Work Stream 2 – tracer short report: Specialised Services (Understanding the new commissioning system in England: contexts, mechanisms and outcomes)

Understanding the new commissioning system in England: contexts, mechanisms and outcomes

Work Stream 2 – tracer short report: *Specialised Services*

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Introduction

The aim of this project is to understand the development of the commissioning system in England following implementation of the Health and Social Care Act 2012 (hereafter 'HSCA12'). An initial phase of data collection (March – December 2015) used interviews and observation to develop an overview of the functioning of the new commissioning system. The second phase of the project (November 2015 – March 2017) built upon these findings, focusing in upon five different service area ('tracers') in order to explore in more depth the issues arising in different contexts. This report summarises the findings of our exploration of the commissioning of specialised services. This 'tracer' was chosen because of its potential to shed light upon the interaction between NHS England (NHSE) and Clinical Commissioning Groups (CCGs), and because it allows examination of the interplay between local and national commissioning.

Specialised services commissioning seeks to ensure that the needs of people with relatively rare conditions (e.g. specialist kidney conditions, cystic fibrosis, rare cancers) are met. The equipment and skills for providing specialised services are often only available in certain regional or national centres, and the costs of providing such services are often high. In 2015-16, specialised services cost around £14bn, approximately 14% of the NHSE budget, and are set to increase to around £19bn, approximately 16% of the NHSE budget, by 2020-21 (National Audit Office, 2016).

Pre-HSCA12

Prior to the HSCA12, a service was considered specialised if it covered a *"planning population (catchment area) of more than a million people"* (NHS Specialised Services, 2013). Primary Care Trusts (PCTs) held responsibility for commissioning these services for their patient populations, and each worked in collaboration with others to provide for populations over broader footprints and to pool financial risk (National Audit Office, 2016). Due to perceived deficiencies in these collaborative processes, primarily a lack of robust and consistent commissioning arrangements throughout the country, the Carter Review of specialised services commissioning was initiated by the Department of Health (2006). This review made a number of recommendations, including: the creation of a National Specialised Commissioning Group to orchestrate commissioning activity; the creation of 10 Specialised Commissioning Groups (SCGs; coterminous with the 10 Strategic Health Authorities) operating with budgets pooled from their constituent PCTs; and a review of the Specialised Services National Definition Set, which contains a list of all services that are designated 'specialised'. These recommendations were enacted in 2007. In March 2010, the House of Commons Health Select Committee (2010) published a report on commissioning, expressing concerns that there remained significant local variation in specialist service provision, that the review of the National Definition Set had

been unsatisfactory, and that the positioning of specialised services commissioning as a pooled responsibility between PCTs left it lacking regulation and accountability. Immediately following publication of this report, the May 2010 General Election saw a change in government, and the new Coalition Government's response (HM Government, 2010b) to the Health Select Committee report highlighted the proposals in the 'Equity and Excellence' White Paper (HM Government, 2010a) would address these concerns.

Post-HSCA12

The HSCA12 altered the basis for deciding what constitutes a specialised service; rather than reflecting planning populations of over one million, the designation is now based on an assessment of four 'factors' (NHS England, 2014, p.8):

1. The number of individuals who require the provision of the service or facility;
2. The cost of providing the service or facility;
3. The number of persons able to provide the service or facility;
4. The financial implications for Clinical Commissioning Groups (CCGs) if they were required to arrange for the provision of the service or facility.

A process of re-assessing the classification of specialised services using these four factors was undertaken by the Department of Health's Clinical Advisory Group for Prescribed Services (comprised of health professionals, patient representatives, and commissioners including GPs). This group took advice from the 60 Clinical Reference Groups, each of which is focused on a particular specialised commissioning area. It recommended that virtually all of the pre-existing specialised services should retain their classification, and also recommended the reinstatement of a number of services removed in a previous iteration of the Specialised Services National Definition Set.

In April 2013, NHSE assumed responsibility for setting the specialised commissioning budget and for commissioning specialised services. Between 2013-2015, 10 (of the 27) NHSE Area Teams commissioned specialised services. In April 2015, NHSE underwent a structural reorganisation, aimed at reducing costs and simplifying organisational operation, in which Area Teams were abolished. Specialised services commissioning became the responsibility of four NHSE regional teams, with commissioning activities carried out through 10 'hubs.' Crucially, these hubs no longer cover a geographical population. Whereas **PCTs commissioned services for their local patient populations, NHSE commissions for England as a whole.** This new approach represents a fundamental change, with the commissioning hubs set up to commission services from specific providers, contracting with them for all the services they provide, including for patients from outside their local catchment area.

Analysis of relevant documents suggests that **the programme theory (Weiss, 1998) underlying the changes to specialised services commissioning was that a centralised commissioning approach orchestrated by NHSE would enhance equity for patients through increased standardisation of care and reduced geographical variability in service provision.** NHSE's Operating Model for Specialist Services Commissioning (NHS Commissioning Board, 2012) explicitly differentiated between commissioning (establishing priorities and strategy), which was to be done at a national level, and contracting (relationship management), which was to be done at a local level (initially through the Area Teams; now through the NHSE regional teams and hubs). The Operating Model thus aimed to facilitate a standardised and equitable approach to specialised services commissioning through centralised oversight, whilst retaining sensitivity to local contexts.

In order to explore the impact of HSCA12 upon specialised services commissioning, we undertook extensive reading of relevant policy and other documents, and conducted interviews with a range of commissioners and service providers in two English Areas:

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million and a large city at its core
- **Area 2** is a highly ethnically and socio-economically diverse metropolitan county, with a population of over 1.25 million and a large central city.

Specialised service commissioning was addressed within the 78 interviews in Work Stream 1, which primarily involved individuals from CCGs and NHSE. Subsequent, more detailed interviews were conducted with seven individuals from CCGs, NHSE and specialised service providers in Areas 1 and 2. Data analysis was iterative, with the findings from the emerging analysis informing later interviews.

This short report highlights three prominent and interacting themes from the project thus far: (1) Scale of commissioning; (2) Governance and accountability; (3) Finance and contracting.

Theme 1: Scale of commissioning

Interviewees understood the logic in the programme theory underpinning the changes to specialised services commissioning, citing the desirability of reducing inequity in access to specialised services, concentrating expertise to make services safer, simplifying the commissioning process by reducing the number of conversations between providers and commissioners, and giving the commissioner (NHSE) more power to influence providers. However, interviewees reported a variety of challenges associated with the changes, which primarily manifested themselves as **tensions in commissioning between national and local scales**.

There were examples of how **the shift to commissioning of specialised services on a national scale had fractured pathways of care**, in which initiatives around prevention and early intervention for particular conditions that might be commissioned by CCGs had become divorced from the specialised end of the pathway which was commissioned by NHSE. This fracturing of pathways also had the ability to increase pressure on local services that had to support an influx of patients from outside the locality at the specialised end of the pathway. An interviewee from a CCG in Area 2 described a scenario within Child and Adolescent Mental Health Services in which non-specialised tier 1-3 services (community and outpatient) are commissioned locally by CCGs to meet the needs of the local population, but specialised tier 4 services (inpatient) are commissioned at a national level by NHSE. This separation of local and national commissioning meant that tier 4 services in Area 2 are available for patients from anywhere in the country, which reduced capacity for the local population [7160, Area 2, CCG, Oct 2015].

Following **NHSE's internal reorganisation in April 2015**, members of the specialised services commissioning teams who had been working on an Area Team footprint were asked to cover a much greater footprint**. Interviewees noted that as a consequence of the change, the relationships and local knowledge that they had established were less relevant and they felt that they now had less autonomy** due to having to report directly to managers at the regional level [5931, Area 2, CCG, Aug 2015]. Over a year after this reorganisation, an interviewee from an NHS Trust explained that NHSE commissioners had to seek decisions from a national team. This was intended to allow NHSE to control spending; however, local commissioners felt that it stymied local decision-making and innovation:

> "It's made it more difficult, like I say, to get business cases and developments through because I think the local commissioners, you know, as in our regional team that we liaise with, so our day-to-day supplier managers, have got very little control or decision making ability. They have to pass almost every decision up to the national team. The national team don't sort of have the time or inclination to comment on what's happening in [Area 2], unless it's part of a national decision that they're making everywhere." [14376, Area 2, Provider, Jul 2016]

In April 2015, NHSE formally launched 'Collaborative Commissioning', a policy initiative intended to overcome the tensions created by trying to commission both nationally and locally (NHS England Specialised Commisioning National Support Centre, 2015). This initiative involved CCGs and NHSE working together in Specialised Collaborative Commissioning Oversight Groups in order to design and develop commissioning pathways to mitigate issues of fragmentation. Interviewees recognised the logic in attempting to create pathways rather than commissioning services in isolation, but **raised questions about how far collaborative commissioning was actually being realised in practice**. Around six months after the launch of the initiative, a CCG member suggested that different statutory responsibilities (i.e. towards local populations for CCGs; towards the national population) might be acting as a barrier to genuinely collaborative commissioning. This interviewee identified a number of related issues, including: lack of pooled budgets; powerful incentives for NHSE and CCGs to protect their own budgets; and little capacity for CCGs to engage with collaborative processes around specialised services that might offer only marginal benefits to their local population [7160, Area 2, CCG, Oct 2015].

Around a year after the introduction of the initiative, questions remained about the extent to which Specialised Collaborative Commissioning Oversight Groups were able to exert influence. **The initiative was perceived as being overtaken by forthcoming Sustainability and Transformation Plans (STPs)** and their emphasis upon place-based commissioning:

> "…[Area 2 Specialised Collaborative Commissioning Oversight Group] can make suggestions to the National Oversight Group but it can't actually change anything without agreement from the National Oversight Group because the statutory responsibility for specialised commissioning is identified against specific services and it would require a legislative change in order to change that… So I think it will stay in parallel until STPs either prove themselves or don't. If they don't, it would have a stronger role, I guess, but if they do prove themselves we may see, I guess, the dismantling of that over time and those responsibilities allocated to STPs." [10648, Area 2, CCG, Mar 2016]

Interviewees thus appeared to understand the rationale for changes to specialised commissioning, but felt that in practice, the changes had led to fragmentation of pathways, and unresolved tensions between commissioning responsibilities at national and local scales.

Theme 2: Governance and accountability

Interviewees suggested that the changes to specialised services commissioning had created **confusion around governance and accountability**. One CCG interviewee felt that the basis on which decisions were reached about classifications of specialised conditions was unclear. She also felt that NHSE was largely unaccountable, and that the various changes instituted by NHSE

since taking on specialised commissioning had made it hard to keep track of where responsibilities were allocated in the system:

> "The world of specialised commissioning is really remote, extremely unaccountable, I don't know where accountability sits… services are managed nationally and I understand that some of the point in some of the areas but in others in order to get service improvements you need local pathways and those local pathways aren't in place or can't be in place because the local relationships aren't there. So specialised commissioning appears to go through a reorganisation every ten minutes so you never really know who's responsible for what." [3393, Area 1, CCG, May 2015]

This sense of confusion appeared to be exacerbated by the April 2015 restructuring of NHSE and the development of Collaborative Commissioning, which had moved some of the responsibility for commissioning specialised services back to the smaller footprints of CCGs and regions. The **feeling of continuous reorganisation of specialised services commissioning** was articulated by a former NHSE specialised services commissioner who had moved to work in a CCG. She highlighted it as a challenging factor shaping local service delivery:

> "So it always is feeling like this flux, which is difficult to do strategic planning and local planning on operational plans on that footprint because it's feeling like there's that constant evolution of where services may or may not land going forward." [5931, Area 2, CCG, Aug 2015]

There were perceptions that the **commissioning system was now lacking an effective mediator holding a comprehensive strategic overview**. There was an expectation from some providers that NHSE should fulfil this role, but that it was failing to do so, and this failure was acting as a barrier to decision-making and innovation. Post-HSCA12, and particularly following the internal re-organisation of NHSE, decision-making appears to have become centralised, more remote, and lacking a strategic overview. An interviewee from an NHS Trust suggested that **NHSE was initially underprepared to act in a commissioning role**, and that its **internal reorganisation in April 2015 had caused delays which stifled innovation and resulted in a loss of knowledge about specialised services**:

> "the disorganisation since the Health and Social Care Act, and the fact that NHS England's taken quite a while to stop being a rabbit in the headlights and actually start commissioning things, they've spent a long time looking at their own organisation and their own structure, and they actually lost an awful lot of knowledge of the services they commissioned… It's been really hard to get decisions made." [14736, Area 2, Provider, Jul 2016]

This perception of lost knowledge was echoed by a former NHSE specialised commissioner, who cited challenges from the demarcating of commissioning team staff into contract managers and service specialists:

> "we've carved up the commissioning functions and the operational versus strategic… there is a danger that we've lost organisational memory, we've lost some of the skill set. So, for example, the specialised commissioning team, there was a decision that the structure would work that you would either be a contract manager or you would be a service specialist. That's not how we commission. We commission on the commissioning cycle, and there's a danger that we've deskilled

> staff over time or potential that we will deskill them going forward." [5931, Area 2, CCG, Aug 2015]

Interviewees thus painted a picture in which specialised services commissioning was perceived to undergo frequent confusing reorganisation, coupled with a lack of strategic oversight by NHSE, which led to delays in decision-making at local levels and the potential de-skilling of commissioning team members who were now asked to work on specific aspects of commissioning, rather than more holistically.

Theme 3: Finance and contracting

There were perceptions that the move of specialised services commissioning from the pre-HSCA12 Specialised Commissioning Groups into the post-HSCA12 NHSE had been much more complex than anticipated, with NHSE struggling to perform the administration of commissioning specialised services from providers on a standardised, national scale:

> "…when it came into NHS England, you can imagine the number of different arrangements and policies and ways in which it was organised and commissioned, varied up and down the country… a lot of the first part of the work was developing those national policies… NHS England, they under-estimated… I think they naively thought, oh that's fine, just bring ten teams together, and it'll all be wonderful. And I think they got the shock of their lives to be honest, the level of complexity of this." [5930, NHSE Area 2, Aug 2015]

Post-HSCA12, providers of specialised services reported an increase in administrative workload, but attributed this to a number of factors, none of which are direct consequences of the Act itself: NHSE's April 2015 reorganisation and the move to more central control over commissioning processes following the abolition of Area Teams; the Department of Health re-writing their contract templates to be more detailed, alongside commissioners preferring to regulate through contractual mechanisms with providers; and the NHS regulator (then Monitor; now NHS Improvement) seeking greater detail in reporting from providers.

A provider in Area 1 highlighted challenges for financial administration and oversight around referrals within the specialised services system, arising from **a lack of cohesion between GPs, NHS Trusts, and NHSE**:

> "I audited three months of referrals of [local] GPs into [Area 1 hospital Trust] for MSK [musculoskeletal services] and about half of them were for what we call normal variance, so for problems which are perfectly capable of being managed by our community team here… and yet there's no incentive on GPs or health visitors to do the right referral, they just do the referral and the problem is solved. There is an incentive at [Area 1 hospital Trust] to flood themselves, because they get the specialist tariff for every patient they see and there isn't the same incentive on the CCG to manage it, because the budget is paid by NHS England who don't know what's going on." [12580, Area 1, provider, May 2016]

This interviewee highlighted how **Trusts have an economic incentive for providing specialised rather than non-specialised services**, since NHSE pays Trusts on a specialised tariff based on the referral practices of **GPs who are disconnected from the economic consequences of the type of referral that they make**. The picture in the post-HSCA12 landscape therefore seems to be disjointed; there is no incentive for GPs to choose non-specialised referrals, an economic

benefit for providers to deliver services on a more lucrative specialised tariff, and **no levers by which NHSE can control this activity.**

Summary

- The HSCA12 changes to the specialised commissioning system have seen care pathways become fragmented, with unresolved tensions between commissioning responsibilities at national and local scales
- Specialised Commissioning Collaborative Oversight Groups were created with the intention of addressing this problem. However, CCGs have limited capacity and few incentives to prioritise this activity, and uncertainty surrounding their status in the context of STP development is a problem
- There was a lack of clarity over governance and accountability, with a particular tension between the need to control spending and the need to support local innovation
- Specialised services commissioning appears to have undergone frequent confusing reorganisation, coupled with a lack of strategic oversight by NHSE, which seems to have led to delays in decision-making at local levels and the potential de-skilling of commissioning team members
- There also appears to be perverse incentives built into the new system, with no incentive for GPs to choose non-specialised referrals, an economic benefit for providers to deliver services on a more lucrative specialised tariff, and no levers by which NHSE can control this activity.

Actionable messages

Specialised services commissioning seeks to ensure that the needs of people with relatively rare conditions are met. Prior to HSCA12, specialised services were commissioned by PCTs for catchment areas of more than one million people. Post-HSCA12, they are commissioned by NHSE for the country as a whole. The rationale for this change was to increase standardisation of services and reduce geographical variation in access.

Interviewees accepted the rationale for the changes. However, some problems were identified which highlight the need for:

- NHSE could usefully clarify their intentions regarding Specialised Commissioning Collaborative Oversight Groups, and consider how best to incentivise CCG participation
- The development of STP plans and 'place-based' commissioning structures offers an opportunity to consider a return to commissioning for (larger scale) geographical populations. However, this would require the creation of a regional tier of organisations with statutory responsibility for a defined budget
- It is important that future disruption to NHSE's specialised commissioning teams is kept to a minimum, and retaining and developing skilled staff is made a priority
- Perverse incentives need to be addressed urgently in any future development of NHS tariffs and contract models.

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