NHSProviders

Briefing

January 2023

SPECIALISED SERVICES AND SYSTEM WORKING

Risks and opportunities

Key points

- Integrated care boards (ICBs) are taking on a bigger role in commissioning specialised services. From 2023/24, they will plan many of these services via joint working arrangements with NHS England (NHSE) and from 2024/25 they are expected to take on delegated functions and budgets for some services.
- Trust leaders are committed to working with NHSE and ICBs to make new arrangements work. However, they see opportunities and risks in the proposals, the impact of which will vary depending on populations, geographies and how specialised services are currently delivered:
  - In some services, trust leaders see opportunities to join up care more effectively by taking an end-to-end view of pathways across specialised and non-specialised services.
  - Trust leaders are enthusiastic about provider collaboratives enabling trusts to work with commissioners in new ways and play a leading role in driving better care and value. Greater local leadership of specialised services could be provided by trusts working together in provider collaboratives and learning from progress in the mental health sector.
  - However, ICBs are new organisations, taking on an extensive portfolio of responsibilities and will need to ensure they are ready to provide the focus and prioritisation which commissioning specialised services will require.
  - ICBs will need to ensure they have the right capabilities and relevant expertise, much of which is currently concentrated in NHSE. Trust leaders will also want to be sure that there is no increase in administrative burden for trusts delivering these services as they shift from working with NHSE to dealing with multiple commissioners.
- It is important that a move to more local planning of specialised services does not lead to a loss of the patient and clinical insights that inform specialised commissioning so constructively today.
- Specialised services will also need appropriate financial prioritisation – across both revenue and capital funding – to sustain high quality care for patients and support innovation.
- Changes to specialised commissioning need to be implemented in a way that supports innovation and does not unintentionally either reduce the NHS's capacity to innovate, or erode its contribution to economic growth by pioneering new treatments and technologies.
- Any substantial change programme can have unintended consequences. It is vital that NHSE works with trusts and system partners to manage the transition process and to understand and evaluate the full impacts of these changes, on outcomes and resources, over time.

1

Introduction

Health and care needs in England are changing, as people increasingly live longer with multiple conditions. Organisations across the NHS, and wider partners, are working together through integrated care systems (ICSs) to join up services to better meet these needs, and support people to stay well wherever possible.

The Health and Care Act 2022 placed ICSs on a statutory footing from July 2022 by establishing integrated care boards (ICBs) to commission NHS services and establishing integrated care partnerships (ICPs) to plan to meet the wider health, care and wellbeing needs of populations. Over winter 2022/23 ICSs are developing strategic priorities for the next several years via integrated care strategies and joint forward plans.

In this context, NHS England (NHSE) is progressing plans to change how specialised services – a portfolio of around 150 services accessed by people often with rare or complex health needs (see box for more detail) – are commissioned. From April 2023, NHSE plans to give local systems a bigger role in planning and shaping many specialised services. This will be enabled through two routes – either by NHSE working with ICBs to jointly commission services or by NHSE delegating responsibility and budgets to ICBs for those services.

Specialised services already draw on a range of capabilities – multidisciplinary teams of health professionals with specialist knowledge and experience, purpose-built equipment and facilities, and innovative technologies and therapies. They also serve smaller patient populations. In consequence, specialised care is often comparatively cost intensive. NHSE is also progressing proposals to change how funding is allocated to ICBs for specialised services by introducing a population needs-based allocation mechanism.

In light of these developments, this briefing aims to:

- Outline the changes NHSE plans to implement from April 2023; and provide some preliminary analysis of the benefits and risks inherent in greater system leadership of specialised services. It is informed by extensive engagement with both trusts and NHSE. It is published as systems and national bodies prepare for implementation in 2023/24 with a view to sharing trust leaders' analysis of the opportunities these changes offer, foregrounding some risks which must be addressed, and informing decisions around transition planning. While our analysis inevitably captures a trust perspective on the proposed changes, it remains essential that national policy makers continue to engage users of specialised services as specialised commissioning policy evolves.

Specialised services

Specialised services are a diverse portfolio of around 150 services generally accessed by people living with rare or complex conditions. These include services for people with physical health needs, such as cancer, neurological, and genetic conditions, and some mental health problems such as adults with eating disorders and children and young people with complex mental health needs. These services are often delivering cutting edge care informed by latest developments in medical innovation and are correspondingly costly. While in many cases treating relatively rare conditions, collectively the specialised services portfolio delivers care to large numbers of people. In 2022/23, specialised services were allocated around £22.9bn nationally, roughly 15% of the overall NHS commissioning budget.

Specialised services are delivered by a range of trusts, including specialist trusts focused on particular clinical areas or patient groups, and some tertiary centres that deliver specialist services alongside more common physical or mental health care. It is common for providers of specialised services to deliver care to patients living across large, multi-ICS geographies.

National programme to localise commissioning of specialised services

2

Background

To date, ICSs have not played a major role in the planning of specialised services. Since 2013, NHSE has held legal and operational responsibility for commissioning specialised services – planning services, setting clinical standards, allocating resources, contracting with, and reimbursing providers and monitoring service performance. In practice, NHSE's national teams focused on setting strategic direction and priorities, and regional teams led on more operational commissioning, including contracting, supporting service developments and monitoring.

In recent years, NHSE has signalled that systems would, in time, play a greater role in planning specialised services, but formal changes were limited, and ICSs' involvement in specialised commissioning has to date been largely advisory, particularly as they initially inherited the responsibilities of clinical commissioning groups (CCGs). The passage of the Health and Care Act 2022 provides a platform for systems to take on a new role in relation to specialised services, including through enabling the delegation and joint exercise of statutory functions between NHS organisations, including NHSE, ICBs and providers.

Over a similar period, provider collaboratives have emerged as key partnership vehicles which are intended to take a leading role implementing some ICS ambitions. Collaboratives are partnership arrangements that bring together two or more trusts (and, in some cases, other partners from the voluntary or independent sectors) to drive economies of scale and improve care for local populations. NHSE mandated acute/specialist and mental health trusts to be part of at least one collaborative from July 2022, with community and ambulance trusts joining collaboratives where doing so could help improve care for patients.

For several years mental health and learning disability trusts have been joining together as part of NHS-led provider collaboratives to drive change in specialised mental health, learning disability and autism care. One focus among these mental health collaboratives has been rethinking commissioner – provider relationships, with many collaboratives developing lead provider arrangements whereby they take on some specialised mental health planning responsibilities from NHSE. This has involved budgets for defined pathways being devolved to collaboratives with trusts working together, including sub-contracting among collaborative members, to discharge operational planning and service transformation responsibilities.

NHS England's 'Roadmap' for specialised services

In May 2022, NHSE published a document, the ***Roadmap for integrating specialised services within ICSs***, outlining concrete proposals for how it would progress systems playing a more leading role in specialised services. The 'roadmap' set out a number of planned changes, the most material of which are summarised below:

- Service portfolio analysis. During 2022, NHSE conducted an analysis of the specialised service portfolio to determine which services could be locally led by ICSs. Services were assessed against two criteria: i) suitability for local commissioning and ii) readiness for local commissioning in 2023/24. A range of factors and insights informed the assessments, including the scale of financial volatility associated with the services, the numbers of providers delivering care, opportunities to drive patient benefits and the pipeline of future clinical innovations in a service area. Based on that, the portfolio was divided into three categories:
  1. services which are suitable and ready for greater ICS leadership from April 2023
  2. services which are suitable for greater ICS leadership but are not ready at this point
  3. services which are not suitable for ICS leadership and will remain nationally commissioned (including so-called highly specialised services which serve small numbers of patients – usually less than 500 per year – and are delivered by a few centres around the country).

NHSE plans to continue conducting service portfolio analysis to reassess services' suitability for local commissioning. In time, it is possible that more services will be assessed as suitable and ready for greater ICS leadership.

- ICB role. NHSE's policy is that over time ICBs will take on a greater role in commissioning the specialised services which are assessed as suitable for local leadership. This role will take two possible forms:
  1. joint commissioning with NHSE where ICBs are not ready to take on full delegation (by forming a joint committee with NHSE as a transitional step)
  2. taking on delegated responsibility whereby operational responsibility for commissioning these services sits with ICBs and budgets are delegated (underpinned by an oversight and governance arrangement with NHSE based on a delegation agreement).

An increased role around specialised services is intended to complement ICBs' existing portfolio of commissioning responsibilities across primary, community, acute, ambulance and mental health services with a view to supporting more joined up planning and care delivery. The roadmap states that ICBs can begin to take on these responsibilities from April 2023, and the portfolio of specialised services led by ICBs will grow over time as more services are assessed as ready for delegation. NHSE expects many ICBs will work together in groups to commission specialised services over multi-system footprints. Latest national policy indicates – subject to approval from NHSE's board – that joint working arrangements will be the default model in 2023/24 , with full delegations planned to go live in 2024/25.

Changes to funding allocation formula. The bulk of NHS funding is allocated to ICBs by NHSE based on a funding formula which tries to account for differences in populations' demographic characteristics and health needs (informed by the independent advisory committee on resource allocation – ACRA). To date, specialised services have been funded using a different mechanism, more strongly influenced by historic spending patterns. As part of the move to systems leading specialised services, NHSE plans to transition to providing funding to ICBs for specialised services. This will initially use historic spend information that supports host-based allocations but over time, this will transition towards an allocation based on a population needs-based formula, bringing these services more into line with other funding streams. NHSE expects to implement a 'needs-based' allocation model in a phased way from 2024/25, with 'pace of convergence' safeguards to ensure systems do not see destabilising changes in funding levels.

- **The role of NHSE.** Since 2013, NHSE has been solely responsible for commissioning specialised services. In the future, NHSE will continue to hold legal accountability for the whole portfolio (including where services are delegated) and perform a number of functions nationally. These will include: commissioning services which need to be planned nationally; setting national service specifications and clinical policies for all specialised services; facilitating clinical engagement with specialised service planning; and supporting patient and public involvement in national planning. Alongside, NHSE will develop an oversight and assurance framework, informed by a data infrastructure, to monitor how ICBs are discharging any localised commissioning responsibilities. Where joint commissioning is used, NHSE will continue to hold much of the operational commissioning responsibility and work with ICBs to make decisions about specialised services.

The 'roadmap' also set out a rough timeline that NHSE and ICSs would work to in order for the first tranche of localised commissioning arrangements to go live from the start of 2023/24 (see box below). In addition to playing a larger role in specialised services, from 2023/24 ICBs are expected to be taking on commissioning responsibility for pharmaceutical services, ophthalmic services and dental services which were previously directly commissioned by NHSE.

Key milestones in transition to localised specialised commissioning

November 2022	The 'roadmap' required ICBs and partner organisations to work together to develop proposals for how they would commission services assessed as suitable and ready for local leadership in 2023/24 – either taking on delegated responsibility or through joint working arrangements with NHSE. These discussions were to lead to written proposals – known as a pre-delegation assessment framework (PDAF) – submitted to NHSE in November 2022.
December 2022 - January 2023	Drawing on national and regional teams, NHSE plans to undertake an assessment exercise over the winter of 2022/23 to scrutinise systems' PDAF submissions and assess ICBs' readiness to take on greater local leadership of specialised commissioning. A moderation panel will assess systems' proposals for how they will plan services in 2023/24 and make recommendations regarding the model – joint committees or delegation – systems will use.
February 2023	Final decisions on joint exercise and delegation arrangements with ICBs in 2023/24 are to be approved by NHSE's board and communicated to systems. ICBs and partners are to make local preparations for localised commissioning arrangements over the winter ahead of the new financial year.
April 2023	The first tranche of joint commissioning arrangements for services assessed as suitable and ready for local leadership 'go live'.
April 2024	Systems which work with joint commissioning during 2023/24 may transition to taking on delegated responsibilities from 2024/25. NHSE plans to continue to assess the specialised service portfolio for readiness for local commissioning. Some services which have subsequently been assessed as suitable and ready for delegation may be delegated or jointly commissioned from 2024/25. As ICBs take on delegated responsibilities, the funding they receive for specialised services will transition towards a population needs-based allocation (phased in over several years with pace of change safeguards).

3 Potential impacts, risks and opportunities

Over the last few months, NHS Providers has engaged with leaders in trusts to understand how they are preparing for these developments and their analysis of the impact it may have for their patients, services, and organisations, recognising that these are likely to vary between systems and trusts depending on populations, geographies and service delivery arrangements.

Overall, trusts see a rationale for moving to more locally led models of commissioning for some specialised services. They are fully committed to system working to join up care to better meet patients' needs, and see bringing some specialised services together with other aspects of care as part of that process.

However, trust leaders also recognise that asking ICBs to play a greater leadership role in specialised commissioning marks a significant change of approach which brings risks as well as opportunities. This change process is happening at a time when ICBs are recently established and managing an unusually challenging set of operational pressures.

Below we briefly outline some headline opportunities and risks articulated by trust leaders, spanning both joint working arrangements and delegated models. While these two arrangements will present some slightly different questions and challenges, here we analyse them together pointing to the key issues that policymakers and systems will need to consider as they move into implementation.

Opportunities

Scope to better join up pathways of care in some clinical areas. The division in commissioning responsibilities between local commissioners and NHSE meant that in some specialities – for example cancer and neurological care – many patients' pathways of care included services commissioned by both ICBs and NHSE. Transitions between these services can lead to poorly coordinated care for patients (an issue which can be compounded when patients are also accessing social care services commissioned by local authorities). By localising more commissioning responsibilities, ICBs and partners will, in theory, be in a position to take a more end-to-end view of some pathways of care which could support a more coordinated experience for patients and a more sensible operating context for health professionals.

Incentivise preventative and early interventions. One consequence of the division of responsibility and budgets between local commissioners and NHSE for different aspects of the same care pathways has been that local commissioners have a limited financial incentive to invest in early intervention or preventative measures that save money elsewhere in the pathway. By joining up financial planning locally and given the significant proportion of NHS resources devoted to specialised services, ICBs will have a stronger incentive to seek opportunities to identify early disease, develop more cost-effective models of care, and/or invest in preventative interventions and models of support (in disease areas which are amenable to preventative interventions).

Scope for trusts' and collaboratives' expertise to shape the design and development of specialised services. NHSE has sought to engage a range of stakeholders in discharging its role as commissioner for specialised services. But moves to localise decision-making present new opportunities for trusts and ICBs to work together more closely in shaping and improving these services, including bringing trusts' clinicians and operational teams more fully into discussions about planning and improving specialised services. One mechanism to enable this, which some trusts are exploring, are provider collaboratives. Over the last few years, NHS-led mental health provider collaboratives have been taking on some planning, improvement and monitoring functions which previously sat with NHSE, often via lead provider models. Other collaboratives are exploring related models based on taking on delegated functions from ICBs in the future with a view to more flexibly deploying the combined capabilities of commissioners and providers. As specialised service planning is localised, collaboratives could be vehicles through which trusts work with commissioners in new ways and play a leading role in driving better care and value.

Risks

Clinical and patient voice in commissioning decisions. NHSE has been the central point for clinical and service user input into specialised commissioning decisions over the last decade. Patient charities and service users, along with interested clinicians, have helped to shape national policy through patient and partner groups, clinical reference groups and national programmes of care. NHSE plans to maintain a national infrastructure for patient and clinical voices to inform and oversee delegated arrangements, including through national groups such as the patient and public voice assurance group. Alongside that continuing national infrastructure, there will be an important task for ICBs and providers to ensure joint committees or delegated models embed arrangements which ensure local decisions on specialised services are informed by high-quality input from patients and clinicians.

Provider voice. The prospect of meaningfully improving specialised services will be substantially aided if trusts' expertise is brought to bear early in planning discussions, alongside other valuable perspectives from clinical and health professionals, service users and the voluntary sector. Trusts can contribute an understanding of education and workforce considerations as well as links to research and innovation programmes. The design of localised arrangements – be it joint committees or delegations to ICBs – will naturally bring together NHSE and ICBs as commissioners of services. Trust leaders are keen to ensure that these approaches build on existing links between providers and specialised commissioning teams in NHSE regions so that discussions are informed by the range of insights that providers can bring. Ways of working will need to be established which allow trusts' clinical and operational insights and views to be expressed in local decision-making processes. This will include in 2023/24 as joint committees of NHSE and ICBs lead commissioning decisions; they will need to find ways to embed provider voice in local deliberations around specialised services.

Geographical variations in care. The move to national commissioning of specialised services a decade ago was partly informed by a recognition that specialised services varied around the country, both in access and quality. Over the last decade NHSE has sought to bring greater uniformity to specialised services, including through setting national standards and service specifications. Much of this national architecture will remain in place as ICSs play a greater leadership role, so scope for divergences in care should be partly limited. But the move to localised decision-making, via joint committee or full delegations, could see variations in service offers emerge incrementally as partners respond to local priorities and challenges.

Fragmentation of commissioning relationships. Many trusts delivering specialised services treat patients from large geographical footprints spanning multiple ICBs under a single commissioning relationship with NHSE (facilitated by the regional teams). Moving from centrally held contracts to ICBs leading commissioning of services may result in trusts needing to develop contracting, relationship management and reporting infrastructure across several systems to discharge the same responsibilities. Even where ICBs group together to jointly commission some services, this could see an increase in administrative burden and costs for providers (and commissioners). It will be important that ICBs and trusts develop ways of working which enable providers to devote maximum management bandwidth to service delivery, improvement and transformation and minimise low-value bureaucracy.

ICBs' capabilities and expertise. ICBs are relatively young organisations whose staff have expertise in commissioning locally delivered acute, community, mental health and in many cases general practice services. They are in the process of facilitating system planning processes to develop joint forward plans and defining their ways of working with local partners to address operational priorities. Taking on a leadership role for specialised services represents an expansion of their remit and will call for a knowledge base and skill set which many ICBs may not yet have in-house. Joint committee arrangements should support NHSE regional teams to help with this transition given their established role in operational commissioning for specialised services. Looking ahead, it will be important that ICBs can access constructive support to discharge these responsibilities effectively, particularly from the point at which delegated commissioning arrangements go live.

Access to capital. ICBs and system partners will determine how to deploy capital allocations made to systems based on their local priorities and population needs (this is in addition to some national capital programmes led by NHSE). Specialised services, which are often comparatively capital intensive due to requiring specific technologies, equipment and facilities, will be one of many priorities for systems to weigh up. Some trust leaders expressed concern that under a more localised model of leadership, specialised services may struggle to secure appropriate capital investment within systems given their service portfolio, the relatively small number of patients who access these services, and the range of other priorities that systems will be seeking to progress. The national context of constrained capital envelopes and substantial backlog maintenance needs could exacerbate this risk.

Revenue prioritisation. ICBs have emerged in statutory form at a challenging time for the NHS in the wake of a long slowdown in NHS funding growth, and when demand for care is outstripping resource growth. They will face a real challenge to meet population health needs effectively within available resources. At the same time, ICBs will be looking to make a demonstrable impact on high-profile operational priorities such as urgent and emergency care, addressing care backlogs and bolstering access to primary care services. In this context, there may be a risk that specialised services are gradually deprioritised to free up resources for other service areas. The fact that specialised services are likely to contribute in a relatively marginal way to some of ICSs' core objectives – population health, inequalities, productivity – may heighten this risk.

Long-term sustainability of centres of clinical and research excellence. Some trusts are centres of clinical expertise for particular conditions or population groups and serve several systems spanning large geographies. Organisational configurations vary, but in some cases, trusts have built up a community of clinical expertise, research infrastructure, industry partnerships, equipment and organisational capabilities over time. Moves to delegate commissioning will not inherently alter this, with ICBs being free to continue commissioning care based on existing delivery models. However, over time the quality of these centres may decline if ICBs respond to unintended incentives – particularly at a time when system finances are under pressure – to commission services at local providers within their footprints and reduce flows of patients to out-of-system regional centres. As well as shoring up local financial performance, developments of this type may have some real benefits in supporting more accessible care for some patients and supporting joint working within systems. However, there is a risk these improvements come at the expense of centres of clinical excellence and incrementally curtail their capacity to drive clinical innovation.

4

Looking ahead

Trust leaders will seek to maximise the opportunities of localised specialised commissioning arrangements – whether joint working arrangements or delegation – in partnership with ICBs. They are committed to realising the benefits of system working and see real opportunities to work together across traditional boundaries to improve care for patients and communities.

NHS Providers has a long-standing interest in specialised services spanning both mental and physical health services. We work closely with other provider membership bodies, including the Federation of Specialist Hospitals and the Shelford Group, to monitor, interpret and influence national policy around specialised services. Over the last several months, we have worked with members to understand a range of trust leaders' views regarding the implications of statutory ICSs playing a bigger role in specialised commissioning. We have represented trusts' views in the provider implementation reference group as part of NHSE's programme delivery architecture for the changes to specialised services. In 2023, we will continue engaging with members, partners and policymakers to further explore how to create the most favourable conditions for the transition to a more localised model of specialised commissioning.

As implementation proceeds, trust leaders would welcome a focus on monitoring and evaluation of the impacts of the changes to specialised commissioning. The areas outlined below merit sustained attention:

- **Care quality.** NHSE is rightly maintaining its role setting standards around specialised services are to flourish, their financial resourcing – spanning revenue and capital – will, at least, need to maintain its relative prioritisation over time in the face of many competing service priorities. ICBs and partners will want to work together to ensure that their local decisions, informed by input from NHSE, do not see other priorities unintentionally crowd out necessary investments in specialised services.

Enabling provider collaboratives to maximise their value. Trust leaders see real opportunities to improve care for local populations through working in provider collaboratives. Moving to a more localised model of specialised commissioning presents further opportunities for providers and commissioners to work together in new ways, with collaboratives acting as a possible vehicle to bring together their capabilities and focus them on service improvement and transformation. Mental health collaboratives, many of which are working through lead provider models, have taken steps in this direction.

- **Capacity for innovation.** NHS care is constantly evolving as new technologies and techniques are incorporated into clinical practice. Specialised services, often delivered in centres of clinical excellence, are the crucible of many of these developments, pioneering cutting edge techniques supported by bringing together multidisciplinary teams leading research, education and service delivery. Trust leaders are emphatic that the NHS's long-term ability to deliver outstanding care – and support economic growth – is partly dependent on continued innovation. National policymakers must ensure that these changes to commissioning arrangements facilitate this, and do not unintentionally contribute to an operating environment which is less conducive to innovation.

5

Conclusion

Specialised services are a vital part of NHS care. For people with rare or complex conditions, the care and technical expertise of these services can be life changing or lifesaving. These services also play an integral part in the NHS's interactions with the research and innovation sector and hence contribute to economic growth.

NHSE's proposals to enable statutory ICSs and partners to plan and shape many of these services based on local needs and priorities is an important milestone in the development of system working but the jury is still out as to whether the majority of specialised services, can and should, be effectively devolved either in joint arrangements with NHSE or under a fully delegated arrangement. Trust leaders discern both opportunities and risks in the implementation which they are keen to manage proactively. While the local implications of these changes are likely to vary across systems and trusts, trusts are keen to address questions around clinical input to local decision making, how to minimise any potential for fragmentation associated with more local specialised commissioning, and ongoing resource prioritisation for specialised services.

Looking ahead, trusts are making the case for a flexible approach to the implementation process – ahead of, and subsequent to, April 2023 – which will give them and their partners the best chance to make the changes work. In the near term, this includes clear communication of decisions and expectations to facilitate timely planning within systems and joint committees. In addition, it includes a commitment from national bodies to ongoing evaluation of impacts (recognising a potential for unintended consequences), supporting local systems to develop planning arrangements that make sense based on their contexts, and an approach which can empower trusts delivering specialised services to innovate, including working through provider collaboratives where appropriate.

We are grateful to have had the opportunity to engage with NHSE as these plans have taken shape. Over the coming months, NHS Providers will be continuing to work with members to interpret and influence national decisions around the transition and supporting the sharing of ideas and local approaches.

Your feedback on this briefing and the development of our wider offer is very welcome – to share your learning so far or offer feedback on our approach, please contact david.williams@nhsproviders.org

For more information:
www.nhsproviders.org/specialisedservicesandsystemworking

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