

# North West London Commissioning Partnership

Part 1 - The Manifesto

Part 2 - Implementation Plan

Part 3 - The Case for Change

Final Draft

3 July 2009

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## **Version Control Log**

<b>Version</b>	<b>Date</b>	<b>Comments</b>
First Draft V.01	01 June 2009	Development of the functional structure of the Partnership
First Draft V.02	03 June 2009	Spelling correction
Second Draft V.01	21 June 2009	Incorporating comments and further work
Final Draft V.01	30 June 2009	Final version issued to JCPCT and PCT boards
Final Draft V.02	3 July 2009	Incorporating JCPCT comments on 3 July 2009

## Acronym Table

Acronym	Detail
A&E	Accident & Emergency
ACV	Acute Commissioning Vehicle
AHSC	Academic Health Science Centre
CD	Clinical Directorate
C&W	Chelsea and Westminster Hospital NHS Foundation Trust
CCG	Collaborative Commissioning Group
CCI	Collaborative Commissioning Intentions
CE	Chief Executive
CEC	Commissioning Executive Committee
CN	Clinical Network
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CSL	Commissioning Support for London
CSP	Commissioning Strategic Plan
DH	Department of Health
DNA	Did Not Attend
DoC	Director of Commissioning
DoF	Director of Finance
DSP	Director of Strategic Planning
FT	Foundation Trust
H&F	Hammersmith and Fulham PCT
HfL	Healthcare for London
HRG	Healthcare Resource Groups
INWLCC	Inner North West London Care Community
ISIP	Integrated Service Improvement Programme
JSNA	Joint Strategic Needs Assessment
JCPCT	Joint Committee of Primary Care Trusts

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Acronym	Detail
K&C	Kensington & Chelsea PCT
KPI	Key Performance Indicator
LA	Local Authority
LAS	London Ambulance Service
LPFIT	London Programme for IT
MD	Managing Director
MFF	Market force factors
NHSL	NHS London
NICE	National Institute of Clinical Excellence
NSF	National Service Framework
NWL	North West London
OBC	Outline Business Case
OP	Operational Plan
OD Plan	Organisational Development Plan
PbR	Payment by Results
PBC	Practice based commissioning
PCT	Primary Care Trust
PEC	Professional Executive Committee
PROMS	Patient Reported Outcome Measures
SPD	Strategic Planning Directorate
SLA	Service level agreement
VSM	Very Senior Manager
WCC	World Class Commissioning
WTE	Whole Time Equivalent

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# PART 1 THE MANIFESTO

## 1. Introduction

Individually, the eight North West London (NWL) Primary Care Trusts (PCTs) face a number of difficult challenges: satisfying increasing patient demand with potential budget constraints; dramatically improving World Class Commissioning (WCC) assessment scores; scarce commissioning talent; delivering Healthcare for London (HfL); and addressing below par acute performance. The scale of the challenge is such that PCTs will not be able to effectively address these demands alone.

Collectively, through the North West London Commissioning Partnership (the Partnership), the eight NWL PCTs can tackle these challenges successfully and become a leading commissioning entity for the benefit of patients in NWL. The Partnership will be formed by bringing together two existing functions (the clinical expertise from the Clinical Networks and the NWL Collaborative Programme as the strategic function of the Partnership) to work in an integrated way with the newly implemented Acute Commissioning Vehicle (ACV) and Clinical Directorate. In doing this, the Partnership will embed clinical leadership into strategic planning, service design decisions and contracting to ensure that the services commissioned reflect the needs of the population and are delivered in the most personalised, practical and clinically effective way possible.

The Partnership builds on existing commissioning resources in the sector and does not create another layer of bureaucracy. It aggregates existing resources and positions them through a combined commissioning delivery unit to address the healthcare market in NWL, in the most effective manner to meet the challenges PCTs face. The Partnership will work closely with Commissioning Support for London (CSL) to make sure that CSL products support the delivery of the Partnership's strategic goals.

The Manifesto sets out the need for, and purpose of, the Partnership. It outlines and addresses the success measures and benefits, the proof of concept, risks and mitigations, and the need to drive improvements in clinical quality. Part 2 of this document covers the Implementation Plan through to the end of 2009 and Part 3, The Case for Change, provides the detail on the Partnership in terms of the drivers for change, the financial case, the functions, the staffing structure and the governance arrangements. The Case for Change (Part 3) is summarised below.

## 2. The Case for Change

The external and internal environment in which NWL PCTs operate is increasingly complex and challenging. NWL PCTs face the following challenges:

- Financial constraints: record levels of investment in the NHS are coming to an end whilst demand continues to rise. All PCTs face a future<sup>1</sup> where there is a clear need to make efficiency gains and improve productivity of all healthcare services, the acute sector in particular. National analysis suggests that efficiencies and savings are achieved through aggregation, leverage and commissioner led actions such as shifting activity out of the acute sector and long-term condition management. There is evidence to suggest that considerable savings can be made: PCTs in NWL currently spend 7% more than other PCTs in London on acute care and the Partnership will be responsible for commissioning on behalf of 1.85m people - a commissioning organisation of this size

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<sup>1</sup> Dealing with the Downturn, NHS Confederation Annual Conference, Paper 4, June 2009.

would be expected to have an expenditure of up to 15% less than the average of the current 8 PCTs.

- **World Class Commissioning (WCC):** the assurance process across NWL has demonstrated variable levels of capability and capacity (management and clinical) to deliver the commissioning agenda. The Partnership will tackle this by bringing together current resources and supplementing them with additional talent to drive better outcomes for patients and commissioners. Furthermore, NWL PCTs, like other PCTs in London, will need to make considerable changes to the way they commission to improve WCC assessment to meet aspirational assurance level 4.
- **Delivering Healthcare for London (HfL):** the programme has highlighted significant variation in the health and well being of Londoners and in the quality of health services available to them when they become ill. The programme of change in healthcare provision across London and within the NWL sector will result inevitably in changes to both the acute and non-acute provider services and primary care. Coordination of this level of change needs to be undertaken at a sector level.
- **Managing performance:** acute performance in NWL (like other parts of London) is below the targets set and expected by patients. In addition, NHS London is devolving performance management of acute providers through Sector Chief Executives and ACVs. Although PCTs retain legal responsibility and accountability for the achievement of NHS performance, the Partnership will act as the delivery unit for PCTs. There are considerable benefits in consolidating resources into a strong team that can monitor proactively acute performance on behalf of PCTs and support the robust implementation of actions in response to variation from expected performance.

### 3. Vision and Goals

The overall vision is that the Partnership will enable the PCTs to improve significantly the WCC competencies related to acute commissioning and use these competencies as a lever to improve healthcare for patients in NWL. The Partnership's vision statement states that:

*"The Partnership will tangibly improve hospital healthcare performance through World Class Commissioning. North West London will have access to higher quality, innovative healthcare and a higher quality of patient experience"*

#### 3.1 Strategic Goals

The six strategic goals for the Partnership support the vision of continuous improvement of acute trust performance for the benefit of patients:

1. Delivering an effective acute commissioning capability which aggregates the commissioning intentions of the NWL PCTs and Practice Based Commissioners (PBCs) to reflect local priorities.
2. Developing delivery strategies and ensuring appropriate service availability – supporting the implementation of HfL and providing a coherent operating model for provider reconfiguration.
3. Driving up acute performance and delivering improved health outcomes – a step change in performance across the NWL provider landscape, as a minimum ensuring delivery of all national targets, where possible exceeding them.
4. Ensuring services offer quality and value for money.
5. Ensuring that patient experience continually improves.
6. Improving the WCC scores in NWL – the ACV will be focused on achieving level 4 for acute commissioning.

### 3.2 Direct benefits

The six direct benefits are summarised below. The Partnership will:

1. Drive improvements in acute hospital performance and clinical quality.
2. Make effective use of scarce resources.
3. Improve the health outcomes of the local population.
4. Drive down acute costs in non-tariff price negotiations.
5. Ensure volumes of acute care are managed appropriately and provider productivity improvements are realised.
6. Develop a best practice approach to commissioning.

These are discussed in detail in Part 3 (The Case for Change), and the net costs and benefits are summarised below.

## 4. Benefits and Costs of the Partnership

The table below shows the total expected net costs and benefits of the Partnership for each year to 2012/3. The costs include the SPD and the ACV but not the Clinical Networks, which are centrally funded.

Cost / benefit headings	2009/10 post rollout	2010/11	2011/12	2012/13
Existing running costs <sup>2</sup>	£3.72m <sup>3</sup>	£6.38m	£6.38m	£6.38m
Partnership running costs <sup>4</sup>	(£4.02m)	(£5.28m)	(£5.16m)	(£5.16m)
<b>Net cost reduction (increase)</b>	<b>(£0.30m)</b>	<b>£1.10m</b>	<b>£1.22m</b>	<b>£1.22m</b>
PCT retained staff costs <sup>5</sup>	(£0.37m)	(£0.63m)	(£0.63m)	(£0.63m)
Other PCT retained costs <sup>6</sup>	(£0.76m)	(£1.31m)	(£1.25m)	(£1.25m)
Efficiency benefits	£0.00m	£23.14m	£69.43m	£115.71m
<b>Net benefit of Partnership</b>	<b>(£1.43m)</b>	<b>£22.31m</b>	<b>£68.77m</b>	<b>£115.05m</b>

Note: rounding may affect totals

The efficiency benefits and cost reductions set out in the table above have been modelled based on three key workstreams of improvement:

1. Allocative efficiencies as a result of greater transparency and shared management of acute volumes across the sector.

<sup>2</sup> Including the costs of the North West London Collaborative Programme

<sup>3</sup> Part year cost

<sup>4</sup> Including transition costs and the expected costs of the Strategic Planning Directorate (pending approval of the Collaborative Commissioning Group)

<sup>5</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>6</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space vacated by the acute commissioning staff)

2. A gradual reduction in the use of interim and consultancy support with greater sharing in areas of limited expertise.
3. Standardisation and price-based negotiation in non-tariff acute care. In the long term, PCT Directors of Finance have agreed that the most significant area of efficiency benefit is (1) allocative efficiencies.

The Case for Change (Part 3) includes a breakdown of expected benefits for each PCT. In light of the number of interdependencies and unpredictability of acute activity levels across the sector, the PCT Directors of Finance have agreed that accurately forecasting the savings profile in each area with an acceptable degree of confidence has not been possible. The approach taken to modelling the savings from each area has therefore been based on consultation across the sector to identify examples of savings as proof of concept, combined with a top-down assessment against total expenditure. Examples of savings include benchmarking spend per weighted population to indicate NWL spends £632 per person compared to £589 across London (equating to £81m per annum) and an analysis of existing non-tariff pricing to save between £0.8 and £6m per annum. The Case for Change (Part 3) also includes a projection of reduced spend on interim staff to give a net staffing cost reduction of £1.1m in 2010/11 (table 11). In year 1, the Partnership will focus on the following work programmes:

1. Benchmarking clinical practice and outcomes
2. Trust productivity
3. Care pathway transfers from acute to community based services

As set out in Table 3 in the Case for Change (Part 3), a sensitivity analysis has been conducted on the total savings opportunity using three scenarios (best, mid and worst case), which have been agreed by the Directors of Finance as an achievable but conservative assessment. After consultation, it has been agreed that the mid-case scenario (2-10%) is the most realistic. The best case scenario was rejected in light of the expected NHS funding envelope as a result of the economic downturn.

The benefits come directly from the creation of the Partnership and not from CSL. However, in order for the magnitude of benefits to be realised, CSL and the Partnership need to operate as planned along with other current PCT borough based initiatives and reconfiguration of the provider landscape.

#### 4.1 PCT cost contributions to the Partnership

The PCT Chief Executives have agreed that the cost contributions to the Partnership will be allocated to each of the PCTs based on their capitation weighted populations. The expected annual cost contributions for each PCT are outlined below:

PCT	% Contribution <sup>7</sup>	2009/10 contribution <sup>8</sup>	2010/11 contribution	2011/12 contribution	2012/13 contribution
Brent	15.92%	£0.64m	£0.84m	£0.82m	£0.82m
Ealing	17.54%	£0.71m	£0.93m	£0.91m	£0.91m
Hammersmith &	9.75%	£0.39m	£0.52m	£0.50m	£0.50m

<sup>7</sup> Based on weighted population

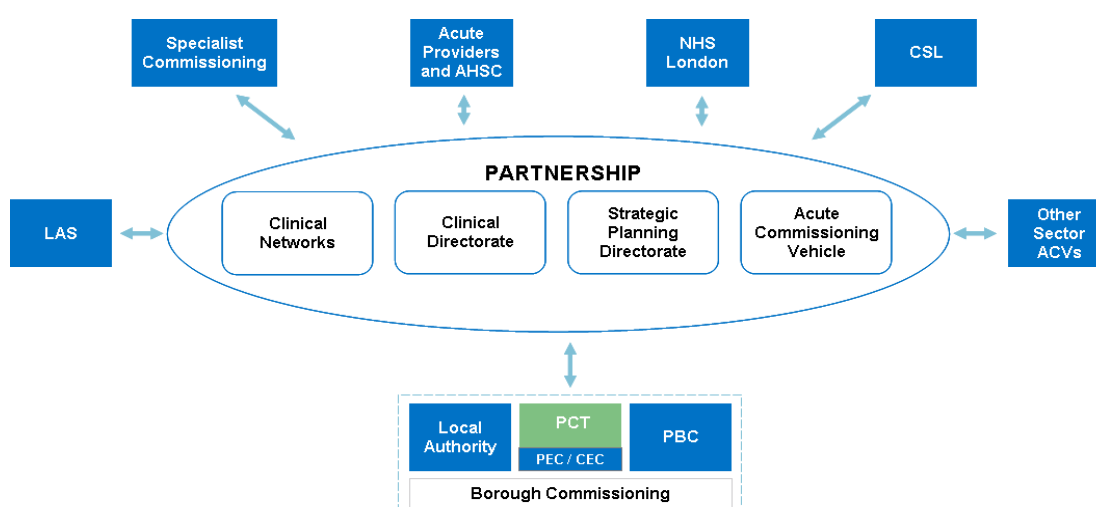
<sup>8</sup> The contributions in the first and second years of operation include transition costs

PCT	% Contribution <sup>7</sup>	2009/10 contribution <sup>8</sup>	2010/11 contribution	2011/12 contribution	2012/13 contribution
Fulham					
Harrow	10.11%	£0.41m	£0.53m	£0.52m	£0.52m
Hillingdon	12.38%	£0.50m	£0.65m	£0.64m	£0.64m
Hounslow	11.99%	£0.48m	£0.63m	£0.62m	£0.62m
Kensington & Chelsea	9.61%	£0.39m	£0.51m	£0.50m	£0.50m
Westminster	12.70%	£0.51m	£0.67m	£0.66m	£0.66m
<b>Total</b>	<b>100%</b>	<b>£4.02m</b>	<b>£5.28m</b>	<b>£5.16m</b>	<b>£5.16m</b>

Note: rounding may affect totals

## 5. Extent and role of the Partnership

The Partnership will consist of the ACV, the Strategic Planning Directorate (SPD), the Clinical Directorate (CD) and the Clinical Networks (CN), which will all interact closely under the umbrella of the Partnership - the key relationships are:



The principal activities of the Partnership components are summarised below:

### 5.1 Clinical Networks (the networks)

The networks will inform the strategic direction and also contribute performance data to aspects of contracting and performance management of the acute providers. The networks have a track record in advising on the development of services across the sector ensuring successful implementation of various national strategies ranging from NICE (National Institute of Clinical Excellence) Guidance to National Service Frameworks. They have a reputation for delivery, clinical engagement and innovation both within London, nationally with peers, and with the Department of Health. The current funded networks include Cancer, Cardiac/Stroke and Critical Care, with the opportunity to include others as they develop across London's sectors, for example in Maternity.

## 5.2 Clinical Directorate

Clinical leadership is critical to support the Partnership in pursuit of the strategic goals. Reflecting this, the Clinical Director will develop a robust structure which will support the Partnership in improving the quality of care provision through challenging provider performance and practice. The Directorate will also provide clinical input into the pan-sector strategy and redesign work of the Strategic Planning Directorate. A further important role will be to develop a reliable clinical governance framework which will support sector wide improvements in patient safety and clinical quality. Strong links will be forged with PCT clinicians and PBCs (Practice Based Commissioners) to develop the essential relationship between borough based commissioning and acute commissioning.

The Clinical Directorate will link closely with the Clinical Reference Group (CRG), which will continue to develop/inform sector-wide clinical strategy and policy. In similar manner to the Clinical Directorate, the CRG will further develop links with PBCs to ensure that PBC priorities are reflected in the sector wide work plan.

## 5.3 Acute Commissioning Vehicle (ACV)

The ACV will create a single commissioning, procurement and contracting unit to strengthen the approach to commissioning services from acute providers in NWL. This approach will significantly raise the standard of acute commissioning in the sector. Whilst lead commissioners currently exist for each of the major acute providers in the sector, a single team of specialists focused on applying best practice approaches consistently to commissioning will yield better commissioning results. The three principal functions of the NWL ACV are:

- Commissioning of acute hospital services from acute providers. This specifically involves responsibility for contracting from, procuring and stimulating the acute provider market. The scope of this commissioning function will include out-of-sector providers, out-of-London providers and private providers. The responsibility for provider contracts that include both primary and secondary care (e.g. Clinicenta) will be discussed with PCTs on an individual basis and support provided as required.
- Performance management of acute providers against the acute targets. Out-of-sector providers will be performance managed by their respective ACVs. In London, other ACVs will have responsibility for sharing performance information regarding out-of-sector providers with the NWL ACV. Performance information regarding out-of-London providers will be collected and analysed by the ACV. The Partnership will have oversight of clinical standards of sector acute providers offering scrutiny and assurance to PCTs.
- Implementing the commissioning consequences of acute sector strategic change as services are reshaped with the implementation of HfL, clinical networks and local initiatives.

## 5.4 Strategic Planning Directorate (SPD) – formally the NWL collaborative programme

This directorate will be the strategic arm of the Partnership. The workload in terms of sector wide strategy for the sector has grown significantly of late with the increasing impetus of the implementation of HfL and the need for Strategic Plan submissions to NHS London. The staffing structure and costs of running this function are reflected in the Case for Change and the benefits and cost table above.

The SPD will focus on two core functions and a number of sector-wide corporate functions. The two core functions are integrated strategic planning (determining the strategy for the implementation of HfL and securing a viable provider landscape) and delivering HfL for NWL (picking up from the work of the NWL Collaborative Programme). The sector wide SPD

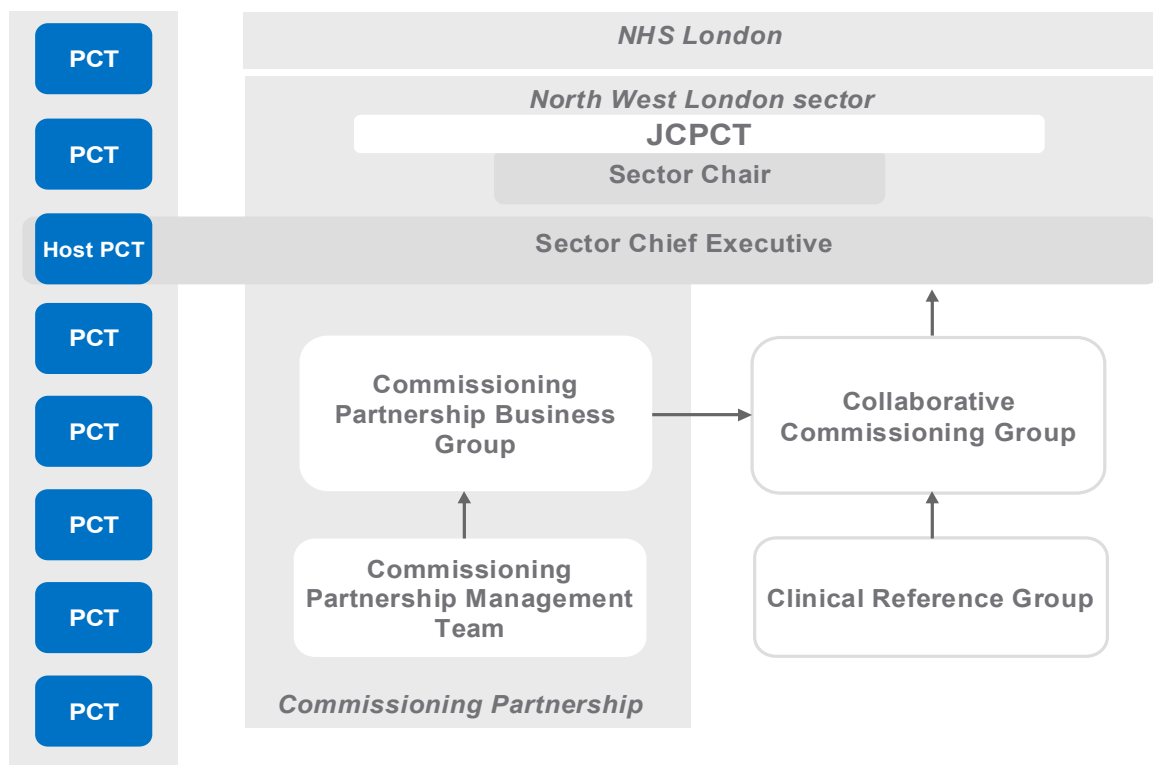
functions are workforce planning, estates planning, travel time analysis, stakeholder engagement, communications and consultation.

### 5.5 Management Structure and Governance arrangements

The Partnership will be united under the current Memorandum of Understanding for the Joint Committee of PCTs, led by the Sector Chair (Peter Molyneux) and Sector Chief Executive (Michael Scott). The staffing structure in the Case for Change includes three Directors: a Managing Director (Paul Jenkins) for the ACV; a Clinical Director; and a Director of Strategic Planning.

The creation of the Partnership will be formalised with an Establishment Agreement and the relationship between the Partnership and PCTs will be governed by a joint Service Level Agreement (SLA) (scrutinised through the Commissioning Partnership Business Group).

Detailed information concerning the staffing structure, governance and organisational design for the Partnership is included in The Case for Change. The diagram over the page summarises governance of the Partnership:



### 5.6 Commissioning Support for London

The Partnership will work closely with CSL to minimise duplication. The Partnership will drive, on behalf of the NWL PCTs, an intelligent customer relationship with CSL to get the best from the acute products and services it will provide. CSL business case promotes a range of products to be provided on behalf of London PCTs; one of the first products is a data validation tool used to improve claims management with acute providers. This product will be phased in from early 2010 and be in full operation by the end of 2010. The Partnership will work with CSL to mitigate the risk of any adverse impact on current claims management systems in individual PCTs.

## 6. Key Risks

### 6.1 Risks from PCTs' perspective

Risk	Mitigations
Concerns that acute provider performance and escalating activity will suffer during the transitional period.	<ul style="list-style-type: none"> <li>Robust Implementation Plan is being produced</li> <li>Staff who currently lead on the relationship with their acute provider are being identified and robust hand-over processes are planned</li> </ul>
The commissioning skills required for borough-based commissioning will be lost.	<ul style="list-style-type: none"> <li>The Partnership is looking at rotational and flexible career opportunities</li> <li>A robust development programme is being identified for Partnership staff; options for knowledge sharing are being considered</li> </ul>
Duplication of roles in PCT and Partnership and / or the creation of an unresponsive 'service provider'.	<ul style="list-style-type: none"> <li>The functions of the PCT and Partnership have been defined and will be defined in more detail during the transition phase</li> <li>An SLA is being produced to hold the ACV to account and clarify the commitments of the PCTs as intelligent customers</li> <li>The performance of the Partnership will be measured using KPIs</li> </ul>
Dislocation from local populations.	<ul style="list-style-type: none"> <li>Provides staff with greater flexibility to work in Partnership</li> </ul>
Loss of flexibility and control over service redesign.	<ul style="list-style-type: none"> <li>SPD has remit over sector-wide service redesign and PCT initiatives will remain locally led</li> </ul>
Loss of control over individual PCT finances and failure to achieve savings claimed..	<ul style="list-style-type: none"> <li>Responsibility for final budgetary sign off remains with PCTs.</li> <li>Savings linked to benefits realisation plan.</li> </ul>
Risk that the Partnership is not sufficiently resourced	<ul style="list-style-type: none"> <li>Partnership combines scarce resources and provides a singular focus for staff.</li> <li>Partnership form and capacity reviewed regularly</li> </ul>

### 6.2 Risks to the successful creation of the Partnership

Risk	Mitigations
Unable to staff the Partnership due to reluctance of staff to transfer and loss of good staff to other commissioning roles in London (e.g. CSL). This would delay the ability of the Partnership to provide services to PCTs.	<ul style="list-style-type: none"> <li>Staff consultation to commence on 13 July 2009</li> <li>Partnership attractive to staff through branding and scale of challenge</li> <li>Identification of more staff than required for the Partnership and use of HR framework</li> <li>Hub and spoke model ensures strengthened collective working whilst allowing staff to work closer to home for at least part of the week</li> </ul>
Delays in roll-out of CSL products could result in duplication since PCTs need to improve capability to improve performance against WCC competencies.	<ul style="list-style-type: none"> <li>CSL roll-out being closely monitored</li> <li>Develop mitigations for CSL delays</li> </ul>
Clinical Engagement is low and could put at risk clinical buy-in to the Partnership.	<ul style="list-style-type: none"> <li>CRG actively engaged in the development of the leadership model for the Partnership</li> <li>Clinical workshop, including PBC, on 29 June</li> <li>Clinical engagement strategy already integral to the CCI initiatives</li> </ul>
Shortage of office space in Westminster due to delayed Community Provider team move.	<ul style="list-style-type: none"> <li>Provider notice to vacate served and temporary accommodation being sought</li> </ul>
Flu pandemic results in staff unable to work.	<ul style="list-style-type: none"> <li>Business continuity plan to be developed</li> </ul>

## 7. Implementation of the Partnership

The implementation process has already begun with the appointment of the Sector Chair, Chief Executive and Managing Director for the ACV. From July onwards, the transfer of staff into the Partnership will be critical to get the Partnership fully staffed and ready for business before the next round of contract negotiations begins later this year. A detailed Implementation Plan is included in Part 2 and the key milestones are below:

Function	Activity	Planned date
<b>ACV:</b>	• Staff consultation process commences	July 2009
	• Develop Partnership branding	July 2009
	• Stakeholder communications	Early Aug 2009
	• Transfer staff to manage Imperial contract	Early Aug 2009
	• Commence Performance Management function	Mid Aug 2009
	• Sector approach to Claims Management agreed (in conjunction with CSL)	End Aug 2009
	• Design detailed processes for ACV	Sept 2009
	• Transfer remaining acute provider teams	Oct 2009
	• Fully staffed and operational	Nov 2009
<b>SPD:</b>	• SPD relocates to host site at NHS Westminster	Sept – Dec 2009
<b>CD:</b>	• Clinical co-design workshop	June 2009
	• Development of sector wide clinical forums (PBC)	July 2009
<b>Networks:</b>	• Cardiac / Stroke Network relocate to host site at NHS Westminster	Sept – Dec 2009

At the end of 2009/10 the Partnership should be fully operational and the first round of contracts with acute providers will have been negotiated using the new processes and ways of working designed by the Partnership.

Branding of the Partnership is an important activity to help it attract the best talent and to facilitate a fresh start in terms of the new organisation and approach to sector wide commissioning. By launching the Partnership with a distinct identity, providers will know that the PCTs in NWL are taking further positive action toward becoming World Class Commissioners.

## 8. What does success look like?

A full set of Key Performance Indicators for the Partnership will be developed and used as the performance tool for the constituent PCTs through the Commissioning Partnership Business Group and formal JCPCT reporting. The concept of the Partnership will be proven when the success measures above become tangible resulting in direct benefits for PCTs and patients. The Commissioning Partnership Business Group will deliver regular scrutiny of the Service Level Agreement between the constituent members and the Partnership.

The first review of the Partnership's performance will occur in April 2010 after the first contract negotiations have been completed. The proof of concept will be tested at this point. The table below shows the success measures for each year to 2012/3.

2009/10	2010/11	2011/12	2012/13
<ul style="list-style-type: none"> <li>Fully staffed with new talent in place</li> </ul>	<ul style="list-style-type: none"> <li>Improved WCC assessment scores – to at least level 3 (average across PCTs)</li> </ul>	<ul style="list-style-type: none"> <li>Improved WCC assessment scores to level 4 (average across PCTs)</li> </ul>	<ul style="list-style-type: none"> <li>Maintaining level 4</li> </ul>
<ul style="list-style-type: none"> <li>PCTs delegate acute commissioning</li> </ul>	<ul style="list-style-type: none"> <li>Reduced acute spend 2% (based on 2009/10 SLAs)</li> </ul>	<ul style="list-style-type: none"> <li>Reduced acute spend 6% (based on 2009/10 SLAs)</li> </ul>	<ul style="list-style-type: none"> <li>Reduced acute spend 10% (based on 2009/10 SLAs)</li> </ul>
<ul style="list-style-type: none"> <li>Current acute performance targets are delegated to Partnership.</li> </ul>	<ul style="list-style-type: none"> <li>Acute performance management being actively used to improve service quality, performance and health outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Majority of acute performance management metrics are RAG rated green</li> </ul>	<ul style="list-style-type: none"> <li>All acute performance management metrics are RAG rated green</li> </ul>
<ul style="list-style-type: none"> <li>Standardised productivity designed</li> </ul>	<ul style="list-style-type: none"> <li>Standardised productivity metrics achieved.</li> </ul>	<ul style="list-style-type: none"> <li>Standardised productivity metrics achieved.</li> </ul>	<ul style="list-style-type: none"> <li>Standardised productivity metrics achieved.</li> </ul>
<ul style="list-style-type: none"> <li>New processes designed and implemented</li> </ul>	<ul style="list-style-type: none"> <li>Borough infrastructure in place to support transfer of healthcare services out of acute</li> </ul>	<ul style="list-style-type: none"> <li>CSL products being used for the benefit of PCTs. Partnership driving new products from CSL</li> </ul>	<ul style="list-style-type: none"> <li>CSL products being used for the benefit of PCTs. Partnership driving new products from CSL</li> </ul>
<ul style="list-style-type: none"> <li>Clear and coherent negotiation strategy for next contracting round</li> </ul>	<ul style="list-style-type: none"> <li>Contracts negotiated in line with negotiation strategy</li> </ul>	<ul style="list-style-type: none"> <li>Greater risk sharing and pooling of budgets being considered</li> </ul>	<ul style="list-style-type: none"> <li>Evidence of health inequalities being reduced across the sector</li> </ul>
<ul style="list-style-type: none"> <li>Strategy, Operating &amp; Organisational Development (OD) plans in place and approved by NHS London</li> </ul>	<ul style="list-style-type: none"> <li>Benchmarking of acute providers driving reduction of non-tariff costs</li> </ul>	<ul style="list-style-type: none"> <li>Non-tariff costs within an acceptable range across NWL</li> </ul>	<ul style="list-style-type: none"> <li>Almost aligned non-tariff costs in NWL</li> </ul>
<ul style="list-style-type: none"> <li>Sector approach to claims management in place providing support to PCTs</li> </ul>	<ul style="list-style-type: none"> <li>CSL claims management up and running and adding value for PCTs</li> </ul>	<ul style="list-style-type: none"> <li>CSL Claims management delivering significant financial savings for PCTs</li> </ul>	<ul style="list-style-type: none"> <li>CSL Claims management delivering significant financial savings for PCTs</li> </ul>
<ul style="list-style-type: none"> <li>Contract teams in place managing NWL acute contracts</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in over performance</li> </ul>	<ul style="list-style-type: none"> <li>Minimal cases of unplanned over performance</li> </ul>	<ul style="list-style-type: none"> <li>Minimal cases of unplanned over performance</li> </ul>

## 9. Summary

This Manifesto provides the JCPCT and Boards with a summary of the proposals for the development of a Partnership for NWL building on the proposals articulated in the Outline Business Case agreed in principle at PCT Board meetings in March/April 2009.

The PCTs have agreed to amalgamate resources and on behalf of the constituent members, the Partnership will drive improvements in performance and clinical quality of hospital care and patient experience, achieve above benchmark WCC assessments (for the competencies supported), deliver sector initiatives for HfL, attract the best talent and develop the health market in NWL.

The Partnership will enable the PCTs to achieve their goals in an efficient manner whilst securing significant benefits in terms of cost savings through aggregated commissioning.

## PART 2 IMPLEMENTATION PLAN

This section describes the Implementation Plan to establish the Partnership. The implementation phase began in June 2009 with the substantive appointment of the Managing Director of the ACV component of the Partnership.

### 1. Phasing

A phased transition to full operation is planned to:

- Allow each function of the Partnership sufficient time to become sufficiently resourced with Directors and staff with the appropriate skills and competencies.
- Develop the detailed operational processes required to raise the standard of commissioning rather than transferring existing practices. This will occur at the outset with the Imperial contract, but as the Directors are recruited into the Partnership it will become their responsibility to drive improvements in commissioning practice to achieve better World Class Commissioning (WCC) scores. Best practice should be determined once and then rolled across all acute contracts. The PCTs have agreed that the initial focus will be on the Imperial contract.
- Provide sufficient time for each PCT to test operational readiness before final transfer of responsibility and for the Partnership to take on performance management responsibility for acute providers, in keeping with the ongoing devolution of responsibility from NHS London. As a result of the NHS London requirements, the performance management function will need to begin in August 2009. The initial activities of performance management are likely to be collation of data and reporting back to NHS London. Over time this function is expected to develop into a value adding function that uses lead indicators to pick up trends in performance, and by working closely with the other functions in the ACV, drives improved performance and quality through the contract levers.

Two key phases have been identified through to the end of 2009:

1. Transition to the Partnership
2. Establish and operate

A draft Implementation Plan is included below and this shows the intended sequence of activities for each phase from June to the end of 2009.

A number of workstreams have been created to inform the development of the Partnership:

- Project Group (Directors of Commissioning)
- Human Resources (includes branding)
- Clinical
- Finance
- Information (includes Commissioning Support for London (CSL))
- Governance
- Infrastructure

To date, the development of the Partnership has been informed by the work conducted within these workstreams. The sections below outline briefly the progress to date within each of these areas.

## **2. Workstreams**

### **2.1 Project Group**

The project group meets fortnightly and have been driving forward individual PCT engagement in the development of the Partnership. The group have been informing the development of various aspects of the Partnership including organisation structure, functions of the Partnership, key challenges and concerns. The group will continue to drive forward transition planning and will play an important role in ensuring seamless transfer of functions into the Partnership.

### **2.2 Human Resources (HR)**

The HR Directors have been meeting fortnightly to outline the HR processes that will underpin the transition to the Partnership. The workstream has produced a draft transition document and is finalising the consultation document. Affected staff have now been identified and HR Directors are working locally to discuss options with these staff members. Branding of the Partnership will also be driven forward in July 2009 to tie in with recruitment.

### **2.3 Clinical**

This workstream will work to ensure that robust clinical leadership and governance is in place within the Partnership. An initial meeting has been held to identify options for practice based commissioning (PBC) links with the Partnership. A workshop was held on the 29<sup>th</sup> June to discuss further the clinical umbrella under which the Partnership will function. As a result of the workshop the organisational structure has been amended to further demonstrate a clinically driven organisation which provides clinical leadership and assurance to both the SPD and the ACV. Future meetings will be held to discuss the remit of the additional clinical forums that were considered e.g. sector wide PBC forum.

### **2.4 Finance**

The Finance Directors have been meeting weekly to work through the finance information within the business case. The workstream has provided a forum for scrutinising the financial benefits case and the working through the financial mechanics of the Partnership. The workstream will inform the transition planning in July 2009.

### **2.5 Information**

A sector wide information group has been set up to discuss information sharing between vehicles to ensure that the performance management function can be devolved from NHS London to the sector. North West London is leading on London-wide discussions regarding the sharing of data, knowledge and intelligence between organisations for the purpose of contract and performance management. A separate working group has been set up with representation from all sectors, NHS London and CSL. This group met for the first time on 22nd June and will meet each month to ensure that the sector vehicles access, process, store and share information appropriately. The workstream is working in partnership with CSL to ensure that existing functions are strengthened whilst avoiding duplication. A workshop will take place on 30th June between CSL and sector PCTs to finalise product development and confirm the nature of future joint working.

## **2.6 Governance**

The project team has commenced the development of the Establishment Agreement for the Partnership and the Service Level Agreement between PCTs and the Partnership. The governance workstream will drive forward both of the documents to the satisfaction of PCTs. In terms of clinical governance, the clinical co-design workshop on 29 June agreed the forums that need to be in place to drive forward clinical governance. The Clinical Director in the new Partnership structure will be responsible for implementing a robust clinical governance framework.

## **2.7 Infrastructure**

Ad-hoc meetings have taken place with the host PCT to ensure that the infrastructure timeline reflects that of the Implementation Plan.

## **3. Operational Readiness**

Based on feedback from all PCTs on lessons learnt for joint working, the Partnership will conduct a readiness assessment to ensure that it is ready to commission on behalf of the sector PCTs, at which time the respective elements of acute commissioning in each PCT will cease. The readiness test will be based on the availability of sufficient resources (skills and capacity), infrastructure and processes to allow higher standards of acute commissioning. Robust operational readiness is critical to the success of the Partnership because PCTs are placing considerable trust and investment into the Partnership. A premature start to operations would put at risk the ability of the Partnership to establish the respect of acute providers and the constituent PCTs in the sector.

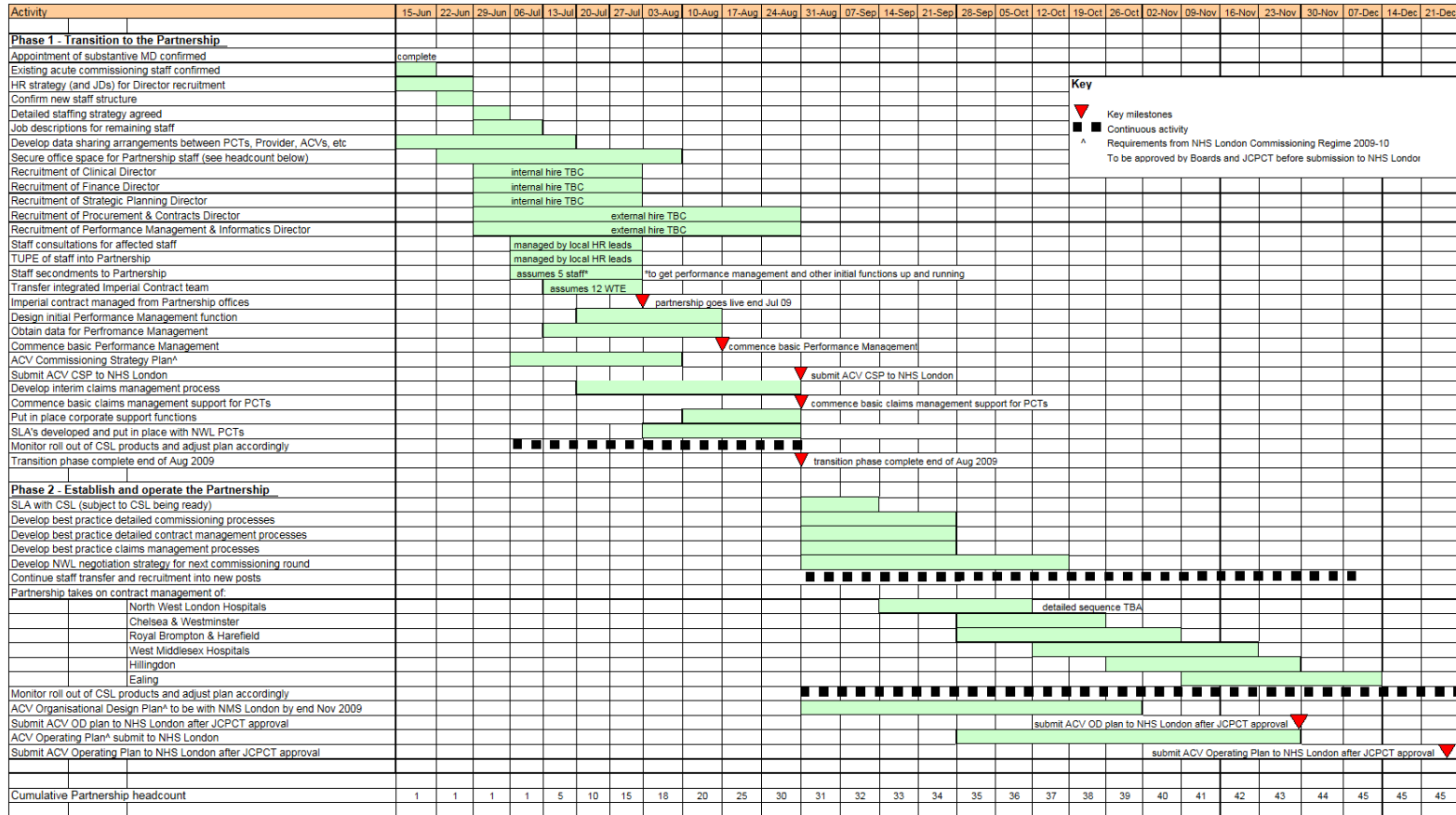
## **4. Impact of CSL product release**

The exact timing of CSL's product roll-out is unclear and will need to be monitored during the implementation phase. The Implementation Plan assumes CSL products will not be ready until early in 2010.

Establishing a complete claims management function within the Partnership in 2009/10 would put at risk the existing claims management functions in PCTs, potentially disrupt staff transfer and potentially duplicate effort and outputs. It is not therefore currently proposed to create a main stream claims management function within the Partnership. It is proposed that PCTs would continue to undertake their own analysis on claims management (including clinical validation through PBC) until CSL delivers this function. However, the Partnership will be able to automate and standardise the analysis across the eight NWL PCTs. This will ensure that the existing functionality is maintained but also ensure that additional financial benefits are realised through economies of scale in the short term. It will be possible to automate the majority of this function keeping the human resources required to a minimum.

## 5. Draft Implementation Plan

### North West London Commissioning Partnership Draft Implementation Plan to end of 2009



## PART 3 THE CASE FOR CHANGE

### 1. Background

#### 1.1 Introduction

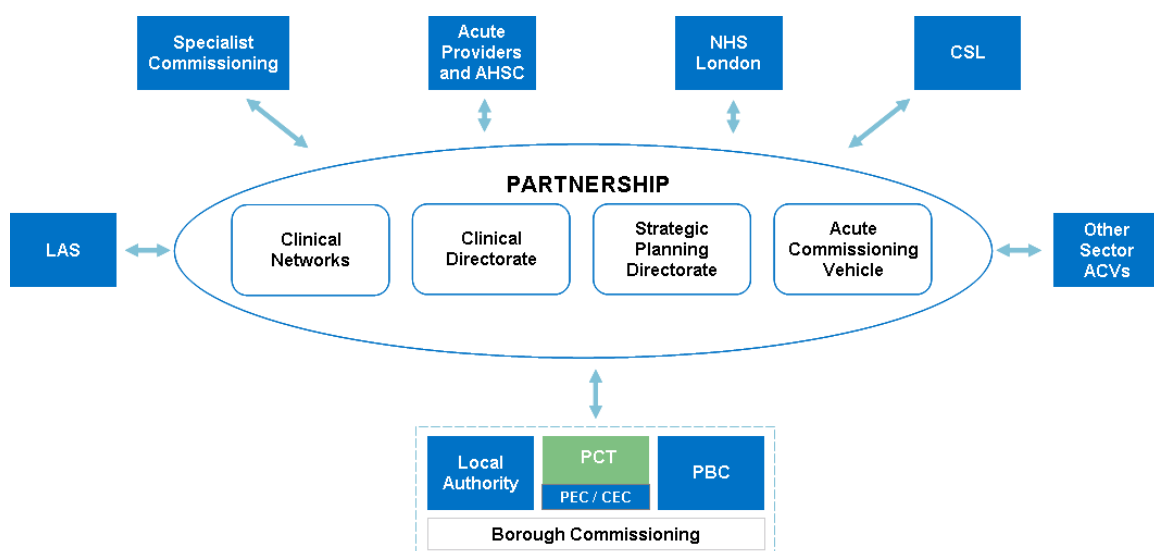
The establishment of the North West London (NWL) Commissioning Partnership (hereafter referred to as the Partnership) is one element of the Strengthening Commissioning Programme across the NHS in London. The eight constituent PCTs in NWL are:

- Brent
- Ealing
- Hammersmith and Fulham
- Harrow
- Hillingdon
- Hounslow
- Kensington and Chelsea
- Westminster

The PCTs recognise the value of pooling their existing acute commissioning capabilities to become world class commissioners. The principal goal of the Partnership is to improve healthcare for patients in NWL by improving the performance of acute sector providers. Strong sector arrangements between NWL PCTs already exist through the JCPCT, supported by the Collaborative Commissioning Group (CCG), Clinical Reference Group (CRG) and a number of sector-wide networks (cancer, cardiac and critical care). The Partnership builds upon these sector arrangements, and is designed to capitalise on the diversity of the PCTs to capture the best elements of acute commissioning.

The Acute Commissioning Vehicle, the Strategic Planning Directorate, the Clinical Directorate and Clinical Networks (CNs) will fall under the umbrella of the Partnership, which will be hosted by NHS Westminster (the host).

**Figure 1 Structure of the Partnership**



## 1.2 Vision and Goals

The overall vision is that the Partnership will enable the PCTs to significantly improve in the World Class Commissioning competencies related to acute commissioning and use these competencies as a lever to improve healthcare for patients in NWL. This can be summarised into a vision statement as follows:

*“The Partnership will tangibly improve hospital healthcare performance through World Class Commissioning. The people of North West London will have access to higher quality, innovative healthcare and a higher quality patient experience”*

### 1.2.1 Strategic Goals

The strategic goals for the Partnership support the vision of improving acute trust performance:

1. Delivering an effective acute commissioning capability which aggregates the commissioning intentions of the NWL PCTs and practice based commissioners (PBCs) to reflect local priorities.
2. Developing delivery strategies and ensuring appropriate service availability – supporting the implementation of HfL and providing a coherent operating model for provider reconfiguration.
3. Driving up acute performance and delivering improved health outcomes – a step change in performance across the NWL provider landscape, as a minimum ensuring delivery of all national targets, where possible exceeding them.
4. Ensuring services offer quality and value for money.
5. Ensuring that patient experience continually improves.
6. Improving the WCC scores in NWL. The ACV will be focused on achieving level 4 for acute commissioning.

### 1.2.2 Design Principles

Five design principles were outlined in the Outline Business Case (OBC). The design principles set the rules within which the Partnership will operate and its relationships with PCTs, providers and other organisations. These design principles have been referred to when further detailing the design of the Partnership in this document.

**Table 1 OBC design principles**

Design principle	Design principle description
1. The Partnership will improve the patient experience at every possible opportunity by improving acute performance.	Patients are at the heart of everything PCTs do. Commissioning is the key lever for PCTs to ensure patients receive quality services and care. The Partnership will be designed with the necessary ability to effect positive change for patients.
2. Do things once rather than eight times, wherever beneficial.	Where there is opportunity to minimise bureaucracy and maximise value for money, activities will only be undertaken once for the eight PCTs.
3. Lean, simple and robust governance.	The governance structure of the Partnership will ensure the Partnership management structure is lean and the governance is simple to navigate, but not at the expense of quality or effectiveness.

Design principle	Design principle description
4. A delivery vehicle that serves its PCTs.	The Partnership is a delivery vehicle for the eight PCTs, and does not challenge the statutory basis of PCTs; PCTs remain accountable for commissioning. The Partnership is a customer-focussed unit, serving its PCTs equally and being responsive to their needs.
5. The Partnership will build on existing capabilities to develop new expertise as required to deliver its objectives.	The Partnership is about PCTs becoming better commissioners, not about restructuring existing capabilities. To achieve WCC, the PCTs are committed to enhancing their capabilities and expertise within the Partnership by developing their people, recruiting additional resource or buying external support, as necessary.

### 1.3 Rationale for the Partnership

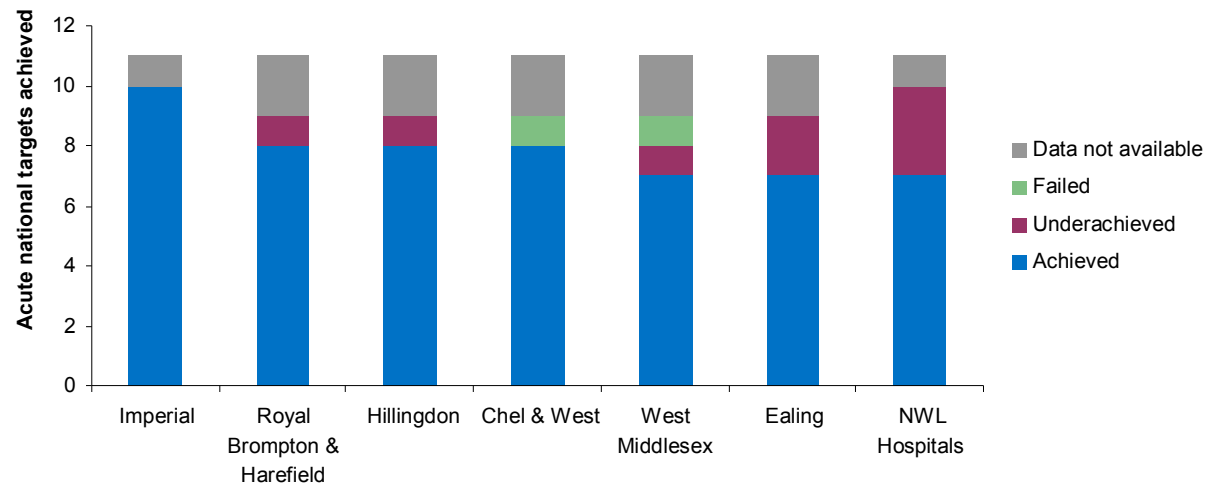
There are a number of reasons why this Partnership is being developed. The six key reasons are highlighted within this section. The benefits section identifies how the Partnership will address the current challenges identified.

#### 1.3.1 Acute providers in NWL are currently not meeting national targets

In 2008/09 there were 13 national priority indicators for acute and specialist trusts outlined by the Care Quality Commission. These include indicators such as the 18 week referral to treatment time and one month diagnosis to treatment for all cancers. In addition, there are 10 'existing commitments' for each of the acute and specialist trusts, these include targets such as total time in Accident and Emergency (A&E). Whilst performance outputs have not yet been published for 2008/9, evidence collated from each PCT shows that the seven acute providers are currently failing to meet several of the targets.

In 2007/08 there were 11 existing national targets outlined by the Care Quality Commission. All but one of the acute providers in NWL either underachieved or failed at least one of these targets, see figure 2:

Figure 2 Sector acute performance against the 11 2007/08 existing national targets



Source: Care Quality Commission. Annual Health Check 2007/08

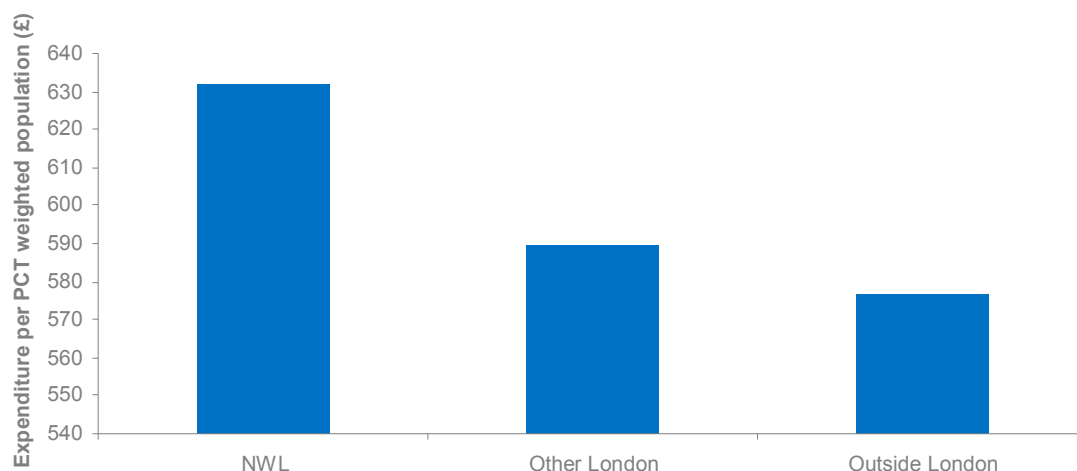
### 1.3.2 There are notable health inequalities in London

Lord Darzi's report *Healthcare for London: A Framework for Action* (published in July 2007) illustrated inequalities in healthcare both within London and when comparing London to the rest of England. *Healthcare for London: A Framework for Action* reported 27% of Londoners are dissatisfied with the running of the NHS, compared to 18% nationally.

### 1.3.3 NWL PCTs currently spend more on acute services than the PCTs in other areas of London or in the rest of England

There is evidence to suggest that currently the PCTs in NWL are, on average, spending more on acute services than the other PCTs across England. Figure 3 overleaf illustrates that the PCTs in NWL spent £632 per person on general and acute commissioning. This is higher than the other PCTs in London (£589 per person) and the other PCTs in the rest of England (£577 per person). If the effects of Market Force Factors (MFF) (supply side) are broadly consistent across London, then the 7% higher expenditure in NWL may be driven by supply induced demand and/or the strength of acute commissioning. For example, physicians (supply side) may refer patients to other specialist departments thereby creating greater demand.

Figure 3 Acute commissioning expenditure per member of the population (2007/08, weighted)



Source: Expenditure data from the 2007/08 PCT annual accounts. Weighted population data 09/10 from the Department of Health (DH) website.

### 1.3.4 Performance against WCC competencies below average across the NWL PCTs

In March 2009 the NHS published their first WCC scores. Each PCT was rated against each of the 11<sup>9</sup> competencies. The WCC programme is one of the key priorities of the NHS with the purpose of delivering better care, better value and better health for all.

Table 2 WCC competency scores across NWL and across England

Competency	Average score – eight PCTs NWL	Average score – rest of England
1. Locally lead the NHS	2.00	2.01
2. Work with community partners	2.00	2.08
3. Engage with public and patients	1.25	1.69
4. Collaborate with clinicians	1.75	1.82
5. Manage knowledge and assess needs	1.38	1.76
6. Prioritise investment	1.25	1.44
7. Stimulate the market	1.00	1.12
8. Promote improvement and innovation	1.50	1.65
9. Secure procurement skills	1.38	1.32

<sup>9</sup> The results shown and discussed are only for WCC competencies 1 to 10. Competency 11 is assessed within the governance component of assurance and has not been included in the score comparison.

Competency	Average score – eight PCTs NWL	Average score – rest of England
10. Manage the local health system	1.25	1.71
<b>Totals</b>	<b>14.75</b>	<b>16.60</b>

Source: DH World Class Commissioning Assurance team

The Partnership will specifically contribute to PCTs improving WCC competencies numbers 4, 5, 7, 8, 9, and 10.

### 1.3.5 There are currently a number of vacant acute commissioning posts and 18.9 WTE contractors working in acute commissioning in the sector

There is currently a notable shortage of commissioning capacity within NWL. It is proving difficult for the PCTs to recruit staff with the required skills and a significant number of commissioners are employed as interims. Individual PCT recruitment from this limited resource pool is leading to competition between PCTs which wastes recruitment effort, adds cost and potentially undermines the strong working relationships between PCTs and between providers and PCTs.

This shortage in expertise means that a number of key aspects across the commissioning cycle are not taking place, such as stimulating markets and managing the supplier network.

Furthermore, the landscape of PCT commissioning across London is undergoing a significant shift. There are an increasing number of attractive employment options available to expert commissioners, such as:

- Commissioning Support for London (CSL) which went live during April 2009
- The other sectors within London are all developing ACVs
- PCT Very Senior Manager (VSM) salaries are being brought into line with the populations served by those PCTs. Therefore, there may be more attractive salaries available to expert commissioners in the larger PCTs outside of London
- Local Authority (LA) commissioners pay scales for VSMs are higher than current counterparts

### 1.3.6 Variability in the quality of relationships between PCTs & acute providers

PCTs in NWL already work together to pool expertise and increase their leverage over providers. For each of the seven acute trusts in NWL there is a coordinating commissioner:

- Brent – NWL Hospitals NHS Trust
- Ealing – Ealing Hospital NHS Trust
- Hammersmith & Fulham – Imperial College Healthcare NHS Trust
- Hillingdon – The Hillingdon Hospital NHS Trust
- Hounslow – West Middlesex University Hospital NHS Trust
- Kensington & Chelsea – Chelsea & Westminster Hospital NHS Foundation Trust
- Kensington & Chelsea – Royal Brompton & Harefield NHS Trust

Despite these coordinating commissioner arrangements, there is variability across the sector in the quality of relationships with the acute providers. The commitment of providers to their relationship with the PCT and the measures set out in the contract also vary. The current differences in the way in which providers are managed, their compliance against standards set out in the contracts and the strength of the relationship with the PCT, leads to inequalities in service provision and thus inequality in care for patients.

## 2. Benefits of the Partnership

### 2.1 Benefits

Six key benefits of the Partnership have been identified and are discussed in this section. The benefits outlined by CSL have been considered to ensure that the benefits listed below are exclusive to the Partnership. Appendix B provides a detailed classification of all of the potential benefits associated with the Partnership along with information on proposed Key Performance Indicators (KPIs) to be used to track realisation of the benefits.

#### **Benefit 1 – The Partnership will drive improvements in acute hospital performance by:**

- Implementing more robust and consistent performance management and contracting processes. The Partnership will be able to standardise and monitor the performance reporting processes to provide PCTs and PBCs with accurate up to date information on the performance of each of the acute providers against their SLAs.
- Benchmarking the performance of the acute providers across the sector. This data can be used to inform the commissioning process, challenge provider performance and improve the quality of provision, by comparing providers and increasing competition to drive these improvements.
- Benchmarking the performance of acute providers with national and international peer group comparable organisations.
- Sharing performance metrics with PCTs and PBC clusters.
- Enhancing focus on improving performance against national targets (including 18 weeks, MRSA / C. diff. and Accident and Emergency waiting times) and local imperatives.

#### **Benefit 2 – The Partnership will make effective use of scarce resources by:**

- Investing once rather than eight times in people, systems and processes. This approach is particularly prudent in light of the challenging financial outlook.
- Attracting the best commissioning talent by becoming a leading commissioning organisation.
- Developing and recruiting to attractive posts and reducing the reliance on interim staff.
- Developing specialism in acute commissioning with clear career pathways for employees.
- Undertaking capacity reviews to address sector wide issues on behalf of all PCTs thereby reducing duplication and improving outcomes.
- Increasing the skills/experience of PCT staff through job rotation into the ACV, developing a highly competent workforce.

Currently PCTs in the sector are reliant on interim commissioning staff which can lead to greater staff turnover. This lack of continuity is undermining the overall level of capability and driving up costs due to the additional expense of employing agency staff. Of the 60.4 Whole Time Equivalents (WTEs) currently employed in acute commissioning across the sector 18.9 are temporary staff. If these temporary staff were employed as permanent staff then this would represent an annual saving of approximately £950k (based on the average temporary staff member costing £500 per day working 225 days per year). It is unrealistic to assume that all staff employed by the Partnership will be permanent staff. However, a significant reduction in interim staffing expenditure is anticipated once the Partnership is fully

established. The cost calculations in section 2.2 of this document assume that once the Partnership is fully operational only 15% of staff will be temporary staff.

There are currently a number of vacant posts in acute commissioning across the sector. This shortage of procurement skills is not unique to NWL. Under the WCC framework, competency 9 (secure procurement skills) only achieves a national average score of 1.32. NWL will be better positioned to face the competition for the best commissioning staff at the sector level rather than as individual PCTs.

### **Benefit 3 – The Partnership will improve the health outcomes of the local population by:**

- Ensuring greater clinical involvement through collaborative working arrangements of the Clinical Directorate, the CNs, the SPD, CRG and PBCs. This will help to identify model services and pathways which deliver improved health outcomes.
- Enforcing the Commissioning for Quality and Innovation (CQUIN) payment framework and ensuring that appropriate clinical quality metrics are introduced into acute contracts.
- Ensuring robust processes are in place to collate and analyse acute provider patient feedback. The Partnership will be responsible for driving this forward, sharing patient feedback with the PCTs and using this feedback during future acute commissioning negotiations. The ACV will also work with providers to set Patient Reported Outcome Measures (PROMs) thresholds and hold providers to account where performance does not meet the agreed levels.
- Delivering significant improvement in a number of the WCC competencies, specifically improvements in acute provider contracting, procurement and performance management (Competencies 9 & 10) to drive improved health outcomes. The WCC competencies assurance process reflects the performance of acute commissioning and borough based commissioning. It is important that the PCTs work closely with the Partnership in order to also drive forward improvements in borough based commissioning.
- Applying robust clinical governance scrutiny across hospitals, as responsible commissioners, thereby ensuring trusts can demonstrate standards for better health.

### **Benefit 4 – The Partnership (through the ACV) will drive down acute costs in non-tariff price negotiations**

The ACV will be responsible for an acute commissioning budget of £1.38bn<sup>10</sup> and will be commissioning on behalf of 1.85m<sup>11</sup> people. Therefore the ACV will have greater buying power during contract negotiations which it can use to drive down non-tariff prices. Approximately one third of acute expenditure is on non-tariff activity.

Furthermore, there are currently variations in the non-tariff prices across the sector. The ACV will be able to benchmark these prices across the sector and use this information to become more selective in the commissioning process.

If these variations are reduced then a financial benefit could be achieved. This financial benefit has not been quantified as there are expected to be other external factors which will

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<sup>10</sup> Calculated through summing the current 2009/10 acute commissioning expenditure from each of the PCTs within NWL

<sup>11</sup> Calculated using the latest PCT population figures from the Department of Health in 2007/08

impact non-tariff prices in the near future. Therefore, it was felt that any quantification of this expected benefit would be unreliable.

### **Benefit 5 – The Partnership will ensure volumes of acute care are managed appropriately and provider productivity improvements are realised by:**

- Introducing a range of volume reducing incentives into acute provider SLAs. Volume reducing metrics and improvements in productivity which will be reviewed and introduced into the acute provider SLAs are:
  - Driving down the ratio of short stay admissions to A&E attendances.
  - Reducing the number of planned procedures which are cancelled by the providers.
  - Reducing the number of outpatient follow-up appointments permissible by the providers. This can be monitored using the new to follow-up outpatient ratios.
  - Reducing the number of readmissions for the same specialty within a specified time period.
  - Reducing consultant to consultant referrals.
  - Reducing Did Not Attend (DNA) rates.
- Developing strong relationships with borough based commissioning. Borough based commissioning will play a key part in ensuring primary and community infrastructure is developed to deliver services in response to acute care pathway redesign. PCTs are developing commissioning strategic plans regarding the level of acute activity to be recommissioned out of hospital, and the Partnership will implement these contractual changes.

### **Benefit 6 – The Partnership will develop a best practice approach to commissioning in the sector by:**

- Forming strong and consistent relationships with acute providers and striking the balance between competition and cooperation using best practice relationship management techniques from across the sector. The Partnership will place significant emphasis on building strong contractual relationships with acute providers.
- Developing commissioning processes and procedures to identify a best practice approach for the Partnership (specifically the ACV) that can be applied to each contract.
- Implementing a better sector wide approach to managing contract non-compliance using a comprehensive performance management system.
- Harnessing and sharing claims management best practice across the sectors PCTs and PBCs and adding sector wide rigour to validation of provider invoices. There is currently a degree of inconsistency in the quantity and nature of invoice validation challenges being raised with acute providers in NWL. The Partnership will support the sector during the transition towards CSL products (in 2010) in this area.

#### **2.1.1 Financial Benefits Summary**

The benefits outlined above will give rise to a range of efficiency and volume reducing savings. We have carried out a sensitivity analysis to illustrate what the potential savings will be across the sector in best, mid and worst case scenarios. This analysis is illustrated in table 3.

**Table 3 Expected cumulative percentage savings on acute commissioning expenditure**

Scenarios	2009/10	2010/11	2011/12	2012/13
Best case	0%	3%	9%	15%
Mid case	0%	2%	6%	10%
Worst case	0%	1%	3%	5%

Table 4 outlines expected annual savings if these percentages are applied to the acute commissioning expenditure with the North West London providers (£1.15bn)<sup>12</sup>. Note that these savings have not applied to the total acute commissioning expenditure in the sector (£1.38bn) because it will be difficult for the Partnership to influence the out of sector providers managed by other ACVs.

**Table 4 Expected future savings from the Partnership**

Scenarios	2009/10	2010/11	2011/12	2012/13
Best case	-	£35m	£104m	£174m
Mid case	-	£23m	£69m	£116m
Worst case	-	£12m	£35m	£58m

The efficiency benefits set out in the table above have been modelled based on two key workstreams of improvement: 1) allocative efficiencies as a result of greater transparency and shared management of acute volumes across the sector; and 2) standardisation and price-based negotiation in non-tariff acute care. In the long term, PCT Directors of Finance have agreed that the most significant area of efficiency benefit is allocative efficiencies.

In light of the number of interdependencies and unpredictability of acute activity levels across the sector, the PCT Directors of Finance have agreed that accurately forecasting the savings profile in each area with an acceptable degree of confidence has not been possible. The approach taken to modelling the savings from each area has therefore been based on consultation across the sector to identify examples of savings as proof of concept, combined with a top-down assessment against total expenditure.

There is supporting evidence to suggest that these efficiency savings are reasonable. Firstly, figure 3 in section 1.3 of this document shows that in NWL the acute expenditure per weighted population is £632. This compares to £589 across the rest of London and £577 across the rest of England. If the NWL sector is able to reduce acute expenditure per weighted population to the same level as the rest of London, this would represent a saving of 7% which equates to £81m per annum.

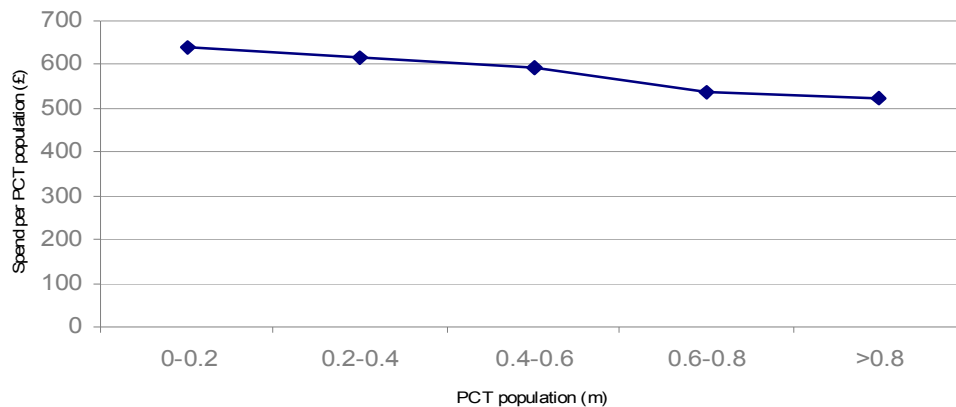
Secondly, there is evidence to suggest that PCTs that are responsible for commissioning for larger populations, and therefore who have greater bargaining power, are able to reduce their per population expenditure on acute commissioning.

Figure 4 illustrates this using data from the PCTs across England. The chart shows that for PCTs with a population less than 200,000, the average annual acute commissioning

<sup>12</sup> Source: 2009/10 North West London PCT SLAs

expenditure is £640 per person. For PCTs with a population of greater than 800,000, the average annual acute commissioning expenditure is £524 per person. This represents a potential 18% saving for PCTs which are responsible for commissioning on behalf of larger populations. The Partnership will be responsible for commissioning on behalf of 1.85m people.

Figure 4 Relationship between acute commissioning expenditure and PCT population



Source: the expenditure data are taken from the 2007/08 PCT annual accounts<sup>13</sup>. The PCT population data are taken from the Office of National Statistics and are from mid 2007.

Thirdly, an analysis was conducted which benchmarked non-tariff expenditure across the PCTs. This analysis suggested that there are potential savings of between £0.8m and £6m if the Partnership is able to successfully standardise non-tariff prices across the sector. There are concerns that imminent non-tariff reviews by some of the providers in the sector will make it challenging for the Partnership to realise these benefits.

It is important to note that the savings outlined in this section can only be achieved with the success of other current programmes which will have an impact on acute commissioning expenditure within the sector (e.g. the rollout of CSL and provider landscape reviews). In addition, any savings are contingent on the financial regime remaining the same (e.g. any future updates to HRG 4 may have an impact on savings).

### 2.1.2 Benefits Realisation

The key benefits identified will be tracked and measured against a number of KPIs. Table 5 summarises the benefits, the KPIs and the measurement enablers. These will form one part of the Partnership performance dashboard and will be reported on regularly to the PCTs and the JCPCT. It is anticipated that the benefits will not begin to be realised until 2010/11 but the baseline for each of the benefits will be established from August 2009. The measurements outlined within the table 5 are not exclusive to each benefit, for example: measurements of volume reducing metrics as identified against benefit 2 will also lead to improvements in patients' experience. Further work will be carried out to inform the projected benefits (quantitative and qualitative) over a three year time frame. These will then be tracked through the performance dashboard and a detailed benefits realisation plan.

<sup>13</sup> The specific line item used is the General and Acute line within the Purchase of Secondary Care section of the annual accounts. 2007/08 was the most recent period for which this analysis has been carried out

Table 5: Benefit KPIs and measurement enablers

Benefit	KPIs	Measurement enablers
Benefit 1 - The Partnership will drive improvements in acute hospital performance	<ul style="list-style-type: none"> <li>Performance dashboard to be produced with baseline performance and projected improvements</li> </ul>	<ul style="list-style-type: none"> <li>Provider performance reports which will demonstrate performance against:                             <ul style="list-style-type: none"> <li>The 17 acute targets</li> <li>Other acute targets (national and local)</li> </ul> </li> <li>WCC competency 10</li> </ul>
Benefit 2 - The Partnership will make effective use of scarce resources	<ul style="list-style-type: none"> <li>Staff turnover rates</li> <li>Staff satisfaction</li> <li>Reduction in % of temporary staff over time</li> <li>Stable running costs of the Partnership which meet forecasted running costs</li> </ul>	<ul style="list-style-type: none"> <li>HR report on recruitment and retention and temp staff usage</li> <li>Learning &amp; Development programme for staff informed by skill gap review</li> <li>Staff satisfaction surveys</li> <li>Robust OD Plan</li> <li>Partnership end-of-year financials</li> </ul>
Benefit 3 – The Partnership will improve the health outcomes of the local population	<ul style="list-style-type: none"> <li>Improvement of CQUIN scores within the sector against current baselines</li> <li>PROMs key performance indicators</li> <li>Number of patient feedback returns</li> <li>Patient feedback scores (inc. quality)</li> <li>Improved patient health outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Acute CQUIN scores within the sector</li> <li>Patient feedback data collection and analysis reports</li> <li>Action plans for addressing patient concerns/issues</li> <li>Patient feedback meetings with Providers</li> <li>WCC competency 3</li> <li>Performance against outcome measures e.g. infection rates</li> </ul>
Benefit 4 - The Partnership will drive down acute costs in non-tariff price negotiations	<ul style="list-style-type: none"> <li>Acute expenditure per weighted population (non-tariff prices)</li> <li>Comparison of sector wide and national non-tariff activity costs</li> <li>Strong informed negotiations with providers</li> </ul>	<ul style="list-style-type: none"> <li>Non-tariff price comparison reports</li> <li>Robust negotiation strategy</li> </ul>
Benefit 5 - The Partnership will ensure volumes of acute care are managed appropriately and provider productivity improvements are realised	<ul style="list-style-type: none"> <li>Measurement of volume reducing metrics such as reduction in consultant to consultant referrals, short stay admissions to A&amp;E, outpatient, new to follow-up ratios</li> <li>Overall reduction in acute activity against forecast growth (per weighted population)</li> <li>Increased number of volume reducing metrics negotiated and in contracts</li> </ul>	<ul style="list-style-type: none"> <li>Baseline of all volume reducing measurements within contracts captured and analysed</li> <li>Analysis and projections for volume reducing metrics and their impact on contracts and PCTs</li> <li>WCC competency 9 and 10</li> <li>Evidence in contracts of volume reducing metrics</li> </ul>
Benefit 6 - The Partnership will develop a best practice approach to commissioning in the sector	<ul style="list-style-type: none"> <li>Improvement in WCC competency scores (competency 9 and 10)</li> <li>Maximised value for money – sector wide comparison of claims management/invoice validation challenges, strong sector wide evidence based negotiations</li> </ul>	<ul style="list-style-type: none"> <li>WCC assurance process</li> <li>Quality of contracts; contractual levers within the contracts and tracking processes in place</li> <li>Comparison of contract performance to national benchmarks and targets</li> <li>Savings realised through effective validation of data</li> </ul>

## 2.2 Costs

### 2.2.1 Current Costs

There are currently 60.4 WTE employed in acute commissioning across the Sector. The salaries of these staff plus on-costs and a proportion of overheads equates to annual costs of £5.28m. In addition £1.1m<sup>14</sup> is spent on the NWL Collaborative Programme, which will be incorporated into the Partnership in the future. Table 6 illustrates the breakdown of the £5.28m running costs for each PCT:

**Table 6 Breakdown of current acute commissioning costs in North West London**

PCT	Current acute commissioning WTE	Annual costs
Brent <sup>15</sup>	3.60	£0.36m
Ealing	3.50	£0.34m
Hammersmith & Fulham	9.47	£0.69m
Harrow	4.65	£0.41m
Hillingdon	9.40	£0.88m
Hounslow	12.80	£1.06m
Kensington & Chelsea	9.55	£0.87m
Westminster	7.46	£0.69m
<b>Total</b>	<b>60.44</b>	<b>£5.28m</b>

Source: North West London PCTs (Note: totals correct, rounding may affect addition of parts)

Where there are contract staff amongst the WTEs in the table above, the additional costs of employing contractors have been reflected in the cost calculations. A detailed list of assumptions used is in Appendix D.

### 2.2.2 Future Running Costs

The NWL PCTs will be responsible for contributing to the running costs of the Partnership. Estimates for the running costs of the Partnership have been calculated using both a top down and bottom up approach. These are discussed in turn below. The transition costs of migrating to the Partnership structure are discussed separately in the following section of this document.

#### Bottom-up Approach

The bottom-up approach for calculating the future running costs uses the following inputs:

<sup>14</sup> This was the actual cost of the NWL Collaborative Programme in 2008/09, including the costs of external consultants

<sup>15</sup> The view of Brent PCT is that they are currently under-resourced in their acute commissioning capability because the PCT has not been filling vacant posts in anticipation of the Partnership going live

- Salaries and on-costs of the Sector Chief Executive, Partnership Directors and Partnership staff. There are expected to be 44.4 WTEs employed by the Partnership (excluding employees of the SPD). See section 4.1 for a detailed breakdown of the staffing structure.
- An allocation of the overheads and support functions provided by the host (e.g. building costs, finance, IT and HR costs).
- Technology and training costs for the staff employed by the Partnership.
- The costs of the SPD.

The bottom up approach suggests that once the Partnership is fully operational annual running costs will be £5.16m including the cost of the SPD (£3.98m excluding the costs of the SPD). For a list of the assumptions used in these calculations refer to Appendix D. Table 7 below summarises the future running costs of the Partnership.

**Table 7 Expected future annual running costs of the Partnership**

Cost category	2009/10 post rollout <sup>16</sup>	2010/11	2011/12	2012/13 <sup>17</sup>
Salaries and on-costs of Partnership staff	£2.15m	£3.42m	£3.31m	£3.31m
Allocation of facilities costs at host site <sup>18</sup>	£0.28m	£0.47m	£0.47m	£0.47m
Allocation of support functions at host site (e.g., HR, Finance, IT)	£0.08m	£0.13m	£0.13m	£0.13m
Technology and training costs	£0.03m	£0.06m	£0.06m	£0.06m
<b>Total cost acute commissioning</b>	<b>£2.53m</b>	<b>£4.08m</b>	<b>£3.98m</b>	<b>£3.98m</b>
SPD running costs <sup>19</sup>	£0.69m	£1.19m	£1.19m	£1.19m
<b>Total cost of the Partnership</b>	<b>£3.23m</b>	<b>£5.27m</b>	<b>£5.16m</b>	<b>£5.16m</b>

(Note: totals correct, rounding may affect addition of parts)

### Top-down Approach

NHS organisations typically spend 0.34%<sup>20</sup> of their annual expenditure on contracting, procurement and performance management skills. The sector has an annual acute commissioning expenditure of £1.38bn. Using this proxy, the expected running costs of the Partnership equate to £4.68m per year. However, this figure represents the costs of contracting, procurement and performance management staff only and does not include overhead costs or costs associated with the SPD.

<sup>16</sup> Assumes a mid-point staff moving date of 1 September 2009

<sup>17</sup> These are the expected annual running costs once the Partnership is fully operational with only 15% temporary staff

<sup>18</sup> Assumes that all Partnership staff will be located at the host site

<sup>19</sup> These expected costs have not yet been approved by the Collaborative Commissioning Group

<sup>20</sup> Source: "Necessity not nicety", NHS 2009 Commercial Strategy and Operating Model

### 2.2.3 Transition Costs

The costs associated with the transition to the Partnership include:

- The costs of staff and the programme office employed to manage the co-design process and manage the implementation of the Partnership.
- The potential legal costs of the consultation process if relocated staff raise a legal challenge.
- The costs of advertising and recruitment consultancies for roles which are not filled by current commissioning staff.
- Travel costs for one year for staff who are required to relocate.

The estimated transition costs in 2009/10 are £796k and the estimated transition costs in 2010/11 are £15k. A breakdown of these costs is shown in table 8. For a list of assumptions used in these calculations is set out in Appendix D.

**Table 8 Transition costs associated with the Partnership**

Cost category	2009/10	2010/11
Programme office	£410k	-
Permanent and temporary staff	£148k	-
Recruitment agency costs	£187k	-
Legal costs	£31.5k	-
Staff travel costs	£20.5k	£15k
<b>Total</b>	<b>£796k</b>	<b>£15k</b>

(Note: totals correct, rounding may affect addition of parts)

### 2.2.4 Cost Contributions

The future running costs have been combined with the transition costs to calculate the expected contributions to the Partnership from the PCTs in the sector. The expected contributions are outlined in table 9 below. The contributions are in current prices and do not account for inflationary changes.

**Table 9 Partnership cost summary**

Cost category	2009/10	2010/11	2011/12	2012/13
Acute commissioning costs	£2.53m	£4.08m	£3.98m	£3.98m
SPD costs	£0.69m	£1.19m	£1.19m	£1.19m
Transition costs	£0.80m	£0.01m	-	-
<b>Total</b>	<b>£4.02m</b>	<b>£5.28m</b>	<b>£5.16m</b>	<b>£5.16m</b>

(Note: totals correct, rounding may affect addition of parts)

The cost contributions to the Partnership will be allocated to each of the PCTs based on their weighted populations. These are the actual populations of the PCTs but weighted by the

Department for Health based on age and deprivation factors. The Chief Executives of the PCTs agreed to use this approach for allocating cost contributions. The expected annual cost contributions for each PCT are outlined in table 10.

**Table 10 Cost contributions from each of the PCTs in the sector to the Partnership**

PCT	% Contribution <sup>21</sup>	2009/10 contribution <sup>22</sup>	2010/11 contribution	2011/12 contribution	2012/13 contribution
Brent	15.92%	£0.64m	£0.84m	£0.82m	£0.82m
Ealing	17.54%	£0.71m	£0.93m	£0.91m	£0.91m
Hammersmith & Fulham	9.75%	£0.39m	£0.52m	£0.50m	£0.50m
Harrow	10.11%	£0.41m	£0.53m	£0.52m	£0.52m
Hillingdon	12.38%	£0.50m	£0.65m	£0.64m	£0.64m
Hounslow	11.99%	£0.48m	£0.63m	£0.62m	£0.62m
Kensington & Chelsea	9.61%	£0.39m	£0.51m	£0.50m	£0.50m
Westminster	12.70%	£0.51m	£0.67m	£0.66m	£0.66m
<b>Total contributions</b>	<b>100%</b>	<b>£4.02m</b>	<b>£5.28m</b>	<b>£5.16m</b>	<b>£5.16m</b>

(Note: totals correct, rounding may affect addition of parts)

## 2.3 Costs vs. Benefits

The costs and benefits of the Partnership discussed in sections 2.1 and 2.2 of this document have been combined to estimate the total net benefit of forming the Partnership.

An estimate for the costs of staff that have some acute commissioning responsibilities but are expected to remain with the PCTs is included within the net benefit calculations. These costs will not form part of the cost contributions to the Partnership. However, they still represent a proportion of the future costs of acute commissioning in the sector. Therefore they have been included in the net benefit calculations.

An estimate for other costs that will be retained by the PCTs (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff) are included within the net benefit calculation. These costs will not form part of the cost contributions to the Partnership. However, they still represent a proportion of the future costs of acute commissioning in the sector. Table 11 summarises the expected net benefits associated with the Partnership for its first four years of operation. For simplicity it has been assumed that acute commissioning expenditure in the sector would remain constant if the Partnership was not formed.

<sup>21</sup> Based on weighted population

<sup>22</sup> The contributions in the first and second years of operation include transition costs

Table 11 Total net benefits of the Partnership

Cost / benefit headings	2009/10 post rollout <sup>23</sup>	2010/11	2011/12	2012/13
Existing running costs <sup>24</sup>	£3.72m	£6.38m	£6.38m	£6.38m
Partnership running costs <sup>25</sup>	(£4.02m)	(£5.28m)	(£5.16m)	(£5.16m)
<b>Net cost reduction (increase)</b>	<b>(£0.30m)</b>	<b>£1.10m</b>	<b>£1.22m</b>	<b>£1.22m</b>
PCT retained staff costs <sup>26</sup>	(£0.37m)	(£0.63m)	(£0.63m)	(£0.63m)
Other PCT retained costs <sup>27</sup>	(£0.76m)	(£1.31m)	(£1.25m)	(£1.25m)
Efficiency benefits <sup>28</sup>	£0.00m	£23.14m	£69.43m	£115.71m
<b>Net benefit of Partnership</b>	<b>(£1.43m)</b>	<b>£22.31m</b>	<b>£68.77m</b>	<b>£115.05m</b>

(Note: totals correct, rounding may affect addition of parts)

After consultation, it has been agreed that the mid-case scenario (2-10%) is the most realistic. The best case scenario was rejected in light of the expected NHS funding envelope as a result of the economic downturn.

Table 12 shows the net benefits and payback period for each PCT in the sector. Appendix D contains a detailed breakdown of the net benefits for each PCT.

Table 12 Net benefit and payback period of the Partnership for each PCT

PCT	Net benefit 2009/10 post rollout	Net benefit 2010/11	Net benefit 2011/12	Net benefit 2011/12	Payback period <sup>29</sup>
Brent	(£0.47m)	£2.90m	£9.84m	£16.77m	271 days
Ealing	(£0.45m)	£4.34m	£13.99m	£23.63m	249 days
Hammersmith & Fulham	(£0.18m)	£2.49m	£7.76m	£13.01m	237 days

<sup>23</sup> Assumes a mid-point staff move date of 01/09/2009

<sup>24</sup> Including the costs of the North West London Collaborative Programme

<sup>25</sup> Including transition costs and the expected costs of the Strategic Planning Directorate which have not yet been approved by the Collaborative Commissioning Group

<sup>26</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with the PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>27</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff)

<sup>28</sup> The efficiency savings assume that the mid case scenario outlined in benefits section of this document are achieved

<sup>29</sup> There is no payback period for some of the PCTs because the net benefit of the Partnership in 2009/10 is positive

### Part 3 The Case for Change

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PCT	Net benefit 2009/10 post rollout	Net benefit 2010/11	Net benefit 2011/12	Net benefit 2011/12	Payback period <sup>29</sup>
Harrow	(£0.20m)	£1.98m	£6.39m	£10.73m	248 days
Hillingdon	(£0.11m)	£3.10m	£9.28m	£15.45m	224 days
Hounslow	£0.04m	£3.05m	£8.65m	£14.23m	Immediate
Kensington & Chelsea	£0.11m	£2.41m	£6.58m	£10.73m	Immediate
Westminster	(£0.16m)	£2.05m	£6.30m	£10.52m	239 days

(Note: totals correct, rounding may affect addition of parts)

### 3. Role of the Partnership

#### 3.1 Scope

The Partnership will consist of the ACV, the SPD, the CD and the CNs, which will work closely under the umbrella of the Partnership. This section outlines the functions of the ACV, the SPD, the CD and the CNs. Table 13 provides a summary of the roles of the Partnership and the roles of the PCT in relation to the commissioning cycle. A more detailed breakdown of the roles and responsibilities against the commissioning cycle functions is provided in Appendix C.

##### 3.1.1 Responsibility and accountability for Commissioning

In May 2009 a co-design workshop was held with representatives from each of the PCTs to design the functional structure of the ACV. The output of the workshop is summarised in Table 13 which shows an overview of the key roles of the Partnership and the PCTs. Appendix C provides a detailed breakdown of the responsibilities and accountabilities against each of the sub-steps, the following definitions were used to determine overall responsibility and accountability for each of the sub-steps within the commissioning cycle functions:

- Responsible (R) – (the doer) the individual(s) who perform(s) an activity. They are responsible for action / implementation. Responsibility can be shared.
- Accountable (A) – (the buck stops here) the individual who has the decision making authority and power of veto. This individual is held responsible in the event of failure. There can only be one accountable person assigned to an activity / decision.
- Consulted (C) – (in the loop) the individual(s) who are consulted prior to a final decision or action being taken. This is a two-way communication.

Table 13 Overview of the key roles undertaken by the Partnership and the PCTs

Stage	The Partnership	PCTs
Plan	<ul style="list-style-type: none"> <li>• Prepare acute specific sector wide strategic, operating and organisational development plan</li> <li>• Provide analytical support for strategic and capacity planning</li> <li>• Support the design and testing of pan-sector service re-design</li> <li>• Develop improvement plans for acute services against WCC competencies based on PCT plans and other inputs</li> </ul>	<ul style="list-style-type: none"> <li>• Engage key stakeholders (clinicians, PBCs, patients and LA) in the development and production of the JSNA, CSP, OP and OD Plan</li> <li>• Undertake strategic and capacity planning</li> <li>• Interface with public health and reconcile capacity plan</li> <li>• Prioritise strategies and report them to the ACV</li> <li>• Collate and analyse non-acute information</li> <li>• Identify local care pathways and undertake redesign</li> </ul>
Engage	<ul style="list-style-type: none"> <li>• Lead on collecting, analysing and disseminating patient feedback on acute services</li> <li>• Collate and analyse patient feedback (acute providers) across the sector (root-cause analysis) and feedback to the PCTs</li> <li>• Provide acute benchmarking information - sector wide stakeholder engagement for strategic redesign</li> </ul>	<ul style="list-style-type: none"> <li>• Lead and drive local public and clinical engagement</li> <li>• Involve patients/public in improving services</li> <li>• Lead on collating and analysing primary care/community/mental health service patient feedback</li> <li>• Resolve issues arising as a result of delivery of care</li> <li>• Proactively identify areas for improvement and challenge the acute commissioning portfolio and associated areas, based on acute services data, benchmarking and best practice</li> </ul>
Contract and Procure	<ul style="list-style-type: none"> <li>• Undertake contracting and procurement of all acute provider contracts</li> <li>• Undertake negotiations with all acute providers across the sector</li> <li>• Maximise the benefit from CSL (acute related products)</li> <li>• Ensure contract and regulatory compliance</li> <li>• Assess acute provider market and identify gaps</li> </ul>	<ul style="list-style-type: none"> <li>• Engage and develop primary care, community care and voluntary sector.</li> <li>• Engage with GPs to ensure the offer of choice is in place and viable</li> <li>• Assess market and identify gaps/opportunities</li> <li>• Make payments to the providers</li> </ul>
Manage	<ul style="list-style-type: none"> <li>• Performance manage all acute providers against contract (national and local targets)</li> <li>• Undertake and cascade pan-sector coding and pharmaceutical reviews</li> </ul>	<ul style="list-style-type: none"> <li>• Provide support to PBC including budget setting and monthly monitoring</li> <li>• Implement local demand management plans</li> </ul>

## 3.2 Partnership activities

### 3.2.1 Acute Commissioning Vehicle

The three principal functions of the ACV (with support from CD, SPD and CNs) are:

- Commissioning of acute services from acute providers. This specifically involves responsibility for contracting and procuring acute services, performance management of acute providers and stimulating the acute provider market. The Partnership will also support other functions of the commissioning cycle: care pathway/service redesign and public/patient engagement. The commissioning remit of the ACV will include out-of-sector providers, out-of-London providers and private providers. The responsibility for provider contracts that include both primary and secondary care (e.g. Clinicienta) will be discussed with PCTs on an individual basis during the implementation phase.
- Performance management of acute providers against acute targets. Out-of-sector providers will be performance managed by their respective ACVs. Other ACVs will have responsibility for sharing performance information regarding out-of-sector providers with the NWL ACV. Performance information regarding out-of-London providers will be collected and analysed by the ACV.
- The commissioning consequences of acute sector strategic change as services are reshaped with the implementation of HfL and local initiatives.

The ACV will not lead on directly commissioning services from the London Ambulance Service (LAS) but will be responsible for liaising with South West London Commissioning Unit (responsible for commissioning from LAS on behalf of London) regarding performance and activity and feeding this information back to the PCTs. The LAS Whole Systems Transformational Programme, a pan-London programme to improve performance delivery of the LAS has recently been established. A key role has been identified within the Partnership to provide sector-wide input to this programme. The sector representative will liaise regularly with the PCTs regarding the developments of the programme.

The acute trusts for which the ACV will have lead commissioning responsibilities are:

- Ealing Hospital NHS Trust
- The Hillingdon Hospital NHS Trust
- NWL Hospitals NHS Trust
- Imperial College Healthcare NHS Trust
- Chelsea and Westminster NHS Foundation Trust
- Royal Brompton and Harefield NHS Trust
- West Middlesex University Hospital NHS Trust

### 3.2.2 Clinical Directorate

The three principal functions of the ACV (and the functions of the Partnership as a whole) will be driven forward by strong clinical leadership. The Partnership's organisational structure includes a Clinical Director and a clinical team who will provide clinical leadership to the ACV and the SPD. This directorate will have three key roles; providing clinical input and challenge to

contracting and negotiations; providing clinical input into sector wide strategic and service redesign work of the SPD; and developing and enforcing a strong clinical governance framework for the Partnership. The Directorate will develop strong links with the:

- CRG
- PBCs through PEC (Professional Executive Committee) Chairs, PCT Partnership relationship leads and a sector wide PBC forum (options currently being considered). PBCs are incredibly important to the success of the Partnership. They will play a significant role in influencing the changes to provider service reconfiguration along with primary and community service transformation. Local PBC developments should be captured in PCT CSPs but a PBC sector wide forum is being considered to further inform potential changes to acute provision

The clinical leadership model (Clinical Directorate, CRG and PBCs) will focus on:

- Quality monitoring
- Providing clinical leadership with a real link back to PBC priority setting
- Becoming part of the contract negotiating team and contract review meetings
- Setting standards for clinical terms in the contract review and wider CQUIN discussions
- Providing clinical evidence and advice in the development of procurement strategies and specifications
- Providing clinical input into sector wide service reviews and redesign

### 3.2.3 Strategic Planning Directorate

Pan-sector strategic direction has previously been informed by the NWL Collaborative Programme. The Collaborative Commissioning Intentions (CCI) plan describes a five-year strategy for commissioning at a supra-PCT level. It draws on the Commissioning Strategies developed for each of the eight PCTs in NWL and the Healthcare for London (HfL) programme, focusing specifically on those areas where there is significantly greater value in commissioning collectively than individually.

This Directorate will incorporate the NWL Collaborative Programme and will function as the strategic arm of the Partnership. The two core functions within the Directorate will be integrated strategic planning and delivering HfL. A number of sector-wide corporate functions will be covered, which may change over time: workforce planning, estates planning, travel time analysis, stakeholder engagement, communications and consultation.

#### Integrated Strategic Planning

NHS London has signalled that each Sector will need to develop an integrated strategic plan which will:

- Demonstrate how the sector intends to implement HfL
- Develop options (including a credible Implementation Plan) for service reconfiguration needed in order to implement HfL

- Demonstrate how the sector intends to secure a viable provider market, by reviewing the viability of provider organisations (including community providers)

To achieve this, the SPD will have a key role in ensuring that all PCTs in the sector work collaboratively so that there is consistency across the PCTs as they implement their strategies. This will involve: making appropriate links with neighbouring sectors regarding cross-boundary issues; linking to pan-London programmes of work that impact specialist / tertiary providers; and developing enabling strategies for delivering the sector plan, including clinical and stakeholder engagement, estates, and Workforce for London.

### **Delivering Healthcare for London**

The Directorate will be responsible for delivering HfL across the sector. HfL is the London vehicle to deliver the Next Stage Review (NSR). The SPD will oversee sector wide pathway redesign across primary, secondary and tertiary care. This will help to ensure close collaboration between acute commissioning and borough based commissioning.

Both the ACV and PCTs will need to operate an annual planning and monitoring cycle as outlined by NHS London Commissioning Regime 2009-10 (which is widely available to PCTs). The planning for the Partnership will be led by the SPD, under the integrated strategic planning workstream, with input from the ACV. Both PCTs and the ACV will produce a Strategic, Operating and Organisational Development Plan. These plans will be produced in parallel, with significant discussion to reflect a collaborative approach to strategic and operational planning. Further details on the roles and responsibilities are outlined in section 4.

#### **3.2.4 Clinical Networks**

The ACV and the SPD will work closely with the CNs. The networks will inform the strategic direction, contract development discussions and also contribute (performance data) to aspects of contracting and performance management of the acute providers. They will work along side the SPD to contribute to the delivery of Collaborative Commissioning Intentions (CCIs) and to specifically inform (pan-sector) the following areas of the commissioning cycle across the sector: assess needs and prioritise, care pathway and service redesign, patient engagement and customer service and patient feedback.

Two out of the three CNs will be based at Westminster under the Partnership umbrella. The networks have led the development of services across the sector and successfully implemented various national strategies ranging from NICE Guidance to NSFs (National Service Frameworks). The funded networks relevant to the Partnership NWL include Cancer, Cardiac/Stroke and Critical Care.

**Table 14 Hosting and funding arrangements of the networks**

	<b>Cancer Network</b>	<b>Cardiac/Stroke Network</b>	<b>Critical Care Network</b>
<b>Host</b>	NHS Westminster	NHS Hammersmith & Fulham – moving to NHS Westminster	Ealing PCT
<b>Chair</b>	NHS Kensington and Chelsea Chief Executive	NHS Hammersmith & Fulham Chief Executive	Chelsea & Westminster NHS Foundation Trust Chief Executive

	Cancer Network	Cardiac/Stroke Network	Critical Care Network
<b>Funding</b>	PCTs plus some national monies	Centrally – no funding from PCTs. Non-recurrent money to support stroke work has been received from NHS London 2008/9	Annual membership fee covers both PCTs and NHS/independent providers
<b>Scope</b>	NWL	NWL	London-wide. NHS and independent sector (17 Trusts, 8 independent hospitals, LAS)

### Cancer Network

The network currently has minimal input into provider contracts and this is an area where strong links with the Partnership will help performance management of the providers and improvement in patient care across these pathways. The Partnership can benefit from robust, more up-to-date provider performance data accessible by the network. This data can be used to ensure improved performance management of the providers against cancer targets. It is important to highlight that the network oversees the pathway across primary, secondary and tertiary care and thus would not want to lose this oversight or the relationships that they have with the PCTs to inform primary/community care.

### Cardiac / Stroke Network

The network works across primary, secondary and tertiary care. There are aspects of the Partnership that would be useful to the network such as the ability to communicate once instead of eight times. The network is currently seen as an impartial body and would not want to see this, as this enables them to work constructively with the providers and the PCTs.

### Critical Care Network

The Critical Care Network is the only such network in London and covers both the NHS<sup>30</sup> and the independent sector including 17 trusts and 8 independent hospitals plus the LAS. The network board has clinical/management representation from organisations within the network and is chaired by the Chief Executive of Chelsea & Westminster NHS Foundation Trust.

The networks differ in form, function and funding, the Partnership will need to work with the networks to develop a relationship which is mutually beneficial and delivers improved health outcomes for patients. The networks have identified a number of concerns and benefits about their role within the Partnership and these will need to be addressed in the implementation phase:

- The Critical Care Network model is that of a ‘joint strategic alliance’ with a commissioning advisory arm with separate reporting and accountability. Acute trust provider and independent sector funding for the network is dependent on the network being perceived as

<sup>30</sup> Briefing paper for the Joint Committee of PCTs, Clinical Networks in NWL: Future Positioning to Maintain Delivery, Clinical Engagement and Secure Innovation (April 2009)

'neutral'. This facilitates committed clinical engagement at a personal and at an organisational level.

The networks will work closely with the SPD to contribute to the delivery of the CCI plan and to specifically inform (pan sector) the following areas of the commissioning cycle; assess needs and prioritise, care pathway and service redesign, patient engagement and customer service and patient feedback. To deliver economies of scale, general supporting roles will be shared with the ACV e.g. modelling, data analyst.

### 3.2.5 Performance Monitoring

Performance monitoring will be central to all functions of the Partnership. Performance monitoring falls into two broad categories:

- Performance monitoring of the acute providers by the Partnership
- Performance monitoring of the Partnership by the PCTs

#### **Performance monitoring of the acute providers by the Partnership**

The Partnership will be responsible for the effective delivery of service provision as measured against the 17 acute targets which are currently performance managed by NHS London. The Partnership will be responsible for acute performance on behalf of constituent members.

#### **Performance monitoring of the Partnership expected by the PCTs and the requirements of NHS London**

The PCTs will remain accountable for commissioning acute care that meets national standards of access, quality and value for money but they will delegate responsibility to the Partnership. The Partnership has a central role to play in ensuring the quality of service delivery through regular performance monitoring and the effective use of contract and relationship management with acute provider organisations. The PCT will also need to ensure the quality of service delivery through regular performance monitoring against the conditions set out in the SLA with the ACV.

Both the PCT and the ACV will be required to report quarterly on the above mentioned areas to NHS London. NHS London will evaluate the PCTs and the Partnership's risks by reviewing and challenging their Operating Plans. NHS London will then assign three risk ratings to the PCT, which it will monitor and adjust in-year, publishing them every quarter.

The three risk ratings for the PCT are quality and outcomes, governance and financial. The two risk ratings for the ACV are quality and outcomes and governance. NHS London will review quarterly performance reports submitted by the PCTs and the Partnership and will also hold review meetings with each PCT and the Partnership.

The PCTs will be provided with regular performance reports from the Partnership which will monitor the Partnership's performance against benefit KPIs, the Operating Plan and the terms and conditions set out in the SLA.

A performance dashboard will be produced to capture:

- The performance of each of the providers against the key National (including the 17 acute targets which are currently monitored by the NHS London Provider Agency) and Local targets

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- The performance of the ACV against the terms set out in the SLA and the KPIs identified to track the benefits which will include the financial benefits.
- The performance against metrics set out in the WCC assurance framework
- Clinical Governance assurance productivity metrics

A monthly performance report highlighting all areas of performance will be produced by the Partnership for the JCPCT and the PCTs.

## 4. Organisational Design

### 4.1 Organisational structure

#### 4.1.1 Introduction

The organisational structure of the Partnership has been designed to map the form of the Partnership to the functions as closely as possible. The structure set out below will be supported by specific job descriptions and skill set requirements through the HR workstream. The organisational structure below for each Directorate is indicative only; the final form of each Directorate will be set by each of the Directors once they are in post.

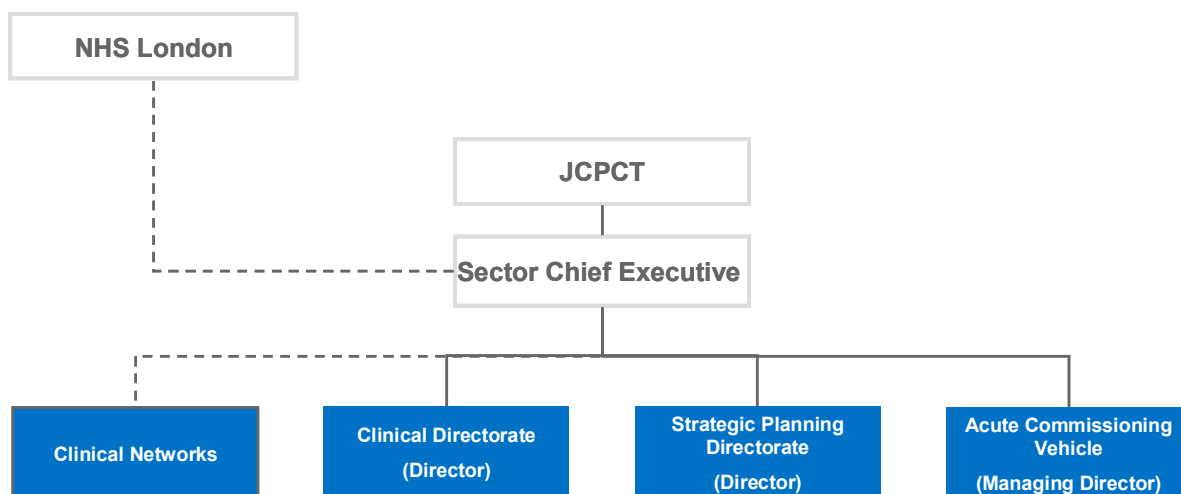
#### 4.1.2 High level management structure

The Partnership will be led by the Sector Chief Executive accountable to the JCPCT Chair. The Sector Chief Executive has three direct reports:

- ACV Managing Director
- Strategic Planning Director
- Clinical Director

It is proposed that the existing CNs will also have a direct line of communication to the Sector Chief Executive to ensure that the Partnership has the appropriate level of clarity regarding the clinical priorities of the networks.

**Figure 5 High level Partnership management structure**

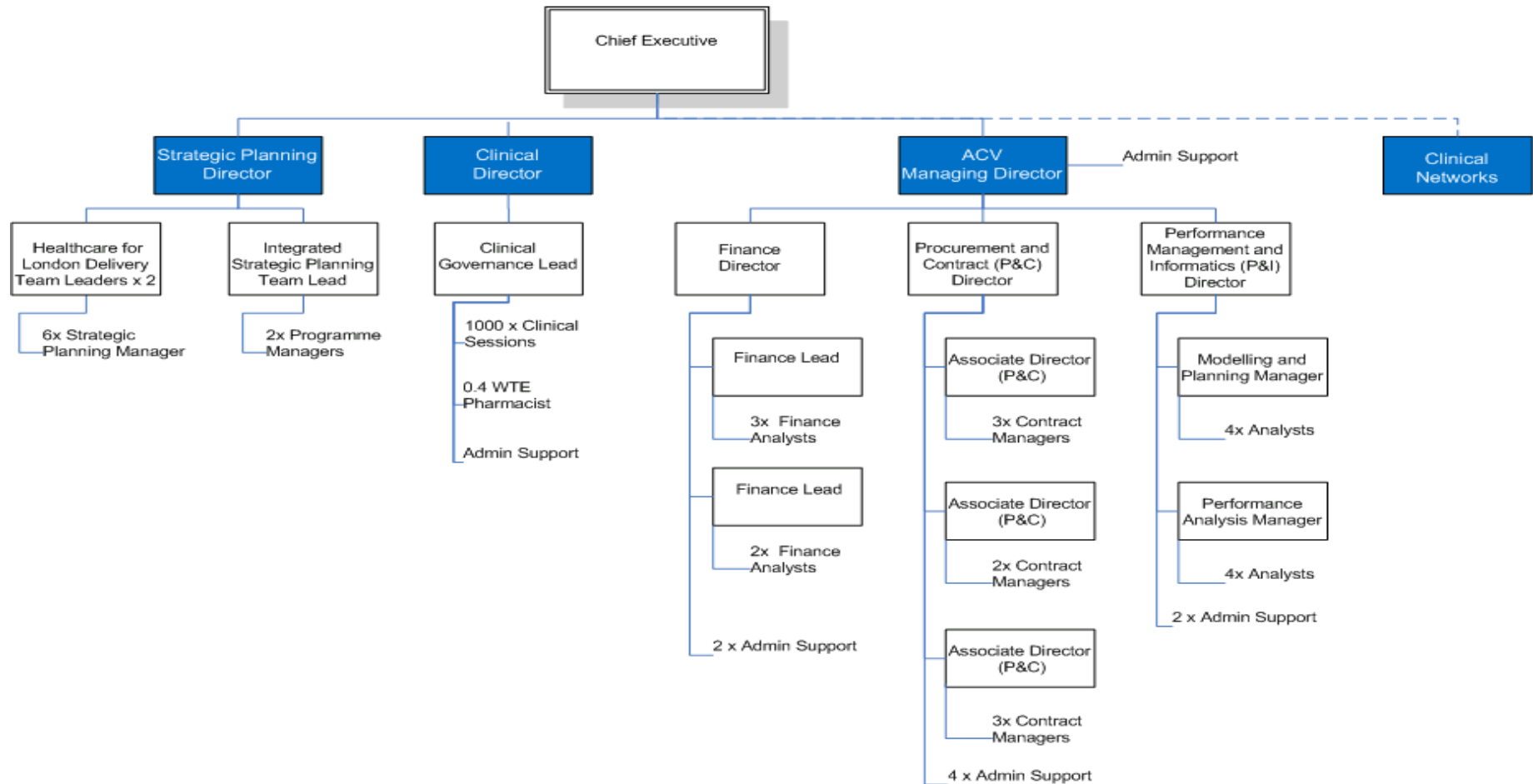


#### 4.1.3 Organisational form

The organisational form of the Partnership, outlined in Figure 6, has been designed in response to a number of organisational priorities. These priorities agreed with the Sector Chief Executive are: (a) to add incrementally to the existing acute commissioning talent pool; (b) to drive a new focus on provider performance; (c) to integrate strategic planning and CNs into the contracting process; and (d) to provide the flexibility to respond to seasonal workload and unplanned project-based requirements; and (e) to improve provider care quality and clinical practice.

To meet these priorities, the Partnership team will operate in a matrix-based structure with individual performance metrics, explained in more detail in subsequent sections.

Figure 6 Organisational form of the Partnership



Note 1: Total number of staff 56.4

This diagram does not demonstrate the working arrangement it purely indicates the reporting lines within the Directorates

Note 2: One P&I analyst and a Finance analyst will provide service to all Directorates (including SPD) as pooled resource

Table 15 demonstrates the primary link between each step of the acute commissioning process (as key functions) within each Directorate. This is intended to show the primary link only, as a matrix-based organisation all Directorates will contribute to all functions to varying degrees.

**Table 15 Link between commissioning functions and Directorates**

Commissioning cycle step	Associated Directorates
Assess sector-wide needs and prioritise	Strategic Planning, Procurement & Contract
Sector-wide care pathway and service design	Strategic Planning, Procurement & Contract
Sector-wide strategic and capacity planning	Strategic Planning, Procurement & Contract, Performance & Informatics
Public/clinical engagement	Performance & Informatics
Customer service and patient feedback	Strategic Planning, Procurement & Contract, Performance & Informatics, Clinical
Stimulate the market	Procurement & Contract
Manage the supplier network	Procurement & Contract
Contract and procure	Procurement & Contract, Clinical
Performance management of acute contracts	Performance & Informatics, Procurement & Contract, Clinical
Coding review and claims management	Performance & Informatics (CSL 2010)
Pharmaceutical cost management	Performance & Informatics, Clinical

#### 4.1.4 Summary roles and responsibilities of the Directorates

##### ACV – Finance

The Finance Directorate will be responsible for financial business planning and accounting for the Partnership. The Director of Finance (DoF) will have a key role in underpinning all commissioning activities with robust and effective financial measures. Key roles and responsibilities include:

- Lead negotiation with key providers
- Provide financial expertise, services and analysis to all other Directorates
- Provide robust financial information to support decision making e.g. development of business cases
- Provide analytical and technical support, for example the interpretation of PbR rules and regulations, variance analysis, forecasting, and risk assessments
- Drive greater consistency of acute commissioning budget setting and tracking, sharing working practices with finance teams from across the sector

- Provide information that will allow sufficient financial challenge in the discussions with providers e.g. PbR process, HRG4
- Liaise with PCT DoFs regarding financial planning and strategy

#### **ACV – Performance Management and Informatics**

The Performance Management and Informatics Directorate will be responsible for driving acute provider performance management (including metrics around under and over performance) and improved knowledge sharing across the sector. It will also be responsible for claims management and invoice validation until these services are available from CSL. Key roles and responsibilities include:

- Sharing information/analysis with PCTs to support acute care needs assessments
- Supporting modelling of service redesign focussing on the impact on the acute sector
- Acute sector health market analysis (within and beyond the sector geography)
- Modelling activity forecasts and cost implications
- Modelling impact of service redesign (with PCTs)
- Providing market analysis to support all other Directorates in negotiations
- Providing claims management and invoice validation services, pending CSL service coming online
- Providing the NWL sector interface to CSL claims management and invoice validation services
- Analysis and modelling of over/under performance
- Monitoring acute provider performance to targets
- Analysis of referral pathways and trends to support PBCs
- Sector-wide monitoring of patient experiences in acute care
- Produce NHS London performance reports and manage the NHS London performance relationship
- Contributing to capacity planning
- Auditing the effect of SLA / FT Contract changes

### ACV – Procurement and Contracting

The Procurement and Contracting Directorate will be responsible for deploying supply-side interventions, specifically developing and negotiating contracts with every provider, running competitive tender processes in line with procurement regulations and best practice, and decommissioning services. Key roles and responsibilities include:

- The primary interface between the Partnership and each provider, leading the contract review process
- Monitoring and improving relationships with each provider to strike the balance between competition and co-operation – driving greater commercial rigour in parallel with co-operative improvements in care
- Validate that there is alignment with the strategy and support the PCTs in the assessment of the market to identify gaps and identify local and major alternative providers
- Where the strategic planning team has identified a need for competition in the market, managing the competitive tender process
- Planning all provider conditioning and negotiation strategies prior to contracting
- Maintain appropriate audit trails for procurement transactions, if necessary responding to queries from the Cooperation and Competition Panel for NHS funded services
- Resolve legal procurement challenges and implement corrective action
- Providing input to the WCC process for competencies 7, 9 and 10

### Clinical Directorate

Improving clinical quality and clinical practice will be central to the functions of the Partnership. The Clinical Directorate will be responsible for providing clinical leadership within the ACV and to the SPD. The Directorate will be responsible for robust clinical governance within the Partnership to ensure that Providers are commissioned in line with a strong focus on quality of care as outlined by Standards for Better Health. The Directorate will put in place a robust clinical governance framework which will cover all aspects of clinical governance including patient safety, clinical effectiveness and assurance of secondary care processes. The Director will be responsible for reviewing and directing the clinical KPIs within provider contracts and also providing clinical advice and scrutiny for the contracting and procurement of provider services. The Directorate will work closely with the CRG to provide robust clinical leadership for the Partnership as a whole. The Director will be responsible for developing an appropriate clinical forum for clinical input (specifically with PBCs) into the commissioning process. A key focus area will be to drive improvement to clinical practice within the sector. Further detail is provided in section 4.2.3 clinical governance. Key roles and responsibilities include:

- Quality monitoring
- Providing clinical leadership with a real link back to PBC priority setting
- Providing clinical challenge during negotiations and performance meetings
- Providing the clinical input for contract negotiations
- Setting standards for clinical terms in the contract review and wider CQUIN discussions

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- Providing clinical evidence and advice in the development of procurement strategies and specifications
- Providing clinical input into sector wide service reviews and redesign
- Setting up and leading on the clinical governance of the Partnership

### **Strategic Planning Directorate**

The SPD will be responsible for developing and delivering sector wide strategic plans, as well as supporting, facilitating and implementing the delivery of sector wide strategy and its associated workstreams in HfL. The approach within the Directorate will be to develop a group of highly skilled core staff who can lead on the SPD functions. Core staff will be supported by appropriately skilled direct reports, but will also work closely with colleagues in the ACV, PCTs, CSL and the Networks where required. The Directorate will coordinate sector-wide communication and engagement/consultation functions through either a 'build' or 'buy-in' approach. Business/analytical support (finance and information) will be provided through the ACV. The Directorate will also draw on, and coordinate where relevant to the core functions, on management and clinical resources within the clinical networks, other sector-wide redesign teams (LPFIT, LHCs), and HfL.

Clinical leadership is critical to support the SPD and the ACV. The development of the most appropriate model of clinical leadership to support both functions will be lead by the Clinical Director in conjunction with the MD (Managing Director and Director of Strategic Planning). Key roles and responsibilities include (under the two core functions):

#### Integrated Strategic Planning

- Develop the Integrated Strategic Plan
- Develop the annual Sector Operating Plan
- Develop an Organisational Development Plan
- Support the development of the Acute Commissioning Strategy
- Sector-wide policy development including stakeholder engagement, workforce planning, estates planning and communications
- Support service reconfiguration work
- Gather evidence to support WCC at a Sector level
- Develop specifications and criteria for potential providers which are in line with the strategy of the NWL
- Act as a gatekeeper for the Partnership on strategic issues, for example provider reconfiguration, and support two-way information sharing with other stakeholders outside the NWL

#### Delivering Healthcare for London

- Leading sector-wide service review, redesign, capacity planning, business case development and travel time analysis

- Working with HfL on projects spanning the whole of London and coordinating the change process following consultation
- Supporting redesign work in individual PCTs on an ad hoc basis
- Highlighting key changes to acute services and develop plans to operationalise these changes, e.g. taking into account NHS London requirements, PCT CSPs and operating plans
- Supporting the design of any sector-wide acute pathways, so that redesign changes are in line with NWL strategy
- Reporting on progress of individual projects and escalate key risks and issues
- Engaging with various stakeholders in developing the individual project plans

### 4.1.5 Working Practices

The success of the Partnership will ultimately be measured on many levels by different stakeholders, e.g. meeting acute health care targets, the quality of the relationship with each provider, the quality of the customer relationship with each PCT, responding to London-wide priorities and reducing the incidence of financial 'surprises' relating to acute care.

In order to meet these multi-faceted challenges, the Partnership, and in particular the ACV, will need to operate on a matrix basis, in which every member of staff is able to manage multiple priorities and to work as an integrated team across many disciplines. As shown in Figure 7 the Partnership will seek to avoid a silo mentality by using integrated teams for each acute provider, each of which will be led by a clearly nominated individual who will become the key point of contact for providers.

Each Director will be appointed as the lead customer relationship manager for specific PCTs and will be expected to respond to the full range of potential working issues, irrespective of the function the query relates to. Whilst this will remove a significant layer of cost from the Partnership, it is expected that investment will be required to ensure the PCT customer experience and escalation is consistent and of a high quality, using frequent communications, SLA monitoring processes and benefits tracking mechanisms.

The provider-orientation of integrated teams will not be at the expense of other priorities. Pending detailed descriptions, each role will include a balanced performance scorecard to include lead responsibilities for each sector-wide target (e.g. A&E waits) and the quality of each PCT relationship. The performance and reward structure for the organisation will enforce matrix working within the team.

The resource allocated to each team has been considered in relation to the total contract value of the sector with each of the Providers and the complexity of the contract. The Sector contract value with Imperial is significantly greater than the contract values with the other 6 providers and thus a team with a greater percentage of seniority has been allocated. The Finance Director has also been identified as the lead Director for this contract. Further analysis into each of the Providers will be carried out to ensure the teams reflect the resource requirements of each of the contracts.

### 4.1.6 Attractive Career Opportunities

To attract the best talent the HR workstream is identifying unique and attractive career opportunities. One proposal includes the development of rotation schemes which provide staff with the opportunity to rotate through the Partnership, PCTs and potentially CSL to build an extensive portfolio of commissioning experience. Learning and development opportunities, to develop staff to become ‘best in class’ are being identified and a robust programme for skills development will be produced. The Partnership aims to combine both public sector and private sector expertise, this will give staff within the organisation the opportunity to share learning across industry sectors.

**Figure 7 Working Practices**

Note 1: The colours indicate the specific lead contractor / negotiator responsibility of the Directors

Note 2: The teams indicate provider specific responsibilities; the resource allocated to the providers will be further detailed by the Directors once they are in post. Red outline shows example.

Acute Commissioning Vehicle							
	Procurement and Contract Director		Performance Management and Informatics Director		Director of Finance		
NCA, NCI and Other London acute providers	Associate Procurement and Contract Director	1x Contracts Manager	Performance and Informatics Manager	Other sectors	Finance Lead	Finance Analyst	Clinical Directorate
North West London Hospitals NHS Trust		1x Contracts Manager		1x (P&I) Analyst			
West Middlesex University Hospital NHS Trust		1x Contracts Manager		1x (P&I) Analyst			
Ealing Hospital NHS Trust	Associate Procurement and Contract Director	1x Contracts Manager	Performance and Informatics Manager	1x (P&I) Analyst	Finance Lead	Finance Analyst	
Imperial College Healthcare NHS Trust		1x Contracts Manager		1x (P&I) Analyst			
The Hillingdon Hospital NHS Trust	Associate Procurement and Contract Director	1x Contracts Manager	Performance and Informatics Manager	1x (P&I) Analyst	Finance Lead	Finance Analyst	
Royal Brompton and Harefield NHS Trust		1x Contracts Manager		1x (P&I) Analyst			
Chelsea and Westminster NHS Foundation Trust		1x Contracts Manager		1x (P&I) Analyst			
1 x Pooled P&I analyst + 1 x Pooled Finance Analyst							

#### 4.1.7 Geographic Location

Based on feedback collated during co-design, it is clear that Partnership staff will need to strike a balance between operating as a close-knit team in one physical location, the host PCT (NHS Westminster), whilst ensuring the benefits of working alongside each PCT locally are achieved. Again, various models for geographic location were considered e.g. central option with 100% team working from one site, hub and spoke by person, hub and spoke by time and local.

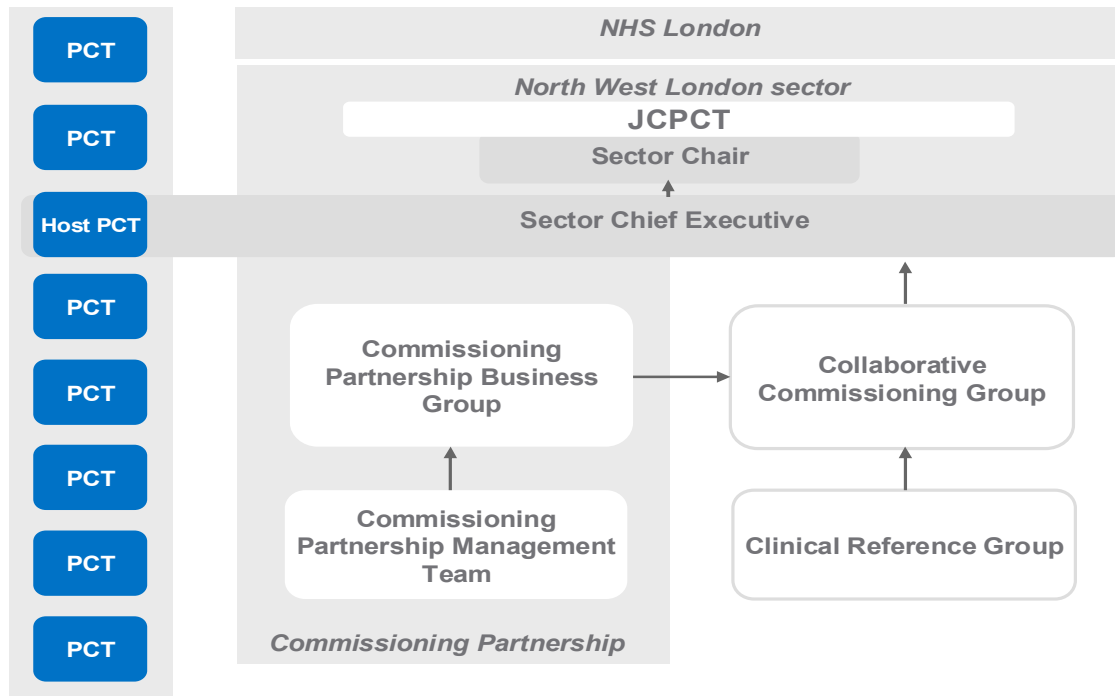
Whilst multi-site technology is improving, the strongest working relationships are developed through physical co-location which facilitates sharing of objectives, priorities and preferred styles of working. It is imperative that these relationships are formed within the Partnership, with providers and PCT/borough based commissioning teams. Building upon the key lessons learnt from professional services organisations reliant on successful multi-site working, the co-design team have concluded that the preferred model, most likely to meet the objectives of the Partnership is hub and spoke by time, pending testing via the HR transition workstream. This model is likely to incur an element of increased running costs through travel expenses and the need for multi-site technology where it is not currently installed in each PCT. However based on the examples of failed collaborative structures, the cost of silo working would be ultimately far greater.

### 4.2 Governance

#### 4.2.1 Introduction

Figure 8 outlines the proposed governance structure:

Figure 8 Governance of the Partnership



## **4.2.2 Corporate Governance**

The key bodies and groups are summarised below:

### **The Joint Committee of PCTs (JCPCT)**

It is proposed that the Partnership will be governed by a body that can reflect the interests of each of the eight member PCTs. The JCPCT will therefore be responsible for oversight of the performance and responsiveness of the Partnership. The membership of the JCPCT includes Chairs and Chief Executives of the NWL PCTs and clinical leadership via PEC Chairs. Draft establishment agreement and Terms of Reference for the JCPCT are attached in Appendix A.

The JCPCT is intended to be a two way representative committee, with issues being escalated and dealt with on behalf of both the Partnership and the PCTs. The Partnership will provide monthly acute contract and performance reporting to the JCPCT and the individual PCTs. For individual contact performance, the Partnership will report directly to each PCT against their schedule of requirements and individual trust performance. The key responsibilities of the JCPCT are to:

- Sign-off the strategic objectives and programme for acute services commissioning in order to ensure that the sponsoring PCTs objectives are met
- Ensure that the annual business cycle is conducted effectively
- Ensure consistency between the strategy and implementation of shared commissioning arrangements and those undertaken at borough level and in specialist commissioning
- Ensure the delivery of HfL as it applies to those acute service areas where responsibility is delegated to the Partnership, including working with PCTs to undertake any consultations on service changes
- Ensure effective and timely reporting of progress and performance to PCTs
- Ensure that the responsibilities of the PCT Chief Executives in relation to the commissioning of services are fully discharged

An establishment agreement is currently being drafted and London wide review of the draft document will be carried out. The agreement will then be reviewed by the JCPCT for sign-off. The current terms of reference for the JCPCT, as shown in Appendix A, will be reviewed and updated to reflect the additional role of the JCPCT in relation to the formation of the Partnership.

### **Collaborative Commissioning Group**

The CCG has responsibility to agree the strategic objectives for the Partnership, to review the Partnerships Strategic and Operating Plans, and to make recommendations through the JCPCT. The membership of the CCG is PCT Chief Executives, the Sector Chief Executive and Managing Director of the Partnership, PCT Directors of Commissioning or equivalent.

### **Commissioning Partnership Business Group**

The membership of the group will be the Managing Director, Directors of the Partnership and Directors of Commissioning (or similar, dependent on the structure of the PCT) from the PCTs.

This group will be responsible for the monitoring of performance/responsiveness of the Partnership and have an 'oversight' of intelligent client functions in the PCTs. The business group provides a PCT/Partnership forum for high level operational challenges and

developments to be discussed and addressed. The business group is expected to be a two way representative board with issues being dealt with on behalf of both the Partnership and the PCTs. Where issues need to be escalated or taken further, these in the first instance will be escalated to the Sector Chief Executive. If issues need to be escalated even further they will be taken to the JCPCT. The Commissioning Partnership Business Group has responsibility to:

- Consider the annual business plan and recommend approval from the JCPCT
- Provide oversight of the Partnership's financial and business performance
- Contribute to resolving and challenging provider performance issues
- Provide oversight on borough and acute commissioning developments

The distinction between the CCG and the Business Group is that the CCG will focus on strategic sector-wide direction and decisions including those of the Partnership. The Business Group will predominantly focus on performance and operational management of the Partnership.

### **Commissioning Partnership Management Team**

Membership of the management team will be the Sector Chief Executive, the ACV Managing Director, Directors of the Partnership and Associate Directors of the Partnership. The Commissioning Partnership Management Team will have responsibility to:

- Direct and manage on a day-to-day basis the operation of the Partnership
- Track and monitor Partnership progress and performance against the business plan and operating plan, identifying and mitigating against operational difficulties and reporting these to the JCPCT as appropriate
- To manage any exceptions to performance and any disputes which occur in line with the agreed procedure
- Provide monthly performance updates to PCTs and the Commissioning Partnership Group

### **Primary Care Trusts**

PCTs will retain statutory accountability for commissioning and performance of all healthcare services (both acute and non-acute). All eight NWL PCTs have agreed to delegate responsibility for delivery of acute commissioning and performance management of acute providers to the Partnership.

A Service Level Agreement (SLA) between the Partnership and the PCTs will provide PCTs with reassurance and clarity regarding the scope and functions of the Partnership, what the PCT can expect from the Partnership and what the Partnership expects from the PCTs. The success of the Partnership and delivery against the KPIs will rely on compliance of the Partnership and the PCTs against the conditions set out in the SLA. The SLA will be produced jointly during the transition phase (July) by the PCTs and the Partnership to ensure that it outlines mutual requirements. The following will be outlined in the SLA:

- Roles and responsibilities
- Services to be provided
- Prices and payments

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- Monitoring (KPIs for Partnership performance are being developed)
- Roles and responsibilities
- Information requirements
- Dispute resolution procedure
- Termination
- Notices

The PCTs will have responsibility for:

- Allocating the totality of resources for their population (including acute expenditure)
- Becoming an “Intelligent Customer” of the Partnership and ensure that the services that are provided by the Partnership are effectively used.
- Ensuring that the services of the Partnership are fully communicated to staff to avoid duplication of work
- Playing an active role in the collective priority setting
- Delivering to the terms set out in the SLA
- Ensuring that PBC groups are involved in discussions regarding acute commissioning and hold them to account for their role in supporting the delivery of agreed objective
- Ensuring that PCT representatives contribute fully in their roles on the CRG, CCG and the Commissioning Partnership Business Group

Effective governance is essential to ensure that the Partnership can be directed by its members, the PCTs. PCT concerns and issues (dependent on the nature of the issue) will be managed through the:

- JCPCT
- Commissioning Partnership Business Group
- Analyst/Contract manager (day-to-day PCT relationship lead)
- Partnership Director (PCT relationship lead)

#### Host PCT

The host PCT will provide various services to the Partnership. (This has been looked at in more detail under the Infrastructure section of this business case). The host will need to:

- Lead the Partnership, through the Chief Executive of the host PCT
- Employ Partnership staff or host secondments
- Assume employment liability for the statutory responsibilities arising from day to day operations of the Partnership. This would include accountability for employment, resource use, and audit

- Accommodate Partnership staff at a suitable location which is attractive to staff to facilitate high quality recruitment
- Supply corporate services and logistical support to the Partnership e.g. desk space, computers, security passes and general IT and facilities support

### **Sector Chair**

- The Sector Chair has responsibility for leading the sector JCPCT and for ensuring that it successfully discharges its overall responsibility for the functions delegated to it by the constituent PCTs. It is imperative that the Sector Chair and PCT Chairs work closely together to promote collective working to strengthen commissioning.

### **Sector Chief Executive**

The Sector Chief Executive has responsibility for the Partnership whilst operating within the functions and responsibilities delegated to it by the constituent PCTs. The Sector Chief Executive's PCT will be the host PCT for the Commissioning Partnership.

## **4.2.3 Clinical Governance**

### **Clinical Directorate**

The Clinical Directorate will have responsibility for ensuring that robust clinical governance is in place within the Partnership along with providing clinical leadership to the Partnership. The team within the clinical directorate (specifically the governance lead) will develop a robust clinical governance framework to ensure that clinical quality; patient safety and clinical practice are challenged and reviewed regularly.

### **Clinical Reference Group**

Membership of the group will be the PEC Chairs, Medical Directors from the Acute Trusts and Directors of Commissioning. The CRG will report to the CCG/JCPCT as the key clinical advisory body to the Partnership. The CRG will work in partnership with the ACV, SPD, CN and PBC to ensure that the sector works to the highest possible clinical standards, and will be the conduit through which clinical advice and decisions are communicated to the CCG. The CRG will have responsibility for:

- Providing a strong model of leadership support to the Partnership
- Providing clinical leadership across both primary and secondary care commissioning
- Uniting primary and secondary care clinicians in ensuring high quality care within fixed resources
- Striking the balance between centralised and decentralised priorities/concerns
- Setting standards of clinical practice
- Advising the annual contracting process including identifying key SLA themes and providing the clinical expertise to support SLA negotiations
- Auditing - ensuring recommendations have been implemented and embedded
- The development of CCI and delivery of CCI initiatives
- Improving clinical practice by sharing clinical benchmark information

#### 4.2.4 Governance of the Partnership at London Level

NHS London has devolved responsibility for performance management of all acute provider targets to the Partnership and will hold the sector Chief Executive directly responsible for performance management of acute provider targets. The governance and financial responsibilities for trusts will remain with NHS London.

### 4.3 Partnership Interrelationships

#### 4.3.1 Professional Executive Committee (PEC)/Commissioning Executive Committee (CEC)

Each PCT's PEC/CEC chair will sit within the JCPCT. Clinical leadership via the PEC/CEC Chairs is vital to the success of the JCPCT and they will have a key role in ensuring local views are represented at the JCPCT. The JCPCT will be the governance body for the Partnership and will report to the eight PCT boards individually.

#### 4.3.2 Clinical Reference Group

The CRG will continue to play an important part in providing clinical leadership for the Partnership. Clinical leadership and involvement is an integral part of the commissioning process as clinicians are best placed to advise and lead on issues relating to clinical quality and effectiveness. WCC competencies also include a commitment to collaborating with clinicians. The CRG will provide a valuable forum for engaging clinicians in commissioning. The Clinical Directorate within the ACV will work closely with CRG. The CRG has been instrumental in agreeing on robust clinical criteria on which to base commissioning decisions. The CRG will work closely with the ACV to provide clinical leadership in the following areas:

- Contracting
- Commissioning/service redesign
- Contributing to a financially balanced community
- Clinical Networks

The CRG will also link with PBC to extend the scope of the clinical leadership provided. Further roles and responsibilities have been identified in the governance section 4.2.3.

#### 4.3.3 Primary Care Trusts

The PCTs will be intelligent customers of the Partnership. An example definition of 'intelligent customer' is:

*'The capability of the organization to have a clear understanding and knowledge of the product or service being supplied'<sup>31</sup>*

The success of the Partnership will rely significantly on the PCTs becoming intelligent customers of the 'services' it provides. This will involve PCTs ensuring that their direction of travel and requirements from the Partnership are clearly outlined and metrics for measuring these are in place. The key to robust management of this relationship will be through a Service

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<sup>31</sup> IAEA Draft Safety Guide DS349, Application of the Management System for Nuclear Facilities, Draft 4: January 2006. <http://www-ns.iaea.org/downloads/standards/drafts/ds349.pdf>

Level Agreement (SLA) which will outline the key responsibilities of the Partnership and the PCT with detailed understanding of the commitment for regular communication (information flows).

### 4.3.4 Practice Based Commissioners

Practice Based Commissioning (PBC) plays a vital role in health reform and will play an essential role in informing acute commissioning of services. PBC is crucial at all stages of the commissioning process.

A PBC workshop was held on 20<sup>th</sup> May to discuss the operational implications that the Partnership may have on PBC. Whilst it was recognised the Partnership could offer some real benefits for PBC, for example benchmarking of trust and cluster performance, concerns were raised that the Partnership may destabilise the existing PBC arrangements in place and have the adverse effect of disengaging PBCs. It was evident that PCTs were anxious not to let this happen.

There is currently a large amount of variation in the quality and quantity of acute information being provided to PBCs. However, the quality and frequency of the information supplied has been criticised in recent surveys and in the WCC assurance programme. Within the recent DH publication "Clinical Commissioning: Our vision for PBC", PCTs are required to supply PBC clusters with accurate, timely data and analysis that includes referral and activity information. PCTs failing to deliver this PBC entitlement will not be able to reach level 2 of WCC.

Some trusts use tools such as Dr Foster or NHS Comparators to provide intelligence to practices, but this information is often out of date and not in a user-friendly format. The Partnership should be able to provide more consistent and timely benchmarking data across a wider geographical area.

The current arrangements within PCTs in NWL require PCTs to limit their practice benchmarking to their own PCT or rely on nationally provided data which is often out of date. The Partnership will be able to:

- Aggregate data for all eight PCTs which will provide a broader benchmarking group and provide practices with a more holistic view of patient flows/pathways.
- Gain a better understanding of a broader range of referral patterns and existing pathways that will provide PBCs with more intelligence on which to base decisions about referral and pathway redesign.
- In addition to providing secondary care activity information, supply practices with information on key acute performance indicators across a range of secondary care providers. This will enable both practices and patients to make more informed decisions about referral and choice of hospital

The main interface between the ACV and PBCs will be through a lead within each PCT. PBC updates and developments (specifically where they affect the level of acute activity commissioned) will be communicated through regular meetings between the PCT (PBCs) and the ACVs.

The PBCs along with the CRG and PCTs will contribute significantly to informing service redesign and identification of quality KPIs and CQUINs. They will inform the ACV on deciding clinical outcomes. They will also play a key role in supporting the ACV provider performance management by providing valuable feedback on provider performance.

Further co-design is required to identify a robust and efficient way for PBCs and the Partnership to work together. The development of a sector wide forum for PBCs, PCT clinicians and the Partnership is being considered.

### 4.3.5 Inner North West London Care Community (INWLCC)

INWLCC is an NHS-led local partnership, working together to deliver an integrated service improvement programme (ISIP), as a key contributor to the achievement of WCC.

The care community delivers a strong programme governance and joint 'infrastructure' of people, processes and technology to enable real partnership working to improve the delivery of patient care. As such, INWLCC will have strong working links with the PCTs, PBC Clusters, the Partnership, and other partner organisations.

Other similar groups may exist throughout the sector; the links between these groups, their PCTs and the Partnership will need to be mapped out during the transition phase.

### 4.3.6 Local Authorities

LAs are currently engaged in the 'assess needs and prioritise' function of the commissioning cycle. The PCTs will maintain their relationship with the LAs and it is anticipated that LA developments and updates will be fed to the Partnership through the PCTs. Engagement of the Partnership with the LAs to date has been minimal but there is a plan to discuss further the details of the interrelationship between the LA and the Partnership and the remit and role of this relationship.

### 4.3.7 Academic Health Science Centre

The vision for the Academic Health Science Centre (AHSC) is; 'quality of life of our patients and local populations will be vastly improved by taking the discoveries that are made and translating them into medical advances - new therapies and techniques - and by promoting their application in the NHS and around the world, in as fast a timeframe as is possible'<sup>32</sup>. The translation of new medical knowledge and advances into everyday clinical practice will require innovative Partnerships between the AHSC, PCTs and other local health partners. The SPD, the CD and the CNs will have a role in supporting the objectives of the AHSC through collaborative working to address patient needs across the sector. This relationship will put foundations in place to deliver innovation and the key objectives of improving quality and health outcomes for patients.

### 4.3.8 Commissioning Support for London

The ACV will have a direct relationship with CSL. The ACV will become the intelligent customer of CSL for products relating to the acute commissioning functions carried out by the vehicle. The PCTs will be the intelligent customers of CSL for products relating to functions outside of the ACV's remit and will also have a shareholder relationship. Links with CSL have already been established but do need to become more robust as the ACV becomes functional. CSL has ambitions to provide a large amount of the knowledge management function to PCTs and the ACVs in London. However, it is clear that a large amount of business support will need to be provided from within the vehicle in the short and medium term to ensure that the maximum benefits are realised. This transition will be carefully managed through the appointment of sector engagement leads at the CSL and a CSL sector wide working group with the ACV. The

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<sup>32</sup> Academic Health Science Centre (website) available at <http://www.ahsc.org.uk/>

ongoing relationship with CSL will be vital to the continued shaping of Partnership functions and products and therefore regular meetings are being set up to facilitate this dialogue.

Recent communication with CSL suggests that the first products to be rolled out (2009/10) are:

- Health Needs Assessment (HNA): Providing robust benchmarking and supporting analytical tools to identify priority areas
- Provider Performance Management & Analysis (PPA): Supporting commissioners in ensuring effective delivery of care with respect to cost, access and quality
- Claims Management & Invoice Validation: Enabling commissioners to challenge erroneous claims and reduce clinically ineffective procedures.

It is assumed that these services will be provided by CSL from January 2010 and therefore the design of the ACV has taken this in to account. There is very little overlap between the first 2 of these products and the outputs of the business support which will be provided from within the ACV. Therefore the vehicle will use these products to complement the products provided internally in the short and medium term. However, the ACV will inevitably become a user of this product in the medium to long term and this relationship will need to be managed through the CSL sector working group to ensure that this function is enhanced in the CSL.

Early communication with the CSL indicates that there is no road map currently agreed for the delivery of products above the initial 3 noted above. It is likely that PCTs and the Partnership will be able to request the creation and development of products from the CSL and this could be done through the ACV. Consequently, the ACV could ask the CSL to deliver some of the functionality which will initially be provided in the ACV. The detail of how this would work and how competing priorities from multiple PCTs/sectors will be handled will need to be discussed. The ACV will be holding a sector wide workshop on the 30<sup>th</sup> June with the CSL and senior representatives from PCTs in the sector, to discuss and resolve these issues.

Once exact time frames for product roll-out have been determined, these will be mapped against ACV functions and adjustments to areas of responsibility within the ACV will be taken into account.

## 4.4 Financial processes

### 4.4.1 Acute commissioning budgets – risk sharing arrangements

As outlined in section 3 of this document, the ACV will be responsible for managing the contracting process on behalf of the sector PCTs. Accordingly they will be responsible for negotiating the SLAs with the acute providers and this will have budget implications for each of the PCTs.

The Chief Executives of the NWL PCTs have agreed that there will not be a formal risk sharing arrangement put in place. Therefore, the ACV will keep the acute commissioning budgets separate and they will remain aligned to each of the individual PCTs. If there is an over-performance by a provider then this will be funded by the particular PCT to which that over-performance applies. Similarly, if there is an under-performance by one of the providers then this will result in a refund for the particular PCT for which the under-performance applies. The rationale for this is that a risk sharing arrangement would not be compatible with the PBC devolved budget arrangements that have been introduced recently. Under these arrangements the PBC clusters are incentivised to reduce their referrals through retaining a share of the

financial benefits of an under-performance by a provider to which they are referring. Without risk sharing the PBCs and the PCTs will remain incentivised to manage an over-performance by a provider. However, in order for this to work effectively, it is essential that the ACV provides the PCTs and PBCs with an early warning if there is an expected over-performance so that risk can be managed as effectively as possible.

The Chief Executives of the eight PCTs have agreed that if there is a significant over-performance which will result in serious financial difficulties for one of the PCTs, then the JCPCT will use a sector investment fund to help reduce the severity for the PCT impacted. Once the ACV reaches a more mature stage of operation then a more sustainable risk pooling approach may be introduced. In this instance the PCTs will each contribute to a risk pool and there will be governance processes in place to determine when the risk pool can be used.

### 4.4.2 Acute commissioning budgets – financial governance

The ACV will be responsible for negotiating the terms and the costs of a provider SLA and for investigating and validating an over-performance. The ACV will feed back its recommendations to the PCTs' Executives for ultimate sign-off. The ultimate financial responsibility for signing off the budget for a provider SLA and an over-performance against that SLA will remain with the individual PCTs. The rationale for these arrangements is that the PCTs remain accountable for their financial performance.

### 4.4.3 Acute commissioning budgets – finance and invoicing arrangements

Two options for the financing and invoicing arrangements for the acute budgets were discussed:

- Option 1 – The acute providers invoice the PCTs directly on a monthly basis according to the terms of the provider SLA and there are quarterly reimbursements if there is an over / under performance
- Option 2 – There is an annual resource transfer from the PCTs to the ACV equal to the budget agreed in the provider SLAs for that year. The providers invoice the ACV on a monthly basis according to the terms of the provider SLAs. The ACV will invoice / reimburse the PCTs on a quarterly basis if there is an over / under performance against the SLA

The Finance Directors chose option 1 because it ensures the least disruption during a period of considerable change. There is unlikely to be a risk sharing arrangement which means that option 2 is an unnecessary requirement and In the event of an over/under performance, option 2 would result in additional transactions as money would be passed from the provider to the ACV to the PCT (or vice versa).

The expectation is that the employees of the ACV will become employees of the host. Therefore, the finance function within the host will be responsible for managing the payroll process for these staff.

## 4.5 Culture

Culture describes how the Partnership delivers its services, how it is regarded by users and how it feels to be a part of it. From an external perspective, it is about the brand experienced by key groups that it regularly interacts with, particularly PCTs, PBC groups, acute providers, CSL and NHS London. The link with brand is important in that it relates to the reputation and “feel” of the organisation. Global private and public organisations take this concept seriously because brand is inextricably linked to performance, reputation and profitability. The Partnership's culture and

brand will be shaped by its goal of professional service provision, and this will be closely tied to its ability to improve up acute commissioning and meet the local priorities of its customer PCTs.

In defining what this means on a day to day basis, it is necessary to link this to the way that Partnership staff engage key groups, the efficiency that underpins its processes, its overall reputation for high quality delivery and the demonstrable values that drive decision making and overall style. The culture of the Partnership can be shaped, developed and sustained through key activities such as the organisational design. It is also important that the culture of the Partnership is consistent with and shaped by the PCTs it serves.

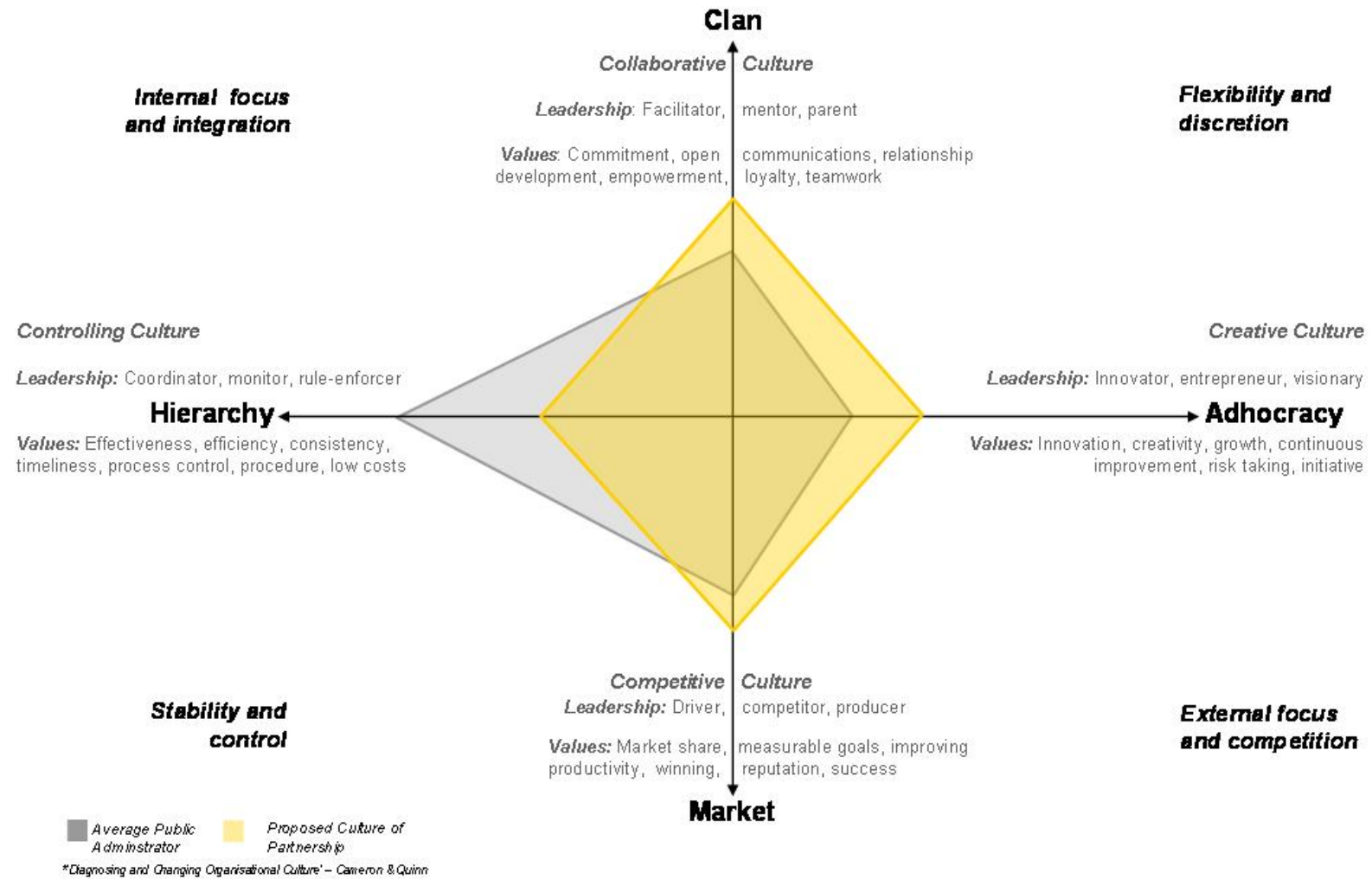
It is essential that in defining what the Partnership seeks to deliver, the management team address a range of issues early on that should include:

- The values necessary to underpin, shape and drive the Partnership especially in regard to how it is viewed by key external groups
- The culture that will drive the delivery of acute commissioning and the experience of its employees
- How the needs of customer PCTs are translated into the operational processes of the Partnership
- The culture that will provide the organisational energy and feel that will enhance the Partnership in a way that enables it to respond to changing needs

### 4.5.1 Culture Map

Figure 9 plots the anticipated culture for the Partnership against a typical public sector organisation. The yellow diamond shows that the Partnership will need to be more innovative to drive improvements in commissioning and develop best practice.

Figure 9 Culture Profile for Partnership



Certain elements of the culture of the Partnership will be core to its ability to function as a high performing organisation:

- A clear mission where aligned to the objectives and goals
- Strong leadership
- Job specifications, the recruitment process, and the training development of staff
- Work based incentives
- Systems for performance management

The Partnership management will play commanding roles in defining and embedding the culture around their staff. They will need to persuade external and internal groups of the validity, impact and value that a pragmatic culture can deliver to the organisation. More critically, however, it is they who will need to consistently live the culture on an ongoing basis.

### 4.5.2 Culture Plan

Setting the organisational culture will be addressed in conjunction with specific groups through a series of structured interactions to ensure colleagues are engaged in developing the culture of the organisation and to ensure wider views are gathered to build an organisation that reflects the views and ideas of its employees and key stakeholders.

There will be three key areas of focus to input into the culture of the Partnership:

- Market research with key groups and individuals
- Analysis of adaptation of current best practice (Leadership Team)
- Adaptation of relevant employee value propositions (Staff Groups)

## APPENDIX A TERMS OF REFERENCE OF THE JCPT

The current approved Terms of Reference are attached below. These will be reviewed and updated to reflect the development of the Partnership.

<b>Title:</b>	<b>Joint Committee of the PCTs</b>
<b>Date approved and approving body:</b>	Approved by the JCPCT on 3 Oct 2008
<b>Purpose:</b>	<p>The JCPCT will lead the development of, and approve, sector wide plans in response to the Healthcare for London framework.</p> <p>It will lead the development of, and approve, collaborative commissioning intentions, including any sector wide response to Strengthening Commissioning, for PCTs in the sector. Commissioning plans of individual PCTs will, therefore, be consistent with and support the service models and standards agreed by the JCPCT.</p> <p>It will be the consulting body for any of these plans which lead to consultation by member PCTs on service change.</p> <p>Decisions made by the JCPCT will be binding on all member PCTs<sup>33</sup>.</p> <p>The JCPCT will also be responsible for ensuring the timely delivery of agreed plans, including the achievement of expected service outcomes.</p>
<b>Membership:</b>	<ul style="list-style-type: none"> <li>• The Chair, Chief Executive and PEC Chair from each of the PCTs in North West London (listed below)</li> <li>• Chairs of the CRG, PRG, CCG and PERG (if these are not already members of the group).</li> <li>• Programme Director, NWL Collaborative Programme</li> <li>• NHS Brent</li> <li>• NHS Ealing</li> <li>• NHS Hammersmith &amp; Fulham</li> <li>• NHS Harrow</li> <li>• NHS Hillingdon</li> <li>• NHS Hounslow</li> <li>• NHS Kensington &amp; Chelsea</li> <li>• NHS Westminster</li> </ul>
<b>In attendance</b>	<ul style="list-style-type: none"> <li>• Programme managers, NWL Collaborative Programme</li> <li>• Network Directors (as required for specific items)</li> <li>• Others, at the request of a member of the JCPCT (as required for specific items)</li> </ul>
<b>Chair:</b> A PCT Chair to be elected by members of the JCPCT	Peter Molyneux (Chair, NHS K&C) until Oct 2009
<b>Vice Chair:</b> To be from another PCT	Mike Robinson (Chair, NHS Hillingdon) until Oct 2009
<b>Tenure:</b>	One year, following which the post will be up for re-election
<b>Secretary:</b>	Patricia Wright, Programme Director
<b>Quorum:</b>	<ul style="list-style-type: none"> <li>• Matters requiring decision by the JCPCT will require a majority agreement by 75% of those PCTs present at the JCPCT meeting when the decision is taken.</li> <li>• For such matters where voting is required each member PCT shall have one vote</li> </ul>

<sup>33</sup> All decisions must take account of the organisational and financial position of member PCTs and the aim should be for decisions to be unanimous

## Appendix A Terms of Reference of the JCPCT

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Title:	Joint Committee of the PCTs
<b>Frequency of Meetings:</b>	<p>and the JCPCT shall reach decisions by a simple majority of PCTs with at least 1 member present, but with the Chair having a second and deciding vote if necessary.</p> <ul style="list-style-type: none"> <li>• Monthly, on the first Friday of each month. The JCPCT will meet in public as necessary depending on the nature of items on the agenda. The Chair will decide which items need to be discussed in public.</li> </ul>
<b>Duties –strategic</b>	<ul style="list-style-type: none"> <li>• Develop Implementation Plans to deliver Healthcare for London where such plans involve service changes beyond single PCT boundaries, linking as necessary with the Healthcare for London programme team.</li> </ul>
<b>Duties – decision making and advisory:</b>	<ul style="list-style-type: none"> <li>• Agree and ensure delivery of a Collaborative Commissioning Intentions Plan (CCI) for the North West London Sector, including an Implementation Plan. Where plans outlined above constitute substantial variation or developments in service, act as the formal consulting body and               <ul style="list-style-type: none"> <li>○ approve the method and scope of consultation</li> <li>○ approve the text of and issue the consultation document</li> <li>○ act as the formal body in relationship with the OSC(s) established by the relevant Local Authorities</li> <li>○ receive the formal report on the outcome of consultation and any other supporting reports commissioned</li> <li>○ take decisions on the issues which are subject to consultation.</li> </ul> </li> </ul>
<b>Duties – monitoring:</b>	<ul style="list-style-type: none"> <li>• Monitor the development and implementation of the CCI</li> <li>• Monitor the work of the sub-groups</li> </ul>
<b>Subgroups:</b>	The JCPCT will be supported in its activities by the Collaborative Commissioning group.
<b>Accountability:</b>	The JCPCT is accountable to the Boards of the eight PCTs in NWL. The JCPCT shall adopt the Standing Orders and Standing Financial Instructions of the Trust which employs the sector wide Strategy Team, apart from the mechanism by which decisions are reached (see Section 5 below). Such Standing Orders will regulate compliance with the Public Bodies (Admissions to Meetings) Act 1960.

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## APPENDIX B DETAILED BENEFITS LIST

Groups	Benefit description	Proposed KPI	Timescale of benefit realisation	Benefit vs. CSL business case	Technical / allocative	Direct / indirect	Financial / non-financial
<b>Benefit 1 - The Partnership will drive improvements in acute hospital performance</b>							
Patients PCTs	The ACV will ensure that performance reporting by acutes is both timely and consistent across the sector. Standardising and monitoring this process will enable the ACV to provide PBCs and PCTs with up to date and accurate information on the performance and referral patterns for each of the acute providers	ACV to monitor the timeliness and quality of acute performance reports as part of the performance dashboard	Within one year	NA	Allocative	Direct	Financial and non-financial
Patient	The ACV can use the consistent performance data to benchmark performance against targets across the sector. This data can be used to inform the commissioning process and will therefore encourage Providers to improve their performance against targets. In addition, the data can be given to GPs and patients to inform patient choice	Acute performance against targets for the seven Acute providers in NWL	Within two years	The expectation is for this benchmarking activity to become the responsibility of CSL but taking follow-up actions will be the responsibility of the ACV	Allocative	Direct	Non-financial
Patients PCTs	The Partnership will be responsible for market management across the acute sector in NWL. The Partnership will introduce consistency across the sector regarding market management activities	No KPI proposed	Within two years	NA	Allocative	Direct	Financial and Non-financial

## Appendix B Detailed Benefits List

Groups	Benefit description	Proposed KPI	Timescale of benefit realisation	Benefit vs. CSL business case	Technical / allocative	Direct / indirect	Financial / non-financial
Patients	The ACV will be well positioned to drive improvements in acute performance through enforcing the Commissioning for Quality and Innovation (CQUIN) payment framework. The ACV can share knowledge and best practice around which are the most appropriate clinical quality metrics to include in the acute SLAs	Acute CQUIN scores within the sector	Within one year	NA	NA	Direct	Non-financial
Patients PCTs	With informal joint-working arrangements, no single individual is responsible for managing performance across all eight PCTs. Under the ACV arrangements there is a specific body whose specific focus will be to improve acute commissioning within the sector	WCC competency scores across NWL	Within two years	NA	NA	Indirect	Financial and non-financial
Providers PCTs	The Providers will only be required to provide information once and in a consistent format. This will enable more comprehensive and more efficient data analysis by the ACV and make life easier for the Providers	No KPI proposed	Within one year	The expectation is that gathering this information will become the responsibility of CSL in the future, but the benefit for the providers will still hold	Technical	Direct	Non-financial
<b>Benefit 2 – The Partnership will make effective use of scarce resources</b>							
Commissioning staff Patients PCTs	The ACV will offer a more attractive and defined career path for specialist Acute commissioners and will therefore be able to attract expert commissioners who will remain with the ACV for a significant period of time	Staff turnover rates within the NWLCP  Staff satisfaction levels	Within one year	NA	NA	Direct	Financial and non-financial

## Appendix B Detailed Benefits List

Groups	Benefit description	Proposed KPI	Timescale of benefit realisation	Benefit vs. CSL business case	Technical / allocative	Direct / indirect	Financial / non-financial
Patients PCTs	The eight PCTs in NWL will no longer be competing for the best procurement skills in the sector. Securing procurement skills is one of the key competencies identified by the WCC report	The score for WCC competency 9 'secure procurement skills'	Within two years	NA	NA	Direct	Non-financial (with some potential financial indirect benefits)
PCTs Taxpayers	The ACV will have a reduced reliance on temporary staff due to the economies of scale achievable through working together as eight PCTs and because the ACV will be an attractive employer for expert acute commissioners	Number of temporary staff on the payroll of the ACV	Within one year	NA	Technical	Direct	Financial (assuming that contractor staff are more expensive than permanent staff)
<b>Benefit 3 - The Partnership will improve the health outcomes of the local population</b>							
Patients	The Partnership will reduce inequality in patient care and patient experiences across the NWL sector	CQUIN scores within the sector  PROMs key performance indicators	Within three years	NA	NA	Indirect	Non-financial
Patients	The ACV will be responsible for improving the patient feedback process within the acute sector. The case for change section of this report identified that the NWL sector was performing worse than the rest of England on WCC competency 3 'engage with public and patients'	The score for WCC competency 3 'engage with public and patients'	Within two years	NHS London document titled 'Core Design Specification for Acute Sector Commissioning Units' states that patient feedback will become the responsibility of CSL in 2011/12	NA	Indirect	Non-financial

## Appendix B Detailed Benefits List

Groups	Benefit description	Proposed KPI	Timescale of benefit realisation	Benefit vs. CSL business case	Technical / allocative	Direct / indirect	Financial / non-financial
<b>Benefit 4 - The Partnership (through the ACV) will drive down acute costs in non-tariff price negotiations</b>							
PCTs Taxpayers	The ACV will be able to drive down non-tariff prices because it will have the capability to benchmark non-tariff prices across the sector and then use its additional leverage and buying power during SLA negotiations	Acute commissioning expenditure on non-tariff items (in real terms) per weighted PCT population member	Within two years	NA	Technical	Direct	Financial
<b>Benefit 5 - The Partnership will ensure volumes of acute care are managed appropriately and provider productivity improvements are realised</b>							
PCTs Taxpayers	The ACV will be able to use its additional leverage and buying power to introduce volume reducing metrics into provider SLAs (e.g. new to follow-up ratios)	Measurement of volume reducing metrics (e.g. new to follow-up ratios)	Within two years	NA	Technical	Direct	Financial
Patient PCTs	The ACV's knowledge management function will have improved forecasting capability. This will enable the commissioners in the sector to meet the needs of the population and also facilitate the interventions which will improve health and reduce acute service usage	No KPI proposed due to the indirect nature of the benefit	Within two years	NA	Allocative	Indirect	Non-financial and financial (if acute service usage can be reduced)
<b>Benefit 6 - The Partnership will develop a best practice approach to commissioning in the sector</b>							
Patients PCTs	The ACV will pool the expertise of acute commissioners who will be able to share best practice and experiences. As experts, the team will develop a greater understanding of what patients want and need from acute services and an in depth knowledge of acute service delivery across NWL	Measured through WCC competencies 9 and 10	Within two years	NA	NA	Indirect	Non-financial <sup>4</sup>

## Appendix B Detailed Benefits List

Groups	Benefit description	Proposed KPI	Timescale of benefit realisation	Benefit vs. CSL business case	Technical / allocative	Direct / indirect	Financial / non-financial
Patients PCTs	Distilling from eight sets of processes and transactions to one will give the opportunity to select only the world class elements	No KPI proposed	Within one year	NA	Technical	Indirect	Financial and non-financial
Providers	The creation of the ACV will mean that acute providers will have a single point of contact across NWL. This will reduce duplication and improve continuity	No KPI proposed	Within one year	NA	NA	Indirect	Non-financial
PCTs	The Partnership will create equality amongst the PCTs within NWL as the Partnership will not be aligned to any particular PCT within the region	No KPI proposed	Within one year	NA	NA	Indirect	Financial and non-financial
PCTs Patients	The Partnership will act on behalf of the PCTs to ensure that maximum value is gained from the services offered by CSL. The added leverage gained by the Partnership will ensure that CSL addresses the sector agenda and priorities	No KPI proposed	Within one year	NA	NA	Indirect	Financial and non-financial
PCTs Taxpayers	Ultimately CSL will be responsible for invoice validation. However, raising challenges with the providers will be the responsibility of the ACV. There is a significant potential saving that can be achieved by aggregating the most successful validations from each PCT and raising these collectively	Annual £ saving from challenging invoices across the sector	Within one year	The expectation is for CSL to be responsible for invoice validation. However, the ACV will be responsible for challenging the invoices with the providers.	Technical	Direct	Financial

## APPENDIX C Commissioning Cycle Functions: Roles and Responsibilities

		Activities	R	A	C	
Plan	Assess needs and prioritise (1.1)	1.1.1	Scan horizon to inform JSNA/CSP/OP	ACV	PCT	PCT/HfL/SHA/PP
		1.1.2	Prepare JSNA/CSP/OP and OD Plan including acute component within timelines including significant clinical input	PCT	PCT	LA/SHA/PP/PBC
		1.1.3	Consult with patient groups, borough, public health and analyse outputs in forming the JSNA/CSP	PCT	PCT	LA/SHA/PP/PBC
		1.1.4	Prioritise strategies and designate to the partnership	PCT	PCT	LA/SHA/PP/PBC
		1.1.5	Develop improvement plans for acute services on WCC competencies based on PCT OD plans and other inputs	ACV	PCT	SHA
		1.1.6	Collate, analyse and benchmark non-acute information (analytical support)	PCT	PCT	-
		1.1.7	Collate, analyse and benchmark acute information (analytical support)	ACV	PCT	CSL
	Care Pathway and Service Redesign (1.2)	1.2.1	Identify opportunities for care pathway redesign (in line with CCI) (with PBCs)	PCT	PCT	PBC/PP
		1.2.2	Ensure strong clinical input into care pathway redesign	PCT	PCT	CN/PBC
		1.2.3	Support the design and testing of the acute side of redesigned care pathways or where the redesign relates predominantly to the acute sector	ACV/SPD	PCT	CN
		1.2.4	Support modelling of service redesign (information analysis – activity/volume into/out of acute sector)	ACV	PCT	-
		1.2.5	Lead discussions and negotiations with acute providers and implement redesigned pathways as requested	ACV/SPD/CN	PCT	CN
		1.2.6	Work closely with Networks to implement service redesign within the acute sector	ACV/SPD	PCT	CN
		1.2.7	Conduct 'best value' reviews for redesigned pathways and use learnings to disseminate good practice throughout the sector	ACV	PCT	CSL
		1.2.8	Provide analysis to support redesign of services, business case production and production of ITTs	ACV	PCT	CSL
	Strategic and Capacity Planning (1.3)	1.3.1	Provide analytical support for strategic and capacity planning for acute services	ACV	PCT	-
		1.3.2	Conduct financial assessment against plans	PCT	PCT	-
		1.3.3	Conduct meetings with PBC to support planning	PCT	PCT	PBC
		1.3.4	Adjust plan based on consultation with public health and PBCs	PCT	PCT	PBC/PP
		1.3.5	Lead on identification of acute services/activities to commission/decommission	PCT	PCT	ACV
		1.3.6	Operationalise acute components of strategic plans produced by PCT, CCI's and public health	ACV	PCT	SPD/CN
		1.3.7	Test assumptions with acute trusts	ACV	PCT	-
		1.3.8	Produce annual report – acute provider performance	ACV	PCT	SPD/CN
		1.3.9	Formulate acute provider monthly and quarterly performance reports	ACV	PCT	SPD/CN

## Appendix C Commissioning Cycle Functions: Roles and Responsibilities

		Activities	R	A	C	
Engage	Public/Clinical Engagement (2.1)	2.1.1	Lead public and clinical engagement discussions	PCT	PCT	PBC
		2.1.2	Set the framework for service redesign and testing	PCT	PCT	PBC
		2.1.3	Drive local engagement	PCT	PCT	PBC
		2.1.4	Collate patient feedback across the sector (trend analysis)	ACV	PCT	-
		2.1.5	Provide analytical function and evidence of compliance (eg, provide intelligent commentary on HCC rating)	ACV	PCT	CSL
		2.1.6	Engage GPs and clinicians in the development of KPIs and CQUiNs	PCT	PCT	PBC/ACV
	Patient Registration and Engagement (2.2)	2.2.1	Ensure effective patient registration processes in place	PCT	PCT	PBC
		2.2.2	Ensure patients are made aware of choice and local services available through campaigns	PCT	PCT	PP
		2.2.3	Engage patients in improving services and care	PCT	PCT	PP/PBC
	Customer Service and Patient Feedback (2.3)	2.3.1	Lead on collecting and collating patient feedback received through PALS and PCT mechanisms	PCT	PCT	PP
		2.3.2	Receive and review acute provider complaint reports	ACV	PCT	SPD/CN
		2.3.3	Collate and analyse acute trust specific complaint figures	ACV	PCT	-
		2.3.4	Resolve issues arising as a result of acute delivery of care	ACV	PCT	SPD/CN
		2.3.5	Send surveys (GP bi-annually/PCT quarterly)	PCT	PCT	SPD/CN
		2.3.6	Create remedial action plans for follow-up based on acute trust survey data / complaints reports	ACV	PCT	SPD/CN
		2.3.7	Review choose and book feedback	ACV	PCT	-
		2.3.8	Champion the use of choose and book and promote its use by practices	PCT	PCT	PBC
		2.3.9	Proactively identify quality indicators areas for improvement and challenge the acute commissioning portfolio	ACV	PCT	PCT
2.3.10		Provide acute analytical support (eg, PROMs)	ACV	PCT	CSL	
2.3.11		Provide acute benchmarking information	ACV	PCT	CSL	
2.3.12		Undertake root cause analysis of acute issues allocated to it and consult with PCTs on findings	ACV	PCT	PCT	
Contract and Procure	Stimulate Market (3.1)	3.1.1	Engage and develop primary care, community care and voluntary sector	PCT	PCT	LA/PBC
		3.1.2	Manage market development across pathways	PCT	PCT	LA/PBC
		3.1.3	Assess local acute market and identify gaps	ACV	PCT	PCT
		3.1.4	Maximise the benefit from CSL (market intelligence)	ACV	PCT	-
		3.1.5	Undertake regular assessment of the acute market and provide information to the PCTs	ACV	PCT	PCT
		3.1.6	Engage with local and major alternative non-acute providers	PCT	PCT	-
		3.1.7	Support PCTs by providing information on acute contracts performance	ACV	PCT	PCT/CSL
	Manage Supplier Network (3.2)	3.2.1	Ensure DoS is in place for each provider (contractual agreement)	ACV	PCT	-
		3.2.2	Ensure provider C&B info is up-to-date and accurate	ACV	PCT	-
		3.2.3	Engage with GPs to ensure that the offer of choice is in place and viable	PCT	PCT	PBC
	Contract and Procure (3.3)	3.3.1	Set all acute commissioning budgets (agree baseline plan)	PCT	PCT	ACV
		3.3.2	Undertake all procurement of acute services	ACV	PCT	-
		3.3.3	Develop sector negotiation strategy	ACV	PCT	-
		3.3.4	Undertake NWL sector negotiations on all acute contracts	ACV	PCT	-
		3.3.5	Set KPIs and CQUiNs within contracts with measurement metrics	ACV	PCT	PCT/PBC
		3.3.6	Set specifications and criteria for acute providers	ACV	PCT	-
		3.3.7	Write acute contracts	ACV	PCT	-
		3.3.8	Make payments to providers	PCT	PCT	-

## Appendix C Commissioning Cycle Functions: Roles and Responsibilities

		Activities	R	A	C	
Manage	Performance Management of Contracts (4.1)	4.1.1	Deliver all performance management reporting at sector level and to individual PCTs on acute performance	ACV/CSL	PCT	-
		4.1.2	Undertake all performance monitoring of PCT WCC acute outcome measures	ACV/CSL	PCT	-
		4.1.3	Review activity vs plan	ACV/CSL	PCT	PCT
		4.1.4	Review and validate all activity (including non-contract activity)	ACV/CSL	PCT	PCT
		4.1.5	Review SUS data	ACV/CSL	PCT	-
		4.1.6	Reconcile SUS data to SLAM information and provide exception reports to the PCTs	ACV/CSL	PCT	-
		4.1.7	Raise challenges for performance management	ACV	PCT	-
		4.1.8	Conduct monthly meetings with acute providers to understand activity and service developments	ACV	PCT	-
		4.1.9	Implement local demand management strategy	PCT	PCT	PBC/LA
		4.1.10	Monitor acute provider KPIs	ACV/CSL	PCT	-
		4.1.11	Deliver non-acute component of CSP and operating plans within timeframe agreed	PCT	PCT	PBC/LA
		4.1.12	Deliver acute component of CSP and operating plans within timetables agreed with the PCTs	ACV	PCT	SPD/CN
		4.1.13	Provide information on provider performance against acute contracts	ACV/CSL	PCT	-
		4.1.14	Provide notice and ensure compliance with exit clauses for non-performing providers – decommission where appropriate	ACV	PCT	-
		4.1.15	Outline clear process for remedial action	ACV	PCT	-
		4.1.16	Manage acute providers within budget to deliver against all targets	ACV	PCT	-
		4.1.17	Use data to benchmark providers	ACV/CSL	PCT	-
		4.1.18	Assure adherence to national standards including NICE guidance	ACV/CSL	PCT	-
		4.1.19	Provide performance information to PBC clusters via PCTs	ACV	PCT	PBC
		4.1.20	Report all acute commissioning performance (activity against budget/contract)	ACV	PCT	
		4.1.21	Share acute performance information with key stakeholders (including LAs)	ACV	PCT	SHA/LA/PCT
		4.1.22	Evaluate impact of service redesign in terms of impact on acute care	ACV	PCT	SPD/CN
	Coding Review (4.2)	4.2.1	Review clinical coding	PCT	PCT	-
		4.2.2	Identify independent treatment request activities which are not contracted and reflect PCT difference within the contracts	ACV	PCT	PCT
		4.2.3	Cascade pan-sector coding reviews	ACV	PCT	SPD/CN
		4.2.4	Review PBR exclusions	ACV	PCT	SPD/CN
		4.2.5	Monitor against NICE guidance with clinical PCT input	ACV	PCT	SPD/CN
	Pharmaceutical Cost Management (4.3)	4.3.1	Define process for responding to requests for high cost drugs	PCT	PCT	-
		4.3.2	Validate high cost drugs which sit outside of SLA	PCT	PCT	-
		4.3.3	Pan-London consistency.	ACV	PCT	SPD/CN

## APPENDIX D FINANCIAL BUSINESS CASE & ASSUMPTIONS

### Net Benefits by PCT

The following tables give details of the expected net benefits of the Partnership for each of the PCTs in North West London during the first three years of operation:

#### *Brent*

Current acute commissioning staff WTEs = 3.61

Payback period = 271 days

Cost / benefit headings	2009/10 post rollout <sup>34</sup>	2010/11	2011/12	2012/13
Current running costs <sup>35</sup>	£0.31m	£0.54m	£0.54m	£0.54m
Future running costs <sup>36</sup>	(£0.64m)	(£0.84m)	(£0.82m)	(£0.82m)
<b>Net cost reduction (increase)</b>	<b>(£0.33m)</b>	<b>(£0.30m)</b>	<b>(£0.28m)</b>	<b>(£0.28m)</b>
PCT retained staff costs <sup>37</sup>	(£0.05m)	(£0.09m)	(£0.09m)	(£0.09m)
Other PCT retained costs <sup>38</sup>	(£0.09m)	(£0.16m)	(£0.16m)	(£0.16m)
Efficiency benefits <sup>39</sup>	£0.00m	£3.46m	£10.38m	£17.30m
<b>Net benefit of Partnership</b>	<b>-£0.47m</b>	<b>£2.90m</b>	<b>£9.84m</b>	<b>£16.77m</b>

(Note: totals correct, rounding may affect addition of parts)

<sup>34</sup> Assumes a mid-point staff move date of 01/09/2009

<sup>35</sup> Including the costs of the North West London Collaborative Programme

<sup>36</sup> Including transition costs and the expected costs of the Strategic Planning Directorate which have not yet been approved by the Collaborative Commissioning Group

<sup>37</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with the PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>38</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff)

<sup>39</sup> The efficiency savings assume that the mid case scenario outlined in benefits section of this document are achieved

## Appendix D Financial Business Case & Assumptions

### Ealing

Current acute commissioning staff WTEs = 3.5

Payback period = 249 days

Cost / benefit headings	2009/10 post rollout <sup>40</sup>	2010/11	2011/12	2012/13
Current running costs <sup>41</sup>	£0.31m	£0.53m	£0.53m	£0.53m
Future running costs <sup>42</sup>	(£0.71)m	(£0.93m)	(£0.91m)	(£0.91m)
<b>Net cost reduction (increase)</b>	<b>(£0.40m)</b>	<b>(£0.40m)</b>	<b>(£0.38m)</b>	<b>(£0.38m)</b>
PCT retained staff costs <sup>43</sup>	(£0.03m)	(£0.05m)	(£0.05m)	(£0.05m)
Other PCT retained costs <sup>44</sup>	(£0.02m)	(£0.04m)	(£0.04m)	(£0.04m)
Efficiency benefits <sup>45</sup>	£0.00m	£4.82m	£14.45m	£24.09m
<b>Net benefit of Partnership</b>	<b>(£0.45m)</b>	<b>£4.34m</b>	<b>£13.99m</b>	<b>£23.63m</b>

(Note: totals correct, rounding may affect addition of parts)

<sup>40</sup> Assumes a mid-point staff move date of 01/09/2009

<sup>41</sup> Including the costs of the North West London Collaborative Programme

<sup>42</sup> Including transition costs and the expected costs of the Strategic Planning Directorate which have not yet been approved by the Collaborative Commissioning Group

<sup>43</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with the PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>44</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff)

<sup>45</sup> The efficiency savings assume that the mid case scenario outlined in benefits section of this document are achieved

## Appendix D Financial Business Case & Assumptions

### Hammersmith & Fulham

Current acute commissioning staff WTEs = 9.47

Payback period = 237 days

Cost / benefit headings	2009/10 post rollout <sup>46</sup>	2010/11	2011/12	2012/13
Current running costs <sup>47</sup>	£0.46m	£0.79m	£0.79m	£0.79m
Future running costs <sup>48</sup>	(£0.39m)	(£0.52m)	(£0.50m)	(£0.50m)
<b>Net cost reduction (increase)</b>	<b>£0.07m</b>	<b>£0.28m</b>	<b>£0.29m</b>	<b>£0.29m</b>
PCT retained staff costs <sup>49</sup>	(£0.10m)	(£0.18m)	(£0.18m)	(£0.18m)
Other PCT retained costs <sup>50</sup>	(£0.14m)	(£0.25m)	(£0.25m)	(£0.25m)
Efficiency benefits <sup>51</sup>	£0.00m	£2.63m	£7.89m	£13.15m
<b>Net benefit of Partnership</b>	<b>(£0.18m)</b>	<b>£2.49m</b>	<b>£7.76m</b>	<b>£13.01m</b>

(Note: totals correct, rounding may affect addition of parts)

<sup>46</sup> Assumes a mid-point staff move date of 01/09/2009

<sup>47</sup> Including the costs of the North West London Collaborative Programme

<sup>48</sup> Including transition costs and the expected costs of the Strategic Planning Directorate which have not yet been approved by the Collaborative Commissioning Group

<sup>49</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with the PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>50</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff)

<sup>51</sup> The efficiency savings assume that the mid case scenario outlined in benefits section of this document are achieved

## Appendix D Financial Business Case & Assumptions

### Harrow

Current acute commissioning staff WTEs = 4.65

Payback period = 248 days

Cost / benefit headings	2009/10 post rollout <sup>52</sup>	2010/11	2011/12	2012/13
Current running costs <sup>53</sup>	£0.31m	£0.53m	£0.53m	£0.53m
Future running costs <sup>54</sup>	(£0.41m)	(£0.53m)	(£0.52m)	(£0.52m)
<b>Net cost reduction (increase)</b>	<b>(£0.10m)</b>	<b>(£0.00m)</b>	<b>£0.01m</b>	<b>£0.01m</b>
PCT retained staff costs <sup>55</sup>	(£0.05m)	(£0.08m)	(£0.08m)	(£0.08m)
Other PCT retained costs <sup>56</sup>	(£0.06m)	(£0.10m)	(£0.04m)	(£0.04m)
Efficiency benefits <sup>57</sup>	£0.00m	£2.17m	£6.51m	£10.85m
<b>Net benefit of Partnership</b>	<b>(£0.20m)</b>	<b>£1.98m</b>	<b>£6.39m</b>	<b>£10.73m</b>

(Note: totals correct, rounding may affect addition of parts)

<sup>52</sup> Assumes a mid-point staff move date of 01/09/2009

<sup>53</sup> Including the costs of the North West London Collaborative Programme

<sup>54</sup> Including transition costs and the expected costs of the Strategic Planning Directorate which have not yet been approved by the Collaborative Commissioning Group

<sup>55</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with the PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>56</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff)

<sup>57</sup> The efficiency savings assume that the mid case scenario outlined in benefits section of this document are achieved

## Appendix D Financial Business Case & Assumptions

### Hillingdon

Current acute commissioning staff WTEs = 9.4

Payback period = 224 days

Cost / benefit headings	2009/10 post rollout <sup>58</sup>	2010/11	2011/12	2012/13
Current running costs <sup>59</sup>	£0.59m	£1.02m	£1.02m	£1.02m
Future running costs <sup>60</sup>	(£0.50m)	(£0.65m)	(£0.64m)	(£0.64m)
<b>Net cost reduction (increase)</b>	<b>£0.10m</b>	<b>£0.36m</b>	<b>£0.38m</b>	<b>£0.38m</b>
PCT retained staff costs <sup>61</sup>	(£0.07m)	(£0.13m)	(£0.13m)	(£0.13m)
Other PCT retained costs <sup>62</sup>	(£0.13m)	(£0.23m)	(£0.23m)	(£0.23m)
Efficiency benefits <sup>63</sup>	£0.00m	£3.08m	£9.25m	£15.42m
<b>Net benefit of Partnership</b>	<b>(£0.11m)</b>	<b>£3.10m</b>	<b>£9.28m</b>	<b>£15.45m</b>

(Note: totals correct, rounding may affect addition of parts)

<sup>58</sup> Assumes a mid-point staff move date of 01/09/2009

<sup>59</sup> Including the costs of the North West London Collaborative Programme

<sup>60</sup> Including transition costs and the expected costs of the Strategic Planning Directorate which have not yet been approved by the Collaborative Commissioning Group

<sup>61</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with the PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>62</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff)

<sup>63</sup> The efficiency savings assume that the mid case scenario outlined in benefits section of this document are achieved

## Appendix D Financial Business Case & Assumptions

### Hounslow

Current acute commissioning staff WTEs = 12.8

Payback period = Immediate

Cost / benefit headings	2009/10 post rollout <sup>64</sup>	2010/11	2011/12	2012/13
Current running costs <sup>65</sup>	£0.70m	£1.19m	£1.19m	£1.19m
Future running costs <sup>66</sup>	(£0.48m)	(£0.63m)	(£0.62m)	(£0.62m)
<b>Net cost reduction (increase)</b>	<b>£0.21m</b>	<b>£0.56m</b>	<b>£0.58m</b>	<b>£0.58m</b>
PCT retained staff costs <sup>67</sup>	(£0.03m)	(£0.04m)	(£0.04m)	(£0.04m)
Other PCT retained costs <sup>68</sup>	(£0.15m)	(£0.26m)	(£0.26m)	(£0.26m)
Efficiency benefits <sup>69</sup>	£0.00m	£2.79m	£8.37m	£13.95m
<b>Net benefit of Partnership</b>	<b>£0.04m</b>	<b>£3.05m</b>	<b>£8.65m</b>	<b>£14.23m</b>

(Note: totals correct, rounding may affect addition of parts)

<sup>64</sup> Assumes a mid-point staff move date of 01/09/2009

<sup>65</sup> Including the costs of the North West London Collaborative Programme

<sup>66</sup> Including transition costs and the expected costs of the Strategic Planning Directorate which have not yet been approved by the Collaborative Commissioning Group

<sup>67</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with the PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>68</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff)

<sup>69</sup> The efficiency savings assume that the mid case scenario outlined in benefits section of this document are achieved

## Appendix D Financial Business Case & Assumptions

### ***Kensington & Chelsea***

Current acute commissioning staff WTEs = 9.55

Payback period = Immediate

Cost / benefit headings	2009/10 post rollout <sup>70</sup>	2010/11	2011/12	2012/13
Current running costs <sup>71</sup>	£0.57m	£0.98m	£0.98m	£0.98m
Future running costs <sup>72</sup>	(£0.39m)	(£0.51m)	(£0.50m)	(£0.50m)
<b>Net cost reduction (increase)</b>	<b>£0.18m</b>	<b>£0.47m</b>	<b>£0.48m</b>	<b>£0.48m</b>
PCT retained staff costs <sup>73</sup>	(£0.00m)	(£0.00m)	(£0.00m)	(£0.00m)
Other PCT retained costs <sup>74</sup>	(£0.08m)	(£0.13m)	(£0.13m)	(£0.13m)
Efficiency benefits <sup>75</sup>	£0.00m	£2.08m	£6.23m	£10.38m
<b>Net benefit of Partnership</b>	<b>£0.11m</b>	<b>£2.41m</b>	<b>£6.58m</b>	<b>£10.73m</b>

(Note: totals correct, rounding may affect addition of parts)

<sup>70</sup> Assumes a mid-point staff move date of 01/09/2009

<sup>71</sup> Including the costs of the North West London Collaborative Programme

<sup>72</sup> Including transition costs and the expected costs of the Strategic Planning Directorate which have not yet been approved by the Collaborative Commissioning Group

<sup>73</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with the PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>74</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff)

<sup>75</sup> The efficiency savings assume that the mid case scenario outlined in benefits section of this document are achieved

## Appendix D Financial Business Case & Assumptions

### Westminster

Current acute commissioning staff WTEs = 7.46

Payback period = 239 days

Cost / benefit headings	2009/10 post rollout <sup>76</sup>	2010/11	2011/12	2012/13
Current running costs <sup>77</sup>	£0.48m	£0.83m	£0.83m	£0.83m
Future running costs <sup>78</sup>	(£0.51m)	(£0.67m)	(£0.66m)	(£0.66m)
<b>Net cost reduction (increase)</b>	<b>(£0.03m)</b>	<b>£0.16m</b>	<b>£0.17m</b>	<b>£0.17m</b>
PCT retained staff costs <sup>79</sup>	(£0.04m)	(£0.07m)	(£0.07m)	(£0.07m)
Other PCT retained costs <sup>80</sup>	(£0.09m)	(£0.15m)	(£0.15m)	(£0.15m)
Efficiency benefits <sup>81</sup>	£0.00m	£2.11m	£6.34m	£10.57m
<b>Net benefit of Partnership</b>	<b>(£0.16m)</b>	<b>£2.05m</b>	<b>£6.30m</b>	<b>£10.52m</b>

(Note: totals correct, rounding may affect addition of parts)

<sup>76</sup> Assumes a mid-point staff move date of 01/09/2009

<sup>77</sup> Including the costs of the North West London Collaborative Programme

<sup>78</sup> Including transition costs and the expected costs of the Strategic Planning Directorate which have not yet been approved by the Collaborative Commissioning Group

<sup>79</sup> Staff who currently spend less than 50% of their time on acute commissioning will remain with the PCTs and will still contribute to the costs of acute commissioning in the sector in the future

<sup>80</sup> This includes costs that will be retained by the PCTs after the migration to the Partnership arrangements (e.g. some PCTs will not be able to reallocate the costs of office space that will be vacated by the acute commissioning staff)

<sup>81</sup> The efficiency savings assume that the mid case scenario outlined in benefits section of this document are achieved

## Financial Business Case Assumptions

### *General assumptions*

- The mid-point date for staff moving to the Partnership is 01/09/2009
- There are 108 people who are directly involved in acute commissioning across the sector. 63 people spend more than 50% of their time on acute commissioning and 45 people spend less than 50% of their time on acute commissioning (source: NWL PCTs)
- This equates 60.4 WTEs employed in acute commissioning across the sector
- For simplicity inflation or a discount factor have not been included in the model
- Staff on-costs are assumed to be fixed at 25% (source: NWL PCTs Directors of Finance)

### *Current costs*

- Contractor staff are paid £500 per day
- Contractor staff work for 225 days per year
- Permanent staff are paid according to the agenda for change pay scales
- Permanent staff are paid the maximum annual salary for their band
- VSM and Chief Executives are paid according to the pay framework for Very Senior Managers
- 18.9 WTE are temporary staff
- 41.5 WTE are permanent staff
- The following ratios are applied to real estate costs for each of the PCTs when compared to the real estate costs at Westminster:
  - Brent = 0.57
  - Ealing = 0.53
  - Hammersmith & Fulham = 0.81
  - Harrow = 0.32
  - Hillingdon = 0.63
  - Hounslow = 0.53
  - Kensington & Chelsea = 0.89
  - Westminster = 1
- The above ratios are taken from CB Richard Ellis
- Office utilities costs are £1,000 per person per year (source: Westminster PCT finance team)
- Office furniture costs are £250 per person per year (source: Westminster PCT finance team)

## Appendix D Financial Business Case & Assumptions

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- IT costs are £330 per person per year (source: Westminster PCT IT team)
- Training costs are £1,000 per person per year
- Support functions (e.g., HR, IT, Finance) cost £3,000 per person per year (source: Westminster PCT finance team)
- The NWL Collaborative programme costs £1.1m per year (£600k funding + £500k external consultancy expenditure). Source: NWL Collaborative Programme PMO

### **Future acute commissioning costs**

- The percentage of the interim partnership staff will be 33% in first year, 25% in second year and 15% in the third and subsequent years. These assumptions were agreed by the NWL Directors of Finance
- 44.4 WTE are employed by the ACV
- Permanent staff are paid according to the agenda for change pay scales
- Permanent staff are paid the maximum annual salary for their band
- VSM and Chief Executives are paid according to the pay framework for Very Senior Manager
- The SPD costs £1.19m per year, which can be broken down as follows (source: NWL Collaborative Programme PMO):
  - Staff salaries and on-costs = £784,569
  - Indirect costs = £39,000
  - External consultancy costs = £200,000
  - An allocation of overhead costs at the host PCT = £163,368
- Office costs are £9,364 per person (source: Westminster PCT finance team)
- Utilities costs are £1,000 per person per year (source: Westminster PCT finance team)
- Office furniture costs are £250 per person per year (source: Westminster PCT finance team)
- IT costs are £330 per person per year (source: Westminster PCT IT team)
- Annual training costs are £1,000 per person per year
- Support functions (e.g., HR, IT, Finance) cost £3,000 per person per year (source: Westminster PCT finance team)
- Current staff who spend less than 50% of their time on acute commissioning will remain with their PCTs
- The NWL PCTs will not be able to reallocate their accommodation costs to other areas of their business after the Partnership goes live
- Some PCTs anticipate additional costs / resource requirements as a result of interfacing with the Partnership. These assumptions were agreed by the Directors of Finance from each of the PCTs:

## Appendix D Financial Business Case & Assumptions

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- Brent = 1 full time VSM
- Ealing = no additional costs expected
- Hammersmith & Fulham = 1 full time VSM
- Harrow = 1 full time band 8a
- Hillingdon = 1 full time VSM
- Hounslow = 1 full time VSM
- Kensington & Chelsea = no additional costs expected
- Westminster = £150,000 per year (two additional posts)

### **Transition costs**

- Programme office costs of £410,000
- £143,750 worth of Westminster PCT staff time
- 25% of posts will be recruited externally
- Recruiting for external positions above band 8 will require the services of a recruitment consultancy
- Recruitment agency costs are 30% of the annual salary of the position
- Assessment centre costs are £675 per person and an average of 6 people will attend each assessment centre
- 5% of relocated staff will raise a legal challenge which will cost £10k per person
- Additional travel costs of relocated staff will be paid for by the Partnership
- Relocated staff currently live in the same zone as their PCT location and use public transport to get to work
- Relocated staff will use public transport to get to work at the host location

### **Efficiency savings**

- Efficiency savings have been applied to the acute provider expenditure with the North West London providers only (£1.15bn) as demonstrated below:

#### **Best case, mid case and worst case percentage efficiency savings**

	2009/10	2010/11	2011/12	2012/13
Best case	0%	3%	9%	15%
Mid case	0%	2%	6%	10%
Worst case	0%	1%	3%	5%