Report of the Overview and Scrutiny Committee on Health

Review of Kensington and Chelsea Primary Care Trust’s Commissioning Priorities

June 2008
FOREWORD

The Department of Health issued the document ‘A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services’ on 13 July 2005. Within this report, Overview and Scrutiny Committees (OSCs) were encouraged to focus their attention on the work of commissioners.

While making several recommendations, one of the aspects of this report is to help explain to those not versed in the complexities of the National Health Service, how the system operates and where the levers of power lie, so that the changes which are coming in the near future can be placed in context and better understood.

As scrutiny of a primary care trust’s (PCT’s) commissioning function is an important way for an OSC to review the services provided to the NHS, the Royal Borough of Kensington and Chelsea’s OSC on Health has done precisely that in this Review of Kensington and Chelsea PCT’s commissioning priorities.

OSCs and Commissioning (“A stronger local voice”, page 17)

The OSC has a vital role in scrutinising the activities of organisations that provide local health and social care services and asking:

• Whether the services are appropriate to the needs of local people;
• If decisions are based on evidence; and

If the experiences of patients and users of services are leading to improvements in the way services are delivered.

RECOMMENDATIONS AND KEY FINDINGS

1. There should be a shared understanding of "needs" between health and social care. This must include a shared understanding of the present population as a baseline for future predictions. We welcome the development of projections based on predicted growth of the population as a whole and for older people in particular. The PCT and Council should have an understanding of predictive population change for all the different care groups (e.g. children, disabled, learning disability and mental health).

2. The Sub-Group is pleased that work is underway by the PCT and Council to develop a Joint Strategic Needs Assessment (JSNA). This should be an integral part of local commissioning. We expect the JSNA will 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. Its existence will also underpin local accountability and essential local discussions of priorities in resource allocation. We therefore recommend that the JSNA is published on the Internet and include web links to all needs assessment reports that have been produced in the local area. It would also be good practice if, alongside the JSNA, all local commissioning strategies are published and commissioners show aims and objectives of the respective organisations (as commissioning intentions will have to take these into account).

3. At the right time, the OSC on Health needs to look at the proposal currently being developed on closer working between the PCT and Council.

4. Kensington and Chelsea PCT’s Commissioning Strategy must align with both Adult Social Care’s and Families and Children’s commissioning strategies.

5. Professor Sir Ara Darzi’s definition of a “polyclinic” serves a population of about 50,000 people. When the PCT is describing developments that are different to the Darzi definition we suggest it uses other terminology to reduce confusion.

6. Patient safety and the quality of care in primary care have to be of paramount importance to Kensington and Chelsea residents.

7. The starting point for deciding where to site a “polyclinic” should not be the simplest option – altering historical provision. Decisions should be based on “needs” (i.e. “polyclinics” or hubs get based where there is “best” patient access, patient outcomes etc). We note the PCT’s public health department has already carried out work on access in a Primary Care Equity Audit.

8. There is need for good join-up and dialogue between the Council’s Planning Department and the PCT regarding future healthcare facilities (e.g. GP practices). The Council should clearly acknowledge the need for primary care practices within the new Local Development Framework and in relation to negotiations with developers on Section 106 (planning gain) agreements. There should be regular dialogue between the PCT and
Planning to ensure opportunities are not missed. The PCT should make full use of the document “A Guide to Town Planning for NHS Staff”.

9. The OSC on Health is concerned whenever the PCT fails to meet Healthcare Commission targets. For measuring body mass index, the Sub-Group understand that GPs can find it difficult to measure the BMI of every patient because it is often not appropriate during a consultation on other matters. We are pleased to be told that the PCT is working with a range of practitioners to meet this target as measurement of BMI need not be done by a GP.

10. The Practice Based Commissioning Group should be asked to make an annual presentation to the OSC on Health on how it has taken user views into account and responded to patient needs and concerns.

11. We support the PCT's aim to deliver care closer to people's homes and out of hospital wherever this is appropriate. We also welcome the shift in the focus of healthcare from treating sick people towards prevention and supporting wellbeing.

12. The PCTs in North West London will need to ensure that shifts in local NHS capacity due to Imperial College NHS Healthcare Trust development as an Academic Health Science Centre (AHSC) does not have a destabilising impact on other NHS providers. We support the PCT Chief Executive's efforts to gain clarity in the form of detailed business/service plans related to the development of the Academic Health Science Centre.

13. Imperial College Healthcare NHS Trust will need to work in partnership with the local health and social care community. The AHSC can minimise the potential for direct conflict with neighbouring trusts by being clear and transparent in its actions.

14. We are concerned that we remain unclear as to how the Chelsea and Westminster hospital fits with the long term plans of Imperial College Healthcare NHS Trust. We recommend that the Foundation Trust and Imperial College NHS Trust work towards some type of charter for collaboration.

15. Imperial College (NHS) Trust, Chelsea and Westminster (NHS) Foundation Trust and CNWL Foundation Trust should sign up to the PCT’s Sustainability Protocol.

16. We support and encourage the PCT in its endeavours to commission from the best providers for our residents. We would support any reduction in the given timescales to move to better providers. We recommend that

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2 The document “A Guide to Town Planning for NHS Staff” outlines the town and country planning system in England at regional and local level and looks at issues specific to the NHS. It explains the correlation between planning and health, and encourages NHS organisations to get involved in the planning process. It is available on the Internet at: http://www.info4local.gov.uk/filter/?item=495293

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after three years there is a report outlining the scale of successfully implementing these policies.

17. The PCT should clearly set out, in financial terms, how the role of the voluntary sector is recognised and developed with the switch to community care.

18. The Sub-Group would like to see and consider: (1) The PCT report on the stakeholder forum to look at proposed commissioning intentions; and, (2) An evaluation of the actual impact of this consultation on PCT commissioning.

19. There should be clear prior consultation by all NHS bodies when there is a substantial change in service as required by law – Section 7 Health and Social Care Act 2001 (if in any doubt see health scrutiny protocols agreed in 2003).

20. As public bodies are paid for out of the public purse, the public should have the ability to find out how that money is spent. For good governance, NHS bodies need to be as transparent as possible (i.e. not confidential matters) with decision making to the public and partner agencies. All NHS bodies (NHS and Foundation Trust) Board papers (inc. agenda, minutes, strategies, performance data etc) should be made fully available on the Internet. This publication of basic information should be a minimum in the twenty-first century.

21. There needs to be clarity in the role of the Kensington and Chelsea LINk and appropriate pathways created to enable the local community to influence the PCT, the PBC Group, Families and Children and Adult Social Care in their commissioning decisions. The LINk will have to work very closely with many partners including the OSC on Health.

22. The future of the provider services of the PCT has to be resolved shortly. We would expect an options appraisal to be the first step in any considerations as stated on page 51 of the Commissioning Strategy Plan (June 2007). This appraisal must include partial integration models such as dividing up provider services between the acute sector providers, the Royal Borough, GPs and third sector. Without a clear provider plan commissioning must be uncertain.
1. INTRODUCTION

1.1 At the OSC on Health meeting on 20 September 2006 it was agreed to carry out a review of Kensington and Chelsea’s Commissioning Priorities during 2007/08.

1.2 The terms of reference of this review are set out in Appendix 1. The membership of the Sub-Group is set out in Appendix 2.

2. BACKGROUND

2.1 In the NHS, money flows into the system mainly from taxes and is redistributed by the government to hospitals and physicians. There is a central government planning agency, the Department of Health (DH) and, at the local level, there are Primary Care Trusts (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 (ONS) population weighted for a variety of factors such as age and deprivation (approx. 180,000 patients), 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", 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. The NHS in Kensington and Chelsea is set out in Appendix 3.

2.2 The primary role of PCTs is to secure the best possible services for their population, whether these are provided directly (in-house) or procured from another provider within their resources. In order to achieve this, PCTs must work closely with local authorities, primary care practices, secondary care providers in the public and private sector, as well as patients and the public. Kensington and Chelsea PCT priorities are set out in Appendix 4.

What is commissioning?

2.3 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 on the commissioning role, both for PCTs and GPs, by government is a recent development in health policy.

2.4 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
vii) Reviewing the effectiveness of services to achieve health priorities, including public and patient involvement.

2.5 Effective commissioning will depend upon PCTs and practices giving equal consideration and priority to each of the seven stages of the commissioning cycle.

Commissioning a Patient-led NHS³

2.6 The DH published in July 2005 “Commissioning a patient-led NHS”⁴. The aim of this strategy was to better reflect patient choices in the way services are commissioned by front-line staff. This was said to require: Better engagement with local clinicians in the design of services; Faster, universal roll-out of Practice Based Commissioning (PBC); and, Developing PCTs to support PBC, and take on the responsibility for performance management through contracts with all providers, including those in the independent sector.

2.7 The “Commissioning a patient-led NHS” guidance was originally clear that, once the reconfiguration was complete, PCTs should not be involved in direct provision of services unless “no obvious alternatives exist”. The White Paper "Our Health, Our Care, Our Say" (2006) has drawn back from this position. But, PCTs as commissioning organisations remain the direction of travel.

The White Paper "Our Health, Our Care, Our Say: A New Direction For Community Services"⁵

2.8 The White Paper signalled a new partnership between local authorities and reformed PCTs as organisations with commissioning responsibilities for health and well-being community services. Together, they should provide strong leadership for joint action to promote community well-being, address inequalities and deliver the health and social care services that people need.

Commissioning Framework for Health and Well-being⁶

2.9 The overarching aim in “Commissioning framework for health and well-being” is to shift the focus of commissioning from treating sickness to preventing ill-health and promoting well-being. It set out a vision, a

⁵ “Our health, our care, our say” webpage is available at: http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/OurHealthOurCareOurSay/fs/en
framework and practical proposals for effective commissioning of health, care and well-being from 2008/09. The DH described good commissioning as: “The means to secure the best value for local citizens. It is the process of translating 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**

2.10 The DH aims to create a "world class" commissioning system. A vision and a set of competencies have been circulated widely within the NHS.

2.11 The vision document said, "This new NHS - locally driven, looking outwards not upwards - is designed to dramatically improve the quality of care and the value we get from the public resources invested in health and care services ... 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."

2.12 "As world class commissioners, PCTs must take on the mantle as trusted community leaders, working with their local population, partners and clinicians leading the local NHS." The term "world class" is aspirational, it says, "a statement of intent" for a "new form of commissioning that has not yet been developed or implemented in a comprehensive way across any of the developed healthcare economies."

2.13 The document then describes the organisational competencies PCTs will need, saying: "World class commissioning PCTs will need to develop the knowledge, skills, behaviours and characteristics that underpin effective commissioning." These are set out describing what PCTs 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; and manage finances. There is more detail in an accompanying document on the competencies.

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7 For more information see the DH webpage "World Class Commissioning" available on the Internet at: 
Commissioning at Kensington and Chelsea PCT

2.14 ‘Commissioning a patient-led NHS’ and the White Paper have had a great impact on the PCT and presented two areas for the Sub-Group’s exploration – (i) the PCT’s commissioning regime (section 3); and (ii) the PCT’s role as a provider (section 4).

3. THE PCT’S COMMISSIONING REGIME

3.1 NEEDS-BASED WORK

3.1.1 The PCT should respond to changes in underlying health needs. The Sub-Group was presented with a number of examples of where needs analysis had clearly informed the PCT’s planning decisions:

- **Population projections** - Projections produced by the Greater London Authority (GLA) are used by the PCT as they believe the ONS figures over estimate inward migration. GLA projections are thought to be better as they incorporate restrictions on growth due to lack of housing. The resident population figure for the Royal Borough is approximately 169,000 and is expected to stay fairly stable. The population is likely to grow at a maximum of 0.8% per year - 3.3% over the 5-year period (p10 Commissioning Strategy Plan). The PCT also does not expect to see the population greatly change its ethnic structure over the next five years (p10 Commissioning Strategy Plan). Overall, population is likely to have minimal impact on service workload. It should be noted that the ONS has estimated the population as 196,800 and rising to 205,800 by 2010 and this is the basis for funding from central government. The PCT is funded on the basis of DH figures in the region of 188,000 while the Council is funded on the basis of DCLG figures in the region of 196,000. With four different estimates we are suspicious about the figures. Commissioning will be flawed if incorrect figures are used.

- **Older people projections** - The PCT does not expect the population to “age” significantly over the next five years (p10 Commissioning Strategy Plan). The Joint Older People’s Strategy used this data.

- **Identification of health priorities for the Families and Children Plan** – For example, dental care.

- **Tendering for Primary Care service** – Tenders are influenced by practice population information and vacant lists

- **New community diabetes services** – There is likely to be an increase in prevalence of obesity and an associated increase in prevalence of type 2 diabetes (p10 Commissioning Strategy Plan).

- **District nursing realignment** – The redesign was based on public health needs based information.

- **Public health** - Epidemiological work is present in planning non-acute services and prevention of ill health work.

**Recommendation 1:** There should be a shared understanding of “needs” between health and social care. This must include a shared understanding of the present population as a baseline for future predictions. We welcome the development of projections based on predicted growth of the population as a whole and for older people in particular. The PCT and Council should have an understanding of predictive population change for
all the different care groups (e.g. children, disabled, learning disability and mental health).

3.1.2 The PCT and Council have to look further than just population profiles and include people’s needs, aspirations and ambitions on services and how health and social care can support these. See section 3.2.32 on “consultation” and section 3.14 on “patient and public involvement” for some more detail on this.

**Joint Strategic Needs Assessment (JSNA)**

3.1.3 The Local Government and Public Involvement in Health Act has put into law the statutory requirement for councils to work with primary care trusts to produce a strategic assessment of the health and social care needs of the local area. This is given more detail in the draft “Commissioning Framework for Health and Well being”.

3.1.4 Between July and December 2008 the local authority and PCT will be producing an assessment of the current and future health, social care and well-being needs of their population, in consultation with the local communities. The JSNA should be a rich source of information for decision-making by Officers, PCT Non-Executives and Councillors.

3.1.5 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 should be the principal source of local targets and action.

*Recommendation 2: The Sub-Group is pleased that work is underway by the PCT and Council to develop a Joint Strategic Needs Assessment (JSNA). This should be an integral part of local commissioning. We expect the JSNA will 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. Its existence will also underpin local accountability and essential local discussions of priorities in resource allocation. We therefore recommend that the JSNA is published on the Internet and include web links to all needs assessment reports that have been produced in the local area. It would also be good practice if, alongside the JSNA, all local commissioning strategies are published and commissioners show aims and objectives of the respective organisations (as commissioning intentions will have to take these into account).*

**Constraints**

3.1.6 The Sub-Group heard about a number of constraints on the ability to carry out needs-assessment work. These include that needs analysis is a resource intensive process and information may not be available.

**Leverage**

3.1.7 The Sub-Group asked about the leverage that needs assessment work has on the PCT’s commissioning processes.
3.1.8 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. Needs based information can be used to assess the referral practice of General Practices. This principle was applied when developing the community based diabetes team and the realignment of the District Nursing service to reflect more accurately varying patient needs across the borough.

3.1.9 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 needs driven - patients are referred to secondary care as their condition requires.

3.1.10 The Sub-Group considered overemphasis on “historic” patient flows/referrals as a potential constraint to new commissioning patterns that responds to needs.

3.1.11 The Sub-Group asked about how the need to prevent illness and promote wellbeing was quantified and prioritised against medical care needs for the purpose of allocating resources. They were told, “The need to prevent illness is quantified by the Public Health directorate, based on epidemiological information, much of which is available from primary care systems. For 2008/09 there has not been a need to choose between preventative and curative care - the PCT has plans to fund both.”

3.2 STRATEGIES AND PLANNING FOR THE FUTURE

Operating Plan 2008/09\(^8\) – Provider\(^9\) and Commissioning

3.2.1 The PCT has set local targets in its Operating Plan, based on local needs assessment. The Plan was submitted to NHS London in December 2007. This report came to the PCT Board on 29 January 2008.

Commissioning Strategy 2007 - 2012

3.2.2 Kensington and Chelsea PCT is developing a five-year Commissioning Strategy for NHS London.\(^10\) Now the PCT is in financial health it can plan ahead constructively. It (and the new Primary Care Strategy) will need to reflect the work that is needed to take forward the Darzi proposals locally. The first draft was circulated to the Sub-Group at its July 2007 meeting.

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\(^10\) For background information on requirements from NHS London see:


(3) NHS London: Provider Management Regime [http://www.london.nhs.uk/resourcelib/Provider%20Management%20Regime%202007M.pdf](http://www.london.nhs.uk/resourcelib/Provider%20Management%20Regime%202007M.pdf)
3.2.3 Kensington and Chelsea PCT’s Commissioning Strategy will form part of discussions in North West London\(^{11}\) and in relation to a London-wide Commissioning Strategy. PCTs in North West London are developing a joint strategy for how healthcare services should develop over the next five to 10 years. A Clinical Reference Group\(^{12}\) (which has clinicians [GPs and doctors] from the eight North West London PCTs and hospitals) will inform the North West London Strategy. This Clinical Reference Group is looking at areas where they believe there is a need for improvement in the quality and consistency of care. The North West London strategy will feed into a London-wide Commissioning Strategy. So the North West London and London-wide commissioning intentions will both incorporate the thinking from "A Framework for Action”.

3.2.4 The Sub-Group was told that senior clinicians on the Clinical Reference Group play an important role in giving clinical leadership when making recommendations for improving the commissioning process. It was noted that the Adult Social Care Commissioning Strategy is for 3 years.

3.2.5 The Sub-Group asked how the PCT and Adult Social Care could commission more together. A proposal is being developed to ensure closer working in future.

\textit{Recommendation 3: At the right time, the OSC on Health needs to look at the proposal currently being developed on closer working between the PCT and Council.}

\textit{Recommendation 4: Kensington and Chelsea PCT’s Commissioning Strategy must align with both Adult Social Care’s and Families and Children’s commissioning strategies.}

\textbf{Healthcare for London}\(^ {13}\)

3.2.6 Professor Sir Ara Darzi’s “Healthcare for London” review will inform all London PCTs’ Commissioning Strategies. He has called for larger and more specialised units that can provide "high quality care" to patients. He also called for large GP practices, known as "polyclinics", to allow patients to receive all but the most urgent treatment under one roof. He has suggested these "polyclinics" serve a population of approximately 50,000 people. Operations under local anaesthetic and treatment for chronic illnesses such as heart failure can be treated at these "polyclinics". Eventually, the "polyclinic" could employ up to 20 GPs, community consultants and visiting surgeons.

\(^{11}\) The North West London NHS Strategy website sets out the work that is going on to plan NHS services across NW London and specifically identifies services where improvements are believed to be needed: [http://www.northwestlondon.nhs.uk/]\(^{1}\)


\(^{13}\) More information on the “Healthcare for London” review is available on the Internet at: [http://www.healthcareforlondon.nhs.uk/]
Primary Care Strategy

3.2.7 The PCT is in the process of putting together a primary care strategy. The PCT’s vision for its Primary Care Strategy was presented to the Sub-Group on 13 September 2007:

**Kensington and Chelsea PCT’s vision for its Primary Care Strategy**

- To provide a greater range of primary and community services for local population
- To improve access to primary, community and diagnostic services
- To provide improved integration across these services including social care
- More care closer to home
- Increasing emphasis on prevention and self management
- Improved access to test results; diagnostics e.g. ultra-sound
- Fewer but larger practices that are geographically spread
- Increasing focus on managing long term chronic conditions and high risk patients
- Developing a model that fits the Kensington and Chelsea’s population differing health needs
- Different organisational models as appropriate to Kensington and Chelsea for example the hub and spoke model will be applied in North Kensington and a federal model may be applied in the south
- Local GPs will be commissioners and providers of primary care
- Within the context of PCT commissioning strategy and Joint Public Health Strategy

3.2.8 Presently 23 out of 43 (53%) practices are single-handed, and 13 out of 43 (30%) are double-handed. Compared with other PCTs, the GP practices are small - the average has a list size of about 4,000 with 2 GPs. All practices' list are open. There is capacity for practices to grow their lists before new GPs are required. The Sub-Group heard that the range and access to care maybe less effective coming from a single-handed practice.

**Recommendation 5: Patient safety and the quality of care in primary care have to be of paramount importance to Kensington and Chelsea residents.**

**Definition of a “polyclinic”**

3.2.9 In Healthcare for London a “polyclinic” is defined as serving a population of about 50,000 people. The key is to be large enough to create a critical mass of specialist services at community level. “Over time, we expect polyclinics to become the site of most GP care. However we do not expect that all GP practices will become part of a polyclinic.” (A Framework for Action p94). Darzi suggests 150 “polyclinics” in London by 2017, which would mean approximately half of all primary care was delivered by “polyclinics”. We note the PCT does not have to plan for all primary care to be delivered by the “polyclinic” model.

3.2.10 The PCT’s Draft Framework for a Primary Care Strategy (presented to the PCT Board on 17 July 2007) uses a population of between 10,000 – 20,000 for a “polyclinic” (107/07 Minutes of PCT Board 25 September 2007). The Sub-Group was told, “We expect that up to 10 GPs will work in each polyclinic, with registered lists totalling 10-20,000 people. Whilst the PBC Group suggested that the size of a “polyclinic” could be between 15-20,000 square feet.
Recommendation 6: Professor Sir Ara Darzi’s definition of a “polyclinic” serves a population of about 50,000 people. When the PCT is describing developments that are different to the Darzi definition we suggest it uses other terminology to reduce confusion.

Where could there be “polyclinics” in Kensington and Chelsea?

3.2.11 “Phase two of the re-use of St Charles may create a polyclinic on the London model within 3 years.” (Commissioning Strategy Plan p55). “It is likely that the PCT’s existing sites at Worlds End ... will be redeveloped.” (Commissioning Strategy Plan p55). The Sub-Group was told that the final configuration for improved primary care is being developed. Sites that could be examined, depending on circumstances, include: St Charles hospital; Vicarage Gate; World’s End; Violet Melchett; Brompton hospital; Gertrude Street; or, as part of other new developments.

3.2.12 The Sub-Group was informed that the PCT would probably have to improve and increase its Primary Care front end at the Chelsea and Westminster Accident and Emergency (A&E) in the next few years. This was also defined as a potential “polyclinic”. Rather than “polyclinic” it could be called an “Urgent Care Centre” for GPs based alongside A&E.

Extended service

3.2.13 The PCT envisages their future GP provision will grow out of “hub and spoke” or federated arrangements where practices will refer patients to the larger centres. The extended services provided at these hubs will be for a wider population of up to 50,000 who are registered at surrounding GP practices. Where there is limited access to buildings to support larger practices the PCT will be looking to develop a federal model where access to services is shared across practices, ensuring all patients are able to access all services in a timely and local manner. It is recognised that one model does not fit all situations. Practice Based Commissioners are supportive of this model.

Recommendation 7: The starting point for deciding where to site a “polyclinic” should not be the simplest option – altering historical provision. Decisions should be based on “needs” (i.e. “polyclinics” or hubs get based where there is “best” patient access, patient outcomes etc). We note the PCT’s public health department has already carried out work on access in a Primary Care Equity Audit.

Managing change

3.2.14 In any estate review, looking forward 5 years, the PCT will be looking to reduce the number of single-handed practices and grow “polyclinics”. The Sub-Group asked how the PCT would commission for the cluster or “polyclinic” model. It also enquired how the high proportion of GPs in the borough close to retirement age, and high GP ownership of premises should be addressed. The Sub-Group heard how there were opportunities around premises, retirement and the contract:

- 74% of the primary care estate has been assessed as satisfactory but needing minor changes. However, there is a shortage of GP practices
in the borough which provide modern, fully accessible facilities (Disability Discrimination Act accessible). Assessment should be carried out against the ambitions set out in the vision for primary care in section 3.2.7 not only DDA.

- 34% of GPs are 55 years or older and so will be retiring in the next 5-10 years. The PCT has the responsibility of re-providing a service to patients when an existing GP leaves. The Sub-Group heard that in the future it will become increasingly difficult for single-handed GP practices to meet the higher service standards specified by the PCT. If a GP retires, the PCT is unlikely to re-provide their service as a single practice.
- There is also leverage over GPs that have one of the nationally negotiated contracts. The PCT hold contracts with 43 GP practices. 22 of these practices hold Personal Medical Services (PMS) contracts which are locally negotiated and they have one Alternative Provider Medical Services (APMS) provider. More information on how contracts differ is given in section 3.2.21.
- The PCT ensures that GPs meet the quality and access terms of their contracts, performance manages them, and can and does take action if contractual standards are not met.

3.2.15 Given the anticipated pace of change, the Sub-Group heard that the process towards "polyclinics" was considered to be manageable. The PCT has commissioned a detailed premises survey on the state of existing GP and health centre premises. This has identified “hot spots” for development. The results of the survey have been shared with the Royal Borough’s Planning department.

3.2.16 The PCT is working with Planning to identify future premises. The PCT expect to be able to take advantage of S106 planning gain in future developments.

Recommendation 8: There is need for good join-up and dialogue between the Council’s Planning department and the PCT regarding future healthcare facilities (e.g. GP practices). The Council should clearly acknowledge the need for primary care practices within the new Local Development Framework and in relation to negotiations with developers on Section 106 (planning gain) agreements. There should be regular dialogue between the PCT and Planning to ensure opportunities are not missed. The PCT should make full use of the document “A Guide to Town Planning for NHS Staff\textsuperscript{14}”.

Clinical involvement

3.2.17 GP collaborative working will be an important factor in the success of any "polyclinic" model of delivery of primary care. As part of developing the

\textsuperscript{14} The document “A Guide to Town Planning for NHS Staff" outlines the town and country planning system in England at regional and local level and looks at issues specific to the NHS. It explains the correlation between planning and health, and encourages NHS organisations to get involved in the planning process. It is available on the Internet at: http://www.info4local.gov.uk/filter/?item=495293
10 year primary care strategy the PCT established a local Clinical Reference Group of 10 local GPs, a dentist and a community pharmacist providing advice on the strategy. This ensures the proposals being developed have the backing of local clinicians. There are regular forums and meetings with practices to keep them abreast of the strategy development.

Prevention

3.2.18 The PCT will need to continue to embed the concept of prevention and the promotion of staying healthy into its work. Unfortunately, many GPs have been known to have a medicalised view of health and well-being.

3.2.19 When the Sub-Group asked about “prevention” (as opposed to treatment) in primary care it heard about the joint public health strategy, involvement of young people in the Children and Young Person’s Plan and about better detection and earlier diagnosis which can lead to better management of disease. We can only hope that plans are effectively implemented.

3.2.20 The PCT Board on 20 May 2008 heard about PCT progress on a number of Healthcare Commission’s targets relating to preventing ill health. The PCT was deemed “red” for “% of people aged 15-24 accepting Chlamydia screening”, “Four week smoking quitters” and “% of women aged 50-70 who underwent breast screening”. The Board heard reassurances that everything was being done to improve the situation.

3.2.21 The PCT was “amber” on the target for measuring the body mass index (a tool to tackle obesity) on 20 May 2008. The Sub-Group heard how GPs are offered financial incentives to integrate service improvements into routine practice and action can take place in other settings such as pharmacies.

Recommendation 9: The OSC on Health is concerned whenever the PCT fails to meet Healthcare Commission targets. For measuring body mass index, the Sub-Group understand that GPs can find it difficult to measure the BMI of every patient because it is often not appropriate during a consultation on other matters. We are pleased to be told that the PCT is working with a range of practitioners to meet this target as measurement of BMI need not be done by a GP.

Market in Primary Care

3.2.22 In 2003 the Health and Social Care (Community Health and Standards) Act created a market in primary care and replaced the old general medical services contract governing general practitioners with a range of alternatives. The changes gave primary care trusts new powers to commission care from “anyone capable of securing the delivery of such services.” The national agreement under which general practitioners were contracted directly to the secretary of state for health was replaced by four contracts called: (1) A General Medical Services (GMS) – this uses a contract between practices and trusts; (2) An Alternative Provider of Medical Services (APMS) – this uses a contract between an alternative provider and trusts; (3) A Personal Medical Services (PMS) – this uses
locally negotiated service contract; and, (4) A Primary Care Trust Medical Services (PCTMS) – this uses a contract enabling trusts to employ general practitioners directly on salary.

3.2.23 The new contract has separated out primary care services into essential services, which are the minimum that must be provided to patients who are ill; additional services, such as screening, child health surveillance, and immunisation; and enhanced services, including such things as management of chronic diseases, minor surgery, and more specialist services currently provided in hospitals, which a practice can choose whether to provide. An important consequence of this is that these services can be subcontracted to different providers.

3.2.24 The PCT does not employ any GPs directly - they have 2 APMS contracts (World’s End and Barlby Road), 22 PMS practices and the remainder are GMS contracts. If a practice list becomes available to tender and/or there was a significant expected increase in the population in a specific location the PCT would tender for the required health care provision. The contract would most likely be an APMS as this provides the greatest flexibility, and all potential providers would be eligible to respond (local GP practices, independent companies).

**Evidence of the impact of the new contracts on health outcomes or patient satisfaction or management of long term conditions**

3.2.25 The Quality and Outcomes Framework (QOF) is a system which specifies clinical and operational standards for the key aspects of primary care. There is a strong emphasis on the management of long term conditions. Every year each practice is assessed by an external assessor, a lay representative and PCT staff on their achievement of QOF. The 2007/08 assessment has been undertaken and is being analysed. In previous years Kensington and Chelsea GPs have always done well against national and London QOF standards indicating they are providing a high standard of care. Part of the assessment asks for evidence from patient feedback groups, and a patient satisfaction survey.

3.2.26 The PCT monitors GPs on the GMS contract which requires them to work within the agreed contractual terms. They monitor this via obtainment of key targets (e.g. flu vaccinations; opening hours and patient complaints). On this evidence the PCT believes the quality of patient care has improved overall since the introduction of the new contract.

3.2.27 General practice services in the UK can now be purchased from corporate contractors using commercial contracts. Commercial contracts have implications for service planning, public accountability, access to health care, and government control.

3.2.28 When the occasion arises to commission new primary care services the PCT will manage this via an open competitive tendering process and so allow commercial providers the opportunity to bid. When the PCT tendered the World’s End Health Centre services a local patient group was established to help draw up the service specification and a representative from the group was on the interview panel. This model will be repeated for any future tendering exercises.
Future Primary care services in the community

3.2.29 In the future, more clinics and diagnostic services will be commissioned to provide direct access to services for GPs and specified primary care professionals. The Darzi's Healthcare for London review, the “unplanned care group” proposed that diagnostics (e.g. Ultrasound, MRI (magnetic resonance imaging) and CT (computerised tomography) scans) and outpatient care (e.g. follow up visits to hospital after an inpatient stay) could be carried out "as locally as possible".

3.2.30 As part of the St. Charles Community Hospital development the PCT is maintaining the X-ray service and is looking to commission further diagnostic services (ECG, Ultrasound) to be available on the St Charles Hospital site. Access to such diagnostic care will ensure the patient will not have to wait so long for test results and so allow the GP to determine their treatment more quickly and easily. As part of the work PBC is doing to support the 18 weeks target a number of clinical areas are being reviewed to minimise and eliminate unnecessary steps in the patient journey for care. The primary care strategy will include integrated working with community services.

Out Of Hours (OOH) service

3.2.31 All Out Of Hours (OOH) services are commissioned against national standards which were prepared by the Department of Health. This includes operational and clinical standards.

3.2.32 The PCTs in NW London jointly tendered for the OOH services, and Kensington and Chelsea PCT along with Westminster and Hammersmith & Fulham PCTs awarded London Central West Urgent Care Collaborative (LCW UCC) the contract for their area. There are quarterly performance management meetings to monitor the service against the service specification.

Consultation

3.2.33 The PCT will be consulting on its primary care strategy to see what patients feel about the proposals (including “polyclinics”). It hopes that consultation responses would provide a good indication of the importance attached to various factors (e.g. importance of proximity of GP practices vs. outcomes). Patients are far more likely to see future changes in a good light if they are convinced that they will be getting a new service which gives better medical outcomes.

3.3 FINANCE AND EFFICIENCIES

Financial position and recovery

3.3.1 Over the 2005/07 period there were considerable constraints on the PCT due to their financial deficit. By the end of 2005/06 the PCT had overspent £25.1 million. The recovery plan required the PCT to make savings of £10 million in 2006/07.
3.3.2 In 2006/07 the PCT's revenue resource limit was £281.2 million. They spent £276.2 million, resulting in an underspend against resource limit of £5 million (of this £2.35 million was a technical adjustment related to the valuation of assets for disposal and does not reflect the operational performance of the PCT). The operational underspend was £2.6 million.

3.3.3 The PCT was in a position to repay all of its accumulated deficit by the end on 2007/08, a year earlier than originally planned.

Where does PCT money go?

3.3.4 The Sub-Group asked for a breakdown of PCT spend. They were presented with approximate figures for 2006/07:

<table>
<thead>
<tr>
<th></th>
<th>£/m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>93.1</td>
</tr>
<tr>
<td>Specialised commissioning</td>
<td>11.2</td>
</tr>
<tr>
<td>HIV and GUM</td>
<td>17.3</td>
</tr>
<tr>
<td>Mental Health</td>
<td>41.8</td>
</tr>
<tr>
<td>Other non-acute</td>
<td>18.4</td>
</tr>
<tr>
<td>Primary Care</td>
<td>51.0</td>
</tr>
<tr>
<td>Provider services</td>
<td>38.7</td>
</tr>
</tbody>
</table>

£271.5m

How flexible is the PCT in its use of monies?

3.3.5 The Sub-Group wanted to explore if the amounts spent by the PCT were the right amounts for each area of work. Two questions were raised: (1) How does the PCT’s allocation of resources match the relative value given to different national initiatives, priorities and targets? (2) How much of the total budget is in effect already committed (e.g. through contracts and joint commissioning) and how much discretion for expenditure actually resides in the hands of the PCT?

3.3.6 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. For 2006/07, Kensington and Chelsea PCT spending on the major programmes was in line with its peer group. The PCT believes that it applies an appropriate resource to national targets such as the '18 weeks wait' initiative. In the case of 18 weeks, commissioning the additional activity is done with the other PCTs, using local hospitals.

3.3.7 Ultimately the PCT has discretion over its entire budget, but in practice until there is an evidenced reason to change patterns of service, up to 85% of the budget is based on the prior year's patterns of referral and existing services.

3.3.8 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.
3.3.9 The Sub-Group noted:

- **There is flexibility in the use of growth funding** - The PCT’s five-year Health Investment Strategy (2008-13) indicated a budget of £269m going up to £301m five years later (excluding inflation). Forward planning indicates that from 2008/09 onwards, once the backlog deficit is cleared, the PCT will have approx. £8million of recurrent growth funding available for investment.
- **Reduction in expenditure in the acute sector will be spent in primary and community services** - The PCT is to try to reduce the percentage of expenditure devoted to acute commissioning, with resources going instead to implementing the primary care strategy and community and provider services. This is wholly in line with the Darzi report “Healthcare for London” and the White Paper “Our Health, Our Care, Our Say”.

### How efficiencies are explored

3.3.10 The Sub-Group wanted to explore how the PCT ensured efficiency in its commissioning. The questions “How does the PCT measure efficiencies in commissioning?” and “How does the PCT ensure good value?” were raised. The Sub-Group was advised that the principal ways in which the PCT ensures efficiency in the commissioning process are:

- **Benchmarking** – Kensington and Chelsea PCT is compared against other PCTs with a similar profile in London and nationally.
- **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.
- **Contestability/market testing** – The PCT is currently working through all their provider services to ensure good value. They are undertaking benchmarking against national reference costs and have 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 save people time and money.
- **Clinic 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 (see section 3.2.12)
- **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.

3.3.11 The Sub-Group was advised that vulnerable people such as the homeless who were not officially resident in the Royal Borough would not be denied treatment on the grounds of non-residence, although the cost of
treatment might be re-charged to another PCT when that area had a stronger link.

**Specific examples of efficiencies**

3.3.12 Specific examples of where efficiencies have been achieved in the past 2 years:

- The reduction of follow up attendances in outpatients, with patients being managed in primary care
- Commissioning complex mental health placements from Central and North West London Foundation Trust instead of more distant providers, so saving money and providing a better service
- Effective commissioning of HIV treatment and care which has reduced the cost per new patient by 30%
- Commissioning a new community diabetes team to provide better, more cost effective, treatment closer to home
- Providing more continuing care placements at Princess Louise Kensington - lower price and better quality
- Commissioning a primary care front end at Chelsea and Westminster A&E, to register unregistered patients and give the GP appointments
- Renegotiation of the GP PMS contract to provide better, more consistent value for money.

**Constant monitoring of the financial position**

3.3.13 The Sub-Group noted that PricewaterhouseCoopers said on page 4 of their Annual Audit Letter (25 September 2007), "The PCT should continue to monitor its financial position in 2007/08 to ensure targets are being met or mitigating actions are put in place where there are variances against the budget." The Sub-Group is pleased that Kensington and Chelsea PCT do this every month.

**Financial position 2008-09**

3.3.14 The “PCT Operation Plan 2008/09” reports “The PCT will receive a 5.5% uplift in 2008-09 ... The Plan assumes that the surplus carried forward will be £3.1m ... The Plan assumes that all historical debt and loans are discharged during 2007-08 ... The overall increase in available funds in 2008-09 compared to 2007-08 is 9.8%” (page 37)

**3.4 PRACTICE BASED COMMISSIONING (PBC)**

3.4.1 Under Practice Based Commissioning (PBC) decision-making will occur closer to the front line. GP practices in Kensington and Chelsea will be commissioning services that meet the health needs of their local population. There is an excellent sign-up by local GPs and they work collectively in one consortium for Kensington and Chelsea (taking into account the North/South differences of needs of patients, patient flows and providers). There is background information on PBC in Appendix 5.
3.4.2 The PCT provided funding to the single consortium, which was responsible for spending it as it considered best. The Sub-Group was informed on 18 June 2007 that effectively the whole of the acute commissioning budget of £104m was devolved to PBC. However, it was also pointed out that it was only the first year of operational arrangements, and PBC had only had a marginal impact so far. The responsibility for acute expenditure which now lay with the GPs' consortium, and the financial risks which this engendered, were noted. The Sub-Group recognised that the advent of PBC had devolved real power to GPs, who now played a lead role in commissioning.

3.4.3 The PBC Group also confirmed that it was responsible for all Acute Commissioning Activity. The Group also said that the PBC budget for 2006-07 was about £50m (referring just to acute care covered by Payment By Results). It was noted that the PBC funding was based on the preceding year budget. Acute Emergency admissions took 37% of the budget; New Outpatients - 12%; Follow up outpatients - 24%; and, Elective admissions - 28%.

3.4.4 The consortium has a decision-making steering group which meets once a fortnight, with plenary meetings of GP practices on a quarterly basis. The commissioning group is six GPs elected by all GPs in the borough. They have a responsibility to ensure that all the GP practices are kept suitably informed. There are annual visits to constituent practices and performance review of practices.

3.4.5 The PCT see the single consortium as a strength that aids designing appropriate care pathways and commissioning appropriate care to meet patient needs.

**Increasing involvement in PBC**

3.4.6 User involvement will need to be built into the plans and will influence the shape local services take, with more tailoring of services to local need. PBC has a Constitution.

3.4.7 The chairman of the PBC steering group has attended all meetings requested by local voluntary groups and this will continue. The steering group has had a presentation on LINks at a recent meeting and are committed to working with them. The work of the steering group is accountable to the Clinical Executive Committee and any significant changes are considered at this meeting, which has Royal Borough representation. The PCT Board receives regular reports as necessary and all commissioning plans are considered within the context of the PCT Commissioning Strategy. The steering group is happy to attend the OSC on Health as requested. The Annual Report is prepared at the end of the financial year.

3.4.8 The question was raised of how decisions of substance before the GPs' consortium steering group would become known to the Council, allowing it to exercise its scrutiny function in appropriate instances. The Sub-Group recognised that this was an area that required further consideration.
There could be a need for a formal mechanism for OSCs to engage with the PBC.

**Recommendation 10:** The PBC should be asked to make an annual presentation to the OSC on Health on how it has taken user views into account and responded to patient needs and concerns.

### PCT ensuring effective practice based commissioning

#### 3.4.9

The consortium monitors expenditure throughout the financial year, allowing remedial action to be taken. In the case of GP practices which were identified as performing poorly as commissioners or in their referral or prescribing practice, the PCT advised that the PBC steering group would aim to offer advice and support. Ultimately, the PCT retained the power to take back the commissioning budget from a GP practice which failed to meet acceptable standards and consistently overspent. To date, there had been no instance where a GP practice had overspent its budget and as a consequence had needed to cut back the service it provided, because all the GPs act as one consortium, which has not over spent to date.

#### 3.4.10

In response to the question “How can the PCT ensure effective commissioning by GPs?” the Sub-Group was informed that the PCT has an advisory and supportive role. The PCT attends the commissioning group and provides information on local health needs, provision of acute commissioning data, cost-effectiveness of services (a PCT website exists to assist GP practices), patient and public views of services, and other data to support PBC. There is an agreed financial framework, a management allowance, key PCT staff support PBC, and there are two monthly meetings separately with the PCT Chief Executive and PCT Director of Finance.

#### 3.4.11

The GPs' consortium is required to present a business case for its proposals to the PCT's Clinical Executive Committee. It is possible that entrepreneurial tension could develop within this relationship in the future.

#### 3.4.12

It was reported that control of PBC spend is ensured as:

- i) The Clinical Executive Committee exercises responsibility for overseeing consortium performance and expenditure and PBC spend.
- ii) The PCT remains a “strategic commissioner”. Spend is monitored and reviewed.
- iii) Ultimate responsibility rests with the PCT board.

#### 3.4.13

In the event that the consortium went into a financial deficit, the PCT would expect it to return to a balanced budget in the following financial year. Failure to do so could result in the PCT rescinding the consortium’s spending powers. The Sub-Group asked about mechanisms for dealing with disputes. It heard that if the PBC group had a disagreement with the PCT the Strategic Health Authority (NHS London) would arbitrate. However, if the PBC group had a disagreement with a Trust this would be
resolved by the PCT, or if the disagreement was both significant and intractable, by formal arbitration between the PCT and the Trust.

**Service development**

3.4.14 Dr Mark Sweeney gave examples of service redesign to come from PBC:

- Anticoagulation is being done by 11 practices. This scheme has been evaluated.
- Community dermatology clinics in both the north and south. This scheme will be evaluated.
- GPs can refer Chronic Obstructive Pulmonary Disease (COPD) patients to a nurse for evaluation
- Patients assessed by community diabetic liaison nurses
- Community based psychology service
- Community Services
- A&E project assists people to register with a GP when they appear at A&E. There has been a positive patient response to this scheme.
- Frequent attendees to hospital (i.e. those with long term conditions) are tracked so that their treatment can be better identified and case managed.

**Incentives**

3.4.15 The Sub-Group asked about incentives in the system for GPs so that PBC begins to make an impact on the design of care. The Sub-Group heard that a budgetary framework has been devised by the PCT, which sets out to control demand, save money and improve care. Incentives are to be used (GPs keep 50% of savings, to be spent on primary care) and certain parts of the budget are to be ring-fenced. The other half of any surplus made by the consortium would be passed back to the PCT.

3.4.16 The planned use of savings must have PCT Board approval. In 2006-07 the savings were approx. £400,000 so there was £200,000 to pay for service developments. PBC funded: a COPD nurse and support team; additional psychology staff; GP computer education and training; setting up GP with special interest training; and, possibly additional emergency equipment such as defibrillators may be funded.

3.4.17 To encourage more consultants giving clinics in the community the PBC group is working closely with the PCT commissioning staff and any developments will be incorporated into the overall plan for the PCT.

**Joint working with social services**

3.4.18 The Council is working with the PBC group, and there are a number of ongoing joint commissioning arrangements. Adult Social Care pioneered an integrated case management scheme with a large GP practice as part of PCB. As regards closer working between the PCT and Social Services, the Sub-Group heard that other PCTs nationally were further developed in providing care on a multi-agency basis, and Kensington and Chelsea PCT was reluctant to put a timescale on when a fully joined-up approach might be achieved.
3.4.19 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.

3.4.20 The PCT shares all national directives for the NHS with the steering group members of PBC and they are invited to key seminars as appropriate.

**Business management**

3.4.21 A question was raised on whether it was reasonable to expect GPs (who might be extremely accomplished in the clinical field) to perform effectively in the business management of their practices. Whilst the principle of a devolutionary approach which placed responsibility in the hands of those closest to the community was acknowledged, the extra demands which this placed on GPs' time was also recognised.

3.4.22 As part of the GP contract they 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.

**PBC both a commissioner and provider of services**

3.4.23 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.

3.4.24 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.

**Future challenges**

3.4.25 The Sub-Group was told that other future challenges for PBC, that have not already been mentioned, include:

- Hospital coding often chaotic, untimely. When the electronic patient record comes (2008/09) it will greatly aid the tracking of patients.
- Computer system failure [e.g. Dr Foster and Secondary Uses Service (SUS)]
- Scrutiny and audit of acute care
- Increasing patient expectations

3.4.26 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.
3.4.27 NHS London has said that one of the key mechanisms for delivery of the Darzi report “Healthcare for London” will be through commissioning and the use of finance by PCTs. However, much of the PCT’s budget is already committed and a large proportion is delegated to PBC Consortium. The Sub-Group asked about this and was told, “PBC will commission local services based on health needs and evidence based approach. The PCT believes that PBC has an appetite for clinically appropriate and evidenced change.”

3.4.28 There are concerns that some GPs may find it difficult to be the “lever for change” if in serving their patients they give over emphasis to a stable NHS structure.

3.4.29 There are a number of concerns relating to the delivery of “Healthcare for London”. For example, the priority for GPs may well remain procuring better health for patients through a stable NHS structure rather than being used as a lever for change.

3.5 INCREASING CHOICE AND ENSURING GREATER RESPONSIVENESS

3.5.1 Patient choice is seen as a major driver for service diversification and improvement. PCTs must support patient choice by providing clear and accessible information about health services. Commissioners will also need to ensure that patients and the community are involved throughout the commissioning cycle. There is background information on Increasing Choice set out in Appendix 6.

3.5.2 PCT’s Acting Chief Executive (March 2008) said, “Patient choice effectively means an end to commissioning elective services. Patients have a free choice as to where they will go for treatment, and GPs and others are tasked with supporting their choices. There will be a significant publicity campaign to launch ‘Free choice’ during April 2008.”

Choose and Book

3.5.3 Choose and Book is a service that will, for the first time, combine electronic booking and a choice of time, date and place for first outpatient appointments. PCTs will 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.

3.5.4 The Sub-Group heard that the PCT has made good progress on implementing Choose and Book. During May 2007, 61% of all referrals made to Consultant-led outpatient clinics by Kensington and Chelsea GPs were booked via Choose and Book. In addition, the PCT is also continuing to make primary care services available for referral via Choose and Book.

3.5.5 However, the PCT Board (20 May 2008) were told that for the Healthcare Commission’s target “% of patients fully booked over choose and book for first patient appointment” the PCT’s performance has reduced to “red”.

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3.5.6 Choice and Book is likely to accelerate the move towards the centres of excellence.

**PCT Prospectus**

3.5.7 The commissioning framework states that "the PCT prospectus will develop as a proactive method of communicating with patients and the public and could provide a focus for debate on local needs, performance of local services and the priorities for improvement”. Prospectuses will set out the results of local needs assessments, publish data on patient satisfaction with services, summarise priorities, forecast future service needs, and "provide direct public accountability for commissioning decisions and performance by explaining what and why particular commissioning decisions have been taken, such as why investment has been made in certain service areas and not in others.”

**Personalisation of care**

3.5.8 The Government has been pushing for the personalisation of care - for example, direct payment and individual budgets. The Council and PCT will need to cooperate effectively around personalised plans. The PCT has said it is at an early stage at addressing the “personalisation” of care agenda and will be working on this further with the Royal Borough.

**3.6 PAYMENT BY RESULTS**

3.6.1 This 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. The system is already in place for elective surgery throughout the NHS and for 70% of all procedures for foundation trusts. Payment by results is expected to increase to 90 per cent of hospital care by 2008.

3.6.2 Instead of being commissioned through block agreements as previously, hospitals (and other providers) will be paid for the activity that they undertake; so PCTs through PBC will commission:

- The volume of activity required to deliver service priorities, adjusted for casemix (i.e. the mix of types of patients and/or treatment episodes);
- From a plurality of providers;
- On the basis of a standard national price tariff, adjusted for regional variation in wages and other costs of service delivery.

3.6.3 This system should ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

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Tariff

3.6.4 The tariff, that the PCT pays the trusts, forces efficiencies. The increase in tariff is based on a central estimate of NHS inflation, less an expectation of efficiency savings of 3% per annum.

3.6.5 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). Where patients choose to go will be important, as it will affect 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.

Impact of choice

3.6.6 The Sub-Group raised a question on the possible downward spiral of hospitals which proved less popular with patients. So far no significant trends in patient choice having such an impact had yet been discernable, although it was recognised that this represented a possibility in the future.

3.7 CONTRACTS WITH PROVIDERS

3.7.1 Contracts will be developed with secondary care providers within a new national contracting framework, with the involvement of practice-based commissioners. It is important that both PCTs and practices manage demand to ensure that budgets are not exceeded, while ensuring that local people have access to appropriate care and treatment. This will, in part, depend on partnership working with local authorities to ensure that health and social care are integrated and achieve the most cost-effective use of resources.

3.7.2 PCTs will be responsible for measuring and reporting on patient experience. Practices will need this information as part of the data on which to base their own commissioning decisions.

3.7.3 The White Paper "Our Health, Our Care, Our Say" gives a commitment that PCTs will stimulate the development of new services that deliver care in community settings, away from hospitals. Whilst welcoming this shift in emphasis the Sub-Group expressed concern if funding to local authorities did not increase adequately to deliver the additional responsibilities.

3.7.4 The PCT will be commissioning more community and practice based health care as patient pathways change.

3.7.5 The PCT is considering the use of “incentives” (authorised by the SHA) to do better than target on hospital based infections and waiting times.
Recommendation 11: We support the PCT’s aim to deliver care closer to people’s homes and out of hospital wherever this is appropriate. We also welcome the shift in the focus of healthcare from treating sick people towards prevention and supporting wellbeing.

3.8 ACUTE PROVISION

3.8.1 The PCT commissioned about 85% of its acute activity from three main providers, Chelsea and Westminster Foundation Trust, St Mary’s Hospital and Hammersmith Hospitals during 2006/07. The PCT has a total of 15 Service Level Agreements (SLAs) with general and specialised acute Trusts, and two mental health Trusts.

Shift Away From Acute Care

3.8.2 The White Paper “Our Health, Our Care, Our Say: A new direction for community services” said there would be a shift in focus from hospital care to preventative services and treatment in community settings. If hospital care is to be delivered in this manner there is a need for careful planning to enable a successful transfer of services. The national guidance “Implementing care closer to home - Convenient quality care for patients”16 aims to provide practical support to commissioners for the provision of more specialised services closer to home.

3.8.3 To ensure the infrastructure is in place there will need to be clear evidence of investment in non-acute commissioning. This should match the disinvestment in secondary care.

The percentage of expenditure devoted to acute commissioning in 2007/08

3.8.4 It has not reduced, but has not increased in 2007/08 by the 3% seen in each previous year. The additional activity to meet the 18 weeks referral to treatment target distorts the picture, but the “overall the rate of increase in acute activity has been halted”.

The percentage of expenditure devoted to acute commissioning in future years

3.8.5 The PCT’s Health Investment Plan 2007-2012 calls for a reduction in acute commissioning in the next five years. The Plan says, “Acute expenditure’s share of the total budget reduces by 3% over the planned period. This increases primary, community and provider share by 4%” (page 7). The Sub-Group heard that £4.3m from secondary care to primary care in 3-4 years is “do able”. This is a clear example of commissioning seeking to change expenditure patterns.

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16 “Implementing care closer to home - Convenient quality care for patients” is available on the Internet at: http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Primarycare/Practitionerswithspecialinterests/DH_074419
The impact of shorter hospital stays on community services

3.8.6 A reduction in hospital beds is likely to increase pressure on home care budgets. If more people are receiving community based health services and spending less time in hospital, local authorities could face rising pressures in the provision of personal and practical care.

3.8.7 The PCT has given reassurances that health costs will not be transferred to the Borough (unless there is agreement about care packages, local arrangements and funding). Any increase in community care costs must be reflected in social care financing. The PCT has said there are no plans to reduce hospital stays without putting appropriate community care in place.

PCT Commissioning Intentions 2008/09 (hospital services)

The PCT’s vision is articulated as:
• Improving health
• Reducing health inequalities
• Commissioning Primary Prevention Services
• Hospital not always the answer (care closer to home) – reduction in acute spend of 5%
• Financial stability – repayment of deficit by 2009, £10m surplus by year 5 for investment
• Specialised care – 100% of stroke, cancer, major trauma services, obstetrics services will only be commissioned from specialist units which meet the very highest of clinical standards and outcome measures
• Shifting the provider landscape – to increase the range of providers and making decisions in relation to best fit of our provider services

The PCT Chairman (PCT Board 27 November 2007) added the need to reflect the patient’s needs and experience, the quality of service provided and cost.

Imperial College Healthcare NHS Trust – An Academic Health Science Centre

3.8.8 An Academic Health Science Centre (AHSC) brings together the delivery of healthcare services, teaching and research in a single partnership. Imperial College Healthcare NHS Trust, the amalgamation of St Mary’s NHS Trust, the Hammersmith Hospitals NHS Trust and Imperial College London, is the UK’s first AHSC. This AHSC will have an increased economic power compared to the two separate hospitals (St Mary’s and Hammersmith hospitals). Having only two main acute providers (Imperial and Chelsea and Westminster) will impact on the PCT’s ability to commission services. Kensington and Chelsea PCT need to ensure they do not become trapped by any “provider capture”.

3.8.9 It is likely there will be rationalisation of services between the various sites. A paper on “A Framework for Action” was taken to the St Mary’s Board in July 2007. It says that there is a real service opportunity to ensure that the AHSC leads in the provision of “trauma services in NW

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17 PCT Board (27 November 2007) Agenda Item 5.1
18 The paper “Framework for Action” was taken to St Mary’s Board in July 2007. It is available on the Internet at: http://www.st-marys.nhs.uk/uploads/board_papers/TBP07-61AFrameworkforAction.pdf
London; stroke services; tertiary paediatric services; and, work with PCTs to set-up a polyclinic in NW London.” (p6)

3.8.10 There needs to be contestability and competition between different providers for a market of healthcare provision to work. During the consultation on the formation of the AHSC the OSC on Health asked questions such as: “How is the AHSC intending to expand its NHS business? What are the goods and services that the new Trust intends to offer in the longer term and what is the rationale for this?” These questions were left unanswered.

3.8.11 Kensington and Chelsea PCT is to commission the AHSC [a large (approx. £1billion) organisation] with a group of PCTs. Kensington and Chelsea PCT is included in the North West London Chief Executives’ strategy group and the clinical reference group.

Managing shifts in local NHS capacity due to the AHSC development

3.8.12 PCTs acting together have the task of managing the provision of specialised and emergency services, which will be done in the context of Healthcare for London.

3.8.13 There is a wide choice of providers in London, and the free choice policy will encourage patients to choose from a wider range than at present, including the Independent sector, provided they can operate at the NHS tariff.

3.8.14 Patient choice alone will determine which Trusts provide elective services in future - PCTs will not have a role in managing the impact of this.

3.8.15 The PCT will have a formal standard NHS contract with the AHSC and will hold them to account for delivery.

3.8.16 As the PCT would have less impact working in isolation it will adopt a joint approach with its local PCTs (e.g. Ealing, Hammersmith & Fulham and Westminster). As a commissioning consortium, the PCTs can exert more influence on the AHSC.

Recommendation 12: The PCTs in North West London will need to ensure that shifts in local NHS capacity due to Imperial College NHS Healthcare Trust development as an AHSC does not have a destabilising impact on other NHS providers. We support the PCT Chief Executive’s efforts to gain clarity in the form of detailed business/service plans related to the development of the Academic Health Science Centre.

Recommendation 13: Imperial College Healthcare NHS Trust will need to work in partnership with the local health and social care community. The AHSC can minimise the potential for direct conflict with neighbouring trusts by being clear and transparent in its actions.

Recommendation 14: We are concerned that we remain unclear as to how the Chelsea and Westminster hospital fit with the long term plans of Imperial College Healthcare NHS Trust. We recommend that the
Foundation Trust and Imperial College Healthcare NHS Trust work towards some type of charter for collaboration.

Sustainability Protocol

3.8.17 The Department of Health report "Health Effects of Climate Change in the UK" was published in February 2008. The guidance indicates that climate change should be at the core of the public health agenda across local authorities, the NHS and their partners. The document also includes a sustainable code for the health sector. The PCT has carried out work with the consultancy "Beyond Green" and have developed a Sustainability Protocol. The PCT is pioneering its use at St Charles.

Recommendation 15: Imperial College Healthcare (NHS) Trust, Chelsea and Westminster (NHS) Foundation Trust and CNWL Foundation Trust should sign up to the PCT’s Sustainability Protocol.

Maternity service

3.8.18 This Healthcare Commission’s Review of Maternity Services 2007 found Chelsea and Westminster, St Mary’s and Hammersmith Hospitals all scored “least well performing”.

3.8.19 The study published on 1st November 2007 in the British Medical Journal found that women who had a planned caesarean section put themselves and their babies at increased risk of serious complications. In the Chelsea and Westminster one in three deliveries is carried out surgically. This will be an important part of the PCT’s maternity review. The Sub-Group noted that Chelsea and Westminster take a high proportion of higher risk patients, because of their paediatric provision and that the Chelsea and Westminster report a higher proportion of patients “choosing” (presumably with the risks fully explained) elective caesarean.

3.9 MENTAL HEALTH PROVISION - CENTRAL AND NORTH WEST LONDON FOUNDATION TRUST (CNWL)

3.9.1 The main provider is Central and North West London NHS Foundation Trust (CNWL) who provide core mental health services for adults, children and older people. Services are currently consortium negotiated. The PCTs and Councils inside the region Central and North West London are in a strong position when they negotiate with the Foundation Trust. The Sub-

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19 The Sustainability Protocol is part of the K&C PCT's Estate Strategy (page 9) which is available on the Internet at: [http://www.kcpct.nhs.uk/pdfs/userUploaded/4.1EstatesStrategysummary120307.pdf](http://www.kcpct.nhs.uk/pdfs/userUploaded/4.1EstatesStrategysummary120307.pdf)


Group heard that the mental health foundation trust is practically "market caught" by this consortium.

3.9.2 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.

3.9.3 The PCT has worked with the London Health Observatory to look at the value of mental health services. This work indicated that costs were found to be reasonable (i.e. the PCT is not buying excess beds for this community). The PCT wishes to explore further the length of mental health stays to ensure these are not longer than expected.

3.9.4 In the paper "Performance Dashboard" presented to the PCT Board in 20 May 2008 the performance result for the Annual Health Check for "Commissioning of early intervention in psychosis services" was deemed to be "amber". The early intervention in psychosis service is expected to be fully funded in 2008/09.

3.10 COMMISSIONING FROM THE BEST PROVIDERS

3.10.1 A number of services will be restructured across North West London. Commissioning for these services will only be from providers that are in full compliance with National Service Frameworks and other guides of best practice. For example:

- Cancer services will only be commissioned from organisations that are compliant with Improving Outcomes guidance.
- Stroke services will only be commissioned from organisations that achieve best practice criteria by April 2008.
- Major Trauma services will only be commissioned from organisations which receive accreditation as major trauma centres.
- No service will be commissioned which will be delivered through the provision of mixed sex wards from 2009/10.
- Specialist leukaemia services.
- Specialist palliative care services will be commissioned in line with the End of Life care National Service Framework. Within the PCT the Gold Standard Framework has been rolled out to improve palliative care in the community.
- Specialist paediatric services will only be commissioned from a centre of excellence with a full range of specialist facilities on a 24 hour basis. The PCT expects to be commissioning specialist paediatric surgery services from facilities on a 24 hour basis by 2009/10.
- In Obstetrics the PCT is committed to ensuring that it commissions only from units large enough to provide safe and high quality services.
- Inpatient specialist services for people with HIV/AIDS will only be commissioned from delegated specialist centres in London (in partnership with the London Specialist Commissioning Group).

Recommendation 16: We support and encourage the PCT in its endeavours to commission from the best providers for our residents. We would support any reduction in the given timescales to move to better
providers. We recommend after three years there is a report outlining the scale of successfully implementation of these policies.

3.11 CONSORTIUM COMMISSIONING

3.11.1 A small number of treatments continue to be commissioned on a regional or national basis, though PCTs and practices will be represented on regional specialised commissioning groups, which in turn feed into the national specialised commissioning group.

3.11.2 About £28m was allocated to consortium commissioning in 2006/07 (£17m - HIV and Genitourinary medicine [GUM], plus £11m - specialised services).

3.11.3 The Sub-Group was told of the specialist commissioning expertise based in particular PCTs which then deliver on a pan-London basis. A London specialist commissioning group exists which manages activities to ensure value is received from consortium commissioning. However, commissioning in a consortium reduces the scope for each PCT to act in its own interest.

3.11.4 In total £19m is spent via consortia. The consortia are managed by the London Specialised Commissioning Group (SCG).

3.11.5 The HIV consortium is managed by the London SCG; the London Ambulance Service by Wandsworth PCT; and the Haemophilia and Bone Marrow consortia by Croydon PCT.

3.11.6 Good value is assured by having expert commissioners for these high value services, and through the approval of the annual SCG plan by the PCTs.

**Strengthen specialised commissioning**

3.11.7 The Carter review of specialised commissioning proposes a more formal governance arrangement for London specialised commissioning. This will include a non executive Board, drawn from the PCTs, and stronger reporting arrangements. The PCT supports these proposals to strengthen specialised commissioning, and does not wish to dilute the specialist nature of this work by bringing it in house.

3.12 SEXUAL HEALTH

3.12.1 The PCT funds a range of primary and secondary care initiatives which provide Kensington and Chelsea residents with access to HIV prevention services. It also funds a number of HIV related organisations who provide support and information to people living with HIV.

3.12.2 The PCT funds a local condom distribution scheme (with Westminster PCT) which provides condoms to both voluntary and borough based primary care organisations as well as training around condom use and health promotion. Condoms are also accessed free through our Contraceptive clinics.
3.12.3 Sexual health treatment services are commissioned via the acute treatment centre at Chelsea and Westminster Foundation Trust. This is a hosted service and as such the PCT commissions activity for all attendees of the service, regardless of PCT of residence.

3.12.4 In addition the PCT is the lead PCT for London for both Pan London HIV Prevention and Sexual Health. The Consultation on London HIV Prevention Draft Commissioning Intentions (2008/09 - 2010/11) was discussed at the OSC on Health on 21 November 2007. The OSC was pleased that a pan-London programme of HIV prevention for African people was proposed. However, the OSC did not think this should be paid for at the expense of HIV prevention for gay men. PCT representatives gave a reassurance that the committee would re-examine the figures and report back to the OSC. The Sub-Group was informed that there will not be any overall loss of HIV prevention services for gay men in London as the new contracts will provide more activity within the same budget. The London PCTs have also agreed to fund the pan London African communities HIV prevention programme.

3.12.5 The Sub-Group noted the Health Protection Agency\(^{24}\) has warned of the continuing HIV and sexually transmitted infection (STI) epidemic in gay men.

3.13 VOLUNTARY SECTOR

3.13.1 Voluntary organisations are commissioned across each client group, with additional generic organisations funded around advocacy, voluntary capacity and organisation representation.

3.13.2 The PCT currently commissions/funds services from the third sector to the value of approximately £2 million across all care groups (Commissioning Strategy Plan p30). The PCT is keen on expanding the shift to the community.

3.13.3 The Sub-Group referred to the aspirational nature of the increased expected role of the voluntary sector in the PCT’s commissioned service. In response, the PCT indicated that the PCT was aware of the potential pitfalls in moving too rapidly towards a significantly increased commissioning role for the voluntary sector.

3.13.4 The PCT recognised that more needed to be done in this area, and said that it would be working with the voluntary sector to take initiatives forward and help voluntary sector bodies develop their delivery capacity. The PCT Board has said it wishes to ensure small voluntary sector groups are not disadvantaged when they are providing commissioned services.

Recommendation 17: The PCT should clearly set out, in financial terms, how the role of the voluntary sector is recognised and developed with the switch to community care.

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3.14 PATIENT AND PUBLIC INVOLVEMENT

3.14.1 The PCT has a patient involvement strategy, and they use a wide range of methods to find out what patients think of the services being commissioned. An example would be the plans for the service changes at St Charles Hospital, or the review of maternity services currently under way.

The Development of Community Engagement by the PCT

In the PCT strategy "Investing in Health" (2007) community engagement is defined by the PCT as:

- Listening to the health needs and priorities of communities
- Listening to feedback from patient and public on their experiences of provider services
- Dialogue with the voluntary/community sector and public involvement organisations such as LINks on their constituents' experiences of provider services
- The involvement of communities in shaping service development and in making decisions about health priorities

Effective community engagement should explicitly challenge health inequalities in two ways: (1) Service development and commissioning priorities should as far as possible reflect need (2) The act of community engagement itself should also challenge inequity by ensuring that all groups are able to participate in decision-making. This is achieved through enabling community members to acquire skills, confidence and increased self-esteem

Kensington and Chelsea PCT aspire to be a leader in the community engagement field. "Investing in Health" identified the following principles:

- Engage meaningfully with the right people at the right time
- Be mindful of diversity and strive to engage hard to hear groups in the community
- Actively listen to what the community and service users have to say about their health and health services
- Work collaboratively with our partners in the third sector

Community engagement should be a useful part of: The assessment of needs; Service development; Service redesign; Evaluation services; Determination of priorities; Making of decisions.

3.14.2 Recent stakeholder engagement has included:

- Three public consultations over service changes in North Kensington
- The National Patient Survey
- The PCT held a stakeholder forum to look at proposed commissioning intentions
- A review of user involvement across the PCT (November 2006)
- Collaboration with the Patient and Public Involvement Forum
- Collaboration with the local government health scrutiny. This is an important way of involving stakeholders. Local authority Overview and Scrutiny Committees (OSCs) have a statutory role to call NHS bodies to account. Health scrutiny is a key vehicle for Councillors, as elected representatives and community leaders, to hold commissioners and providers to account for decision making around healthcare planning and delivery. OSCs are the only democratically elected and accountable bodies to comment on NHS developments.

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25 PCT Board (27 November 2007) Agenda Item 7.1
3.14.3 In terms of public engagement, the Sub-Group (18 June 2007) heard there would be wide engagement on the London strategy “Healthcare for London” and on the NW London strategy. A stakeholder forum on the PCT’s draft five-year strategy had been held recently, but was poorly attended. Other forms of engagement included focus groups, which it was intended to run on a number of specific issues.

3.14.4 The PCT has to meet the challenges of integrating patient and public involvement into all aspects of their commissioning strategies. The White Paper "Our Health, Our Care, Our Say" stated that "The challenge to commissioners is how to make greater local voice, choice and control a reality" And that: "Systematically and rigorously finding out what people want and need from their services is a fundamental duty of commissioners" Also: "organisations commissioning NHS funded care must ensure local people play a full part in the planning, design and delivery of their services. How well they succeed will form part of their overall annual performance rating". The White Paper also said local people’s voices "have to count", and "will be most effective if they directly affect the way resources are used".

3.14.5 The PCT has said "We will ensure that commissioning decisions are informed by user views ... by strengthening the links with User Involvement" (Commissioning Strategy Plan p19).

3.14.6 Making user involvement stronger should help improve services. Patients and the public can contribute to commissioning by: giving feedback on the quality of services; engaging in the development of prospectuses by identifying need, assessing performance and highlighting priorities; and increasing choice by exercising choice where it is available.

3.14.7 The PCT Chairman at the Regeneration Exchange (21 June 2007) mentioned the need for the PCT to improve engagement with the wider public (including “seldom heard” and BME groups) in their commissioning processes.

Recommendation 18: The Sub-Group would like to see and consider: (1) The PCT report on the stakeholder forum to look at proposed commissioning intentions; and, (2) An evaluation of the actual impact of this consultation on PCT commissioning.

Recommendation 19: There should be clear prior consultation by all NHS bodies when there is a substantial change in service as required by law – Section 7 Health and Social Care Act 2001 (if in any doubt see health scrutiny protocols agreed in 2003).

Access to information for public engagement - Board Papers

3.14.8 For good governance, public sector bodies need to be as transparent as possible with decision making to the public and partner agencies.
3.14.9 The Council has a section “Committees-on-line”\(^{26}\) on its website. Agendas, minutes and all papers presented are on-line. Electronic versions of all the papers and published reports from the “OSC on Health”\(^{27}\) are on-line making them accessible to anyone with Internet access.

3.14.10 Electronic versions of the papers from the joint working partnerships such as the “Kensington and Chelsea Partnership”\(^{28}\) and “Health and Well-being Partnership Board”\(^{29}\) are all on-line.

3.14.11 Kensington and Chelsea PCT\(^{30}\) and Imperial College NHS Healthcare Trust\(^{31}\) fully publish their board papers on the internet.

3.14.12 Royal Brompton & Harefield NHS Trust provide just Trust Board minutes on their website\(^{32}\). On the webpage entitled "Trust Board Minutes 2008" it says that "Full agendas and supporting papers are available at the meetings and may also be requested in writing from the director of finance & performance." The full agenda and supporting papers are not freely available on the Internet.

3.14.13 We note, the local Foundation Trusts are making great efforts to increase its membership, which is the statutory mechanism for a Foundation Trust to engage with the population they serve.

3.14.14 CNWL Foundation Trust publishes both the papers for their Council of Members Meetings\(^{33}\) and the CNWL Board of Directors papers\(^{34}\) on the Internet.

3.14.15 The Chelsea and Westminster Foundation Trust publishes the papers for its Members’ Council\(^{35}\). However, Chelsea and Westminster Board papers are not published on the Internet.

3.14.16 The Royal Marsden Foundation Trust's website has a specific "Members' Area" which sets out minutes and agendas of Membership Council

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\(^{26}\) Royal Borough of Kensington and Chelsea’s “Committees on-line” is available at: [http://www.rbkc.gov.uk/meetingsreports/general/](http://www.rbkc.gov.uk/meetingsreports/general/)


\(^{28}\) Papers from the Kensington and Chelsea Partnership are available at: [http://www.rbkc.gov.uk/KCPMeetingsMinutes/general/](http://www.rbkc.gov.uk/KCPMeetingsMinutes/general/)


\(^{30}\) Papers for the Kensington and Chelsea PCT Board are available at: [http://www.kc-pct.nhs.uk/theboardroom/index.htm#meetings](http://www.kc-pct.nhs.uk/theboardroom/index.htm#meetings)

\(^{31}\) Papers for Imperial College NHS Healthcare Trust Board are available at: [http://www.imperial.nhs.uk/aboutus/ourorganisation/boardmeetings/index.htm](http://www.imperial.nhs.uk/aboutus/ourorganisation/boardmeetings/index.htm)

\(^{32}\) There is a webpage entitled "Trust Board Minutes 2008" at: [http://www.rbht.nhs.uk/about/our-work/board/minutes08](http://www.rbht.nhs.uk/about/our-work/board/minutes08)

\(^{33}\) Papers from the “CNWL Board of Directors” are available at: [http://www.cnwl.org/Board_Directors_papers.html](http://www.cnwl.org/Board_Directors_papers.html)

\(^{34}\) Papers from the “CNWL Council of Members Meetings” are available at: [http://www.cnwl.org/com_meetings.html](http://www.cnwl.org/com_meetings.html)

\(^{35}\) Papers from the “Chelsea and Westminster Membership Council” are available at: [http://www.chelwest.nhs.uk/aboutus/meetings.htm](http://www.chelwest.nhs.uk/aboutus/meetings.htm)
meetings. The full agenda and supporting papers of the Membership Council are not freely available to any member of the public with Internet access. The Trust Board’s agendas, supporting papers (not confidential items) and minutes are also not freely available on the Internet.

3.14.17 The OSC on Health will be contacting the regulators (Healthcare Commission and Monitor) to draw their attention to our concerns in this matter.

Recommendation 20: As public bodies are paid for out of the public purse, the public should have the ability to find out how that money is spent. For good governance, NHS bodies need to be as transparent as possible (i.e. not confidential matters) with decision making to the public and partner agencies. All NHS bodies (NHS and Foundation Trust) Board papers (inc. agenda, minutes, strategies, performance data etc) should be made fully available on the Internet. This publication of basic information should be a minimum in the twenty-first century.

A Stronger Local Voice: A framework for creating a stronger local voice in the development of health and social care services

3.14.18 Patient and Public Involvement (PPI) forums have been replaced in April 2008 with a new framework for user and public involvement. The framework will establish a Local Involvement Network (LINk) in their geographical area. Their job will be to gather intelligence about local health services and make recommendations to both providers and commissioners. It is suggested that: Health OSCs focus their attention on the work of commissioners; the duty, under Section 11 of the Health and Social Care Act 2001 (to involve and consult patients and the public in the development, planning and operation of services) is strengthened; and, new standards are developed for the assessment of local arrangements for involving service users.

3.14.19 The PCT expects to have integrated PPI (including the work of its LINk) into commissioning at high management or budgetary levels during 2007/08.

Recommendation 21: There needs to be clarity in the role of the Kensington and Chelsea LINk and appropriate pathways created to enable the local community to influence the PCT, the PBC Group, Families and Children and Adult Social Care in their commissioning decisions. The LINk will have to work very closely with many partners including the OSC on Health.

3.15 PERFORMANCE MONITORING

3.15.1 The Sub-Group asked how the PCT monitors its performance (such as against its own corporate objectives). The Sub-Group heard that the PCT takes a systematic approach to performance improvement. This has

36 A password is needed to enter the Royal Marsden Foundation Trust's "Members' Area" at: http://www.royalmarsden.nhs.uk/RMH/info/foundationtrust/membersresource.htm
included the development of a performance framework and “Performance Dashboard”.

Performance Dashboard

3.15.2 The PCT has many priorities. It measured performance in 2007/08 against 175 indicators (as reported in the attachment to the “Performance Dashboard” paper presented regularly to the PCT Board).

Performance managed

3.15.3 PCT commissioning will be performance-managed and assessed by the Strategic Health Authority (NHS London) and the Healthcare Commission (HCC) on the extent to which it achieves the following nationally set commissioning goals: improving health and well-being; securing access to a range of services; improving quality and efficiency; increasing choice; and promoting patient-centred service redesign.

4. THE PCT’S ROLE AS A PROVIDER

4.1 INTRODUCTION

4.1.1 Looking ahead, the PCT will be focusing on strengthening its commissioning function, and enabling its directly managed services (i.e. provider services) to establish greater independence from the PCT. In the longer term Kensington and Chelsea PCT should be able to split the provider functions from the rest of the PCT.

4.2 SEPARATION OF PROVIDER FUNCTIONS

4.2.1 Within the PCT’s Commissioning Strategy Plan (June 2007) the PCT says, “Kensington and Chelsea PCT are committed to working with NHS London in separating its Provider/Commissioning functions. In doing so we are investigating the viability and feasibility of organisations such as Community Foundation Trusts. We will be looking at Provider services being of a sustainable size and where necessary looking to provide or commission with other PCTs” (p29). “Long term Projects Yr3-5 - Having undertaken an options appraisal we will move forward with a decision to separate responsibilities for services between provider and commissioner.” (p51)

4.2.2 The PCT’s plan for the separation of its provider function is expected by May 2008, and it will be happy to share this with the OSC on Health.

4.3 COMMUNITY NURSING - HEALTH VISITING, DISTRICT NURSING, SCHOOL NURSING AND NIGHT NURSING

District Nursing

4.3.1 District nursing has been recently re-aligned with the GP practices. There are 16 teams across the borough. Each team covers a weighted population of around 10,000 patients.
Community Nursing

4.3.2 The PCT has said, “Investment will be needed to strengthen community nursing teams to ensure a rapid response is managed effectively in conjunction with Primary Care. This will also ensure that care is delivered at home when possible or in an appropriate community (setting)” (Commissioning Strategy Plan p29). Extra investment in funds and personnel is expected to be provided from 2008/09.

4.3.3 Before the PCT decides to become a fully commissioning body it will need to make a decision on how it wishes to manage community nursing in the future (e.g. health visiting and district nursing). Prior to April 2002 they were managed by Community Health Trusts.

4.3.4 How community services are to be managed is currently under review between the PCT, other local PCTs, the Royal Borough of Kensington and Chelsea and PBC.

4.3.5 Before any new body could consider providing community-based services for the PCT, the level of resources being offered against the expectation of service that the PCT wants delivered would have to be clearly set out.

4.4 SPECIALIST NURSING – CONTINENCE, TISSUE VIABILITY AND INFECTION CONTROL

4.4.1 Specialist nursing may be managed in the future through an Autonomous Provider Organisation (APO), but at present this is unclear.

4.5 DIRECTLY MANAGED OLDER PEOPLE’S SERVICES AND CARE HOMES

4.5.1 Older people’s services may be managed in the longer term through an APO. Care homes may not be directly managed in future but at present this is unclear.

4.5.2 Changes to St Charles Hospital have been subject to consultation. The PCT gave approval to proposals for change at its Board on 1 May 2007.

Recommendation 22: The future of the provider services of the PCT has to be resolved shortly. We would expect an options appraisal to be the first step in any considerations as stated on page 51 of the Commissioning Strategy Plan (June 2007). This appraisal must include partial integration models such as dividing up provider services between acute sector providers, the Royal Borough, GPs and third sector. Without a clear provider plan commissioning must be uncertain.

4.6 OTHER PROVIDER SERVICES

4.6.1 The long term plans for other provider services (e.g. Speech and Language Therapy, Podiatry, Day Hospitals, the Learning Disability Community Team and local specialist service at Kingsbridge Road, Outpatient facilities, Family Partnership Team, Dietetics and Nutrition, the Pembridge Palliative Care Unit and Osteopathy) are subject to different strategies, all of which will be shared with the OSC on Health.
5. CONCLUSION

PCT Performance

5.1 The Healthcare Commission gives Kensington and Chelsea PCT a performance rating in the Annual Health Check. In October 2007, Kensington and Chelsea PCT was rated “Good” on “Quality of Service” and “Fair” on “Use of Resources”. The “Good” “Quality of Service” rating places the PCT in the top 30% nationally. The “Fair” result on “Use of Resources” is an improvement on the “Weak” score for 2005/06 and reflects the improvement in the PCT’s financial position.

Provider services

5.2 The long term position of the PCT’s provider function seems to be unresolved. It would be helpful if its future status were resolved. It would be worth considering how to foster closer working with the Council on these services.

22 recommendations and findings

5.3 From this review, 22 recommendations and findings have been made. These are set out throughout the document and again at the start of this report for ease of reference.

Councillor Christopher Buckmaster
Chairman
APPENDIX 1: TERMS OF REFERENCE

TERMS OF REFERENCE

1. The Review

1.1 The aim is to gain a greater understanding and to strengthen the commissioning processes in Kensington and Chelsea PCT.

1.2 The review will focus on addressing specific questions about current commissioning arrangements.

2. Determining Local Needs

2.1 A joint commissioning framework: What work is underway with the Council’s Adult Social Care and Children’s Social Services to develop a joint strategic commissioning framework? Is there a shared understanding of population and shared understanding of needs?

2.2 Needs assessment: How does the PCT determine needs and how does this relate to the needs as assessed by Social Services? What is the level and quality of health needs assessment work in general? What leverage does needs assessment work have on the PCT’s commissioning processes? How does the PCT react to changing needs? How does the PCT exercise its accountability to patients?

2.3 Increased patient choice: The need to increase choice can limit commissioning choices. Can each local NHS body in Kensington and Chelsea articulate what they mean by patient choice? Has this definition of patient choice been communicated to patients? Are patients exercising choice?

3. Setting local priorities

3.1 The impact of national priorities and targets: How does the PCT’s allocation of resources match the relative value given to different national initiatives, priorities and targets?

3.2 The PCT’s commissioning priorities: These seem to be: (1) The need to balance the budget, (2) the four key priorities for 2007/08 contained in “NHS in England: the operating framework for 2007/08”), (3) the raft of other national targets, (4) local targets. Are these priorities correct? Where is the PCT at in setting local targets? How much can the allocation of resources shift in line with more local strategies and local targets?

4. Ensuring efficiency and good value

4.1 Commissioning in a consortium reduces the scope for the PCT to act in its own interest. How much of the expenditure of the PCT is subject to discretion? What amounts are dedicated to consortium commissioning (who controls each consortium?), and to GPs’ practice based commissioning? How can the PCT have a greater control over the use of consortium commissioning budgets?
4.2 With the advent of practice-based commissioning (PBC), the PCT will remain a “strategic commissioner” but practice-based commissioning will occur closer to the front line. How can the PCT ensure effective commissioning by GPs? And how can general practitioners be better managers? Are there enough incentives in the system for GPs to begin to make a significant impact on the design of care?

4.3 Other questions might include: How does the PCT measures efficiencies in commissioning? How does the PCT ensure good value? How does the PCT identify improvements to its commissioning strategy?
APPENDIX 2: SUB-GROUP MEMBERSHIP AND MEETINGS

Members:

- Councillor Christopher Buckmaster (Chairman)
- Councillor Marianne Alapini
- Councillor Joanna Gardner
- Councillor Pat Mason
- Councillor Julie Mills

Officer support:

- Stella Baillie (Head of Adult Services)
- Henry Bewley (Health Policy Officer)
- Ahmed Farooqui (Scrutiny Development Manager)
- Gavin Wilson (Governance Administrator)

Kensington and Chelsea PCT attendees:

- Frankie Lynch (Director Primary Care Commissioning) – 13 September 2007
- Diana Middleditch (Head of Finance and Commissioning) - 18 June and 19 July 2007
- Dr Melanie Smith (Director of Public Health and Partnerships) - 19 July 2007
- Dr Mark Sweeney (Chair of the Kensington and Chelsea Practice Based Commissioning Group) – 13 September 2007

Sub-Group meetings have been held on:

- 18 June 2007
- 19 July 2007
- 13 September 2007
- 7 May 2008
APPENDIX 3: NATIONAL HEALTH SERVICES IN KENSINGTON AND CHELSEA

The following provides a brief description of some of the different components of the NHS working in the Royal Borough of Kensington and Chelsea:

Kensington and Chelsea Primary Care Trust

Kensington and Chelsea Primary Care Trust is a freestanding 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. Functions include:

- Commissioning;
- Primary care development;
- Public health and health improvement;
- Emergency planning;
- Public and patient engagement;
- Financial management; and
- Corporate management.

Kensington and Chelsea Primary Care Trust has to:

- Secure high-quality, safe services;
- Improve health and reduce inequalities;
- Improve commissioning and effective use of resources;
- Manage financial balance and risk;
- Improve public involvement; and,
- Improve co-ordination with social services.

The PCT commissions General Practice services from 43 practices. There are currently 19 dental contracts providing NHS dental care.

The PCT provide a range of primary care services including: 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.

Opticians

There are 23 Opticians with NHS contracts. However these are national contracts administered via Family Health Services (FHS).

Pharmacy

There are 35 pharmacy contracts in the PCT.

NHS London

NHS London is the Strategic Health Authority (SHA) for London. It has three broad functions: (a) Setting the strategic direction for the NHS in London (b) Performance management of the NHS organisations within its boundaries (i.e.
PCTs and other NHS Trusts), and (c) Ensuring co-ordination of plans and activity within its boundaries.

Central and North West London NHS Foundation Trust

Central and North West London NHS Foundation Trust (CNWL) is a Mental Health Trust that provides mental health services for adults, older people and children across the borough. It also provides specialist substance misuse services.

Hospital Trusts

The Chelsea and Westminster NHS Foundation Trust (within the borough), St. Mary’s hospital (outside the borough) and Hammersmith Hospitals (outside the borough) provide a wide range of specialist and acute hospital services with 24 hour accident and emergency departments. The management of St Mary’s Trust NHS Trust, Hammersmith Hospitals NHS Trust and Imperial College London merged in October 2007 to form a single Academic Health Science Centre called Imperial College Healthcare NHS Trust.

The Royal Brompton and Harefield NHS Trust provides a specialist heart and lung hospital locally.

The Royal Marsden NHS Foundation Trust is a comprehensive cancer centre.
APPENDIX 4: KENSINGTON AND CHELSEA PCT PRIORITIES

LOCAL PRIORITIES

1. **Kensington and Chelsea PCT Corporate Objectives 2007/08**

The PCT agreed, at their Board meeting on 22 May 2007, sixteen Corporate Objectives for 2007/08:

i) We will commission services which deliver faster, shorter pathways and one-stop care to deliver the 18 week referral to treatment target.

ii) We will commission services which will ensure our patients have fast speedy access to services.

iii) We will have assurance that our infection control procedures in the services we commission are of high quality.

iv) We will reduce health inequalities through targeted delivery of services.

v) We will accelerate the development of primary and community based services in order to deliver effective health care closer to people’s homes.

vi) We will improve the fabric and infrastructure of primary care and community facilities.

vii) We will ensure good quality services are delivered by Kensington and Chelsea primary care practitioners now and in the future.

viii) We will develop a framework and structure for a separate provider arm.

ix) We will develop a framework and structure for a Strategic Commissioning PCT.

x) We will ensure all provider services are of a high quality and are working towards strategic objectives.

xi) We will significantly strengthen our approach to commissioning mental health services for Kensington and Chelsea residents.

xii) We will incorporate public and individual preferences into our decision-making process.

xiii) We will develop effective partnerships with our stakeholders.

xiv) We will actively engage with our staff ensuring they are involved in decision making processes.

xv) We will become an organisation which is flexible, responsive and high performing.

xvi) We will maintain a good financial position.

2. **Health Investment Strategy 2008 - 2013**

Kensington and Chelsea PCT has produced a Health Investment Strategy. Six points cover the vision for the type of organisation the PCT will be:

1) Responsive to needs of diverse communities.

2) Deliver excellent services which offer equitable access regardless of where people live in borough.

3) Make best use of tax payers' money.

4) Provide up to date, modern and clinically effective care.

5) Delivered by motivated, enthusiastic, trained workforce.

6) Based in modern, locally accessible premises in community.

Aims and Values - six points underpin the strategic aims, day-to-day business and relationship with key stakeholders: improving health; value for tax payers'
money; respect and dignity; driving up standards; listening and engaging; and sustainability.

Financial Strategy for next 5 Years - the key theme is being realistic about resources available to invest in new services, and creative about health care delivery, using limited resources as efficiently as possible. Instrumental in this are:

- Delivering more care closer to patients' homes
- Reducing cost of services delivered directly by the PCT

The PCT will aim to demonstrate excellence in designing and implementing changes to health care provision (e.g. new care pathways, improved care for older people, and care for “high cost” patients with long-term conditions).

Three Key Areas - three priority areas are believed likely to have the greatest health impact over the 5-year period, and into which PCT will invest new developmental resources (identified in long-term financial plans):

1) Care closer to home (accelerating provision of primary and community-based services; a move towards fewer and larger GP practices which provide a variety of support services);
2) Better access to care (services closer to homes; avoiding hospital care where possible; more seamless health/social care provision);
3) Primary prevention of ill-health (community-based health professionals should identify people at risk of preventable, serious ill-health, and offer health checks, screening, and advice); work with partners to develop new approaches, and adopt pro-active stance in a number of areas (e.g. smoking, obesity, exercise, sexual health).

Priorities for Change - areas requiring a significant focus to improve service quality (where PCT "expects a sea change" in the way health and health services are managed and delivered), but where no new investment will be targeted:-

- Developing a Commissioning Strategy (identifying what services need to be commissioned to meet local needs; increasing the range of providers the PCT commissions from - including voluntary and independent sector). Strategy to feed into NW London commissioning strategy;
- Separating responsibilities for commissioning services and direct provision (PCT to have a clear action plan by July 2007 for the separation of functions);
- Improving Mental Health (significantly strengthening the approach to commissioning MH services; examining the feasibility of commissioning more diverse service providers e.g. alcohol and substance abuse);
- Better Engagement (with local community and service users, ensuring services correspond better to local needs; ensuring suitable feedback mechanisms);
- “Doing Things Differently” (developing an organisational culture capable of delivering better performance).

3. Draft Framework for a Primary Care Strategy 2007

This draft report came to the PCT Board on 17 July 2007.
4. PCT Operating Plan 2008/09

The PCT’s commissioning intentions are set out in their “Operating Plan 2008/09” which was submitted to NHS London in December 2007. This report came to the PCT Board on 29 January 2008.

[The report “PCT Commissioning Intensions 2007-2012” came to the PCT Board on 17 July 2007.]


This public health report was presented to the OSC on Health on 16 May 2007.

REGIONAL PRIORITIES


Working across the sector on configuration.


Prof. Sir Ara Darzi has presented a strong case for change in the way in which many healthcare services in London are delivered. To implement the London strategy “Healthcare for London” the PCT will have to adopt new models of care for: Stroke and heart attack; Trauma; Long term conditions; Maternity; Paediatric surgery; and, End of life care.

NATIONAL PRIORITIES

8. The NHS in England: Operating Framework for 2008-09

The Operating Framework details funding to primary care trusts (PCTs) and sets out priorities for 2008/09. The funding that goes directly to PCTs in 2008/09 is nearly £4bn more than in 2007/08 and equates to an above-inflation rise of 5.5 per cent.

Under the framework, PCTs will be expected to work towards achieving five key national targets over the next three years within the context of the Comprehensive Spending Review period, 2008/09 – 2010/11. At the same time, when setting local priorities, they will be able to choose from a group of performance indicators, or “vital signs”, which are being developed by the Healthcare Commission. The performance of PCTs against these indicators will be monitored annually.

The five priority target areas identified in the framework are:

Improving cleanliness and reducing healthcare-associated infections

- Under this heading are much-publicised proposals to penalise hospitals for failing to meet targets for halving MRSA rates by April 2008 and to fine them more generally for failing to report and control outbreaks of “superbugs” such as MRSA and Clostridium Difficile. (The target for MRSA is highly unlikely to be met by the deadline.)

50
Improving access through achievement of the 18-week referral to treatment pledge, and improving access (including at evenings and weekends) to GP services

• 90% of pathways where patients are admitted for hospital treatment should be completed within 18 weeks
• 95 per cent of pathways that do not end in admission should be completed within 18 weeks
• Performance sharing between all providers on 18-week pathways will be introduced, so that each provider receives the credit for delivery, or the penalty for non-delivery, on inter-provider pathways
• Additional penalties are proposed under this heading for failing to meet 18-week treatment targets by April 2008
• PCTs are to ensure that at least 50% of GP practices offer extended opening
• During 2008/09 all PCTs are to complete procurement processes for new GP-led health centres
• The 38 PCTs with the greatest need will receive additional funding to procure 100 new GP practices
• PCTs will be expected to commission dental services to ensure year-on-year improvements in the number of patients accessing NHS dental services
• PCTs will be expected to work with local authorities to identify how new health centres can provide increased integration between health and social care, and support an integrated approach to health and well being.

Keeping adults and children well, improving their health and reducing health inequalities

• Specific mention is made of PCTs working with local authorities and other partners to tackle lifestyle issues such as obesity and alcohol abuse, teenage pregnancy, sexual health problems and “other areas where we know inequalities exist”
• The four areas singled out for particular action by PCTs in 2008/09 under this heading are: Cancer; Stroke; Children’s and young people’s physical and mental health and well being; and Maternity – improving access to high quality care for all.

Improving patient experience, staff satisfaction and engagement

• NHS organisations will be required to measure patient experience as reported by the National Patients Survey; develop strategies to improve reported patient experience; and demonstrably use both national and local data of patient experience to inform commissioning decisions.
• There are also more general requirements to communicate and engage better with local communities and stakeholders
• They will also be expected to encourage staff to participate in the NHS Staff Survey and act on its findings; and help staff “understand their role in delivering a better NHS”.

Preparing to respond in a state of emergency, such as an outbreak of pandemic flu

• All NHS organisations must have robust plans in place to respond to a flu pandemic by December 2008.
Local priorities

In addition to the national priorities, PCTs will also be required to set local improvement plans for areas of concern identified through consultation with patients, public and staff, Joint Strategic Needs Assessments and in agreement with partners.

9. The Annual Healthcheck

The PCT has to make a declaration against Standards (Core and Developmental) to the Healthcare Commission.

10. The White Paper “Our Health, Our Care, Our Say”

The White Paper was published on 30th January 2006 and sets out the UK Government’s vision for the integration of health and social care services outside hospitals, shifting the policy agenda from capacity issues and onto the management of patient expectations. The aims of the White Paper are to: improve health and wellbeing and the prevention of illness; improve access and choice of quality services; provide support for those in greatest need; and ensure care is provided in the most appropriate setting close to home. Underpinning the recommendations is the desire to give people more control of their health and care, building services round the needs of individuals and not service providers. Greater funding will follow the patient; extra investment will be made in community services that are co-ordinated across institutional boundaries, and service improvements will be driven by regular user input.

11. The Commissioning Framework for Health and Well-being

The Commissioning Framework provides details of how PCTs and local authorities should work together. The framework seeks to focus on outcomes rather than processes or outputs, and identifies the key outcomes of effective commissioning. Objectives include facilitating a shift towards personalised services, the promotion of health and well-being, and integrating local services. The document then summarises how commissioning can improve health and well-being, and reduce health inequalities. The framework’s focus is on identifying the needs of the whole community not just those who use services - in partnership with local authorities and local people; using the JSNA; and the development of commissioning plans and services to meet those needs.

12. Outcomes and Accountability Framework for Health and Social Care

The Department of Health has published a draft health outcomes and accountability framework for health and social care. The three high-level objectives - better health and wellbeing, better care and better value – will be underpinned by specified aims and objectives. There will be an indicator for each outcome. Local authorities and PCTs will pick their local outcomes and supporting indicators from a menu of 40 set by the DH.

13. The Disability Equality Duty 2006
The Disability Equality Duty 2006 presents a new way for public authorities to tackle disability discrimination. This means that the PCT will need to introduce policies that actively promote access and involvement of disabled residents.

14. **National Service Frameworks**

NSFs are long-term strategies for improving specific areas of care.

15. **NICE implementation**

The PCT implements National Institute of Clinical Excellence (NICE) guidelines when they are published.
APPENDIX 5: PRACTICE BASED COMMISSIONING

Practice Based Commissioning: Engaging practices in commissioning - Department of Health

This publication sets out proposals for involving GP practices in commissioning health care services, and highlights that changes in the NHS mean that PBC will assume greater importance in the system overall, offering the following benefits: more efficient use of services; greater involvement of front-line doctors and nurses in commissioning decisions; and a greater variety of services, from a greater number of providers, in settings closer to home and more convenient to patients.

Practice Based Commissioning - Department of Health

This document provides guidance on PBC and a framework for local implementation. It highlights the additional positive outcomes of PBC as follows:

- Increased support of clinician-to-clinician dialogue about improving services and developing care processes;
- Early and continuing involvement of practitioners in service development;
- An additional set of levers to aid the active management of the market in the context of Payment by Results and Foundation Trusts.

The paper covers guidance on the following issues: what is meant by the right to an indicative budget; how it is anticipated PBC will develop; risk-sharing, budget-setting and arbitration; and how the DH will support PBC.

Practice-based Commissioning: Practical implementation

This publication provides details for PCTs and practices for implementing PBC for 2007-08.

37 Available on the Internet at:
APPENDIX 6: PATIENT CHOICE

1. **The Principles of Patient Choice**

- Patients should be involved in decisions about their healthcare;
- The NHS should provide services that are responsive to patients’ needs;
- Funding should follow patients, rewarding services that patients value;
- Choice, supported by booking will drive cultural and behavioural change in health services.

2. **Guidance**

The NHS Plan placed a key emphasis on extending patient choice

**Building on the Best: Choice Responsiveness and Equity in the NHS** was published after a national public consultation on patient choice. One of the strongest messages from the consultation was that people wanted improvements in the quality and accessibility of information as an essential prerequisite to making informed choices about their health and healthcare. **Better information, better choices, better health: Putting information at the centre of health** built on the commitments set out in “Building the Best”. It provides a framework to develop resources that meets everyone’s needs for information and sets out a three-year programme of action.

**Choose and Book** - Patients needing elective treatment will be offered a choice of hospitals once their GP has decided that referral is required. These could be NHS trusts, foundation trusts, treatment centres, private hospitals or practitioners with a special interest operating in primary care. As well as choosing where they are treated, patients will be able to choose the date for their treatment, aided by an electronic booking programme. **Choice at Referral: Guidance framework for 2007-08** is the practice guidance on how free choice in elective care should operate.

**Choice Matters 2007-08: Putting patients in control** - This document provides an update on the implementation of patient choice in the NHS since it was introduced at the start of 2006.

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| GLOSSARY |
|------------------|--------------------------------------------------|
| **A&E** | Accident and Emergency (Casualty) |
| **Academic Health Science Centre** | See Appendix 3. |
| **Acute Services/Care** | Medical and surgical care provided mainly in hospitals |
| **Adult Social Care** | Provide a range of care and protection services for adults. |
| **BME** | Black and Minority Ethnic |
| **Carer** | A person who may be paid or unpaid, who regularly helps another person, often a friend or relative with domestic, physical, emotional or personal care as a result of illness or disability. This term does not include health professionals. |
| **Care Pathway** | The full spectrum of care for a specific disease or illness – from onset and diagnosis to treatment, discharge and rehabilitation. |
| **Chelsea and Westminster hospital** | See Appendix 3. |
| **Children and Families Social Care** | Provide a range of care and protection services for children |
| **Choice** | See Appendix 6. |
| **Clinical Governance** | An initiative to assure and improve the quality of clinical care across the NHS. |
| **Clinical Network** | Arrangement for doctors, nurses and other clinicians in hospitals and the community to work together to provide the best possible care. |
| **Community Mental Health Team (CMHT)** | Doctors, nurses and therapists who work in the community to support people with severe mental health problems. |
| **Community Strategy** | A plan that provides a long-term vision to meet the needs of local communities and co-ordinates the actions of public agencies and private and community organisations. |
| **Early Intervention Service** | This is a targeted mental health service for young people before they develop serious mental health problems. |
| **Hammersmith Hospitals** | See Appendix 3. |
| **Imperial College Healthcare NHS Trust** | See Appendix 3. |
| **Integrated Care Pathway** | An Integrated Care Pathway describes the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment. |
| **Local Involvement Networks (LINks)** | LINks are the networks that should provide the community with the chance to say what they think about local health and social care services to influence how services are planned and run. |
| **Misuse** | The term misuse in this document refers to a pattern of |
drug or alcohol consumption which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. Drug or alcohol misuse is therefore use which causes harm to the individual, their significant others or to the wider community. By definition those requiring drug or alcohol treatment are misusers.

<table>
<thead>
<tr>
<th>National Institute of Health and Clinical Excellence (NICE)</th>
<th>NICE is an independent organisation responsible for providing guidance on promoting good health and preventing and treating ill health. The audience for NICE’s public health guidance goes beyond the NHS to include local authorities and other organisations in the public, community, voluntary and private sectors. It comes in two forms: (1) Intervention guidance – covering specific activities aimed at individuals (2) Programme guidance – making recommendations on how to develop both interventions and policies aimed at the general population, community groups and individuals.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Service Framework (NSF)</td>
<td>A series of documents giving specific government guidance in a number of key areas (e.g. NSFs for Older People, Mental Health and Coronary Heart Disease).</td>
</tr>
<tr>
<td>NHS London</td>
<td>The Strategic Health Authority for London</td>
</tr>
<tr>
<td>Overview and Scrutiny Committee (OSC)</td>
<td>This is a Council body that has a statutory obligation to scrutinise the response of the Council and health services to local issues.</td>
</tr>
<tr>
<td>Patient Choice</td>
<td>See Appendix 6.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>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.</td>
</tr>
<tr>
<td>Primary Care Trust (PCT)</td>
<td>This is a statutory body responsible for commissioning health care for local people and reducing health inequalities. See Appendix 3.</td>
</tr>
<tr>
<td>St Mary’s hospital</td>
<td>See Appendix 3.</td>
</tr>
<tr>
<td>Secondary Care</td>
<td>Hospital or specialist care to which a patient is referred by their GP.</td>
</tr>
<tr>
<td>Statutory Organisation</td>
<td>Government organisations which include the NHS, local authorities and their trusts or departments – e.g. PCT, Hospital Trust, Foundation Trust, Social Service Department, Local Education Authority, etc.</td>
</tr>
<tr>
<td>Strategic Health Authority (SHA)</td>
<td>NHS London is Kensington and Chelsea’s SHA. See Appendix 3.</td>
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<tr>
<td>Tertiary Care</td>
<td>Treatment received at centres that provide highly specialised care for less common problems.</td>
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<tr>
<td>Well-being</td>
<td>Well-being (is) the subjective state of being healthy, happy, contented, comfortable and satisfied with one’s quality of life. It includes physical, material, social, emotional (“happiness”), and development and activity dimensions (Felce and Perry 1995; Danna and Griffin</td>
</tr>
</tbody>
</table>
1999; Diener 2000). This is a wide definition. However, councils have the power to do anything which they consider is likely to promote the economic, social and environmental well-being of their areas, in order to respond to the needs of their local communities (Under section 2 of the Local Government Act 2000).

| **White Paper** | A policy document issued by the Government to explain or discuss matters on a major issue. A Green Paper is a precursor to this and is a preliminary report on proposals for a new law to be discussed in parliament. |