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The New Commissioning Landscape

Di Riley, NCIN

5th July 2013

NCRI
National Cancer Research Institute

The National Cancer Intelligence Network is hosted by Public Health England from 1st April 2013

The Health & Social Care Bill

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- **NHS England – formerly the NHS Commissioning Board**
  - "The purpose of NHS England will be to use the £80bn commissioning budget to secure the best possible outcomes for patients."
  - To ensure the whole commissioning architecture is in place and to commission some services

The Health & Social Care Bill (cont)

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- **Public Health England (PHE)**
  - Information & Intelligence to support local PH and public making healthier choices
  - National Leadership to PH, supporting national policy
  - Development of PH workforce
  - Home to NCIN, and two 'main' cancer functions of former regional registries – registration, and analysis

NHS England & CCGs

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- Commissioning Board Established on 1st October 2011
- Full statutory responsibilities to NHS England from 1st April 2013
- One national office in Leeds and four regions
- 27 Area Teams will directly commission GP services, dental services, pharmacy, some optical services and also screening programmes
- 10 Area Teams will also act as specialised commissioning hubs

NHS England & CCGs

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- Clinical Commissioning Groups (CCGs)
  - 212 CCGs
  - 23 Commissioning Support Units – support to CCGs

Health & Wellbeing Boards

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- Forum for local commissioners, public health, social care, elected representatives and Healthwatch (stakeholders and the public)
- Will develop Joint Strategic Needs Assessments and local health and wellbeing strategies
- These will set the local framework for commissioning health care, social care and public health services

Cancer Screening Programmes (from April 2013)

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- **DH** will continue to set the strategy and policy for screening (& immunization)
- **NHS England** – will be responsible for commissioning screening services.
- **Public Health England** – those functions for screening and immunization best carried out nationally

Strategic Clinical Networks

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- Established for major healthcare areas where an integrated, whole system approach is needed to achieve change in quality and outcomes of care for patients.
- The first four areas are:
  - Cancer
  - Cardiovascular disease (incorporating cardiac, stroke, diabetes and renal)
  - Maternity and children
  - Mental health, dementia and neurological conditions
- Networks will be established for up to five years initially
- Each of the 12 geographical areas will contain a support team to provide clinical and managerial support for the strategic clinical networks and the clinical senate.

Map of England showing 12 senate / SCNs geographical areas

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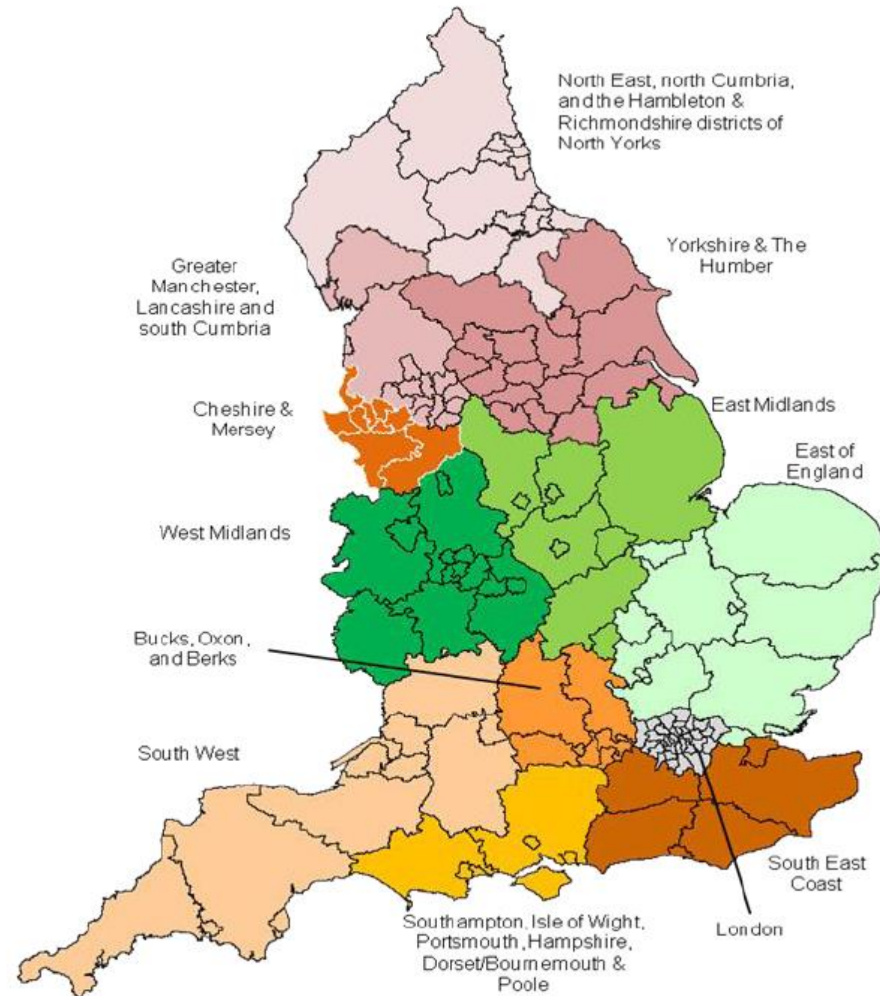
12 clinical senates – clinical advice/leadership at strategic level to CCGs and HWBs

The number of networks nesting within each geographical area is for local agreement, based on patient flows and clinical relationships.

Academic health science networks - (AHSNs) also being developed



New Improvement Body – NHS IQ and it's Delivery Partner

- These two bodies will bring together several legacy organisations
  - NHS Institute
  - NHS Improvement
  - National Cancer Action Team
  - End of Life Care Programme
  - NHS Diabetes and Kidney
  - National Technology Adoption Centre
- Work programme based around Domain priorities
- The NHS IQ ~70 staff, focusing on commissioning of delivery of improvement.
- The delivery body ~200.

The Government Mandate to NHS England

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- To set out the ambitions for how the NHS needs to improve over the next 2 years.
- Based around 5 domains of the NHS outcomes framework
  - Preventing people from dying prematurely
  - Enhancing quality of life for people with long term conditions
  - Helping people recover from episodes of ill health or following injury
  - Ensuring people have a positive experience of care
  - Treating and caring for people in a safe environment and protecting them from avoidable harm
- NHS England legally required to deliver objectives in Mandate.
- NHS England is under specific legal duties in relation to tackling health inequalities and advancing equality.

CCG Commissioning

(Taken from "Manual for prescribed specialised services")

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- **Clinical Commissioning Groups (CCGs) commission services for patients with the following common cancers with the exception of radiotherapy, chemotherapy and specialist interventions:**
  - Bladder and kidney cancer (except specialist surgery)
  - Breast cancer
  - Germ cell cancer (initial diagnosis and treatment)
  - Gynaecological cancers (Initial assessment of all cancers; treatment of early stage cervical and endometrial cancers)
  - **Haematological cancers and associated haemato-oncological pathology**
  - Lower gastrointestinal cancer
  - Lung cancer (including pleural mesothelioma)
  - Prostate cancer (except specialist surgery)
  - Sarcoma (soft tissue where local surgery is appropriate)
  - Skin cancer (except for patients with invasive skin cancer and those with cutaneous skin lymphomas)

Specialist Commissioning

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- All care provided by Specialist Cancer Centres for specified **rare cancers** e.g. Brain, Anal, and head & neck cancers
- **Complex surgery** for specified common cancers provided by Specialist Cancer Centres e.g. Gynae, Urological
- **Certain specified interventions** provided by specified Specialist Cancer Centres e.g. Thoracic surgery, Mohs surgery
- **Radiotherapy** service (all ages)
- **Chemotherapy**: for specified rare cancers, the procurement and delivery of chemotherapy including drug costs
- **Chemotherapy:** for common cancers, the drug costs, procurement and delivery of chemotherapy

Service Specifications

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- Developed for all specialist services & part of NHS E's contract with Trusts for all specialist services
  - 15 national specifications of care for specialist cancer services developed, including for anal cancers - http://www.engage.england.nhs.uk/consultation/ssc-area-b/
- Advisory specifications for CCG commissioned services for Breast, Colorectal and Lung have been developed available on https://www.cancertoolkit.co.uk - aim to describe "What a good service looks like" and hence what should be commissioned.
- Format - schedule taken from the standard NHS Acute Services contract.

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- **74 CRGs are clustered around five national Programmes of Care (PoC),**
- Cancer & Blood Group B
- **Blood & Marrow Transplantation CRG**
  - **Chair - Antonio Pagliuca**
  - **covers Haematopoietic Stem Cell Transplantation (HSCT) services or BMT. The most common clinical indications for HSCT are leukaemias, lymphomas and myeloma**

Service Specifications & Key Service Outcomes

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B04/S/a

2013/14 NHS STANDARD CONTRACT
FOR HAEMATOPOIETIC STEM CELL TRANSPLANTATION (ADULT)

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	B04/S/a
Service	Haematopoietic Stem Cell Transplantation (Adult)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

Intention for adoption from 01/10/13

1. Population Needs

1.1 National/local context and evidence base

The number of stem cell transplants in the UK has risen steadily since 1990, with increases seen in both allogeneic and autologous transplantation. In recent years, year on year increases in allogeneic transplants have been around 4% for the adult population (data source: British Society of Bone and Marrow Transplant (BSBMT) registry).

Nearly two thirds of all allogeneic transplants in the UK are performed to treat leukaemias with nearly 9 out of 10 used in the treatment of a haematological malignancy. The rate of allogeneic stem cell transplant varies across Europe. UK data (including Ireland) suggests an allogeneic transplant rate of 16.5 per million populations (2005-2008) BSBMT registry data. The median age of allogeneic transplant is 31 years with an age range of 0-72 (BSBMT data 1980-2010).

Changes in transplantation practices such as greater use of reduced conditioning regimes and more effective prevention of graft versus host disease (GvHD) are allowing patients of a more advanced aged to be considered for transplant (Popplewell 2002).

Allogeneic stem cell transplant has become a standard treatment in a number of conditions. Disease specific guidelines and consensus reports are available providing a distillation of the evidence base and expert opinion. The BSBMT have produced an indications table, based on literature, expert opinion and current practice. The table provides references for the evidence supporting its

Expected Outcomes

Mortality ra...
- Auto...
- Allo...

The level o... factors, inc... transplant ... survival rat...

The service ... management of treatment related complications, such as infections and graft versus host disease.

The service shall provide long term quality of life monitoring and allogeneic transplant services shall aim to provide a late effects service.

Transplant centres shall inform the lead commissioner of patients being entered into clinical trials.

The provider will agree with the Commissioner on how outcomes of care will be assessed by the provider. There will be an agreed basis for monitoring and sharing patient specific outcomes, both long term and short term with all providers.

Regular and documented clinical audit shall be carried out. A planned programme for future clinical audits shall be made available to the Commissioner on an annual basis.

Each provider must share the results of the BMT programme with all referring clinicians with education and audit reviews (with emphasis on improving communication and collaboration between cancer centres and units).

All tra... Trans...

There... provid...

As a minimum commissioners will want to monitor by each provider separately for:
- 100 day survival post-transplant
- Overall survival rates

Providers will be expected to provide full data to populate the national BMT dashboard, either directly or via the BSBMT registry as agreed with commissioners.

Expected Outcomes

Mortality rates shall be recorded at one and five years.
- Autologous day 100 treatment mortality should be less than 5%
- Allogeneic day 100 treatment mortality should be less than 30%

Providers will be expected to provide full data to populate the national BMT dashboard, either directly or via the BSBMT registry as agreed with commissioners.

Quality Dashboards

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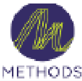
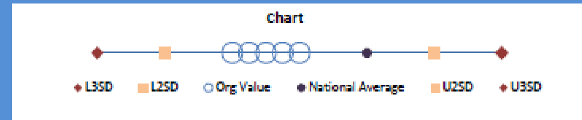


Prepared by Methods Insight Analytics for NHS England

Specialised Burn Care Specialised Service Quality Dashboard

All Providers - Spring 2013



Number of Trusts eligible to submit	Actual number of submissions	Quarterly Indicators (Q4 1213)		Num	Denom	National Mean	Chart	Trend
13	10	BRN01	IBID Minimum dataset completed for in-patients in age group admitted (%)	527.0	631.0	83.52		
13	10	BRN02	Percentage of in-patients in age group admitted in compliance with National Burn Care Referral Guidance (2012)	555.0	631.0	87.96		
13	10	BRN03	% of resuscitation burns in in-patients admitted assessed by a Consultant Burns Specialist within 12 hours of admission	26.0	18.0	144.44	Insufficient data to produce chart	
13	10	BRN04	% of inpatients in age group receiving daily pain assessment (using an appropriate assessment tool)	221.0	631.0	35.02		
13	10	BRN05i	% of non-resuscitation in-patients in age group admitted out of therapeutic dressings within 21 days of 1st assessment by burn care service for patients not receiving skin grafting	113.0	171.0	66.08		
13	10	BRN05ii	% of non-resuscitation in-patients in age group admitted out of therapeutic dressings within 31 days for patients receiving skin grafting	50.0	90.0	55.56		
13	10	BRN06	% of resuscitation patients in age group 95% wound healed and out of therapeutic dressings within 2 days for every 1% of burn area or 31 days whichever the later	10.0	18.0	55.56		
13	10	BRN07	% of in-patients in age group screened for psychosocial morbidity prior to discharge from burns ward	235.0	631.0	37.24		
13	10	BRN08	% of in-patients in age group screened for functional morbidity within 72 hours of admission to the specialised burn service	244.0	631.0	38.67		

Summary - 1

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- A range of new organisations that have a role in commissioning or in supporting commissioning.
- NHS England and CCGs – will both commission aspects of cancer services and will need to work together across patient pathways.

Summary - 2

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- Service Specifications – developed to support commissioning at all levels
- Service profiles and dashboards continue to be developed to support commissioning
- ***Question:*** *who role will it be to oversee the 'quality and integration' for the full patient pathway with multiple commissioners involved?*

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