uk/quad/pdfs0809/5LA\\_PB0809%20Profile.pdf](http://yhpho.org.uk/quad/pdfs0809/5LA_PB0809%20Profile.pdf)

<sup>31</sup> In statistics, an outlier is an observation that is numerically distant from the rest of the data.

<sup>32</sup> The King's Fund report, "Getting the most out of PROMS: putting health outcomes at the heart of NHS decision-making (11 March 2010)": <http://www.kingsfund.org.uk/publications/proms.html>

commissioning by using PROMs to assess value for money. It also shows how clinical teams can benchmark and improve their performance.

- Contestability/market testing – The PCT is currently working through all its provider services to ensure good value. It is undertaking benchmarking against national reference costs and has developed a set of “provider metrics” which will measure the services’ ability to reduce hospital admissions, provide care closer to home and respond appropriately to patients’ needs. Contestability and market testing is expected to become increasingly important in the years ahead.
- Clinical pathways – Pathways are worked up with GPs to ensure that care is integrated and streamlined and represents the best value for money whilst tackling inequalities.
- Care pathways – Improvements are constantly made to the care pathways and service delivery within budgets - the fact that the PCT spends approximately the same amount of money with a Trust each year does not mean that service commissioning has not made real changes to the patient experience at the Trust.
- Clinical audit – The Sub-Group was informed that the evidence suggested that admissions to A&E at Chelsea and Westminster were “appropriate”. However, the PCT would like to improve primary care provision at Chelsea and Westminster A&E in the next few years.
- Applying National Institute of Health and Clinical Excellence (NICE) guidance – The PCT endeavours to ensure NICE guidance is applied. A press release (27 April 10)<sup>33</sup> describes tools<sup>34</sup> available that could help save the NHS money in excess of £600m.
- Information in the acute sector - Information such as referral rates, length of stay, re-admission rates can all be used to improve performance.
- Reducing need via effective health interventions – e.g. preventative and public health work.

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<sup>33</sup> NICE (27 April 10) press release: How NICE could help the NHS save over £600 million

<http://www.nice.org.uk/newsroom/features/HowNICECouldSaveTheNHSOver600million.jsp>

<sup>34</sup> NICE’s cost-saving tools and information can be found at:

<http://www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/UsingNICEGuidanceToCutCostsInTheDownturn.jsp>

*Recommendation (c): The PCT will need to continue to embed into its work the concept of prevention and the promotion of staying healthy.*

### **Making savings**

3.7 The NHS Operating Framework for 2010/11 sets out that "Management and administrative support costs must be reviewed and reduced to maximise the proportion of NHS resources that is invested in frontline services". To achieve this, each Strategic Health Authority (SHA) must meet an aggregate target reduction of 30% in management and agency costs by 2013/14. It will be for SHAs to determine how this is managed across PCTs. The expectation is that:

- Whilst there is no specific target for 2010/11, most progress needs to be made in 2010/11 and 2011/12;
- Co-terminosity can be used as a driver (See "The PCT commissions jointly with the local authority", section 5.38);
- Provider arms are to be included in the aggregate.

3.8 A number of possible areas for exploration are:

- Efficiency savings - NHS Kensington and Chelsea must focus on ways in which reducing costs can also improve the quality of care. There are examples in almost every area of health care where providing care more efficiently can also improve the quality of care.
- Increased productivity - Exploring the scope for increasing productivity.
- Savings from low-priority areas - Cutting unneeded appointments and procedures. The PCT must look at information on need, so that any decision on where to make possible savings can be considered well in advance and not rushed.
- Cutting wastage - Savings from cutting external contracts and supply costs such as waste and food. Reducing energy and resource usage also improves environmental sustainability.
- Cutting expenses<sup>35</sup>
- Invest for the future - Investment to reduce revenue costs.

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<sup>35</sup> An idea taken from the KPMG report, "Tough choices ahead - The future of the Public Sector":

<http://www.kpmg.com/Global/en/IssuesAndInsights/ArticlesPublications/Pages/Tough-Choices-Ahead.aspx>

- Joining-up with other agencies to reduce costs – e.g. In a speech on 10 December 2009, David Nicholson, chief executive of the NHS, said that the Operating Framework will require health services to work more closely with local authorities.
- Cutting staff costs - With forward planning it is possible to plan for a reduction in headcount as people leave, without the need for massive redundancies.
- Improved workforce – The PCT could reduce the amount paid to outside agencies for consultancy work, or agency staff. The Management Consultancies Association suggests that consultants are not appointed when internal staff could do the work, and that they are only appointed when there is a clear focus on delivery, and there is evaluation of value for money. See Appendix 2.

3.9 The PCT continues to monitor areas where savings can be made without compromising quality of care. A selection of the tools the PCT uses to identify opportunities for quality and efficiency improvement is set out in Appendix 3.

#### **4. PRIORITIES AND TARGETS**

##### **Commissioning Strategy: 2010-2015<sup>36</sup>**

- 4.1 Ms Wright, Chief Executive, identified for the Sub-group a number of key strands from the PCT's Commissioning Strategy 2010-15. Fundamental to the PCT is the achievement of improved health of the local population, with the provision of healthcare of the highest order; a focus on providing care closer to home; encouraging individuals to take greater responsibility for their health; and effective integration with social care provision. The two "polysystems" which are being developed to serve the borough are central to the PCT's plans.
- 4.2 The Strategy sets out NHS Kensington and Chelsea's vision, aims, values, commissioning goals and commissioning objectives for the next 5 years, and reflects the Operating Framework 2010/11.

##### **Overall vision**

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<sup>36</sup> NHS Kensington and Chelsea's "Commissioning Strategy 2010-2015": <http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.2CSP260110.pdf>

- 4.3 *"To be the recognised Health Advocate for all residents of Kensington and Chelsea and by 2015 to lead an integrated healthcare system that transforms the way the residents manage their physical and emotional health and wellbeing and helps them become the most engaged and vibrant community in London."*  
(Foreword of the Commissioning Strategy 2010-2015)

### **Aims**

- 4.4 "The PCT aims to keep people healthy for as long as possible. However, it is essential that we commission healthcare which is safe, high quality, efficient and effective for when people become ill. Over the next five years, we plan to move the location of a lot of healthcare provision from acute hospitals to primary and community settings. We will do this by developing integrated healthcare systems known as polysystems.

### **Values**

- 4.5 As a Health Advocate we are committed to:
- Enabling and empowering residents to take responsibility for their health by making healthy lifestyle choices
  - Helping people to make informed decisions and best use of healthcare services
  - Working with residents and partners to optimise and personalise all resources available to improve their health
  - Ensuring people feel cared for and listened to.

### **Commissioning Goals**

- 4.6 Improve the health of the whole population:
- recognising we need to make greater improvements for some residents given our diverse and transient population; so that we reduce health inequalities, whilst striving to improve the health of all of our population
  - working in partnership to address residents' needs when their health is not good
  - offering a combination of universal and personalised services
- 4.7 Improve health care for the whole population:

- by focusing on the safety of the services we commission we will achieve good quality services that meet the expectations of our residents and represent value for money."

### **Priority Outcomes**

4.8 NHS Kensington and Chelsea have identified 10 priority outcomes (Commissioning Strategy 2010-2015):

1. Life expectancy at birth - (a) Male / (b) Female
2. Health Inequalities (intra-ward mortality rates) - (a) Male (b) Female
3. Percentage attendances by 12 weeks of pregnancy.
4. Percentage of babies totally or partially breast-fed at 6-8 weeks
5. Percentage of children who complete MMR immunisation by their fifth birthday
6. Children accessing dentistry (%)
7. Smoking quitters (number of quitters)
8. Care Programme Approach users, Health of Nation Outcome Score assessed in last 12 months (%)
9. HIV late diagnosis indicator (%)
10. Percentage of all deaths that occur at home (%).

### **Local needs**

4.9 "Our [Commissioning] strategy is built upon the information about our population health needs described in the Joint Strategic Needs Assessment (JSNA). It clearly articulates those key areas that are of concern to us as commissioners as we seek to eradicate health inequalities within the borough ... Over the last year we have concentrated on improving the health of our residents in a number of areas identified within the JSNA, with particular emphasis on reducing smoking, managing obesity (particularly in children), improving access to dentists and to advice on sexual and mental health." (Foreword of the Commissioning Strategy 2010-2015). "We used the information from our JSNA to identify our local priorities which are long term conditions, mental health, children's health and sexual health." (Commissioning Strategy 2010-2015). There is more information on the JSNA in section 4.21.

### **Business Plan: April 2010-March 2011**

4.10 The five-year Commissioning Strategy will be refreshed each year with an annual business plan. The first of these is the "Business Plan April 2010-March 2011".<sup>37</sup>

4.11 Section 5 of the Business Plan outlines the PCT's overarching commissioning intentions for 2010-11:

1. To invest a higher proportion of allocation, linked to health need, on keeping residents healthy, and through this reduce health inequalities and improve health outcomes.
2. To commission a higher proportion (78% of total activity) of healthcare in primary and community care settings (including patients' homes).
3. To actively de-commission at least 10% of total activity from acute providers.
4. To drive efficiencies and improved quality in all providers using: Evidence-based service specifications; systematic and informed contract management; CQUIN (Commissioning for Quality and Innovation Network) scheme; penalties.
5. Develop a process of commissioning that improves agreed performance targets including World Class Commissioning outcomes.
6. Develop the primary, community and third sector healthcare market using a range of collaborative and competitive approaches.
7. Support the management of the acute provider landscape through the N.W. London Commissioning Partnership.
8. Maximise commissioning potential through working collaboratively with a range of strategic partners including: N.W. London Commissioning Partnership; Local Specialised Commissioning Group; Commissioning Support for London; Royal Borough of Kensington and Chelsea; Practice Based Commissioners; Local Involvement Network (LINK).

4.12 Section 6 of the Business Plan outlines five annual objectives of the PCT for 2010-11:

1. Ensure the effectiveness of PCT investments to improve health and health services

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<sup>37</sup> NHS Kensington and Chelsea draft "Business Plan April 2010-March 2011" was presented to the PCT Board on 23 March 2010: <http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.1BusinessPlan2010-11.pdf> The final version (reflecting the final contract position for 2010-11) was approved by the Board at its meeting in May 2010.

2. Establish the polysystem care delivery model
3. Externalise the Provider services
4. Improve the performance of the PCT
5. Build strong strategic alliances and partnerships to ensure the sustainability of the vision and plans for our residents

### **NHS Operating Framework for 2010/11**<sup>38</sup>

4.13 The NHS Operating Framework for 2010/11 sets out NHS priorities for the next year. The five priorities continue to be:

1. Improving cleanliness and reducing healthcare-associated infections.
2. Improving access through achieving the 18-week referral to treatment pledge and improving access to GP services.
3. Keeping people well, improving their health (e.g. stroke, cancer) and reducing health inequalities (e.g. a new Start4Life programme aimed at families, and a focus on physical activity for adults aged 45 to 65).
4. Improving patient experience, staff satisfaction and engagement (including working effectively with LINKs and Scrutiny Committees).
5. Preparing to respond to an emergency such as an outbreak of pandemic flu, learning from the experience of swine flu (a pandemic significantly more damaging to health than seasonal flu or swine flu could occur).

4.14 The NHS Operating Framework for England for 2010-11 sets out how the payment system will be changed. In 2010-11 the PCT will receive a 5.14% allocation increase; the allocation increase for the next three years is as yet unknown. There will be 0% uplift in national tariff prices for acute provider sector providers, and the uplift for the next three years will be a maximum of 0%. The uplift in 2010-11 includes an efficiency requirement of 3.5% and it is expected that the efficiency requirement will increase over the subsequent three years. For the first time, "best practice tariffs" will be introduced so that the prices paid reflect the highest quality care, and the NHS will no longer pay for "never events" (i.e. serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. PCTs are required to monitor

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<sup>38</sup> "NHS Operating Framework for England for 2010/11":  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_110107](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107)

the occurrence of "never events" within the services they commission and publicly report them on an annual basis.) To incentivise providers to offer the highest quality care, the first set of best practice tariffs will be for two elective and two emergency areas of service: cataracts; cholecystectomy; fragility hip fracture; and stroke. If these are successful in reducing the variation in quality between providers, the scheme will be expanded.

4.15 Part of a hospital's income will be linked to patients' satisfaction through the Commissioning for Quality and Innovation Network (CQUIN) scheme. All CQUIN schemes will include a patient experience element that will include a national goal, linked to outcomes from the national inpatient survey. The PCT has the power to withhold a proportion of contract payment if providers fail to meet agreed patient satisfaction goals.

4.16 From April 2010, PCTs will not pay if treatment results in one of the seven listed "never events." These are: (1) wrong site surgery; (2) retained instrument after an operation; (3) wrong route of administration of chemotherapy; (4) misplaced nasogastric or orogastric tube not detected before use; (5) inpatient suicide by use of non-collapsible rails; (6) in-hospital maternal death from postpartum haemorrhage after elective caesarean section; and, (7) intravenous administration of mis-selected concentrated potassium chloride.

4.17 Other system levers and enablers include:

- Focus on sharing risks across the whole system and re-balancing risk between providers and commissioners (more services closer to home and less investment and activity in the acute sector)
- Constrain emergency activity through use of the tariff
- Look to produce "year of care" tariffs
- Revise NHS contracts for hospital, community, mental health, and ambulance services
- A separate NHS contract for care homes in 2010
- In 2011/12, contracts that reward integrated care rather than episodic hospital care
- Further guidance on "NHS first" (e.g. the NHS as preferred provider)
- Alignment with local area agreements – SHAs will make links with Total Place pilots

- “Informatics Planning 2010/11” guidance was published alongside the NHS Operating Framework for 2010/11. It suggests a more ambitious and innovative approach to using digital technologies across health and social care.

### **Care Quality Commission**

- 4.18 The Care Quality Commission’s (CQC) annual health check provides analysis of NHS trusts’ performance<sup>39</sup>. For the period 1 April 2008 to 31 March 2009, organisations were assessed on two main elements: a) the annual health check – trusts’ public declarations on compliance with national core standards (including those concerned with safety and cleanliness, safeguarding children, infection control, dignity and respect, and privacy and confidentiality) which is subsequently verified by the CQC, and b) performance against national priorities (e.g. waiting times for cancer treatment; inpatient and outpatient treatment; ambulance response times; patient-reported experience of services; MRSA rates; access to reproductive and sexual health service; and, reductions in deaths from cancer). For PCTs, judgments were made on two areas: (i) Quality of commissioning and (ii) Quality of financial management – using a four-point scale: excellent, good, fair and weak.
- 4.19 NHS Kensington and Chelsea in 2008/09 scored (i) Fair for quality of commissioning (ii) Fair on quality of financial management [2007/08 (i) Good for quality of services (ii) Good for use of resources]. The PCT slipped from being classified as “good” overall to “fair”. It also failed on the targets: Category B calls (19 minute); breast cancer screening; Chlamydia screening; drug users in effective treatment; access to primary dental services. It under-achieved on: access to primary care; four-week smoking quitters. [For a comparison with other local PCTs in 2008/09: Westminster PCT scored (i) Fair for quality of commissioning (ii) Good on quality of financial management; Hammersmith and Fulham PCT (i) Fair (ii) Fair; and, Brent Teaching PCT (i) Fair (ii) Good].

### **World Class Commissioning**

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<sup>39</sup> NHS Performance Ratings 2008-09 - The ratings for all 392 NHS trusts in England (incl. NHS Kensington and Chelsea) can be accessed via: <http://www.info4local.gov.uk/filter/?item=1358758>

4.20 There are 11 organisational competencies which PCTs are assessed on, and must do:

- Locally lead the NHS;
- Work collaboratively with partners;
- Partner with patients and communities;
- Partner with clinicians;
- Manage knowledge and assess needs;
- Identify investment requirements and opportunities;
- Influence provision to meet demand and secure outcomes;
- Drive continuous innovation and improvement;
- Deploy procurement skills to ensure providers have appropriate contracts;
- Performance manage;
- Manage finances.

### **Joint Strategic Needs Assessment**

4.21 Carrying out needs assessment is an integral part of a good commissioning process. By joining-up strategic needs assessment work, the limited resources (of all partners) should be marshalled to their best effect.

4.22 The *Local Government and Public Involvement in Health Act 2007* requires PCTs and local authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and well-being of their local community. The guidance<sup>40</sup> described the stages of the process, including stakeholder involvement, engaging with communities, and recommendations on timing and linking with other strategic plans. It also contained guidance on using JSNA to inform local commissioning, publishing and feedback. A key component of the *Commissioning Framework for Health and Well-being*<sup>41</sup> was the statutory requirement for local authorities and PCTs to produce a JSNA. The JSNA is undertaken jointly by Directors of Public Health, Adult Social Services and Children's Services working in collaboration with Directors of Commissioning.

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<sup>40</sup> DH JSNA guidance:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081097](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097)

<sup>41</sup> "Commissioning framework for health and well-being":

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4143857&chk=qj0MmR](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4143857&chk=qj0MmR)

- 4.23 The Audit Commission has encouraged chief executives, senior officers and lead members to be more demanding about the information they seek and use when making decisions.<sup>42</sup>
- 4.24 In July 2006 Derek Myers, RBKC Town Clerk and Chief Executive, issued the "Smartest Council"<sup>43</sup> management paper outlining the vision for the Council to make best use of technology, work efficiently and maximise customer and staff satisfaction. To be "Smarter", the JSNA should be an integral part of the planning cycle of the Council and NHS Kensington and Chelsea. Investment in all health and adult social care services need to be guided through the JSNA.
- 4.25 The JNSA's design structure should facilitate the making of better decisions. Thinking about this decision-making process is essential in the process of setting up the basic JSNA design structure to ensure an integration of "needs information" into the decisions made. There is little point having an add-on system - the JSNA has to be integral to the whole.
- 4.26 The JSNA should become an invaluable tool in identifying short, medium and long-term health and social care needs and the types of services that are required to meet these needs. The JSNA will need to be embedded within Council and PCT commissioning and strategic thinking. It should be an integral part of a local commissioning framework. Its existence should also underpin local accountability and essential local discussions of priorities in resource allocation. The JSNA should be a rich source of information for decision-making by Officers, PCT Non-Executives and Councillors.
- 4.27 The Sub-group was pleased to hear that the PCT's Commissioning Strategy 2010-2015 used the JSNA explicitly to describe needs and set some overall priorities (see section earlier on "priorities").

<b>Joint Strategic Needs Assessment (JNSA)</b>
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<sup>42</sup> The Audit Commission report, "Is there something I should know? Making the most of your information to improve services": <http://www.audit-commission.gov.uk/nationalstudies/localgov/istheresomething/Pages/Default.aspx>

<sup>43</sup> Royal Borough of Kensington and Chelsea: "Smartest Council": [http://www.rbkc.gov.uk/rbkcdirect/rdcouncilpriorities/cp0306\\_smartest.asp](http://www.rbkc.gov.uk/rbkcdirect/rdcouncilpriorities/cp0306_smartest.asp)

Kensington and Chelsea's current JNSA is available on the Internet at:  
<http://www.rbkc.gov.uk/voluntaryandpartnerships/healthandwell-being.aspx>

*Recommendation (d): The HSC recommends that, in taking forward the Joint Strategic Needs Assessment (JSNA), more consideration is needed on how the information gathered is best used and integrated into decision making. The main part of the work should not just be about data collection, but about information that can be used to help plan services and actions in the future. The JSNA could be improved as an interactive internet tool by linking it to other data sets that are themselves updated. This will minimise the need for officer time and effort.*

### **Patient choice**

- 4.28 Patient choice is seen as a major driver for service diversification and improvement. The PCT supports patient choice by providing clear and accessible information about health services. Commissioners ensure that patients and the community are involved throughout the commissioning cycle.
- 4.29 Where patients choose to go is important, as it affects where resources go and which providers thrive. To proponents, the benefits of extending choice are seen as a lifting of standards, shortening waiting times, greater say for patients in their own treatment, and more efficient, personalised and responsive services. Payment by Results<sup>44</sup> is the system by which hospitals are paid for operations or treatments only when they have done them, with the price fixed by a national tariff for specific procedures. The system is designed to encourage providers to keep costs low and make their care and facilities more attractive to patients. Money following patients should, in theory, prompt providers of acute care to improve the quality of service: "Financial incentives and performance management will drive delivery of the new commitments. The new system of payment by results will support the exercise of choice by patients, improve waiting times for patients and provide strong incentives for efficient use of resources" (The NHS Improvement Plan Executive Summary point 21 p11).

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<sup>44</sup> The National Audit Office report, "Payment by results briefing" (June 2007):  
<http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=ENGLISH^574&ProdID=D7036BD1-D959-4354-A6BC-F9FAF567A3A1>

4.30 'Choose and Book' is a service that combines electronic booking and a choice of time, date and place for first outpatient appointments. PCTs support choice by commissioning a range of services so that patients have four or five hospitals or other appropriate services from which they can choose. At the same time, information will be provided for patients so that they can make an informed choice of hospital.

### **Integrated Performance Paper** <sup>45</sup>

4.31 The PCT has a range of priorities linked to national and local imperatives. The Integrated Performance Report has been produced to provide the Board with a high-level assessment of PCT performance across all Commissioning activities. It includes updates on:

- The CQC assessment of the PCT performance;
- The Quarterly position against the Periodic Review;
- Activity, finance and quality reports for acute, non-acute and primary care.

## **5. COMMISSIONING**

### **Background**

5.1 In the NHS, money flows into the system mainly from taxes and is redistributed by the government to PCTs who then commission care from hospitals, community providers, a range of primary care clinicians and the voluntary and private sectors. There is a central government planning agency, the DH and, at the local level, there are PCTs which are directly responsible for "purchasing" health services for the population within their jurisdiction, based on their needs. The local PCT is given a budget, based on the Office of National Statistics population weighted for a variety of factors such as age and deprivation, to obtain services mainly from NHS providers within a particular geographical area but may, on occasion, buy services from the private sector. At the provider level, there are NHS "trusts",

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<sup>45</sup> The paper, "Integrated Performance Paper" was presented to the Kensington and Chelsea PCT Board on 23<sup>rd</sup> March 2010:

<http://www.kc-pct.nhs.uk/corporate/meetings/documents/3.1integratedperformancereport20100315.pdf>

which are members of the NHS itself, Foundation trusts and there is the private sector. Trusts can be hospitals, mental health trusts, or ambulance services, and their services are commissioned by the PCT and met from taxpayers' money.

### **What is commissioning?**

- 5.2 Commissioning can be described as the process by which funds flow to health providers and best value for patient and tax payers is secured, achieving the best possible health outcomes (including reducing health inequalities) and the best possible healthcare within available resource limits. Commissioning is not new, but the stronger emphasis by government on the commissioning role, both for PCTs and GPs, is a recent development in health policy.
- 5.3 The overall cycle of commissioning can be broken down into seven key functions: (i) Assessment of the health needs of the local population (ii) Reviewing services (iii) Deciding on health priorities (iv) Contracting and procurement of appropriate, effective, safe and affordable services (v) Managing demand for services (vi) Monitoring quality and performance and (vii) Reviewing the effectiveness of services to achieve health priorities, including public and patient involvement.
- 5.4 Effective commissioning will depend upon PCTs and practices giving equal consideration and priority to each of the seven stages of the commissioning cycle. Effective commissioning also has to follow the best available evidence - NICE issued a guide on commissioning high quality services on 4 December 2009.<sup>46</sup>

### **Commissioning Framework for Health and Well-being<sup>47</sup>**

- 5.5 Within "Commissioning Framework for Health and Well-being" the DH described good commissioning as: "The means to secure the best value for local citizens. It is the process of translating

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46 "How to Use NICE Guidance to Commission High Quality Services" explains how NICE guidance can be used to support commissioning. It outlines the support available from NICE and the benefits that using NICE guidance can bring for local populations:

<http://www.nice.org.uk/media/027/17/HowToCommissioningGuideFinal.pdf>

<sup>47</sup> DH report "Commissioning framework for health and well-being":

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4143857&chk=qj0MmR](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4143857&chk=qj0MmR)

aspirations and need, by specifying and procuring services for the local population, into services for users which:

- Deliver the best possible health and wellbeing outcomes, including promoting equality;
- Provide the best possible health and social care provision;
- Achieve this within the best use of available resources.”

### **World class commissioning**<sup>48</sup>

5.6 World Class Commissioning is the tool used to assess the commissioning carried out by the PCT. The vision document said, "Improving commissioning is at the heart of delivering this agenda (i.e. an NHS that is fair, personalised, effective and safe and focused relentlessly on improving the quality of care). The NHS has real potential to develop world class commissioning - investing NHS funds to secure the maximum improvement in health and well-being outcomes." The document then described the organisational competencies PCTs must do. The 11 organisational competencies PCTs are assessed on are set out in section 4.20.

#### **Health Select Committee report "Commissioning" (30 March 2010)**<sup>49</sup>

The Health Select Committee report, "Commissioning" (30 March 2010) was highly critical of the way PCTs commission services across the health sector.

The Select Committee report concludes that PCT commissioning has repeatedly failed to be a cost-effective and efficient system and that commissioning has led to an increase in transaction costs within the NHS, most notably management and administration costs.

Weaknesses are due in large part to PCTs' lack of skills - notably poor analysis of data, lack of clinical knowledge, and the poor quality of much PCT management. The situation has been made worse by the constant re-organisations and high turnover of staff. The committee also questions whether the government's most recent initiative, "World Class Commissioning", will lead to the necessary transformation of PCTs.

Research found misplaced confidence amongst PCTs about their achievements, while

<sup>48</sup> More information available at the DH webpage "World Class Commissioning": <http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm>

<sup>49</sup> Health Select Committee report, "Commissioning" (30 March 2010): <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/268i.pdf> and reported in HSJ article, "PCTs 'too passive on commissioning' (30 March 2010)" <http://www.hsj.co.uk/news/primary-care/commissioning/pcts-too-passive-on-commissioning/5013121.article>

many trusts remain disengaged from specialised commissioning. The report notes that the coming period of financial restraint could threaten funding.

The report concludes that PCTs require a more capable workforce, higher quality management, the ability to attract and develop talent, and more power to deal with providers.

### **Expenditure by area of commissioned work**

5.7 This table below sets out the breakdown of expenditure by area of commissioned work:

<b>Breakdown of 2008/09 revenue spend<sup>50</sup></b>	<b>Area of activity</b>	Largely related to the work of the partnership /organisation (s)
<b>20%</b>	<b>Primary Care</b>	GPs, dentists, opticians and pharmacists
<b>20%</b>	<b>Community Services</b>	Central London Community Healthcare (CLCH)
<b>16%</b>	<b>Mental Health</b>	Central and North West London Foundation Trust (CNWL)
<b>2%</b>	<b>Learning Disabilities</b>	With RBKC
<b>51%</b>	<b>General and acute (inc. A&amp;E and maternity)</b>	North West London Commissioning Partnership

### **THE PCT's COMMISSIONING OF PRIMARY CARE SERVICES**

5.8 The PCT's commissioning of primary care and non-acute services is driven by the assessment of needs in different geographical areas and amongst segments of the population.

#### **General Practice**

<sup>50</sup> Taken from Pie Chart of Revenue Spend in Section 3.7.1 of the "Commissioning Strategy 2010-2015":  
<http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.2CSP260110.pdf>

5.9 In Kensington and Chelsea, there are 43 practices: 43% single-handed, 30% double-handed and 27% with more than 3 partners. The percentage of single-handed GPs is above the national average. By 2017, a third of the GPs will be eligible for retirement. Needs-based information can be used to assess the referral practice of General Practices.

### **Polysystems**

5.10 There are plans for a great expansion of polyclinics in London. NHS London has said that London will have more than 100 polyclinics in the next few years (11 February 2010)<sup>51</sup>.

5.11 The development of polysystems is one of the key initiatives in the N.W. London Sector's draft "Integrated Strategic Plan"<sup>52</sup>. NHS London's assessment (January 2010) of N.W. London PCTs' draft proposals for polysystem implementation found many of their plans to be weak<sup>53</sup>.

5.12 The Sub-group heard that the NHS Kensington and Chelsea's plans for polysystems described them as a "delivery vehicle" for improving services. The Sub-group also heard that there would be costs upfront to create savings in the longer-term. The PCT's chief executive referred to the potential for polysystems to achieve "invest to save" efficiencies through the delivery of improved patient pathways. The PCT's plans for 2010 include: bringing together two single-handed and a double-handed practice at the St Charles Community Hospital; opening a GP-led Urgent Care Centre at the Chelsea and Westminster Hospital; and commissioning new capacity for 6,000 patients at Earls Court. The key milestones are:

- May 2010 - Polysystem hub at St Charles Community Hospital opened
- June 2010 - Refreshed estates strategy approved
- July 2010 - Feasibility study for the south hub completed

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<sup>51</sup> NHS London press release: A hundred polyclinics are on their way in London  
<http://www.london.nhs.uk/news-and-health-issues/press-releases/2010-press-releases/a-hundred-polyclinics-are-on-their-way-in-london>

<sup>52</sup> NWL Sector's draft "Integrated Strategic Plan 2009 – 2014" (January 2010):  
[http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10\\_02\\_10\\_ae.pdf](http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_02_10_ae.pdf)

<sup>53</sup> NHS London response to draft NWL ISP (Jan 2010)  
[http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10\\_02\\_10\\_nhsl.pdf](http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_02_10_nhsl.pdf)

- August 2010 - GP-led Urgent Care Centre at Chelsea and Westminster NHS Foundation Trust opened
- December 2010 - GP-led health centre in Earl's Court opened

### **St Charles Polysystem**

5.13 The St Charles polysystem hub will be open 7 days a week between 8am - 8pm. It will include the following services:

- Four General Practitioners
- Minor Injury Unit services - these will now be overseen by a doctor rather than a nurse
- Medical assessment unit for vulnerable elderly
- Centre for the management of long-term conditions
- Primary mental health services (e.g. cognitive behavioural therapy)
- Direct access to X-ray, ultra sound, phlebotomy, and electrocardiogram (ECG) diagnostic services
- Kidney dialysis unit
- Community pharmacy

5.14 The running of the St Charles site will be a complex operation. Cllr Dr Hanham queried who would be the overall clinical lead at St Charles. The Sub-group heard that there will be an equivalent to a hospital's "Director of Operations" (with a clinical background) to ensure the site is run smoothly. The Sub-group was also told that all the different providers' staff would have common induction training.

5.15 It has been reported that Westminster PCT has claimed that the development of a polysystem hub at St Charles Hospital could mean their cross-border plans "would not make sense from a service or economic perspective".<sup>54</sup> However the Sub-group also heard that an alternative interpretation of Kensington and Chelsea PCT's plans gives the residents of Queen's Park the opportunity to look toward St Charles for services. Another complication, brought to the Sub-group's attention, was that the Urgent Care Centre at the Hammersmith Hospital could possibly move to the Westfield centre at Shepherd's Bush.

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<sup>54</sup> Pulse article: "NHS managers question viability of polysystems rollout" (8 February 10):  
<http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4124947&c=2>

*Recommendation (e): The PCT needs to ensure that its plans for polysystems are fully compatible with those of its surrounding PCTs. For example, plans for a polysystem based at St Charles take due consideration of services based at St Mary's and Hammersmith hospitals; and any potential for a polyclinic at the Charing Cross Hospital site will need to be co-ordinated with the plans for Earls Court.*

### **'South' Polysystem**

- 5.16 The south of the borough is more complicated as it does not have an obvious hub at the moment. Currently, the plans for a polysystem revolve around three centres (World's End health centre, Earl's Court health centre and Chelsea and Westminster hospital). NHS London is, however, keen for a large hub to be created in the south of the borough, and for this to proceed quickly. Consequently, an affordability and feasibility study has been commissioned by the PCT in order to scrutinise the options for development. However it is uncertainty that makes definitive planning difficult for the PCT. For example, there is uncertainty whether Charing Cross or Chelsea and Westminster hospitals will be designated as "Major Acute Hospitals". However, change could bring opportunities for polyclinics. The Sub-group noted that whatever the future may bring for the rationalisation of A&E departments in N.W. London, there will be a strong place for Chelsea and Westminster hospital. Chelsea and Westminster already provides specialist services in paediatric cardiology; burns; maternity; and HIV and sexual health.

*Recommendation (g): The PCT should make full use of any opportunities for polyclinics that arise from hospitals not receiving Major Acute Hospital status. A stronger steer from NHS London and the NWL Commissioning Partnership would help.*

### **Monitoring change**

- 5.17 With all the changes proposed for moving patients from a hospital setting to the community, the PCT will need to carefully watch the changing landscape of demand and provision of services to ensure that patients are provided with the best and most appropriate services.

- 5.18 One of the key initiatives in the N.W. London Sector “Integrated Strategic Plan”<sup>55</sup> is “Development of a Primary Care led Urgent Care Centre at each A&E by 2013 which will shift 60% of emergency activity into polysystems” (page 33). The Sub-group noted that the Primary Care Foundation, which studied the work of GPs already working in emergency departments, found no evidence that providing primary care in emergency departments could tackle rising costs or help to avoid unnecessary admissions.<sup>56</sup> Dr David Colin-Thomé, National Director for Primary Care, admitted that the report provided a “realistic assessment of current primary care services within or alongside emergency departments.”

*Recommendation (f): The PCT should monitor closely the levels of demand for the new services, to ensure their performance matches that planned for changes in the movement of patients. The PCT needs to evaluate the patient flow changes from hospital to community settings, to know that the patient outcomes have improved.*

### **Out of hours**

- 5.19 In response to an enquiry from Cllr Dr Hanham about the future provision of out-of-hours services, the PCT chief executive, Ms Wright, said that the Urgent Care Centre would be able to make direct referrals to the Chelsea and Westminster hospital, if in-patient care was required. GPs would continue to make out-of-hours home visits. Cllr Dr Hanham emphasised the importance of close out-of-hours working between health service and social care providers. Ms Wright referred to plans for workforce development to allow more flexible provision beyond traditional working hours.

### **Practice Based Commissioning<sup>57</sup>**

- 5.20 Under Practice Based Commissioning (PBC), GP Practices commission services as one consortium for Kensington and Chelsea. The consortium monitors expenditure throughout the

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<sup>55</sup> N.W. London Sector “Integrated Strategic Plan 2009 – 2014” (January 2010): [http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10\\_02\\_10\\_ae.pdf](http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_02_10_ae.pdf)

<sup>56</sup> The Primary Care Foundation report “Primary Care and Emergency Departments”: <http://www.primarycarefoundation.co.uk/page22/page28/page28.html>

<sup>57</sup> “PBC Connection” is a web based resource for clinical commissioning available at: <http://pbc.networks.nhs.uk/>

financial year, allowing remedial action to be taken. Ultimately, the PCT retains the power to take back any commissioning budget from a GP practice which fails to meet acceptable standards and is consistently overspent. To date, this has not been necessary. There are incentives in the system for GPs so that PBC begins to make an impact on the design of care - GPs keep 50% of savings, to be spent on primary care, and the other half of any surplus made by the consortium is passed back to the PCT.

**PBC Projects in Kensington and Chelsea in 2009/10<sup>58</sup>**

- Dermatology
- Minor Surgery
- Musculoskeletal (MSK) Triage Service
- Community Chronic obstructive pulmonary disease (COPD)
- Brain-type Natriuretic Peptide (BNP)
- Anti-coagulation
- Prostate Disease - Prostate Specific Antigen
- Chronic Kidney Disease (CKD)
- Audiology
- Urogynaecology
- Primary Care Mental Health
- Community Services

5.21 PBC is said, in the White Paper "Our Health, Our Care, Our Say", to enable health practices to devote more resources to cost-effective services, including social care. PBC could encourage more joint commissioning between primary care and local authority teams in local areas. PBC could also increase the use of Health Act flexibilities. So far, Adult Social Care has carried out some work with the PBC group on work to prevent people going into hospital and on discharge from hospital.

**NHS Networks: 12 Principles for success in PBC<sup>59</sup>**

1. Ensure commitment, transparency and ownership, involving all stakeholders. This means whole systems based planning across SHA/PCT/PBC, all working together and

<sup>58</sup> This table is reproduced from information supplied by Dr Mark Sweeney, Chair, Kensington & Chelsea Practice Based Commissioning (PBC) Group when he gave a presentation to the HSC on 18 November 2009

<sup>59</sup> NHS Networks: 12 principles for success in PBC (20 April 2010)  
[http://pbc.networks.nhs.uk/uploads/capability\\_framework\\_providers\\_network\\_success\\_principles\\_april\\_20101v1.pdf?utm\\_source=Sign-Up.to&utm\\_medium=email&utm\\_campaign=194609-NHS+Institute+Alert+-+April+2010](http://pbc.networks.nhs.uk/uploads/capability_framework_providers_network_success_principles_april_20101v1.pdf?utm_source=Sign-Up.to&utm_medium=email&utm_campaign=194609-NHS+Institute+Alert+-+April+2010)

relating directly to the operating plan.

2. Plan on building long term relationships between PCT and PBC. Take the time to develop good working relationships between consultants and clinicians, local authorities and other clinical providers such as pharmacists and allied health professionals. By continually building and maintaining these vital links across all stakeholders you are better able to consider all points of view and develop whole system planning.
3. Create a compact between PCT and PBC, confirming that both are committed to PBC, visibly and measurably. This will establish an agreed reality - a collective understanding of what the picture looks like and how success is measured. With agreed shared objectives, KPIs and outcomes between clinical commissioners and PCT officers, you enable everyone to get to the same goal and provide the foundation to reward success.
4. Make the person leading PBC senior enough to influence the CEO while also able to conduct effective interaction with GPs. With a PBC champion at board level, they can drive change and be an advocate for business cases.
5. Understand that this process should be led by patients' needs. Change managers should be helping the commissioners to articulate what the system needs and making the conditions right to enable agreement on what needs to happen.
6. Managers should be fully informed on the cost of failure versus the cost of doing nothing. Understanding the impact on the individual patient will enable better decisions.
7. Agree to work with the information you have. Move forward together positively, accepting the imperfections and working to overcome these in time.
8. When the situation seems at its most difficult, stop. Establish time and space to step back and look at what you are doing as a team, take stock and decide what to do to improve together before you move on.
9. Demonstrate strong leadership in forward thinking by creating a culture of prevention and enable future savings by working on predictive measures at patient level.
10. Identify and challenge the barriers for GPs to develop PBC skills and for PCT managers to let go of previous ways of working. There is a lot of fear that needs to be addressed.
11. Be prepared to take a risk and use the support available to enable people to capture the 'if onlys' and ask 'why not?'. By providing support and allowing people time and space to address the difficult issues you start to build and develop capability.
12. Identify, recognise and share good practice illustrating how world-class commissioning and PBC can look when working well. By encouraging the spread of what is successful, such as the composition of a board or the minimum staffing levels or resources required to enable PBC, you reduce time.

5.22 GPs, as part of the GP contract, are funded to employ business managers to support their business. As independent practitioners, it is their responsibility to organise their own business. The PCT only gets involved if there is an issue of poor performance, or lack of contract compliance.

5.23 There is an inherent tension between the GPs as commissioners and providers. Any separate PBC provider unit will have a separate constitution and membership from the commissioning consortium and will be expected to organise it and manage it without PCT support. The PCT will be mindful of any potential conflicts of interest, or suppression of patient choice arising from

GP provision of services. The DH has put rules and guidance in place to help manage this tension.

- 5.24 There seems to be a political appetite to extend GP involvement in commissioning. However the government's financial watchdog has warned that the future of PBC is in jeopardy unless the quality of data available to commissioners improves. This is recognised as a national problem and addressed in the national contract.

### **Dentists, pharmacists and opticians**

- 5.25 The PCT directly commissions dentists, pharmacists and opticians. From the Operating Framework 2010-2011, central budgets for ophthalmic services and pharmacy will be devolved to PCTs (primary dental care has already been devolved). Funding will be allocated at 2009/10 cash levels; funding for growth required for 2010/11 will come from savings made by PCTs as a result of lower tariff prices.

### **NHS Dentistry**

- 5.26 Over the last two years, the PCT has decommissioned three NHS dentists due to poor contractual compliance, leaving them with 16 NHS dentists. However their strategy is to increase quality and capacity by a mixture of approaches and so they have procured: a three-chair dental service in the central part of the borough (opened in May 2010); an additional 16,000 Units of Dental Activity (UDA) over two years from two companies who traditionally have not treated NHS patients (via any willing provider); 11,500 UDAs from a new community dental service to provide services to vulnerable patients as part of the St Charles Hospital polysystem. They are planning a two-chair practice procurement as part of Earls Court polysystem to open in autumn of 2010, and three-chair NHS dental services to open in December 2010. The HSC carried out a "Review of dentistry in Kensington and Chelsea"<sup>60</sup> in 2009.

### **Community Pharmacy**

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<sup>60</sup> The HSC report, "Review of dentistry in Kensington and Chelsea" (2009): [http://www.rbkc.gov.uk/Content/HTTPSQA\\_HNHDS/4c43b45c/4bab9f717cbd405000257647005d8a8d/6b41fa706e1a4d4100257647005d8a8d/28507.pdf](http://www.rbkc.gov.uk/Content/HTTPSQA_HNHDS/4c43b45c/4bab9f717cbd405000257647005d8a8d/6b41fa706e1a4d4100257647005d8a8d/28507.pdf)

5.27 The PCT has 38 community pharmacies in the borough. The biggest challenge to community pharmacies is the lack of high quality accessible premises. This has restricted the number of enhanced services commissioned. A new community pharmacy is being commissioned at St Charles Hospital.

### **Opticians**

5.28 There are 23 opticians in Kensington and Chelsea with NHS contracts. However these are presently national contracts administered via Family Health Services.

### **THE PCT COMMISSIONS COMMUNITY SERVICES**

5.29 Community services include<sup>61</sup> District Nursing, health visiting, community rehabilitation and speech and language therapy. Specialist nursing includes continence, tissue viability and HIV, as well as school nursing and children's community nurses. Nursing home, inpatient rehabilitation and palliative care provision are also provided.

5.30 As PCTs split their commissioning from their provider services, community services have been put together in a number of different ways across London.

5.31 Back in 2008, the HSC recommended an options appraisal that included partial integration models such as dividing-up provider services between the acute sector providers, the Royal Borough, GPs and third sector."<sup>62</sup> An option appraisal was undertaken and presented to the three PCT Boards in January 2009.<sup>63</sup> This considered five options: Community Foundation Trust; Integration with Acute Trust; Primary Care Trust Autonomous Provider Organisation; Social Enterprise; and (For-profit) Private Enterprise - either stand-alone or to tender all services to an

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<sup>61</sup> CLCH services are listed at: <http://www.clch.nhs.uk/services/index.html>

<sup>62</sup> The "Review of Kensington and Chelsea PCT's Commissioning Priorities" report was published in June 2008:

<http://www.rbkc.gov.uk/councilanddemocracy/howwemakedecisions/scrutinycommittees/idoc.ashx?docid=5a9120e4-877a-41bb-8f50-cb52ddcd613e&version=-1>

<sup>63</sup> The paper, "Recommendation for Future Organisation Form - Outcome of the Option Appraisal", presented to the PCT Board on 19 January 2009, is available at:

<http://www.kc-pct.nhs.uk/corporate/meetings/2009/1/documents/2211OutcomeofOptionsAppraisal.pdf>

existing private/voluntary sector entity. This appraisal should have included partial integration models.

- 5.32 The "NHS Operating Framework for England for 2010/11"<sup>64</sup> required "prompt [by March 2010] and clear decisions to be made about the future shape of provider organisations so that we can get on with delivering the benefits to patients" (Page 3). In November 2009, David Nicholson, Chief Executive of the NHS, proposed the idea of "vertical integration" in which hospital trusts take on community services rather than setting up new organisations, and described the idea of many PCT provider arms becoming independent as "nonsense".<sup>65</sup>
- 5.33 Much managerial time and resources were spent in 2009 to create an independent provider organisation locally – "Central London Community Healthcare"<sup>66</sup>. This organisation provides a range of community services in Kensington and Chelsea, Westminster and Hammersmith & Fulham.
- 5.34 There is still uncertainty about the future provision of provider services. Central London Community Healthcare's (CLCH) application to become a Community Trust was submitted to NHS London at the end of January 2010, and on to the NHS Transactions Board at the DH on 16 March. Also, NHS Barnet has recently selected CLCH as their preferred future host for their Community Services - there will be a period of due diligence and consultation before final decisions are made, with a possible merger in 2011.
- 5.35 Going further forward into the future, a number of organisations will be able to tender to provide these services to the PCT for each of the community service workstreams. The PCT will need to examine the best provider for the optimum future provision of community services from the plurality of providers. In this context, the McKinsey report<sup>67</sup> claimed that, if productivity could

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<sup>64</sup> "NHS Operating Framework for England for 2010/11":

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_110107](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107)

<sup>65</sup> Health Service Journal article: Independent provider arms 'nonsense', David Nicholson says: <http://www.hsj.co.uk/5009027.article>

<sup>66</sup> Central London Community Healthcare website: <http://www.clch.nhs.uk/index.html>

<sup>67</sup> Nursing Times article, "Nursing ripe for efficiency drive, says report": <http://www.nursingtimes.net/whats-new-in-nursing/acute-care/nursing-ripe-for-efficiency-drive-says-report/5005907.article>

be increased, the NHS could provide the same level of district nursing services as at present with 15 per cent fewer nurses.

- 5.36 As the community services market opens up, there are risks to Central London Community Healthcare as the less efficient lines of work may no longer be commissioned, affecting the financial stability of the organisation as a whole. There is a possible knock-on risk for NHS Kensington and Chelsea if they are still hosting Central London Community Healthcare when the market is opened up.

*Recommendation (g): The PCT should move quickly to a position where it can commission the best provider, from a plurality of providers, to optimise the provision of each of its community service lines.*

### **THE PCT COMMISSIONS MENTAL HEALTH SERVICES**

- 5.37 The Central and North West London NHS Foundation Trust (CNWL) is the main provider of mental health services for adults, older people and children across the borough. It also provides specialist substance misuse services. Services are currently consortium-negotiated by the PCTs and Councils inside the region of Central and North West London. A case can be made that there should be more scope for competition. There is a cost-per-case arrangement, and funding in Kensington and Chelsea is shared between the PCT and the Royal Borough. There are shared and pooled funding arrangements to supply high-support accommodation for people with mental illness and to fund voluntary sector activity, including management of service user networks.

*Recommendation (h): The PCT should examine the scope for increasing provider competition in the provision of mental health services – in particular, options for service line management.*

### **THE PCT COMMISSIONS JOINTLY WITH THE LOCAL AUTHORITY**

- 5.38 The PCT and the Council can do much commissioning for Kensington and Chelsea residents together. For example, Learning Disability commissioning has been delivered on the PCT's behalf by the Borough since 2003 and the budget was transferred to the Royal Borough in April 2009. Mental health,

substance misuse, children and young people's services, and services for older people are all jointly planned with the Borough. A new Joint Commissioning Board was established in 2009 strategically to align still further the work of the PCT and the Borough. The PCT and Royal Borough are in the process of developing joint commissioning arrangements for carers, voluntary sector and children's services.

5.39 There is scope for further investigation of the join-up of commissioning between the two agencies. The Sub-group heard discussions had taken place with the Council's Chief Executive, Mr Derek Myers, on possible joint posts with the PCT.

5.40 In February 2010, London's boroughs set out a list of demands for new responsibilities that should be devolved to local government after the general election. Chief amongst the proposals in the Manifesto for Londoners<sup>68</sup> produced by London Councils is the devolution of responsibility for providing healthcare and welfare services, including:

- The non-acute budgets of PCTs should become accountable to the London borough in which they operate. National government would set the framework to meet national standards. London boroughs would join-up care budgets to provide integrated commissioning of all these services in support of choices made by patients and their GPs.
- To improve public accountability, governance would be integrated with overlapping membership of PCT boards and London boroughs.
- In the longer term, legislation would be required to integrate these non-acute PCT responsibilities in London local government, offering direct democratic accountability and unified governance.

5.41 A pan-London Health Integration Board has been established to identify ways of supporting and progressing greater integration between boroughs and PCTs. Membership includes chief executive-level representatives from a number of boroughs and PCTs, NHS London and Department of Health representatives, the Chair of London ADASS, and London Councils officers. The Board is looking to support work to bring about deeper

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<sup>68</sup> London Councils' "Manifesto for Londoners"  
<http://www.londoncouncils.gov.uk/aboutus/corporatepublications/manifesto/default.htm>

borough/PCT integration and to promote joint commissioning and related activity in London.

- 5.42 Ruth Carnall, Chief Executive of NHS London, attended London Council's Leaders' Committee on 9 March 2010. Strengthening commissioning through partnerships and integration between PCTs and boroughs in London was discussed.<sup>69</sup> The Chairs and Chief Executives of NHS London and London Councils have agreed that the pace of reform on work around borough-based commissioning needed to be quickened - including rapid preliminary work with a small number of boroughs and PCT chief executives to develop options aimed at accelerating and deepening borough/PCT integration.
- 5.43 The PricewaterhouseCoopers report, commissioned by London Councils, "Total Place – towards a new service model for Londoners"<sup>70</sup> looked at the issue of chronic care in the Capital. They found potential savings of 18 per cent by enabling closer working between the NHS and social services.

*Recommendation (i): The HSC recommends that the PCT and the Council carry out further work to consider areas where they can jointly improve commissioning for Kensington and Chelsea residents.*

- 5.44 The NHS Operating Framework for 2010/11<sup>71</sup> states: "In the current economic climate, it is appropriate that the NHS with the other public services goes further and deeper in making efficiencies to contribute to returning the economy to balance in the timescales identified in the Pre-Budget Report. Our ambition is to achieve very substantial efficiency savings by 2010/11 . . . Accordingly, both [primary care trusts] and NHS trusts will be expected to explore the opportunities identified under the cross-government Operational Efficiency Programme, where further

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<sup>69</sup> The paper, "NHS London – Strengthening commissioning through partnerships and integration" was discussed at the London Councils Leaders' meeting on 9 March 2010:

<http://www.londoncouncils.gov.uk/London%20Councils/Item4NHSLondonStrengtheningcommissioning.doc>

<sup>70</sup> London Councils Report, "Total Place – towards a new service model for Londoners" <http://www.londoncouncils.gov.uk/media/current/pressdetail.htm?pk=926&showpage=-1>

<sup>71</sup> "NHS Operating Framework for England for 2010/11": [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_110107](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107)

efficiency savings can be secured from 2010/11." These include greater use of shared services for back-office operations such as finance and human resources; increased use of collaborative procurement; and more commercial and efficient use of assets, particularly property.

- 5.45 The previous Communities Secretary, John Denham, told the Guardian newspaper that huge savings could be made in the cost of local services by looking at spending on all the local public services in an area through a "Total Place" approach: "An average saving of around 5-6 per cent just through better use of assets across the pilot suggests that this could potentially save in the region of £20bn nationally. Rather than services protecting their own territory and budgets, it means switching resources between different providers. This cuts out duplication, waste and bureaucracy, saving professionals' time and services' money – running into millions of pounds – which can be reinvested." <sup>72</sup> Also according to "Sharing the Gain: Collaborating for Cost Effectiveness"<sup>73</sup> from the Chartered Institute for Public Finance and Accountancy, the NHS and Royal Borough could make big efficiency savings by sharing services. Apart from talking about polysystems for health and social care, the PCT makes little reference to "Total Place" in its Commissioning Strategy, nor to any of the benefits that might accrue from its implementation.

*Recommendation (j): The HSC recommends that the PCT and the Council carry out further work to consider areas where they can share services and save costs.*

## **SPECIALIST CONSORTIUM COMMISSIONING**

- 5.46 A number of treatments are commissioned on a regional or national basis. PCTs are represented on regional specialised commissioning groups, which in turn feed into the national specialised commissioning group.

## **ACUTE COMMISSIONING**

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<sup>72</sup> Guardian article, "Denham targets £20bn in council cost-cutting" (22 February 2010): <http://www.guardian.co.uk/politics/2010/feb/21/denham-targets-20bn-council-savings>

<sup>73</sup> The document, "Sharing the Gain: Collaborating for Cost Effectiveness" and associated toolkit are available to download at: <http://www.cipfa.org.uk/sharingthegain/>

5.47 Acute commissioning decisions are, in the main, made at: (i) the London level; and (ii) the N.W. London level.

**(i) London-wide**

5.48 The Carter review of specialised commissioning proposed a more formal governance arrangement for London specialised commissioning.

5.49 London's 31 PCTs are grouped into six sectors. In March 2009, NHS London named six PCT Chief Executives and six Chairs (Kensington and Chelsea PCT's Chair Peter Molyneux is Chair of the N.W. London sector) to lead commissioning and performance management of hospital services for the whole of London (described by the Health Service Journal<sup>74</sup> as an "inner cabinet"). HSJ reported on 26 February 2010, "NHS London is taking a tighter hold of its many primary care trusts by employing the capital's lead commissioners as directors of the strategic health authority. Five of the existing six acute commissioning sector leads – who have so far split their time with running their PCT – will be made into full time directors for their patch . . . They will remain employees of their PCTs as well as NHS London, but their PCT roles will be covered by deputies." <sup>75</sup> However, the N.W. London sector will not be represented in this way. "The north west London sector will be led by NHS London deputy chief Anne Rainsberry, with Westminster PCT chief executive Michael Scott returning to his PCT full time . . . The new chiefs will be responsible for all performance management in their patch."<sup>76</sup>

5.50 Information on acute services is gathered on a London-wide basis by the Commissioning Support for London (CSL) hub. The CSL provides expert commissioning support on a pan-London basis.

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<sup>74</sup> Health Service Journal article, "London names 'inner cabinet' PCT chiefs": [http://www.hsj.co.uk/jsp/tracking.jsp?a=L&p=\\$in\\_PbpjYyCqTROuU7WRPQPU8tCg5R-2rANqAPkYAFjofY7wkocq2mN7wNa7VN011muXGsVE3o8Q\\$](http://www.hsj.co.uk/jsp/tracking.jsp?a=L&p=$in_PbpjYyCqTROuU7WRPQPU8tCg5R-2rANqAPkYAFjofY7wkocq2mN7wNa7VN011muXGsVE3o8Q$)

<sup>75</sup> Health Service Journal article: NHS London makes lead commissioners directors (25 February 2010) <http://www.hsj.co.uk/news/primary-care/commissioning/nhs-london-makes-lead-commissioners-directors/5011804.article>

<sup>76</sup> Health Service Journal article: NHS London makes lead commissioners directors (25 February 2010) <http://www.hsj.co.uk/news/primary-care/commissioning/nhs-london-makes-lead-commissioners-directors/5011804.article>

- 5.51 The "Healthcare for London"<sup>77</sup> review informs all London PCTs' Commissioning Strategies.
- 5.52 London PCTs have given the London Specialised Commissioning Group responsibility for commissioning services. In addition, the Commissioning Group has been given responsibility for commissioning major trauma services.<sup>78</sup>

*Recommendation (k): The respective functions of the pan-London and the sector-wide commissioning partnerships will need to be clearly distinct to ensure that relationships are complementary.*

### **(ii) North West London Commissioning Partnership**

- 5.53 Acute commissioning is based on clinical need and clinical effectiveness - for example agreeing appropriate numbers of outpatient attendances following surgery, or new pathways of care. In practice, acute commissioning is entirely demand-driven - patients are referred to secondary care as their condition requires. The over-emphasis on "historic" patient flows/referrals is a potential constraint to new commissioning patterns that respond to needs.
- 5.54 PCTs have found it difficult to reduce the percentage of expenditure devoted to acute commissioning. PCTs have so far failed to control demand for hospital services by transferring care into the community, research from the Audit Commission has found. Their report "More for Less"<sup>79</sup> said all of the 6.5 per cent increase in PCT funding in 2008-09 was swallowed up by acute trusts, despite the increase in the tariff being much less at just 2.3 per cent. This was because the number of inpatients increased by 4 per cent and the number of outpatients by nearly 8 per cent - eating up all of the 4.1 per cent real terms gap between NHS commissioners and acute providers. The report

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<sup>77</sup> More information on the "Healthcare for London" review:

<http://www.healthcareforlondon.nhs.uk/>

<sup>78</sup> Taken from the paper, "Review of London PCT collective working arrangements" presented to the Kensington and Chelsea PCT Board on 24 November 2009:

<http://www.kc-pct.nhs.uk/corporate/meetings/documents/5.5.3ReviewofLondonPCTCollectiveWorkingarrangements.pdf>

<sup>79</sup> Audit Commission report, "More for Less: Are productivity and efficiency improving in the NHS?": <http://www.info4local.gov.uk/filter/?item=1381353>

says these figures “suggest that PCTs made little or no inroad in 2008-09 to transferring care from hospital or in dampening demand”.

- 5.55 For NHS Kensington and Chelsea, the main two acute hospital trusts are: (1) The Chelsea and Westminster NHS Foundation Trust (within the borough), which provides a wide range of specialist and acute hospital services with 24-hour accident and emergency departments (2) Imperial College Healthcare NHS Trust, which has formed a single Academic Health Science Centre. St. Mary’s Hospital (outside the borough) and Hammersmith Hospitals including Charing Cross (outside the borough) both provide a wide range of specialist and acute hospital services with 24-hour accident and emergency departments.
- 5.56 Guidance on the Commissioning for Quality and Innovation Network (CQUIN) framework was included in the Operating Framework 2010-11. DH CQUIN framework policy lead Flora Swanborough<sup>80</sup> has said that PCTs are encouraged to avoid duplicating basic contractual requirements in CQUIN schemes. The aim was to have one scheme per provider, and it was therefore important for commissioners to work together to achieve this, for example, along clinical pathways.
- 5.57 A N.W. London Commissioning Partnership has been formed to commission acute care for all PCTs in the sector, comprising Brent, Ealing, Harrow, Hounslow, Hillingdon, Hammersmith & Fulham, Kensington & Chelsea and Westminster. The PCT acute commissioning decisions are now done collectively for the eight PCTs in N.W. London. The Partnership will determine a viable provider landscape configuration in the sector, agree acute sector contracts and performance monitor and manage acute sector contracts. The partnership is overseen by a single Joint Committee of PCTs, a single Chair (Kensington and Chelsea PCT Chair, Peter Molyneux) and NHS London deputy chief (Anne Rainsberry). Commissioning in a consortium potentially reduces the scope for the PCT to act in its own interest.

## **6. TIME OF CHANGE?**

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<sup>80</sup> More detail is available in the Health Service Journal article, “Commissioners must be more 'ambitious' in CQUIN schemes”: <http://www.hsj.co.uk/5009306.article>

## **N.W. London Sector – Integrated Strategic Plan** <sup>81</sup>

- 6.1 The NHS in N.W. London is required to develop a five-year Integrated Strategic Plan (ISP). The ISP incorporates the eight PCTs' Commissioning Strategies. The ISP will take forward the work to deliver the "Healthcare for London – a Framework for Action".
- 6.2 The re-configuration will be a move towards more specialised centres of excellence (aiming at "centralising where necessary") and towards more localised primary care services delivered through polyclinics/polysystems (aiming at "localising where possible"). An NHS London spokesman<sup>82</sup> said: "To give Londoners a better standard of NHS care we need to provide more of the services people use the most, closer to where people live . . . To give people leading expert care we also need to centralise some services to create, for example, dedicated stroke and trauma units."
- 6.3 There is likely to be dramatic change for many acute hospitals in N.W. London over the next few years.
- 6.4 Information was leaked to the press in January 2010 - so the weight given to it must be considered in this light: The N.W. London Commissioning Partnership had developed an acute (hospital) services chapter of a draft ISP (January 2010). This plan referred to a requirement for N.W. London to have three Major Acute Hospital (MAH) sites. NHS London responded to the draft ISP (January 2010) with "a concern that 3 MAH sites are clinically and financially unsustainable". NHS London calls for "a maximum of 3 MAHs in order to prepare the ground for the next stage".<sup>83</sup> NHS London has also commented, "your plan needs to consider the importance of clinical adjacencies in building up the MAH proposals. This approach ensures that the most optimal model is developed and that the drivers for change in one specialty do not become pre-eminent at the potential expense of others. Related to this, your plan should signal the intention to develop proposals for a single major acute site run by Imperial

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<sup>81</sup> Draft N.W. London Sector "Integrated Strategic Plan 2009 – 2014" (January 2010): [http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10\\_02\\_10\\_ae.pdf](http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_02_10_ae.pdf)

<sup>82</sup> BBC News: "London healthcare 'heads towards crisis', say doctors" <http://news.bbc.co.uk/1/hi/england/london/8469907.stm>

<sup>83</sup> NHS London response to draft NWL ISP (Jan 2010) [http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10\\_02\\_10\\_nhsl.pdf](http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_02_10_nhsl.pdf)

College Healthcare NHS Trust in inner N.W. London, taking account of the decisions taken on major trauma and stroke following consultation earlier last year."<sup>84</sup>

6.5 Imperial College Healthcare NHS Trust is currently planning:

- A trauma centre at St Mary's Hospital.<sup>85</sup>
- A Surgical Innovation Centre, through the redevelopment of the Paterson Centre, at St Mary's Hospital.<sup>86</sup>
- A hyper-acute stroke centre at Charing Cross Hospital.
- A new cardiology centre at Hammersmith Hospitals.

### **Trauma and stroke**

6.6 Everywhere else in London (apart from the North West) has co-located trauma services with hyper-acute stroke services. This is because (1) both trauma and hyper-acute stroke services need to be organised with neurology and (2) there is increased potential for confusion for ambulance services with more than one site (e.g. there will need to be additional training for London Ambulance Service personnel to ensure correct diagnosis).

*Recommendation (I): The HSC supports Imperial College Healthcare NHS Trust in its endeavours to co-locate services optimally to give the best patient outcomes working towards NHS London's vision for a Major Acute Hospital. The original Healthcare for London proposal was for the local hyper acute stroke centre to be based alongside the major trauma centre.*

### **Cardiovascular service in London**

6.7 In February 2010, Healthcare for London published its "Cardiovascular Services - Case for change"<sup>87</sup>. There are a

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<sup>84</sup> NHS London response to draft NWL ISP (Jan 2010)

[http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10\\_02\\_10\\_nhsl.pdf](http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_02_10_nhsl.pdf)

<sup>85</sup> The business case to support the establishment of the Major Trauma Centre was also approved by Imperial College Healthcare Board on 25 November 2009.

[http://www.imperial.nhs.uk/prdcons/groups/public/@corporate/@communications/documents/doc/id\\_024010.pdf](http://www.imperial.nhs.uk/prdcons/groups/public/@corporate/@communications/documents/doc/id_024010.pdf)

<sup>86</sup> The business case for a Surgical Innovation Centre was approved by Imperial College Healthcare Board on 25 November 2009.

[http://www.imperial.nhs.uk/prdcons/groups/public/@corporate/@communications/documents/doc/id\\_024010.pdf](http://www.imperial.nhs.uk/prdcons/groups/public/@corporate/@communications/documents/doc/id_024010.pdf)

<sup>87</sup> Healthcare for London "Cardiovascular Services - Case for change":

number of the “key messages” that are about the need for more specialist treatment. For example:

#### **Vascular services**

- The current distribution of abdominal aortic aneurysm surgery across London is not appropriate. About 75% of surgery takes place in six hospitals and 25% is spread across the remaining hospitals.
- Patients achieve the best outcomes following arterial surgery if it is done at a high volume hospital, by a vascular specialist team including surgeons and radiologists.
- As well as saving lives, there are potential cost savings and improvements to patient experience if arterial surgery is undertaken in considerably fewer, high volume hospitals in London.
- The length of stay for patients following vascular surgery varies hugely across the capital and the UK has the longest length of stay in Europe for elective aneurysm surgery. The NHS in London can improve patient experience by performing vascular surgery at specialist units and by adopting better surgical technologies, which are proven to reduce lengths of stay.

#### **Cardiac surgery**

- Patient mortality following cardiac surgery in London is low. To achieve the best outcomes, expertise in some specialist procedures needs to be concentrated amongst fewer surgeons.
- To improve the quality of surgery and promote mitral valve repair over replacement in patients with degenerative mitral valve disease, mitral valve surgery in London should be performed by fewer, specialist surgeons.

6.8 The document also talks about services that should be co-located:

- A quality vascular service needs a range of co-dependent clinical services to achieve the best outcomes and use of resources, e.g. when an ablation is being undertaken, the physician should have access to a cardiac or thoracic surgeon, in the event that sternotomy with cardiopulmonary bypass is required.
- The future provision of vascular services in London needs to ensure that patients who have a major injury or a stroke receive the quality of care they need. It is likely that to achieve this, the format of where and how vascular services

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<http://www.healthcareforlondon.nhs.uk/assets/Cardiovascular/Cardiovascular-case-for-change.pdf>

are provided will need to consider the changes to major trauma and stroke services in London.

- 6.9 The Imperial College Healthcare NHS Trust Chief Executive has said, "As part of the implementation of Healthcare for London, recommendations have been made concerning vascular services. This will require a change in the plans of the highly specialised service which is planned to be located on the St. Mary's site and the more general vascular work, which will be expanded on the Charing Cross site."<sup>88</sup>

### **Cancer services in London**

- 6.10 Healthcare for London published its "Cancer Services - Case for Change"<sup>89</sup> in March 2010. The overarching theme in the case for change is that the lack of progress in implementing co-ordinated cancer services across London means that services may be excellent in some instances, but often provide patients with fragmented care. Excess deaths from cancer account for 20% of the life expectancy gap between the London spearhead groups and the rest of England.<sup>90</sup> The Case for Change will inform the next step of proposing a new model of care. At the centre of these changes will need to be the integrated commissioning of all cancer services, given that most services are highly dependent on each other.

### **London – Integrated Strategic Plan**

- 6.11 NHS London's "Delivering Healthcare for London - An Integrated Strategic Plan 2010-2015"<sup>91</sup> (January 2010) signals the direction of future provision of NHS services in London. The plan points

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<sup>88</sup> "Chief Executive/Principal Report" to the ICHT Board (February 2010):  
[http://www.imperial.nhs.uk/prdcons/groups/public/@corporate/@communications/documents/doc/id\\_024012.pdf](http://www.imperial.nhs.uk/prdcons/groups/public/@corporate/@communications/documents/doc/id_024012.pdf)

<sup>89</sup> Healthcare for London's "Cancer Services - Case for Change" is available on the Internet at:

[http://www.healthcareforlondon.nhs.uk/assets/Cancer/HealthcareforLondon\\_Cancer-services-case-for-change.pdf](http://www.healthcareforlondon.nhs.uk/assets/Cancer/HealthcareforLondon_Cancer-services-case-for-change.pdf)

Also, a "Case of Change - in Brief" is available at:

[http://www.healthcareforlondon.nhs.uk/assets/Cancer/HealthcareforLondon\\_Cancer-services-case-for-change\\_In-brief.pdf](http://www.healthcareforlondon.nhs.uk/assets/Cancer/HealthcareforLondon_Cancer-services-case-for-change_In-brief.pdf)

<sup>90</sup> London Health Observatory, The London Health Inequalities Forecast, 2006.

<sup>91</sup> NHS London report, "Delivering Healthcare for London - An Integrated Strategic Plan 2010-2015 (January 2010)":

<http://www.london.nhs.uk/publications/corporate-publications/delivering-healthcare-for-london--an-integrated-strategic-plan-2010-2015>

out that the quality of healthcare services remains inconsistent and does not support London's status as a world city. For example, in the London region:

- There are more hospital beds than average;
- 15% of the NHS estate is under-utilised;
- London's primary care provision is the worst-performing region in the country on 16 out of 19 indicators;
- There is an over-reliance on A&E, and inconsistent clinical standards.

6.12 The plan also notes that the current overall budget surplus in the London health economy masks chronic financial under-performance by some individual trusts, as well as increasing demand for services and the costs of delivering them. The deficit will be apparent by 2011/12, and is projected to rise to between £3.8 billion and £5.1 billion by 2016/17. In addition, 15% management overhead savings will be required across NHS London in each of the next two years. The delivery of the Healthcare for London proposals is considered vital to addressing this financial position.

6.13 The Sub-group noted that much of the success of the Integrated Strategic Plan for London depends on successfully rolling out the polyclinics (and polysystems/hub working) but the report says: (1) A business model for them needs to be created (2) the workforce needs to be trained (3) an integrated IT system is needed and (4) no budget is mentioned for any double-running costs.

6.14 The Sub-group would have liked the opportunity to have asked NHS London, "How are you going to judge the success or failure of the ISP? What measures will be used to understand if the plans are working?"

### **British Medical Association (BMA) comments on proposals for London**

6.15 The BMA's report, "London's NHS on the Brink"<sup>92</sup>, is critical of many proposals that it says NHS London has made public, including:

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<sup>92</sup> BMA Report, "London's NHS On the Brink":  
[http://www.bma.org.uk/images/onthebrinkreport2010\\_tcm41-193388.pdf](http://www.bma.org.uk/images/onthebrinkreport2010_tcm41-193388.pdf)

- Cutting the number of people going to hospital A&E departments by a target of 60% and the number going to hospital outpatients by 55%
- Diverting millions of patients to "unproven polysystems" or clinics that have not yet been built
- Cutting up to £1.1bn from London hospital budgets "forcing wide scale cutbacks and closures"
- A 66% reduction in staffing of "non-acute services", including community services for older people, and district nurses
- A 33% cut in the length of GP appointment times

### **"Health Care in London" debated in the House of Commons**

6.16 "Health Care in London" was debated in the House of Commons on 9 March 2010.<sup>93</sup> Andrew Lansley (appointed subsequently as the new Secretary of State for Health) moved a motion that called on "NHS London to halt the implementation of current sector-wide reconfiguration proposals across London, including accident and emergency services, until a more effective public consultation is in place." In the debate he also showed scepticism towards the planned development of polyclinics across the capital: "It is astonishing that nowhere in the NHS London document does it say anything about the cost of establishing those polyclinics."

*Recommendation (m): The PCT should take due consideration of the potential for a different political approach to healthcare reconfiguration in London, including polyclinics, that could arise from the new Conservative-Liberal Democrat coalition government.*

### **New government**

6.17 Andrew Lansley has outlined his ambitions for the NHS - set out in the box below. The Conservative-Liberal Democrat Coalition's plans for the NHS are set out in Appendix 4.

**Andrew Lansley outlines NHS ambitions in his first official statement after taking up his post as Secretary of State for Health<sup>94</sup>**

<sup>93</sup> "Health Care in London" debate in the House of Commons on 9 March 2010. <http://www.theyworkforyou.com/debates/?id=2010-03-09d.160.1>

<sup>94</sup> HSJ: Andrew Lansley outlines NHS ambitions (13 May 2010)

"It is an immense privilege to be appointed Secretary of State for Health in the new government.

Just as Britain needs strong and stable government, so we intend to bring to the NHS the consistent, stable reform, which enables it to deliver improving quality of care to patients.

I have met many people working in the NHS and social care; I know they want to focus on patients and to be accountable for the results they achieve.

I am determined that we will have an NHS in which the patient shares in making decisions, where quality standards are evidence based and form the basis of the design of services and their management, and where the objective is consistent improvement in the outcomes we achieve, so that they are amongst the best in the world."

To achieve this in the current financial crisis requires leadership and highly effective management. The NHS will be backed with increased real resources but with this comes a real responsibility. We will need progressively to be more efficient, to cut the costs of what we do now, to innovate and re-design, in order to enable us to meet increased demands and to improve quality and outcomes.

This will not happen in a top-down, bureaucratic system. Decisions must be taken with patients, close to patients and with clinical leadership at the fore.

If we are to succeed in improving the health service, we must also improve the public health of the nation. We must promote good health, stronger locally owned public health strategies and effective screening and prevention of disease.

We will create a more integrated public health service at the heart of healthcare policy. To improve health and wellbeing, we must offer support, security and services to those in need of personal and social care.

There is much to do. If I have learnt one thing over six-and-a-half years as shadow health secretary, it is that in the NHS we have an immense number of talented, committed and capable people, who want to be trusted to get on with the job. It will be my task to enable the NHS to do this, with our shared ambition to achieve the best healthcare service anywhere in the world."

## **National - McKinsey Report**<sup>95 96</sup>

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<http://www.hsj.co.uk/topics/new-government/andrew-lansley-outlines-nhs-ambitions/5014643.article>

<sup>95</sup> Health Service Journal article, "NHS cost-cutting: how to save £20bn by 2014"

<http://www.hsj.co.uk/5006104.article>

<sup>96</sup> Health Service Journal article, "McKinsey exposes hard choices to save £20bn"

<http://www.hsj.co.uk/5005952.article>

- 6.18 A report produced for the DH in March 2009 by McKinsey and Company (which was never placed formally in the public domain but was leaked to the Health Service Journal) provoked much media interest. NHS hospitals in England are rife with waste and inefficiency, consultants McKinsey told the DH in their confidential report<sup>97</sup>. The report identified “over-provision” in the NHS, and, in particular, large variations in performance between organisations. It sets out a number of ways in which the NHS could make savings of £20 billion.
- 6.19 McKinsey looked at the performance of GPs nationally, in terms of patient satisfaction and how many patients they see a week. They believe that the worst 10 per cent of GPs spend only 17 minutes in each hour with patients. This translates into only 77 appointments a week, compared with an average of 126.
- 6.20 The McKinsey report applied a similar methodology to district nurses. Its analysis found that although 15 per cent of the most productive district nurses make on average seven or more visits to patients in a day, almost a fifth make only four visits or fewer a day. On average, district nurses make 5.6 visits to patients a day. If the least productive increased their number of visits so that the overall average increased to 6.6 a day, they say the district nursing workforce could be cut by 15 per cent without any change in the number of patients seen.
- 6.21 The McKinsey and Co. report<sup>98</sup> included potential savings in community care, nationally, of up to 28%.
- 6.22 It claims for GP referrals to outpatient clinics, that up to £400m could be saved if referrals to specialisms such as general medicine were cut by almost half.
- 6.23 The report is clear that the bulk of the savings would need to come from the acute sector. It says a third of the total savings will come from “acute staff productivity”, such as if they made better use of their existing space or if they increased their number of beds per square metre in order to vacate space, which would then not need to be heated and maintained.

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<sup>97</sup> Health Service Journal article, “McKinsey cost-saving proposals focus on waste in acute sector”: <http://www.hsj.co.uk/5005785.article>

<sup>98</sup> Health Service Journal article, “DH is told 137,000 NHS posts must go in next five years”: <http://www.hsj.co.uk/5005782.article>

- 6.24 They also pointed out “inefficiencies” in the patient pathway, with 40% of patients in a typical hospital only there because of delays in tests or therapies, or lack of alternative services closer to home. They also said there is considerable wastage on unnecessary diagnostics, follow-up appointments, and treatments such as tonsillectomies, varicose vein removal and some hysterectomies.
- 6.25 The McKinsey report claims up to £700m is spent unnecessarily on hospital procedures from which there is limited clinical benefit. It suggests that some of these procedures could be cut by as much as 90 per cent. Such cuts to patient care could prove controversial, but McKinsey's research suggests a significant proportion of patients choose not to have certain procedures once they are guided through the full implications and likely outcome. For mastectomy procedures, the number of patients opting to have them almost halves. For others, such as prostatectomies, there is a quarter drop-out.

*Recommendation (n): All investment in activities that is not evidence-based should be re-examined before being resourced.*

- 6.26 The consultants<sup>99</sup> looked at the overall time nurses in hospital settings spent on patient care and other duties, with implications for the ratio between qualified and unqualified staff. The interpretation appears to be that more Health Care Assistants should be employed to carry out this work, while fewer registered nurses are needed for the more technical side of care.
- 6.27 They believe nearly £9 billion could be saved by 2013-14 from increasing productivity in hospitals and non-acute settings, and through driving down the costs of external suppliers and contractors.
- 6.28 The report sets out a range of advice to enable NHS organisations to achieve suggested savings:
- PCTs re-negotiate GP and provider arm contracts to drive down costs.
  - Increase the productivity of the least well-performing GPs. The least productive GPs have only 77 appointments per

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<sup>99</sup> Nursing Times article, “Nursing ripe for efficiency drive, says report”:  
<http://www.nursingtimes.net/whats-new-in-nursing/acute-care/nursing-ripe-for-efficiency-drive-says-report/5005907.article>

week, while the average is 126. If the worst improved, the same number of patients could be seen with 3,500 fewer GPs, saving the NHS almost £400m a year.

- Stop or reduce elective procedures that are ineffective (e.g. tonsillectomy, cosmetic (e.g. tattoo removal), have a narrow margin between risk and benefit (e.g. knee joint surgery) or where other interventions should be tried first (e.g. hysterectomy for non-cancerous heavy menstrual bleeding).
- Explore the use of alternatives to reduce routine referrals to outpatient appointments.
- Reduce variability in outpatient referrals.
- Review how much of nurses' time is spend with patients. Of the 25 minutes per hour acute and general ward nurses spend with patients, only 15 minutes is spent on "physical care" as opposed to "psychosocial care".
- Increase district nurses' patient-facing time. For example the number of district nurses could be reduced by 15 per cent if the average number of visits increased from 5.6 to 6.6 per day.
- Increase clinical productivity. The least productive 10 per cent of doctors and nurses see a fifth of the patients seen by the most productive 10 per cent.
- Increase the rate of patients treated as day cases. In some specialties, such as gynaecology and breast surgery, the rate could be increased by 40 per cent.
- Reduce the variation in prescribing. The amount PCTs spend on prescribing per weighted head of population ranges from £85 to £192.
- Reduce unnecessary spending on supplies by £1.9bn. For example, GP supplies could be 15 per cent cheaper if they used national procurement contracts and the NHS Purchasing and Supply Agency. In some areas of procurement, e.g. microfilming and waste, the NHS is paying more than 40 per cent over the odds.
- Better joint working with the Council and/or other PCTs – PCTs do not "have to all re-invent the wheel" when carrying out national programmes. The National Audit Office<sup>100</sup> cited the fragmented approach to the government's Chlamydia screening programme for wasting millions of pounds of taxpayers' money.
- Not wasting NHS space - Spare land and buildings can be sold to make £8.3bn, and underused space should be put out of

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<sup>100</sup> National Audit Office report, "Review of the National Chlamydia Screening Programme": <http://www.info4local.gov.uk/filter/?item=1380830>

use to save £400m on heating and maintenance. Greater use of 'hot desking' could be made. The square metre to bed ratio could be cut.

*Recommendation (o): If it is necessary for the PCT to make substantive savings, it should investigate the potential for making savings in each of the following areas: PCT renegotiate GP and provider arm contracts; increase the productivity of the least well-performing GPs; stop or reduce elective procedures that are ineffective; explore the use of alternatives in order to reduce routine referrals to outpatient appointments; reduce variability in outpatient referrals; review how much of nurses' time is spent with patients to increase nurses' patient-facing time; increase clinical productivity; increase the rate of patients treated as day cases; reduce any variation in prescribing; reduce unnecessary spending on supplies; better joint working with Council and/or other PCTs; and not wasting NHS space.*

## **APPENDIX 1: TERMS OF REFERENCE AND MEMBERSHIP**

### **1. TERMS OF REFERENCE<sup>101</sup>**

1.1 *"This review would be intended to:*

- *Consider the Primary Care Trust's (PCT's) priorities in the light of the current financial climate, and any implications for future proposals;*
- *Focus on identifying and addressing particular areas for consideration, these include:*
  - *The future PCT's budgets after the general election; the cost of spend if current levels of activity (related to any adjusted changes in need) are maintained; and the possible gap;*
  - *The evidence on the range and quality of PCT commissioning for Kensington and Chelsea residents; including the use of Practice Based Commissioning (PBC);*
  - *Understanding of the current PCT priorities and the use of the Joint Strategic Needs Assessment (JNSA);*
  - *The future development of health community services.*
- *Suggest ways in which the PCT and its partners can improve efficiencies in commissioning; and,*
- *Make recommendations to the PCT as appropriate."*

### **2. MEMBERSHIP OF THE SUB-GROUP**

2.1 The Sub-Group for this review comprised: Councillor Terence Buxton; Councillor Christopher Buckmaster (Chairman of the Sub-Group); Councillor Dr Iain Hanham; Councillor Pat Mason; Councillor Mary Weale (representing the Housing, Environmental Health and Adult Social Care Scrutiny Committee); Mr John O'Donnell (representing the Family and Children's Services Scrutiny Committee); and Andreas Lambrianou (PCT Non-Executive Director).

2.2 The Council's officer support came from: Henry Bewley (Health Policy Officer) – Lead officer; and, Gavin Wilson (Governance Administrator). The review was also fully supported by officers from the PCT.

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<sup>101</sup> Agreed at the HSC on 28<sup>th</sup> January 2010.

## **APPENDIX 2: GOOD USE OF MANAGEMENT CONSULTANTS**

The NHS paid £350 million to management consultants in England in the year 2008-09.<sup>102</sup>

The House of Commons Health Committee Fifth Report of Session 2008-09 "The use of management consultants by the NHS and the Department of Health"<sup>103</sup> said "It is important to know whether the NHS and DH are getting value for money from the contracts agreed with management consultants" (page 6).

The Management Consultancies Association (MCA) in its report "Improving care, reducing cost"<sup>104</sup> suggests a number of ways of "Improving the use of consultants in the NHS" (page 17).

### **Improving the use of consultants in the NHS**

The focus should be on ensuring that the NHS gets the best possible value from Management consultants. The MCA believes that there are three things the NHS could do differently:

#### **1. Reduce its reliance on interim managers**

The resources the NHS requires to manage its business fall into three broad categories: fulltime employees, interim managers, and management consultants.

Like many other parts of the public sector, the NHS takes a long time to recruit people (whereas ministerial initiatives wait for no man) and finds it hard to attract people of sufficient calibre. It therefore makes substantial use of external labour, sometimes hiring back former employees on a temporary and more expensive basis. This problem is compounded by widespread confusion about the difference between interim managers and consultants, despite attempts by the National Audit Office and Office of Government Commerce to distinguish between the two. Interim managers fill a gap of months when a fulltime person cannot, for whatever reason, be found; typically, they cost less than consultants.

Consultants, because they bring specific expertise, are more expensive and are primarily used for discrete projects. As a result, money is wasted on paying interim managers which could be better used to attract good permanent staff.

To resolve this:

<sup>102</sup> The Times article, "NHS spent £350m on management consultants"

[http://www.timesonline.co.uk/tol/life\\_and\\_style/health/article6259718.ece](http://www.timesonline.co.uk/tol/life_and_style/health/article6259718.ece)

<sup>103</sup> This Health Committee's report, "The use of management consultants by the NHS and the Department of Health":

<http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/28/28.pdf>

<sup>104</sup> The Management Consultancies Association report, "Improving care, reducing cost":

<http://www.mca.org.uk/sites/default/files/MCA%20NHS%20Report%20FINAL.pdf>

- The NHS should change its recruitment policies and rules so that more high-quality people can be recruited quickly.
- It should examine accounting and budgeting procedures that allow managers to use temporary external labour while limiting their ability to recruit fulltime staff.
- Consulting firms should not seek to fill a long-term role in a client organisation with expensive consulting resource, but focus on shorter-term projects designed to deliver clear benefits.

## **2. Change procurement processes**

NHS procurement processes often fail to distinguish effectively between consulting and interim management services, encouraging expensive “bodyshopping” where more targeted consultancy work would be more cost-effective.

Moreover, the decentralised nature of the NHS means that consulting work is sometimes being duplicated. The situation could be improved by:

- Enabling the end-users of consulting services to debate their requirements with potential suppliers as a precursor to bidding for the work. “Competitive dialogue” has proved to be a useful tool in focusing in on what is needed in relation to IT projects and could be extended into the procurement of other consulting services.
- Sharing information about past and future consulting projects across different areas of the NHS, opening up the possibility that the input of consultants hired by one PCT, for example, could be accessed by another.

## **3. Focus on delivery**

One difference between consultants and interim managers is that the former are contracted to deliver something and are prepared to carry at least some of the risk involved in doing so. By contrast, interim managers are used to administer an existing process: their remit is to run it, not to change it, and they are rarely tasked with delivery. In order to ensure that management consultants are used only where it is appropriate to do so:

- The NHS should focus more clearly on the outcomes of consulting projects, rather than their inputs, as this is less likely to lead to using consultants in positions where fulltime staff would be more appropriate.
- Consulting firms should articulate more clearly and meaningfully the outcomes and benefits of their work.
- The NHS and consultancies should negotiate more performance-related contracts, rewarding consultancies for their successes rather than paying solely according to time expended. The Department of Health has, for instance, built an obligation to share risk into its FESC (Framework for Procuring External Support for Commissioners). This model could and should be extended into other areas where external advice and support is purchased.

### **APPENDIX 3: A SELECTION OF THE TOOLS THAT HELP THE PCT IDENTIFY OPPORTUNITIES FOR QUALITY AND EFFICIENCY IMPROVEMENT**

<b>High Impact Actions for Nursing and Midwifery</b>	The website contains 600 submissions from nurses and midwives describing actions that can help to transform the care that patients receive as well as reducing costs. Eight areas are set out in more detail in the downloadable document and more work is under way to explore these and further quantify their potential impact.	<a href="http://www.institute.nhs.uk/building_capability/general/aims/">www.institute.nhs.uk/building_capability/general/aims/</a>
<b>London Quality Observatory</b>	The London Quality Observatory facilitates local benchmarking, the development of metrics and the identification of opportunities to help frontline staff innovate and improve.	<a href="http://www.qualityobservatory.nhs.uk/index.php?option=com_content&amp;view=article&amp;id=2&amp;Itemid=2">http://www.qualityobservatory.nhs.uk/index.php?option=com_content&amp;view=article&amp;id=2&amp;Itemid=2</a>
<b>NHS Better Care, Better Value indicators</b>	The quality and value section of the NHS Institute for Innovation and Improvement website provides information about high-level indicators of efficiency that can identify potential areas for improvement.	<a href="http://www.institute.nhs.uk/quality_and_value/introduction/quality_and_value.html">http://www.institute.nhs.uk/quality_and_value/introduction/quality_and_value.html</a>
<b>NHS Comparators</b>	This comparative analytical service enables providers and commissioners to improve the quality of care they deliver, by helping them to investigate in detail variations in activity, costs and outcomes.	<a href="http://www.ic.nhs.uk/nhscomparators">www.ic.nhs.uk/nhscomparators</a>
<b>NHS Evidence – Innovation and Improvement</b>	The Innovation and Improvement section of the NHS Evidence website provides information resources including best available evidence, tools and techniques, case studies and policy.	<a href="http://www.library.nhs.uk/improvement">www.library.nhs.uk/improvement</a>
<b>NHS Evidence – Quality and Productivity</b>	A Quality and Productivity section on the NHS Evidence website will act as the national evidence base on how to improve quality while making cash-releasing savings.	<a href="http://www.evidence.nhs.uk/qualityandproductivity">www.evidence.nhs.uk/qualityandproductivity</a>
<b>NHS Institute for Innovation and Improvement</b>	The website includes hundreds of quality, safety and cost improvement tools and approaches, as well as details of powerful improvement programmes that have been developed by clinicians including the Productive Series of strategies for improving 'high volume' care.	<a href="http://www.institute.nhs.uk">www.institute.nhs.uk</a>
<b>NICE guidance</b>	The National Institute for Health and Clinical Excellence (NICE) cost-saving guidance, costing tools, recommendation reminders and commissioning guides are all designed to support service providers.	<a href="http://www.nice.org.uk/about/nice/whatwedo/nicelandthenhs/UsingNICEGuidanceToCutCostsInTheDownturn.jsp">www.nice.org.uk/about/nice/whatwedo/nicelandthenhs/UsingNICEGuidanceToCutCostsInTheDownturn.jsp</a>
<b>Programme Budget Atlases</b>	The Programme Budget Atlases enable PCTs to: link programme budgeting expenditure data with a wide range of outcome and activity data; and, use maps, distribution and correlation plots to provide an illuminating and user-friendly way of analysing and presenting data.	<a href="http://www.nchod.nhs.uk">www.nchod.nhs.uk</a>
<b>Programme budgeting tools</b>	The tools enable PCTs to identify: how they spend their allocation over 23 diseases and subcategories; how their expenditure distribution pattern compares with those of other PCTs; and, how their expenditure distribution has changed over time.	<a href="http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743">http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743</a>

## **APPENDIX 4: THE COALITION - OUR PROGRAMME FOR THE NHS<sup>105</sup>**

The Government believes that the NHS is an important expression of our national values. We are committed to an NHS that is free at the point of use and available to everyone based on need, not the ability to pay. We want to free NHS staff from political micromanagement, increase democratic participation in the NHS and make the NHS more accountable to the patients that it serves. That way we will drive up standards, support professional responsibility, deliver better value for money and create a healthier nation.

- We will guarantee that health spending increases in real terms in each year of the Parliament, while recognising the impact this decision will have on other departments.
- We will stop the top-down reorganisations of the NHS that have got in the way of patient care. We are committed to reducing duplication and the resources spent on administration, and diverting these resources back to front-line care.
- We will significantly cut the number of health quangos.
- We will cut the cost of NHS administration by a third and transfer resources to support doctors and nurses on the front line.
- We will stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services.
- We will strengthen the power of GPs as patients' expert guides through the health system by enabling them to commission care on their behalf.
- We will ensure that there is a stronger voice for patients locally through directly elected individuals on the boards of their local PCT. The remainder of the PCT's board will be appointed by the relevant local authority or authorities, and the Chief Executive and principal officers will be appointed by the Secretary of State on the advice of the new independent NHS board. This will ensure the right balance between locally accountable individuals and technical expertise.
- The local PCT will act as a champion for patients and commission those residual services that are best undertaken at a wider level, rather than directly by GPs. It will also take responsibility for improving public health for people in their area, working closely with the local authority and other local organisations.
- If a local authority has concerns about a significant proposed closure of local services, for example an A&E department, it will have the right to challenge health organisations, and refer the case to the Independent Reconfiguration Panel. The Panel would then provide advice to the Secretary of State for Health.
- We will give every patient the right to choose to register with the GP they want, without being restricted by where they live.
- We will develop a 24/7 urgent care service in every area of England, including GP out-of-hours services, and ensure every patient can access a local GP. We will make care more accessible by introducing a single number for every kind of urgent care and by using technology to help people communicate with their doctors.

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<sup>105</sup> Taken from "The Coalition: Our programme for government"

[http://www.cabinetoffice.gov.uk/media/409088/pfg\\_coalition.pdf](http://www.cabinetoffice.gov.uk/media/409088/pfg_coalition.pdf)

DH Press release: Coalition Document Sets Out Positive Direction For Health And Social Care (20 May 2010)

[http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH\\_116236](http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_116236)

- We will renegotiate the GP contract and incentivise ways of improving access to primary care in disadvantaged areas.
- We will make the NHS work better by extending best practice on improving discharge from hospital, maximising the number of day care operations, reducing delays prior to operations, and where possible enabling community access to care and treatments.
- We will help elderly people live at home for longer through solutions such as home adaptations and community support programmes.
- We will prioritise dementia research within the health research and development budget.
- We will seek to stop foreign healthcare professionals working in the NHS unless they have passed robust language and competence tests. Doctors and nurses need to be able to use their professional judgement about what is right for patients and we will support this by giving front-line staff more control of their working environment.
- We will strengthen the role of the CQC so it becomes an effective quality inspectorate. We will develop Monitor into an economic regulator that will oversee aspects of access, competition and price-setting in the NHS.
- We will establish an independent NHS board to allocate resources and provide commissioning guidelines.
- We will enable patients to rate hospitals and doctors according to the quality of care they received, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.
- We will measure our success on the health results that really matter – such as improving cancer and stroke survival rates or reducing hospital infections.
- We will publish detailed data about the performance of healthcare providers online, so everyone will know who is providing a good service and who is falling behind.
- We will put patients in charge of making decisions about their care, including control of their health records.
- We will create a Cancer Drugs Fund to enable patients to access the cancer drugs their doctors think will help them, paid for using money saved by the NHS through our pledge to stop the rise in Employer National Insurance contributions from April 2011.
- We will reform NICE and move to a system of value-based pricing, so that all patients can access the drugs and treatments their doctors think they need.
- We will introduce a new dentistry contract that will focus on achieving good dental health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren.
- We will provide £10 million a year beyond 2011 from within the budget of the DH to support children's hospices in their vital work. And so that proper support for the most sick children and adults can continue in the setting of their choice, we will introduce a new per-patient funding system for all hospices and providers of palliative care.
- We will encourage NHS organisations to work better with their local police forces to clamp down on anyone who is aggressive and abusive to staff.
- We are committed to the continuous improvement of the quality of services to patients, and to achieving this through much greater involvement of independent and voluntary providers.
- We will give every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices. This includes independent, voluntary and community sector providers.

## **GLOSSARY**

<b>A&amp;E</b>	Accident and Emergency (Casualty).
<b>Acute Services/Care</b>	Medical and surgical care provided mainly in hospitals.
<b>Adult Social Care</b>	Provide a range of care and protection services for adults.
<b>Care Pathway</b>	The full spectrum of care for a specific disease or illness – from onset and diagnosis to treatment, discharge and rehabilitation.
<b>Care Quality Commission (CQC)</b>	Inspectorate for health and social care.
<b>Central and North West London (CNWL) Foundation Trust</b>	NHS organisation providing mental health services in Central and North West London.
<b>Central London Community Healthcare (CLCH)</b>	Provider of community services to Kensington and Chelsea, Westminster and Hammersmith and Fulham PCTs.
<b>Chelsea and Westminster NHS Foundation Trust</b>	This NHS trust provides acute services from the hospital on the Fulham Road.
<b>Cholecystectomy</b>	A cholecystectomy is the surgical removal of the gallbladder.
<b>Clinical Governance</b>	An initiative to assure and improve the quality of clinical care across the NHS.
<b>Clinical pathways</b>	Clinical pathways, also known as care pathways, are one of the main tools used to manage the quality in healthcare concerning the standardisation of care processes.
<b>Commissioning</b>	The process of deciding what local people need from the NHS and buying those services with public money from the most appropriate providers.
<b>Community Mental Health Team (CMHT)</b>	Doctors, nurses and therapists who work in the community to support people with severe mental health problems.
<b>CQUIN</b>	Commissioning for Quality and Innovation Network.
<b>Department of Health (DH)</b>	Central government planning agency for health and social care.
<b>Elective surgery</b>	Surgery that is an option or that may be elected.
<b>Endocrine</b>	The bodily system that consists of the endocrine glands and functions to regulate body activities.
<b>GPs</b>	General Practitioners.
<b>Health Scrutiny Committee (HSC)</b>	This is a Council body that has a statutory obligation to scrutinise the local health services.
<b>Hammersmith Hospitals</b>	Hammersmith Hospital and Queen Charlotte's & Chelsea Hospital, based on Du Cann Road (Hammersmith), part of Imperial College Healthcare NHS Trust.
<b>Imperial College Healthcare NHS Trust</b>	Imperial College Healthcare NHS Trust is the largest NHS trust in the UK. The Trust has five hospitals: Charing Cross Hospital; Hammersmith Hospital; Queen Charlotte's & Chelsea Hospital; St Mary's Hospital; and the Western Eye Hospital.
<b>Integrated Strategic Plan (ISP)</b>	A five-year plan for the NHS in (1) London and (2) the N.W. London region.
<b>Intravenous</b>	Administered into a vein.
<b>Joint Strategic Needs Assessment (JSNA)</b>	PCTs and local authorities are required to jointly produce a needs assessment of the health and well-being of its local community.
<b>Local Area Agreements (LAA)</b>	LAAs are three-year action plans for achieving better outcomes, developed by councils with their partners.
<b>Local Involvement Networks (LINKs)</b>	LINKs are the networks that should provide the community with the chance to say what they think about local health and social care services, in order to influence how services are planned and run.
<b>Nasogastric</b>	Relating to, or involving, the nasal passages and the stomach.

<b>National Institute of Health and Clinical Excellence (NICE)</b>	NICE is an independent organisation responsible for providing guidance on preventing and treating ill health.
<b>Neurology</b>	The medical science that deals with the nervous system and disorders affecting it.
<b>NHS London</b>	The Strategic Health Authority for London.
<b>Orogastric</b>	Pertaining to the mouth and stomach.
<b>PBC</b>	Practice Based Commissioning.
<b>Postpartum</b>	Of, or occurring in, the period shortly after childbirth.
<b>Primary Care</b>	The part of the NHS where family doctors (GPs) and community nurses work. It is called primary care because it is usually the first part of the NHS a person will meet as a patient.
<b>Primary Care Trust (PCT)</b>	This is a statutory body responsible for commissioning health care for local people, and reducing health inequalities.
<b>Provider arm</b>	Provision of services remains with the PCT but with separate finance and governance arrangements so that the provider service is treated like any other provider.
<b>Polyclinic</b>	Lord Darzi's London vision described polyclinics as "a large community based health centre, serving a population of 50,000 or more and housing a range of primary, community and secondary care professionals".
<b>Polysystem</b>	Healthcare for London defined "polysystems" as a polyclinic hub plus GP practices participating in a network.
<b>SPOT</b>	Spend and Outcome factsheets and Tool.
<b>St Mary's hospital</b>	Hospital based at Paddington, part of Imperial College Healthcare NHS Trust.
<b>Stroke</b>	A stroke is the sudden death of brain cells in a localized area due to inadequate blood flow.
<b>Secondary Care</b>	Hospital or specialist care to which a patient is referred by their GP.
<b>Strategic Health Authority (SHA)</b>	NHS London is Kensington and Chelsea's SHA.
<b>Total Place</b>	Total Place is a programme of work to map all of the public money spent in an area.
<b>Trauma</b>	A serious injury or shock to the body, as from violence or an accident.
<b>UDA</b>	Units of Dental Activity
<b>Urgent Care Centre</b>	A medical facility where patients can be treated without an appointment, and receive immediate, non-emergency care.