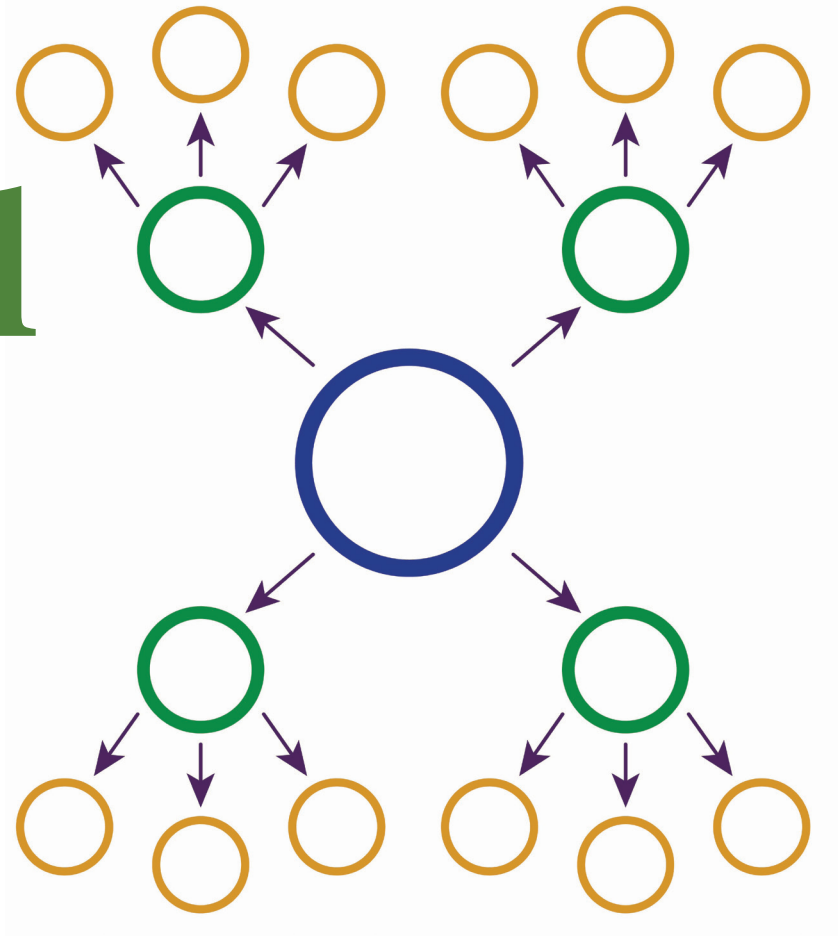
Special case



From April, some integrated care boards will take on full delegation of specialised services. An HFMA roundtable, supported by Boehringer Ingelheim, looked at the practical issues around this major change in commissioning. Steve Brown reports

The commissioning and provision of specialised services in England is a complex business. For the past decade, specialised services – everything, from chemotherapy and kidney dialysis through to gene therapies and hand transplants – has been commissioned by NHS England, standardising services and eliminating variation in access and provision.

But, while not wanting to lose these benefits, the NHS is now changing arrangements again, getting integrated care boards (ICBs) more involved in an attempt to join up the whole patient pathway from primary care right through to complex tertiary services.

Earlier this year, the HFMA organised a roundtable, supported by Boehringer Ingelheim, to discuss how the national policy is being implemented in practice and the challenges and opportunities it presents for ICBs and providers.

HFMA ROUND TABLE

The service moved a small way towards handing over responsibility for commissioning services to ICBs in April 2023 with the creation of joint commissioning arrangements. But while these will continue in many areas, a number of ICBs will move this April to fully delegated commissioning of suitable specialised services (*see The story so far, p3*).

Justine Stalker-Booth, deputy director of finance for specialised commissioning at NHS England, gave the roundtable a summary of the reasons behind the move to more localised commissioning.

'What is really behind delegation is integration,' she said. 'It's about looking across the whole patient pathway and utilising the resources available in the most effective way.'

She said the aim was to remove barriers to upstream investment, which have been created by having different commissioners for different parts of the pathway.

She added that there was also a need to think about the right payment methodologies to support the provision of services in the most appropriate way.

'Specialised services cover many different service areas, and they can be quite different to services traditionally commissioned locally,' she said. 'So it is about ensuring we have the right incentives in the system, no disincentives and how we make that work.'

Lee Rowlands, contracts director at Manchester University NHS Foundation Trust and chair for the roundtable, asked participants for examples of how delegation might work on the ground and help to improve pathways.

Liesl Hacker, assistant director of finance strategy at The Christie NHS Foundation Trust, said a key benefit will be clarity in frontline services. 'The prescribed services manual is very clear about what is specialised and what is not,' she said. 'But that's often not how services are managed on the ground. The split has always seemed relatively arbitrary, and trying to explain to clinicians which bit of their work on their patients was specialised and which bits weren't hasn't always made sense in terms of the management of the service.

'So I think it is a real move forward to be managing services in their entirety – the whole pathway – rather than what can appear to be an arbitrary split.'

Fixing fragmentation

Dan Gilks, associate director of finance at University Hospitals Coventry and Warwickshire NHS Trust, gave an example of current fragmentation in the funding arrangements that could be fixed with delegation.

'We had a case recently to increase usage of Ustekinumab to better manage gastrointestinal disease – it's mainly used for Crohn's and ulcerative colitis,' he said.

'You have a fragmented commissioning arrangement [between upstream management of the condition and possible bowel resection].

This report is part of an event sponsored by Boehringer Ingelheim Ltd. Boehringer Ingelheim Ltd were in attendance at the event, but had no involvement in the write up of this report.

SHUTTERSTOCK


Justine Stalker-Booth


Lee Rowlands


Nicola Malyon


Liesl Hacker


Dan Gilks


Andrew Johnson


James Bevan


Lisa Spencer


Paula Monteith


Madi Parmar


Helen Maguire

But with drugs in particular in specialised commissioning, there are two levels of fragmentation.'

With high-cost drugs currently sitting outside of the delegation and continuing to be funded by NHS England, there is a danger that local teams don't consider the costs.

He said there was 'always a kind of balance to be struck', but suggested it was possible to hit a barrier, with people only really focused on the things that will impact their own budget.

Ms Stalker-Booth saw a similar issue arising around devices. 'We have a national high-cost device budget and I can see some new devices coming in that will release efficiency and savings for local systems,' she said.

Supporting the use of devices that have good clinical and cost-effective evidence was the right thing to do for patients, but currently the costs would sit in the national budget and the potential savings would be realised locally. 'We want to fund these, but we need to work together to find a solution to enable that to happen,' she said.

Ms Stalker-Booth said a good example of how delegation could support a whole pathway approach was in spinal surgery, undertaken in specialist centres.

'An ICB might be able to invest in the musculoskeletal pathway, meaning some patients might not need to be referred for spinal surgery,' she said.

Participants

- James Bevan, Boehringer Ingelheim
- Dan Gilks, University Hospitals Coventry and Warwickshire NHS Trust
- Liesl Hacker, The Christie NHS Foundation Trust
- Andrew Johnson, Cambridge University Hospitals NHS Foundation Trust
- Helen Maguire, Guy's and St Thomas' NHS Foundation Trust
- Nicola Malyon, NHS Herefordshire and Worcestershire Integrated Care Board
- Paula Monteith, National Casemix Office
- Madi Parmar, NHS Coventry and Warwickshire Integrated Care Board
- Lee Rowlands (chair), Manchester University NHS Foundation Trust
- Lisa Spencer, NHS England Clinical Reference Group
- Justine Stalker-Booth, NHS England (specialised commissioning)

HFMA ROUND TABLE

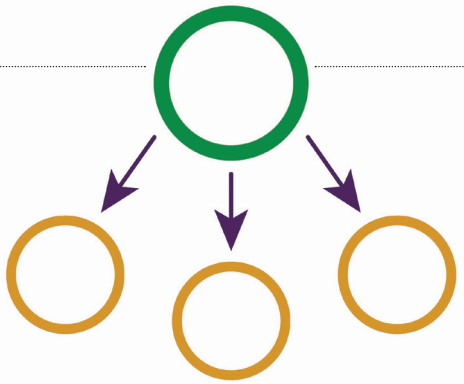
So, if the surgery is delegated, funded on a tariff basis and the ICB can commission a local service that helps to avoid the need for surgery, the funding will now be in one place with a single commissioner looking at the whole pathway. 'That is quite a good theoretical example of how things could change on a local level,' she said.

Andrew Johnson, head of income at Cambridge University Hospitals NHS Foundation Trust, agreed that pathway redesign was the real prize, especially for cross-cutting services such as neurology and cancer, both improving patient experience and outcomes and efficiency.

'I think there are possibilities to get some things done that previously may have stalled when two different commissioners owned the problem and no one wanted to pump prime the cash to start a pathway redesign process,' he said.

However, participants also identified concerns. Madi Parmar, chief finance officer of Coventry and Warwickshire Integrated Care Board, acknowledged the business case for delegation centred around supporting a left shift – doing more preventative work upstream to avoid higher-cost tertiary work downstream.

But she said the reality was more



complicated, with systems needing resources to improve access to more general services to support elective recovery.

'There's a real tension for me in all of this about financial sustainability of large specialised services versus improving access for populations,' she said. 'While I can see some real advantages with the delegation and it solves some problems, we need to be conscious it is going to create other problems, not least across geographical boundaries.'

HFMA ROUND TABLE

Ms Hacker agreed that ICBs had significant competing priorities with ageing populations and accident and emergency pressures. Where did specialised services fit in this list of 'immediate' priorities?

'We do need to start integrating [specialised services into the whole pathway] – but is there a need for a transition period or a sort of ringfencing of funding that would alleviate some of those risks?' she asked.

Mr Johnson also added a concern about the limited commissioning experience in ICBs as they take on specialised commissioning, especially given the context of ICBs having to reduce headcount to cut running costs.

"There are possibilities to get some things done that previously may have stalled when two different commissioners owned the problem and no one wanted to pump prime the cash to start a pathway redesign process"

Andrew Johnson, Cambridge University Hospitals NHSFT

Nicola Malyon, deputy chief finance officer at Herefordshire and Worcestershire Integrated Care Board, added that the contracting form could be important in enabling pathway redesign. 'Currently the majority of funding [for specialised services] is on block, and with only a small amount being variable, we are limited,' she said. 'I'm not sure about the timeframe for moving to a different contracting form to enable that shift – it limits our ability to change.'

Ms Stalker-Booth said the transition should be managed carefully, with services considered and monitored on a service-by-service basis.

'We have service lines for every single service – more than 300, of which 138 are being delegated,' she said. 'The money needs to be allocated against each service line.

'We have some very enthusiastic clinicians in the national team, through the clinical reference groups, and, of course, they will focus on their own services. But if the money is locked in an overall block, it becomes a barrier, because our clinical colleagues won't know what the current funding for a service is and that won't help service redesign.'

Instead, continued monitoring of spend at service line level was key. 'That means we can look at those services individually and ICBs can start thinking about the pathway for neuro or the pathway for spinal and the funding is identified,' she said. 'So there are real opportunities, but we need to be very careful about how we transition this to a local level, with national and regional teams supporting ICBs and their providers.'

The story so far

Certain NHS services are considered to be specialised, either because they involve highly complex treatment or the conditions involved are rare and the services can only be provided in specialist centres. There are 154 'specialised' services, with a total cost of around £23bn.

The specialised nature of the services involved has required a different approach to commissioning. Prior to 2013, primary care trusts (PCTs) were responsible for commissioning all services for their populations, including those considered to be specialised. To do this, and reflecting that these services needed to be commissioned across broader geographical footprints, the PCTs joined together through specialised commissioning groups.

This led to different standards and access policies emerging across the country, which is why NHS England became the accountable commissioner for specialised services in 2013. It has led to big improvements, with the creation of national standards and service specifications and clear clinical access policies setting out what is routinely commissioned. High-cost drugs and devices are also better managed and procured centrally, delivering better value.

Despite this, there is recognition that the current system means the patient pathway is fragmented, with misaligned incentives and bureaucratic barriers. In particular, having different commissioners for different parts of the pathway makes it harder for commissioners to invest upstream to reduce or eliminate more significant interventions further along the pathway – the investment comes out of one budget, while the potential benefits are felt in another.

There can even be confusion locally, with the dividing line between what is commissioned as a core activity and what is specialised not being clear to the frontline clinicians.

The aim is to get a balance between national consistency and universal access and local decision-making for the benefit of local populations. This will be supported by a move from specialised commissioning budgets that are largely based on historical usage to the use of population-based budgets, set using a needs-based formula.

Having moved to an interim set-up of joint commissioning boards in April 2023 – bringing together NHS England and integrated care boards in English regions – this year 20 ICBs (the boards that sit within the regions of East of England, Midlands and the North West) will take on full delegated responsibility for the 59 services assessed as ready for greater ICB leadership. (A further 29 services are expected to transfer in the future, while 89 will continue to be commissioned nationally. Some services cover multiple service lines, with some of those service lines being delegated, while others are retained.)

Starting point

The Midlands is one of the regions in the delegation vanguard this April. 'We are proposing a risk pool model for delegation to start with, because it is just too difficult without an interim step,' said Ms Parmar.

Ensuring a fair starting point was a complicated process, she said. 'If you are going to start moving money around for services, you need to understand that your fixed costs for those services are covered from the outset.

'I think the risk pooling arrangement is probably going to see very little change to start with in terms of delegation, because there is an awful lot of work to get underneath the hood to be able to do that delegation at ICB level. It is probably more of a stepped transition process.'

Ms Stalker-Booth agreed. She said that changes in pathways and funding flows would take time. But it was important for services and systems to feed back on the payment mechanisms that might start to help pathway

redesign from 2025/26 onwards, she added.

Helen Maguire, head of income at Guy's and St Thomas' NHS Foundation Trust, raised a specific concern about income for specialist providers that attract income from multiple regions and ICBs. She was concerned in general about spend being reduced, but she was particularly worried about commissioners outside the trust's own locality.

'If ICBs view this as funding for their services and take the view it is down to them where they spend it, there is a danger they will ignore specialist trusts [outside their area] in favour of spending it in their own area for preventative activity,' she said. Full pathway commissioning was the right way to go, but the financial risk for specialist trusts was a worry.

HFMA ROUND TABLE

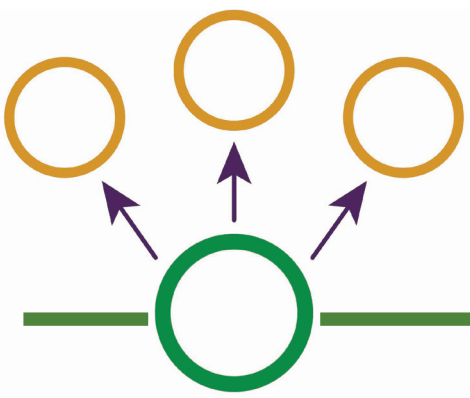
Mr Gilks said that when responsibility for specialised commissioning moved to primary care trusts, the use of the payment by results system meant the risk fell largely on the commissioners. But under current block contract arrangements, he suggested the risk fell squarely on providers.

Low-volume activity

The arrangements for low-volume activity (LVA), which make payments to providers based on an average of the three previous years' activity, rather than relying on individual case-by-case invoicing, were also seen as a risk. For specialised services, costs can be high.

'Activity is very variable for out-of-area work and all you need is a few cases,' said Ms Hacker. This could raise costs above the level covered by the block amount. Even though this would correct itself over time, it could leave specialist providers with an in-year pressure. It would only take one area arguing that they had seen fewer transplants this year and looking to reduce its payment to cause a major financial risk for a specialist provider.

Ms Stalker-Booth said NHS England would welcome feedback on services where it is felt they are not appropriate to be in the LVA block. She cited renal transplants, which are not included in the first services to be



A clinician's view

Lisa Spencer (pictured right) is a respiratory consultant working at Aintree University Hospital, part of Liverpool University Hospitals NHS Foundation Trust, and a member of NHS England's respiratory clinical reference group. She said the drive to integrate services was definitely needed.

'There are aspects of specialised care that can be delivered closer to home and it is better for patients, but we must work to maintain standards of care with ongoing specialist support and guidance.' This has already been happening in Merseyside (and in other parts of the UK), although services have been set up in a piecemeal fashion. There is an expectation that this model would be expanded, but Dr Spencer said there didn't appear to be a funding stream to support a transition to regional services.

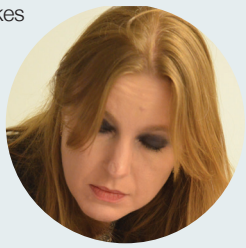
She said that the lung fibrosis specialist centre in Liverpool had been commissioned in 2014 and had been set up with insufficient infrastructure for the longer term, with many other centres in the same situation. Referrals have subsequently grown, but the centre has not been able to recruit the necessary staffing to meet this growing demand due to a lack of funding.

All centres in England are now being asked to move to a more regional pathway, with more treatment undertaken locally, but without additional resources to support it and with no surplus staff to devolve to local trusts.

Lee Rowlands (pictured left) said that a core goal of the changes around specialised commissioning had to be to support ways of making meaningful change happen. 'Otherwise we just stay with what we've got and we never change anything.'

Dr Spencer demonstrated the complexity of current specialised funding arrangements by describing her understanding of how the lung fibrosis service is funded. The largely outpatient service is funded by ICBs through normal outpatient funding. This pays a unit price for a general respiratory appointment (the high-cost drugs are paid for by NHS England).

'So when we see a patient in our special service, we get a standard payment for a 30-minute outpatient session, which might be enough time for much simpler conditions,' she said. But this does not cover the typical 45 minutes needed in a specialist session. 'This is not recognised, so we are losing money,' she said, adding that this makes it difficult to argue for increased staffing to cope with rising demand as the increased activity is likely to lead to higher 'losses'.

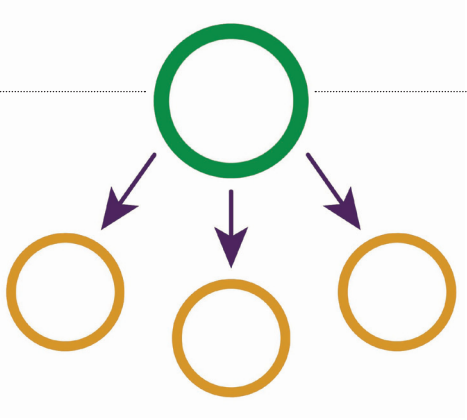


Paula Monteith (pictured right), head of the National Casemix Office at NHS England, explained that there was a real issue in identifying specialised and non-specialised outpatient activity. For example, there is a single treatment function code for adult respiratory medicine, which means there is no way to tell from the data whether an attendance was for a specialised service or a more routine activity. 'The solution is to start encouraging people to record diagnosis in outpatients,' she said. There are fields in the outpatient data set, but they are largely unused, and older electronic patient record or patient administration systems may not support utilising them.

While trusts have argued that they do not have the coding staff to start recording this activity, Ms Monteith said that trusts could adopt the same approach for recording diagnosis in outpatients as they already have successfully adopted when recording procedures in outpatients – which are often implemented via pick-lists.

'For example, to reduce the burden on coding staff, you could work with your clinicians to identify the five most common diagnoses that you see in clinic, with an "other" category to cover other diagnoses, and use this information to start to differentiate between specialised and more routine appointments,' she said.

Madi Parmar (pictured above) said that providers often used workarounds to identify specialised outpatient attendances. For example, she said, for some services, if a referral came from a consultant, it could be identified as specialised, while a GP referral would be non-specialised.



delegated, but could be for 2025/26. 'They are in the block at the moment,' she said. 'But it is very much a clinician view that this should be on an activity basis as soon as possible to remove any disincentive for providers not to take on extra activity. If that isn't appropriate to be covered by the LVA process, we need to raise that and propose how it could be managed.'

She added: 'We need to work out what services are appropriate to be funded on a variable basis at a unit price – for example, because it is high-cost, tertiary surgery and has significant levels of cross boundary flows.

'We need to balance the incentives and risks for commissioners and providers, and what should be funded on a block basis, because there are opportunities to do something different with that money. We need the right reimbursement model for each service.'

Participants also called for NHS England to clearly identify an arbiter for cases of disputed payment. Ms Stalker-Booth said NHS England was setting out delegation guidelines, including identifying specific service lines that would be best overseen by using a lead-ICB-type approach, whereby the lead ICB agreed the total payment with the provider and then agreed the fair shares with other ICBs.

HFMA ROUND TABLE

Even so, Mr Gilks said an arbitration framework would be useful for the first year, with a referee identified up front to intervene if payment issues arise. He suggested this could be the NHS England regional team.

Ms Stalker-Booth also raised the issue of funding for clinical networks – such as the operating delivery networks. These networks are not directly linked to patient care, so are not suitable for funding on a population basis.

However, Ms Stalker-Booth said these were very important teams, providing support and insight into specialised services. Currently, the funding for these networks will continue to sit with regions, but she said there was no reason why over time the funding couldn't pass to ICBs.

However, this would have to continue to be on a host basis. She added that some networks had been established for many years with recurrent funding needed on an ongoing basis.

Other strategic networks had been set up for a time-limited period to deliver a specific goal. The network funding should ideally remain ringfenced overall, but how the funding was used within that ringfence could change following review.

Mr Rowlands moved discussion on to ICBs' capacity to take on delegation. 'We are moving from a model where we have expertise at regional and national level, working with a limited number of centres, to one where quite a lot of that working will be at ICB level,' he said. 'We have people who have built up quite a lot expertise – in women's services, neonatal or other services – and ICBs have a lot on their plate. How do we cope with all that?'

Ms Parmar saw this as a key issue. 'The knowledge transfer and the bandwidth of ICBs is probably one of our overriding concerns,' she said. 'If we look at the number of webinars run in February and March about detail in terms of business intelligence analytics, contracting, drugs… it highlights the wealth of knowledge transfer that's still happening. The reality is we are not going to be ready for 1 April. We really do need a pragmatic transition period.'

Mr Gilks agreed. It would take two to three years before 'proper commissioning' started to happen, with all the governance and financial issues sorted, he said.

Mr Johnson raised a concern about the duplication of effort specialist providers might have to put in, talking to multiple ICBs – particularly while knowledge levels build up. 'In the meantime, I've got no extra staff,' he said. 'I think it will take a long time to bed in. There will be a big bang [introduction] but there will be tail-ending work for a number of years to come.'

Population-based funding

Mr Rowlands also tabled the issue of the planned move to population-based funding. Since 2013 NHS England has allocated funding for specialised services at regional level on the basis of the services provided in that area. This has involved a single contract between the relevant NHS England region and each provider in that region.

While this has kept transactions to a minimum, it has meant resources are not necessarily allocated according to the needs of the population.

From 2024/25, allocations will be made

NHS England responds

NHS England was keen to clarify and respond to issues that came up in the discussion:

- **Sustainability of large tertiary services and the risk of loss of business, particularly from out-of-area flows** NHS England is keen to see the inequity of patient access to specialised services addressed, as this is also a barrier to improved population health. It has set out mandatory business rules that apply when commissioning-led service changes are proposed to mitigate the impact of these on provider sustainability. It is a practical reality that building up local services and workforce will only be viable where there is a critical mass to do so, and that this will take time and careful prioritisation.
- **Competing priorities and capacity for taking on specialised commissioning work** Delegation provides an opportunity for better integration of specialised commissioning and local service commissioning by focusing on whole pathways of care. ICBs taking on delegated responsibility can focus on services where they can have the biggest impact. Existing NHS England regional teams, currently providing commissioning, analytical and financial services, will continue to provide those services to support ICBs.
- **Role of the region** In 2024/25, support hubs will be regionally employed. This means the region will employ the staff discharging contracting, analytical and financial functions on behalf of the ICBs, and so will act with holistic oversight similar to the system-wide arbiter role proposed in the discussion
- **Convergence to a needs-weighted formula** There has been a lot of engagement and a full independent consultation on the derivation of the needs-weighted formula through the Advisory Committee on Resource Allocation (ACRA), which has approved the construct as being robust. A pace-of-change convergence from current historic actual population-based usage to a needs-weighted population-based allocation has been proposed. The 2024/25 convergence approach is one of levelling up, not redirecting existing funding. NHS England expects to consider convergence in the round, taking account of the impact of convergence in the core services formula as well, as the needs-weighted formula is implemented over time.

Many of these points are already reflected in published FAQs available on the NHS Futures website where all specialised commissioning delegation papers are available.

at ICB level to support full delegation in the areas taking this forward. The aim is to move from the current historic actual usage basis of funding to setting budgets using a needs-weighted allocation formula. Initially, the pace of change or convergence with the new target allocation will be slow to avoid destabilising providers and services.

Ms Parmar said a key concern was that the allocation formula was informed heavily by inpatient coding, when a lot of specialised services were outpatient-based.

She said she had been reassured that it was not significant in terms of how money would be allocated, but she suggested it was still likely to be a problem.

There was also a heavy weighting towards the elderly in the core allocation formula, when a lot of specialised services are provided to other population groups.

Ms Parmar said convergence was her biggest concern around delegation, with some systems having convergence on their core allocations and specialised services allocations moving in opposite directions. This could put further pressure on how specialised services are sustained and pathways revised.

But even more of an issue was uncertainty. 'We don't know what convergence means beyond 2024/25, so we can't really plan for the medium term,' she said.

"It is a real move forward to be managing services in their entirety rather than what can appear to be an arbitrary split"
Liesl Hacker, The Christie NHS Foundation Trust

Mr Johnson was also concerned that the allocation formula may not match the way block contracts for different providers were constructed historically. Ms Hacker pointed out that convergence took place at a high level, moving the whole specialised commissioning budget towards its fair share. But within this overall picture, some individual services could be under or over their share of resources.

'When you look at the granular level of convergence, there are areas – cancer in the North West, for example – which are under-invested in,' she said. 'But the overall convergence policy might be to reduce spending. So we are having negative convergence applied to our contracts, but the data would suggest we should actually be spending more on cancer.' This was a 'significant issue' that would exacerbate underfunding problems.

However, Mr Gilks said the move to population-based funding could help start a conversation about variation in access rates to different services, and comparing actuals with expected access rates.

'That could store up arguments in future for different ICBs about why they should pay a share of a block when they don't recognise what they are getting for this share,' he said.

Summarising the discussion, Mr Rowlands said the roundtable had clearly identified the need for the financial architecture around specialised services to keep evolving – both in terms of the payment models used and the allocations methodology.

He said it was also clear how important people with specialised services knowledge were to the success of the delegation policy. It would be important to move the existing expertise in regions or locally into the ICBs and to support continued collaboration across organisations. Networks would continue to be a vital part of this process of retaining and sharing knowledge.