Devolve to evolve?

The future of specialised services within integrated care

Robert Ede and Dr Sean Phillips

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About the Health & Social Care Unit, Policy Exchange

Policy Exchange is an independent, non-partisan educational charity which seeks new policy ideas to deliver better public services, a stronger society, and a more dynamic economy.

The Health and Social Care Unit at Policy Exchange looks to tackle the most pressing questions facing the NHS and social care sector today and looks to ensure that the needs of consumers are placed at the forefront of the national conversation.

The Unit is led by Robert Ede and includes Sean Phillips (Research Fellow), Yu Lin Chou (Research Fellow) and Dr David Landau (Senior Fellow, and a clinical oncologist by background). Previous research includes:

- **At Your Service** – A proposal to reform general practice in England, with the introduction of a new unified front door for consumers called 'NHS Gateway'.
- **A Wait on Your Mind** – Our assessment of the policy response required to address the waiting list for elective care in England. The report set out a series of practical proposals to address unknown clinical risks, and to introduce 'operational transparency' across waiting times in the NHS.
- **Realising the Research Effect** – A long-read outlining opportunities to boost clinical research activity in the NHS.
- **21st Century Social Care** – Called for landmark reforms to social care in England. At its core was a simple realisation: that complex long-term social care should be financed principally out of general taxation and made available on similar terms to the services delivered through the NHS.
- **The Wolfson Economics Prize 2021** – The second biggest economics Prize in the world in cash-terms, on the subject of hospital planning and design. We had 98 entries from 15 countries, with the finalists including an NHS consultant in emergency medicine. The Prize is part of a broader series of work from the Unit on the hospital of the future, which aims to ensure that the 'biggest hospital building programme in a generation' from the UK Government delivers for patients, staff and the taxpayer.

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Executive summary

This report assesses the future for specialised services in the NHS in England. Specialised services support people with rare and complex conditions. A full description is shown on page 17.

Specialised Commissioning is the 'biggest part of the NHS you've never heard of'. The definition of specialised commissioning has expanded greatly over the past decade – 149 adult and paediatric specialised services in England are now commissioned in this way. These range from the relatively common (kidney dialysis and chemotherapy are typical examples) to other diseases (such as Barth syndrome or Vein of Galen Malformation) which are diagnosed in the NHS only a handful of times each year.

The cost of specialised services has risen faster than other parts of NHS spending. The allocation for specialised services has grown by 50% in eight years (from £13bn in 2013 to £20bn by 2020/21 – see Fig 1). This growth contrasts to primary care and community nursing which have seen their share of the NHS budget shrink despite ongoing pressures.[1] The taxpayer now spends significantly more on this one part of the NHS than it does on police services and fighting crime in England.[2]

This often-overlooked area of NHS policy is now back in the spotlight. NHS England is intending to radically reform how specialised services are planned, reimbursed, and delivered, with proposals to delegate responsibility for commissioning at least half of these services from the national level to 42 integrated care boards (ICBs) across England.

In part, this area is overlooked due to its complexity. Specialised commissioning was created as a policy response to the need to share risk across geographies – whilst overseeing the work of disparate centres of excellence, caring for relatively few patients. Each of the services therefore is faced with a different set of challenges and operates in different contexts. Whilst this approach has brought successes, attempting to characterise and plan for these under a single organisational term of 'specialised services' was always ambitious. We now argue that the term has become so broad as to be unhelpful. As we move towards integrated care, we need to refine the taxonomy of specialised services.

It signifies an unwinding of the centralisation strategy which has endured for the past decade. Following the passage of the 2012 Health and Social Care Act, the definition of specialised services was greatly expanded. This was partly driven by necessity given the small size of clinical commissioning groups, but also in a recognition that specialised services had been under-prioritised in planning pre-2012.

1. Jones, A and Wyatt, S. Midlands and Lancashire Commissioning Support Unit. What is driving the rising costs of specialised services? November 2020. [link].
2. Total police funding for England and Wales was £15.9bn in 2021/22. [link]

There is mixed evidence on whether centralisation has been a success. This hugely diverse set of services have benefitted from nationally mandated service specifications, a ringfenced budget and a powerful position within national policy. Yet by the same token, there have been consistent issues with data availability, costs and transparency, fragmentation of service delivery, and inequalities in access amongst more deprived and marginalised groups. Some of these are long-standing issues; in 2016 the National Audit Office (NAO) found that NHS England lacked robust data on provider costs, access to services and outcomes. There is also significant intra-disease inequality, with certain high profile specialised services achieving much better outcomes.

The pandemic has added to these challenges. Much like every other area of the NHS, specialised services are suffering from the ripple effects of COVID-19. Waiting times have lengthened substantially. For example, children and young adult patients with an atrial septal defect in Birmingham must now wait on average 18 months for surgery. This non-invasive procedure would typically lead to a quick recovery, yet current waiting times mean treatable congenital heart problems have now become life threatening. Other specialisms are in much the same place and the pressures on the specialist workforce are often as significant as the well-documented issues within routine and emergency care. These headwinds are partially offset by the small number of positives that have emerged from the pandemic – notably an acceleration of the integrated and partnership working between health and care organisations, and an openness towards digitally-enabled care.

Certain services are ripe for delegation. Several services – including chemotherapy and dialysis mentioned above – do not sit easily within the 'specialised' designation**.** This has been informally accepted for some time and the creation of provider collaboratives in mental health shows the potential to plan services in a more strategic way. ICBs can take this approach further, offering the appropriate 'Goldilocks' level of scale, so that the planning decisions can be made as close to the ground as possible.

For other services, the case is weaker. Specialised services such as haemophilia are comprehensive and involve fewer interfaces with other parts of the system. It is sensible that NHS England has already confirmed that all highly specialised services will continue to be commissioned centrally. Many of these, such as proton beam therapy, are delivered by a small number of regional or national centres and draw a large catchment area. The push to work at system level also has obvious limitations in application for providers who deliver a mix of specialised and highly specialised care; for example, only 4% of patients at Great Ormond Street Hospital come from within the local ICS.

No reforms are immune to risk. We are concerned by the limited engagement in the difficult choices that will accompany these reforms. Moving towards population health budgets will bring major practical challenges for care which is not closely linked to the local pathway. As do new rules which introduce system-level control totals for capital spending.

The consequence is that specialised services, commonly capital-intensive and requiring innovative reimbursement mechanisms, will need to be retrofitted into a different system architecture. Workarounds are likely to be needed. If done poorly this could lead to a muddying of the governance and commissioning waters, and distortions in funding and access to care.

This threatens the world-class status of some specialised services. From pioneering hand transplants to cutting-edge cell and gene therapy medicines, specialised services often demonstrate the NHS as its most innovative and capable. Many centres are national assets with global reputations that are seen as central to the UK's mission to become a healthcare and life science superpower.

Any policy change must safeguard what is working well. But the wider pressures on the NHS – from routine to emergency care – are immense. With declining public satisfaction in the health service and a need to refocus on core political priorities, there is an expectation for the different parts of the NHS to rally round and work 'as one'. This interdependency and preference for generalism will be unfamiliar territory for specialised providers, who have operated with a high degree of autonomy in the previous system.

Shared working arrangements should be mimicked at the centre. Specialised Commissioning has become an influential part of NHS England. One interviewee for this paper described it as a 'fiefdom' with its own organisational silo, culture, and priorities. This may have carried historic advantages, but the ethos of collaboration being instilled at an ICS level should be mimicked at the centre. As the role of the centre is reviewed alongside the creation of ICSs, this is a moment to achieve closer alignment between NHSE and DHSC. Specialised services offer a potential starting point. This must be done with due care, but over time could lead to more shared programmes of work and may strengthen the case for reunification.

Ultimately difficult choices lie ahead in three main areas:

- **First: agreeing a vision for delegated service delivery.** Pushing responsibility for services away from the centre and into ICSs makes it possible for local leaders to adapt how services are delivered to suit their populations. But this needs to be counterbalanced with the need for nationally agreed standards – underpinned by service specifications in line with the latest standards of care, including the evidence that centralising specialist care improves care quality. What degree of 'warranted variation' should be accepted? And given that services evolve, where should responsibilities lie for writing, maintaining and auditing these standards in the future?
- **Secondly: determining speed and timing**. The passage of the Health and Care Bill onto the statute book has been less contentious than previous reforms, and broadly command support across the NHS. The principle of integrated care is a fine one. Our current system creates unwelcome friction for the patient. In HIV

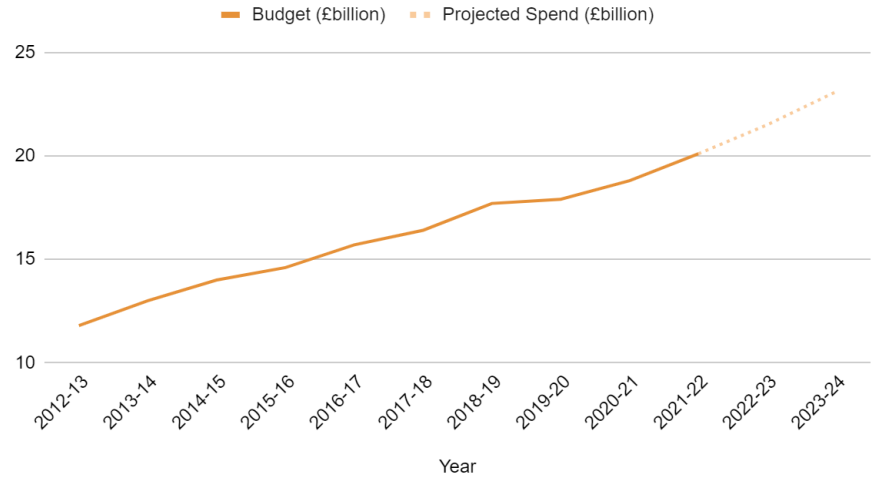
services, local authorities are responsible for HIV testing, but NHS England is the commissioner for HIV treatment and care. Within neurology, CCGs are responsible for commissioning neurology services provided in the community, whilst NHSE is responsible for commissioning across the network of three neurology centres and 24 neuroscience centres. Often this leads to misaligned incentives. Patients find themselves repeating their story as they bounce around the system. Sorting these problems out is worth doing. The strongest advocates suggest that an integrated approach can also improve the quality, equity, and value of care. Evidence from 20-years of pilots is inconclusive. As we have argued in our previous research,[3] is also remains unclear how the new legislation will help to solve the most immediate challenge: access. A question looms. Should services be delegated hard and fast, recognising that ICBs need power and responsibility to be real successes? Or should NHS England and the Government be more cautious, cognisant of the scarce change management capacity within the NHS and the inconsistent starting point of the 42 different geographies?

- **Finally: charting a path towards financial sustainability.** Treatments and diagnostics for specialist services are often, by their very nature, specialised and costly. The onset of new treatments should be celebrated; the NHS is right to reach towards the frontiers of medical science. Patients who decades ago would have died due to a lack of viable treatments are now living fulfilling lives. But these breakthroughs, and their accompanying infrastructure, have created budgetary pressures, whilst current payment models are not designed for curative treatments. So should Ministers and NHS England accept the increases in the specialised commissioning budget as an inevitable consequence of better care, or introduce innovative reforms to ensure its financial sustainability over the longer term? Can both be done in tandem?

These changes are potentially massive. If the Home Office was proposing to redesign how police services are funded and planned across England, there would be enormous levels of scrutiny in Parliament. Yet for a part of the NHS which carries the equivalent annual cost to the taxpayer, 'specialised services' were mentioned just 20 times during the passage of the Bill.

3. Robert Ede & Sean Phillips, 'A Wait on Your Mind', Policy Exchange. July 2021. [link]

Figure 1: Specialised Commissioning Budget 2013-2024



With the Bill now on the statute book as law, the political window to shape the next phase has largely closed. The emphasis is now on guidance, in the form of a framework and roadmap, which are to be published by NHS England in the coming weeks. It will be important that publication is accompanied by scrutiny, given this is such a large and growing area of NHS spending. This report intends to address this gap.

Policy Recommendations

This report sets out a series of recommendations which we would like to see taken forward.

Our summary of these reforms is as follows: the breadth and size of the specialised commissioning portfolio is too large, and this is a good moment to separate it into more logical groupings. However, the delegation process is not without risk, and should therefore be divided into stages.

Initially there should be a focus on devolving commissioning responsibility for the 'dead certs' – more commonly used services such as chemotherapy, specialist mental health, adult cardiology and dialysis where there is a high degree of interface with other parts of the system and a low level of justification for retaining central commissioning responsibility in an era of population-health. Even for these relatively common condition areas, there will still be enormous complexity associated with devolution – as the dynamic between NHSE at the centre and ICBs remains unclear.

These initial delegations should begin from April 2023 and be aligned to the sign-off of five-year system budgets. Services which the case is weaker should retain under central commissioning responsibility, with any delegations deferred until 2024/25 at the earliest. It is important to learn the lessons from previous attempts at reform, such as the over-devolution in 2002.

Our policy recommendations seek to set out steps that should be taken by DHSC, NHS England, ICSs, specialist providers and other bodies to learn the lessons from previous unsuccessful attempts at reform. These are broken down into governance and oversight; delegation approaches; patient input, financial control and workforce.

Delegation framework and approach

1. NHSE should announce its intention to **pilot delegation amongst a small set of services from April 2023 at the earliest**. Suggested services include dialysis, chemotherapy, specialist adult cardiology, and mental health. The NHS should also consider delegating services initially to a small number of 'trailblazer' ICSs which have reached organisation maturity. All delegation must involve close collaboration with the existing NHS regional teams.
2. NHSE should publish its **emerging framework and guidance for the delegation of services in advance of the 'go live' date of ICSs in July** to allow for proportionate scrutiny. This should include a feasibility study and impact assessment.

Governance, and oversight

3. **Both DHSC and NHSE should commit to undertaking a review of their workforce**, with the intention to reduce headcount at the centre. The objectives of this exercise should also include greater alignment of DHSC and NHSE, including through running joint policy programmes, to streamline the policies, strategies, and guidance from the centre. The review should feed into the ongoing Public Bodies Review Programme led by the Cabinet Office. This should in turn enable greater political oversight and accountability for specialised commissioning strategy.
4. **There should be a commitment to redeploy specialised commissioning expertise from NHSE to ICSs or regional offices to support emerging ICSs in their commissioning responsibilities.** This will be gradual and focus initially on the commissioning teams working on services such as dialysis, mental health, specialist adult cardiology, and chemotherapy. Roles could be via secondment or permanent redeployment. Necessary relocation incentives may be required.
5. There should be a **renewed emphasis on data recording and transparency on specialised services**. This should include linkage across primary and secondary care for conditions not incorporated within the NHS Spine (which supports the IT infrastructure in England). Historically, the quality and coverage of specialised services activity data has been poor, and it continues to fail to include the influence of high-cost medicines.
6. As part of the new delegation regime, the NHSE Specialised Commissioning team should announce a **series of accompanying reforms to ways of working**. These should include:
    - Increased transparency over the cost of providers for services. This should be published in the public domain on an annual basis.
    - A commitment to review any service specification which is either older than six years, or where major new treatments or techniques have been introduced within that timeframe. Refreshed service specifications should include mandated data collection as a basic requirement of providers, and ensure outcomes are defined against the latest standard of care as opposed to historic processes.
    - A stocktake of data collection in specialised services, including working closely with relevant GIRFT initiatives and patient representative groups to minimise risk of duplication. The stocktake would assess whether the appropriate data collection is in place to support measurement of progress against the desired clinical outcome.
7. A **Governance framework for provider collaboratives and their relationship with ICBs** should be developed by NHSE and be

published ahead of the 'go live' date in July 2022. The most recent guidance on Provider Collaboratives was published in 2021 prior to the Bill achieving Royal Assent and made only brief reference to the risks and accountabilities that will come with providers playing a fuller role in the designing and planning of services, alongside their traditional delivery role. The new document would contain practical tools and explain how to draw upon the lessons from provider collaboratives in mental health, such as the management of conflicts-of-interests, including over 'make or buy' decisions.

Patient and citizen input

8. Each ICS which accepts responsibility for commissioning a delegated service should **involve patients and their carers in service design**. This would be best achieved through a hybrid approach which draws on the insights from national patient charities and on-the ground service users through the new Integrated Care Partnership. It is unlikely to be suitable for rarer conditions, and all highly specialised services, which will remain under central commissioning control.
9. One specific policy idea would be to ringfence a **proportion of the rebate from the current and future VPAS scheme** to be allocated towards patient and advocacy groups, enabling them to resource activities at an ICS level. Patient and carer input into service design is of critical importance. However, charities are concerned about their ability to engage across up to 42 different geographies. We would suggest that the initial pot is £20m to cover the first two years of ICS implementation, and the remainder of the current VPAS scheme which runs until 2024. This would equate to around £240,000 per ICS per year. Grant requests would need to be made and the pot would be controlled by a steering committee led by a senior former executive within the third sector. The Secretariat would be provided by DHSC, with input from NHSE and the PPV Assurance Group. A weighting criterion would be deployed to ensure that smaller charities would not be disadvantaged. This would exist separately to and independent of any allocation mechanism than pharmaceutical companies have in awarding grants to patient advocacy groups directly.

Financial control

10. **Responsibility for medicines procurement, strategy and policy should remain at the centre within NHSE**, but with greater input and alignment with DHSC and wider Whitehall agendas. Responsibility for medicines spend should be delegated alongside services on a case-by-case basis.
11. **NHSE should proceed with extreme caution in moving to a**

population-based allocation mechanism, to reflect the unique costs associated with delivering some specialised care. A review to the national funding formulary may be required. Initial baseline allocations should be based on pre 2020 figures (adjusted for inflation) to exclude any possible extreme effects of the pandemic on activity.

12. DHSC and NHSE should regularly review the impact of the **introduction of the aligned payment and incentive system across all specialised commissioning contracts,** given the risk that this adds a considerable financial complexity and burden for providers who require funding for multiple geographies. This should include assessment, so that costs borne by one part of the system (e.g., transportation) are factored into assessment of new technologies such as suitable home therapies.
13. DHSC should commission an **independent review of procurement and holistic commissioning in specialised services**. The review would look at all priority areas of spend, including devices, and medicines, and should be led by a former Government official with familiarity of medicines spend but also the interrelationship with industrial strategy. The review should interview patients to understand their experiences of different care, and how improved approaches to procurement can deliver on the 'triple aim' within the Health and Care Act whilst addressing health inequalities. The scope of the review would encompass an evaluation of novel payment mechanisms, to reflect the 'true value' of medicines across the pathway, the interrelationship with integrated care budgets, and the anticipated arrival of very high-cost medicines with curative potential and long-term benefits. The review should be announced this year and report in 2023, to inform ongoing procurement frameworks including the negotiations over the replacement to the existing Voluntary Scheme for Branded Medicine Pricing (VPAS).
14. DHSC and HM Treasury should commit to **greater transparency over the use of the rebate from the existing VPAS scheme within the NHS**. ICS footprints should also have sight on rebate payments with measures introduced to ensure that they benefit from the high-degree of price control achieved through the cap on in-year sales.
15. **Integrated Care Boards must include a specific impact assessment on specialised services as part of their capital and estates plans**. There should be sufficient flexibility in capital programmes to approve projects where the benefits will be derived beyond the given geographical footprint.
16. **NHS England/Improvement and DHSC should introduce a ringfenced capital spending pot for nationally significant specialised projects**. New capital rules set a system-level allocation on capital spending.[4] This is likely to constrain the ability for

4. NHS England and Improvement. Capital guidance 2022 to 2025. April 2022. [link]

hospitals delivering specialised care to make nationally strategic, transformational investments in equipment or facilities, especially when those are designed to serve a broader catchment area than the ICS itself. For the short-medium term, DHSC should consider allowing for an appropriate degree of ring-fencing of capital budgets. This is consistent with other national priority areas such as the New Hospital Programme and reflects that a significant proportion of specialised services will continue to be nationally commissioned.

Workforce

17. The upcoming framework 15 workforce plan being developed by Health Education England (HEE) within NHSE should explore the balance between and prioritisation afforded to super specialisation and generalist roles in training.

Introduction

> *"The NHS tends to be a victim of fashion. It goes from one extreme to the other – one minute it wants everything to be ultra-local, the next everybody wants to run the NHS by national diktat. If we're honest with ourselves, it needs to be more nuanced, and I hope it will be."*
>
> John Murray, former Director, Federation of Specialist Hospitals (2017-2021)

Whilst often over-looked in debates surrounding the NHS, specialised services are back in the spotlight. As part of the arrangements formalised through the Health and Care Act, NHS England (NHSE) has signalled its intention to delegate responsibility for commissioning certain services to the Boards of Integrated Care Systems. Currently 149 services are commissioned nationally and delivered by specialised providers across England.[5] These range from the relatively common (such as kidney dialysis and chemotherapy) to other diseases (such as Barth syndrome or Vein of Galen Malformation) which are diagnosed in the NHS a handful of times each year.

The huge variety of services and condition types makes them individually rare but collectively strong. Each of the services is faced with a different set of challenges and operate in different contexts, but all have arguably benefitted from the decision to centralise control, funding and support following the 2012 Health and Social Care Act. After a decade of relative stability, the status of specialised services is under review. A clause to enable the delegation of services was included within the Health and Care Act which received Royal Assent in April 2022.

There appears to be a consensus that the definition of specialised services has become too broad. Many also believe that integrated care systems offer a 'goldilocks' scale for commissioning some of the services with larger patient populations in a way that Clinical Commissioning Groups (CCGs) never could be due to their smaller size.

There is likely to be less consensus on the exact number of services which should be delegated, nor the objectives of this exercise. Indeed, throughout our research we have found a lack of transparency and communication around these far-reaching reforms. This is causing considerable worry for patient advocates, and specialist providers. Despite being one of the most technical parts of the NHS, changes to specialised commissioning should be of wider political and public concern, given that the budget has grown by more than 50% from 2013 to 2020. This growth contrasts to primary

5. NHS England & Improvement. Specialised Services. 2022 [link].

care and community nursing which have seen their share of the NHS budget shrink despite ongoing pressures.[6] The taxpayer now spends more than £20.5bn a year on specialised services. That is projected to grow to £25bn by 2025.[7] We already spend more on this single part of the NHS than we do on the police and fighting crime. Designing the system so that it delivers value for money and the highest quality care should matter to all of us.

Box 1: What are specialised services?

Unlike most health care services which are delivered locally, specialised services are planned nationally and regionally by NHS England. They are termed 'Prescribed Specialised Services' – meaning that the Secretary of State for Health and Social Care, having received appropriate advice, has required NHS England to commission the service.[8] Currently, 149 services fall into this category – ranging from common interventions such as kidney dialysis, chemotherapy and radiotherapy to range conditions which are only diagnosed in England a handful of times a year.

Services are generally provided in relatively few hospitals and accessed by small numbers of patients. They are usually for patients who have rare conditions or who need a specialised team working together at a centre.

Highly specialised services are a subcategory of specialised services. Typically, these would treat no more than 500 patients per year, and are therefore delivered nationally through a handful of centres of excellence.

In April 2013, NHS England & Improvement took on responsibility for commissioning specialised services, including setting the budget for these services. Pre 2013, ten strategic health authorities and ten co-terminus Specialised Commissioning Groups were responsible for commissioning highly specialised services, and all other specialised services on behalf of 151 local primary care trusts.

NHS England & Improvement has used four criteria in determining whether a service should be classified as specialised:

- The number of individuals who require the service;
- The cost of providing the service or facility;
- The number of people able to provide the service or facility and
- The financial implications for Clinical Commissioning Groups (CCGs) if they were required to arrange for provision of the service or facility themselves.

Specialised services funded by NHS England & Improvement are grouped into six National Programmes of Care: blood and infection; cancer; mental health; internal medicine; trauma; and women and children.

This report from Policy Exchange assesses the current state of play in specialised services. We then consider the justification for delegating services in the shift to integrated care, and the offer for those services which will remain under central control. In this paper we try to set out answers to the following three questions:

6. Jones, A and Wyatt, S. Midlands and Lancashire Commissioning Support Unit. What is driving the rising costs of specialised services? November 2020. [link].
7. Edwards N. Specialised commissioning: lessons from history and looking to the future. 2020. Nuffield Trust comment [link].
8. Prescribed Specialised Services Advisory Group (PSSAG). Terms of reference. 2014. [link]

1. How can we ensure the NHS delegates appropriate services at a scale and in a way that brings **genuine patient benefit**?
2. Can we mitigate against **unintended consequences** and spill over effects that have characterised previous attempts at reform?
3. What should be the **longer-term strategy** for the provision of specialised care in England?

Our report draws upon a series of semi-structured interviews with healthcare leaders, researchers, and patient advocates. We also hosted two roundtables, one focused on the provision of specialised care and the second on the national strategy. The authors also undertook a rapid review of external literature.

Chapter one opens the report by considering the current landscape for the commissioning of specialised services. It also considers the confluence of specialised commission strategy with priority NHS and Government agendas, including the shift towards integration and wider efforts to bring spending on healthcare towards sustainable levels.

Chapter two sets out the considerations that policymakers must be mindful of when choosing to delegate a service.

Chapter three considers what should come next and sets out a series of recommendations for NHSE, ICS leaders, and the UK Government.

Figure 2: Timeline of specialised services policy in England, 1962 – Present

1962

The Hospital Plan for England and Wales formally established 'norms' within NHS care – including the number of beds per 1,000 population and used 14 Regional Health Authorities as the basis for rolling out District General Hospitals. Single speciality hospitals were deprioritised, with those requiring specialised care needing to travel further to Regional Hospitals where services such as cardiac and neurosurgery were based. Regional centres developed around existing teaching hospitals – distorting the distribution with more specialities in London and the larger cities.[9]

1970s

A major reorganisation in 1974 to strengthen management within the NHS leads to the introduction of the Resource Allocation Working Party (RAWP) – the first attempt at a needs-based formula by accounting for mortality data among regional populations. The RAWP was abolished in 1991 but needs-based formulae have persisted in the NHS ever since.

1980s

The Supra Regional Services Advisory Group was introduced, tasked with assessing the suitability of services for designation and funding for specialised services.

1990s

The decade heralded the introduction of the internal market through separating the provision of services from purchasing (or commissioning).

2002

Responsibility for specialised commissioning is devolved to 303 primary care trusts, which held responsibility for 80% of the NHS annual budget. Ten strategic health authorities are responsible for commissioning highly specialised services.

2006

A review led by Professor Sir David Carter criticised the consistency and effectiveness of specialised commissioning under Primary Care Trusts (PCTs).[10] At the time 35 services were identified as specialised. New arrangements brought greater central oversight – through the creation of the National Specialised Commissioning Group. Services at the regional level were commissioned through Specialised Commissioning Groups, who played an important non-statutory role. [11]
The budget for specialised services is estimated to be £3.48bn (2004/05).

2012

The Health and Care Act 2012 passes into law. The Bill heralds the creation of NHS England & Improvement and centralises responsibility for specialised commissioning. The definition of Specialised Services grows significantly. Service specifications were introduced for each prescribed specialised service.

2013

NHS England formally takes on responsibility for commissioning specialised services.
As part of the changes to the definition, the budget for specialised services grows to £13bn (2013/14).

2014

The publication of the Five Year Forward View sets out a vision for the NHS to 2019, based around seven new models of care. A focus on population health management and localism signalled possible reforms to the organisation of specialised services.
The budget for specialised services grows to £14.6bn (2014/15).

2020

Integrating care – Next steps to building strong and effective integrated care systems across England is published. Proposals including putting allocative decisions "in the hands of local leaders" and signalling an intention to create a single pot including "the majority" of specialised commissioning spend.
The budget for specialised services hits £20bn for the first time (2019/20).

2021

2021 - The Health and Care Bill is introduced to Parliament in July. It received Royal Assent on 28 April 2022.
The budget for specialised services hits £21bn (2020/21).

9. The DFID Health Systems Resource Centre. The UK National Health Service, 1948-1999. 1999. [Link]
10. Carter, David. Review of Commissioning Arrangements for Specialised Services. 2006. [Link]
11. House of Commons Library. Briefing paper. NHS Commissioning before April 2013. 2016. [Link]

Chapter 1: Getting to this point – A potted history of specialised services

In this chapter we will explore the current organisational structure for commissioning specialised services, and then explore how this may evolve following the shift to care designed around integration.

> *"After NHS England took over the responsibility in 2013, one of its most challenging tasks, not least in financial terms, was to secure common service standards. The objective was of course not to level down, but level up, in the finest traditions of the present Government. That levelling up was expensive."*
>
> Lord Lansley, Former Secretary of State for Health, January 2022

How are specialised services commissioned currently?

The placement of specialised services within the healthcare policy framework has proved to be a contentious area for health policymakers for the past four decades. As outlined in the timeline [page 20] there have been various attempts to centralise and then devolve commissioning responsibility. These have shifted between extremes; pushing responsibility too far in either direction with elevated expectations of the ability for structural change to deliver service improvement.

As we now look to the upcoming changes, there is an opportunity to grasp the lessons from previous reforms to increase the likelihood of successful implementation this time around.

The genesis of specialised commissioning was as a mechanism for managing financial risk. The costs and requirements of delivering specialised care struggle to fit neatly within a system architecture built around geographical, population-based allocations, such as in the NHS in England. This may help to explain the see-saw manner of historic reforms, as successive policymakers have grappled with trying to find an optimal resting place for specialised services within the organisational hierarchy. As Nigel Edwards of the Nuffield Trust has noted, this is a uniquely English problem. The NHS differs from other healthcare systems in European countries such as the Netherlands (which operates under a Bismarck-model) where tertiary hospital providers are given subsides in return for

expanded responsibilities to provide specialist care.6

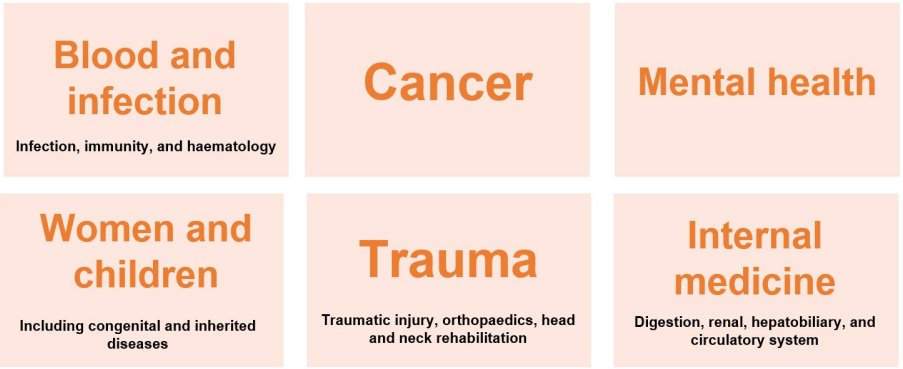
A commitment to needs-based formula for routine activity means that specialised services has been reimbursed differently. This reflects that care is often (although not always) very expensive, provided by relatively few centres, and is accessed by a small number of patients.[12] In recent years, NHS England & Improvement (NHSEI) has used four criteria in determining whether a service should be classified as specialised:

- The number of individuals who require the service;
- The cost of providing the service or facility;
- The number of people able to provide the service or facility and
- The financial implications for Clinical Commissioning Groups (CCGs) if they were required to arrange for provision of the service or facility themselves.

In total, 149 services are currently classified as a specialised service. Approximately 70 of these services are deemed as 'Highly Specialised' – where they would typically treat no more than 500 patients per year. Examples include proton beam therapy for specific cancer treatments, multiple sclerosis management for children, and adult hand transplantation services.[13]

Within NHSE, specialised services are broken down into six National Programmes of Care (NPoCs). These are shown in Fig 3.

Figure 3: Specialised services are broken down into six broad areas. Source: NHS England & Improvement pamphlet [link]



Within each NPoCs these are several Clinical Reference Groups (CRGs). CRGs are responsible for providing clinical advice and leadership related to the design of specific services.[14]

Alongside these six condition groupings, the Specialised Commissioning team within NHSE holds responsibility for cross-cutting research and medicines initiatives. This includes genomics, the Innovative Medicines Fund, and the Cancer Drugs Fund. Whilst health is a devolved responsibility, the specialised commissioning team also input directly into groups such as the UK Rare Diseases Framework Board, which is convened by DHSC with representation from all four nations of the UK.

12. National Audit Office. The commissioning of specialised services in the NHS. 2016. [link]
13. NHS England & Improvement. Highly specialised services 2019. [link]
14. NHS England & Improvement. National Programmes of Care and Clinical Reference Groups. Accessed: 2022. [link]

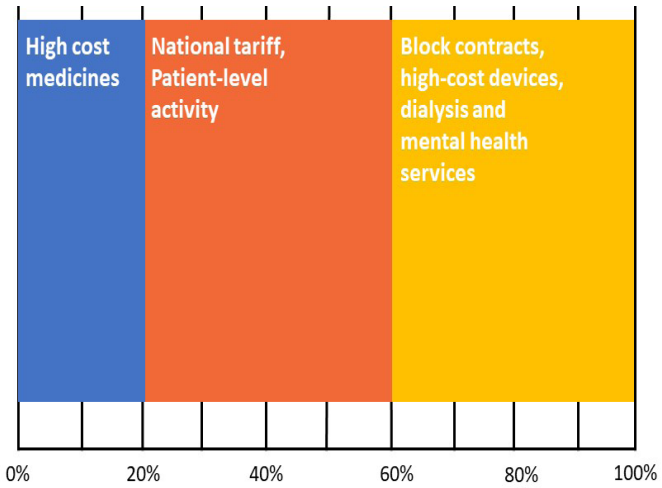
NHSE is responsible for determining policy and strategy objectives and managing the process whereby future services are considered for designation. The organisation is supported in its work by the seven regional teams (see Figure 4). These have responsibility for delivering against the strategy set nationally and securing services in line with the national standards and specifications.

Figure 4: The seven NHS England regions. Source: NHS Graduate Management Training Scheme

How is the money spent?

As outlined in Fig 5, roughly 20% of the specialised service budget goes towards medicines [see Box 3 for further detail], with the remaining 80% broken down equally into activity delivered under a national tariff payment system through Patient Level Contract Monitoring (PLCM) (40%) and block contracts, high-cost devices, dialysis and mental health services (40%).

Figure 5: Estimared utilisation of the specialised service budget, by area of spend. Source: The Strategy Unit, 2020



Success at the centre? Appraising the current commissioning approach

In the last major healthcare reforms in 2012, 209 Clinical Commissioning Groups (CCGs) were created, each responsible for populations numbering between 100,000 and 300,000. The decision was taken that many specialised services would struggle to be commissioned at this scale. The only alternative was therefore to centralise with support from the regional teams. At the time, the following four areas were identified by the NHS as key drivers behind the decision to bring responsibility for commissioning under national control from 1 April 2013:[15]

Box 2: Drivers of the decision to centralise commissioning of specialised services:

- **Direction of travel:** the NHS reforms provide an opportunity and responsibility to design the commissioning of specialised services in line with the direction set out by Sir David Carter and his review.
- **National consistency based on national direction:** national clinical and commissioning leadership, planning and co-ordination are essential to achieve consistency in the delivery of commissioning functions and to minimise duplication.
- **Improved quality and value for money:** current arrangements do not provide sufficient rigour in financial planning and control; they do not always ensure equity of access to services or consistency in the design and application of quality standards.
- **Outcome based commissioning:** the NHS Outcomes Framework places a clear responsibility on commissioners to ensure that services deliver improved outcomes for patients across each of the five domains.

Did the end result deliver against these drivers? The changes since 2013 did herald a period of relative stability, with the creation of clinically led service specifications and national policies for funding. Many in the specialised care community believe this has been a positive change, with national service specifications acting as a bulkhead against 'postcode lotteries' which characterised care pre the 2012 HSCA.

However, as well as bringing advantages, centralisation has exacerbated existing problems and created new ones too. Patient groups have highlighted that service specifications are good in principle but must be 'iterative' documents which are regularly updated to keep pace with developments in treatment and the latest standard care (for example to reflect that HIV is now a manageable chronic disease, requiring ongoing care rather than a focus on measuring viral load) – and have pointed to inconsistent implementation across provider footprints.[16]

Other common challenges cited by condition representative groups and the pharmaceutical industry include issues with data availability, costs and transparency, fragmentation of service delivery, and inequalities in

15. The Specialised Services Commissioning Transition Team. Securing equity and excellence in commissioning specialised services. November 2012. [link]
16. National AIDS Trust. Written evidence submission to a House of Commons Health and Social Care Select Committee inquiry. March 2021. [link]

access amongst more deprived and marginalised groups. Some of these are long-standing issues. In 2016, the National Audit Office (NAO) found that NHSE lacked robust data on provider costs, access to services and outcomes. Accurate data on how much NHS England & Improvement pays for a service and what patients receive was – according to the NAO – only available for around a third of the total budget spent on specialised commissioning as most services were locally negotiated and therefore not paid under the national tariff.10 The NAO produced a framework to attempt to explain the rise in costs, composed of ten possible factors. These ranged from demographic change to rising unit costs of specified activity, to changes in the case mix and new and improved diagnostics and treatments.

A subsequent report from the Public Accounts Committee, also published in 2016, called for NHSE to make "tough decisions" to remain within its budget for specialised commissioning, including calling for specific interventions in the following three areas:

- Ensuring new medical equipment and medicines are affordable;
- Ensuring services are delivered cost-effectively; and
- Better management of the level of demand for the specialised services it [NHSE] commissions.

Has NHSE made significant progress against these areas listed above? Since 2016 the budget has continued to grow at around 8% per year. Specialised commissioning now consumes more than 16% of the total budget of the NHS. This carries consequences for other areas of spending, such as general practice, whose budgets have grown at a slower rate.

Box 3: Under the spotlight: Medicines spend in the NHS

The NHS in England is estimated to spend £16.7bn per year on medicines.[17] The figure has grown from around £13bn in 2010, but a series of policy mechanisms, discounts and rebates mean that the headline figure is deceptive. Indeed, evidence from the OECD suggests that the NHS is more effective than comparator healthcare systems in keeping the price of drugs within sustainable levels.

How is the price controlled?

In the UK, pharmaceutical products are priced by the manufacturer and are not subject to direct price controls. However various mechanisms have been in place since the 1950s to control the price of branded medicines (i.e., those within their patent) in their totality. The latest is the 2019 Voluntary Scheme for Branded Medicines Price and Access (VPAS).[18]

The five-year scheme was agreed by pharmaceutical industry, the NHS, and UK Government (negotiating on behalf of all devolved nations). The objectives of the scheme are to strike the balance between three competing priorities, namely: 1) Affordability; 2) Patient access and 3) Supporting the development of new medicines. Under the deal:

- The total bill for branded medicines will not grow by more than 2% in any of the five years.
- Any spend above 2% will be repaid by each manufacturer to the UK Government in the form of a rebate.
- Participating manufacturers are also subject to an overall profit cap of 6% return on sales and 21% return on capital.

Under the current scheme the rebate is calculated each December using sales figures from the previous 12 months. It is then paid directly to DHSC where it is used towards discretionary Government spending. Some analysts have suggested this approach obscures the true cost-effectiveness of the scheme.

Approximately 80% of branded products are covered by the voluntary scheme. Those not covered are including within a statutory scheme which also has price control. By contrast, generic medicines are not subject to price control.

NHSE has a legal duty to fund all new medicines and devices which are approved by the National Institute for Health and Care Excellence (NICE). Manufacturers can still secure a deal with NHSE for access to a medicine even if it has not been formally approved as cost effective by NICE. The current VPAS includes a commitment to driving uptake of new, approved medicines, although official statistics show that the UK still lags behind comparator countries.[19]

The scheme runs until the end of 2023 – meaning that attention is now beginning to turn towards the negotiations for the replacement which will be introduced from January 2024.

How does this relate to spend within specialised services?

Whilst contributing a relatively small amount to the total volume of medicines prescribed, specialised services are increasingly taking up a higher proportion of the value of drugs in England. Approximately 20% of the total specialised commissioning budget goes towards high-cost medicines. This includes specific pots such as the Innovative Medicines Fund, an extension of the Cancer Drugs Fund which together intends to enable access to the most clinically promising treatments prior to NICE approval. Together these offer a total of £680 million of ringfenced NHSE funding.

17. NHS Business Services Authority. The Systematisation of medicines optimisation. NHS Clinical Commissioners. 2021. [link]
18. Department of Health and Social Care. Voluntary scheme for branded medicines pricing and access. 2018. [link]
19. Office for Life Sciences. Life Science Competitiveness Indicators 2021. [link]

The ongoing struggle to achieve financial control

> *"At a national level in specialised services you're dealing with a handful of well-known and very powerful providers. That negotiation is quite different to what would happen locally"*
>
> Roundtable participant, 2022

We are now six years on from the NAO report. Are the same factors creating cost pressure? There have been limited national studies, and the lack of transparency and cost information hindered our ability to undertake primary analysis for this paper. Representatives of specialist providers continue to cite the challenges of moving from the PCT/SHA to a national commissioning model as part of the explanation for the growth in cost. Many services were historically deprioritised compared to local priorities, and the centralisation process exposed significant levels of unmet need. This was alluded to by Lord Lansley in his remarks in the House of Lords which opened this chapter.

It is also important to note that a certain amount of growth in the medicines spend – which in total is estimated at 9% per year – has been unavoidable.5 Conditions such as MS were historically underserved by treatment options, but since the early 2000s we have seen the introduction of twenty disease-modifying therapies. Consequently, the medicines bill for MS has grown from effectively zero to £300m in twenty years.[20]

In return, thousands of people living with multiple sclerosis are benefitting from life-changing drugs, living longer and with a higher quality of life. Scientific and biopharmaceutical breakthroughs of this kind should be celebrated. However, with more than 7,000 medicines and vaccines in the global pipeline, including for conditions without current licenced treatments, we can expect cost pressures to grow.[21]

As we set out in Box 3, the NHS is fortunate to benefit from much stronger price control and negotiation than many other advanced healthcare systems. In the following two chapters we explore how the NHS can continue to strike the right balance between signalling that the NHS is a good commercial partner whilst maximising taxpayer value for money.

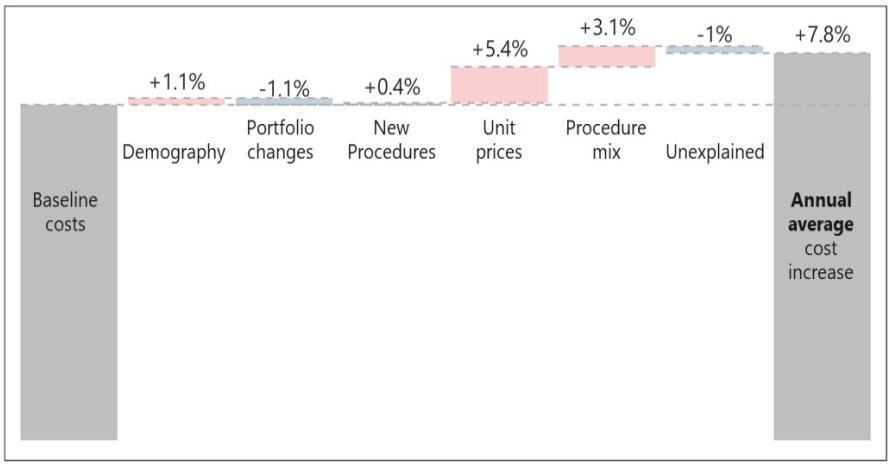
Beyond medicines, there has also been growth in the cost of procedures. This reflects that specialised services are typically more capital intensive than routine services. One more recent analysis produced for the NHSE Midlands Region by the Strategy Unit covering two years of recent spend from 2017/18 and 2019/20 found that nearly 70% of the increase in costs could be attributed to the growth in unit prices. This reflects adjustments to national prices (and top up payments) which have had a material effect on cost growth. Examples cited in the research include:

- Increases in the tariff for low-volume, high-cost neurosurgery
- Increases in the tariff for high volume, low-cost cancer related outpatient attendances.

20. Raising the Bar audit of MS services, unpublished.
21. The Association of the British Pharmaceutical Industry. 2022. [Link]

The research also found substantial variation between the respective National Programmes of Care. It was notable that this research was only able to achieve narrow coverage of datasets covering a subset of specialised services spend, with the authors remarking that the quality and consistency of information has been poor, and particularly so in terms of spend on high-cost drugs and devices.

Figure 6: A breakdown of the growth in the cost of delivering specialised services in the NHS England & Improvement region. Source: The Strategy Unit, 2020 [link]



Any debate over growing costs in specialised services need to be placed in the wider context around public sector spending. By 2024/25 day to day Government spending on health will represent 39% of total day-to-day spending on public services by central Government (this calculation excludes major costs such as the state pension). Following the announcement of the Health and Care Levy, we are likely to be entering a period of constraint. Sajid Javid MP, Secretary of State for Health and Social Care has recently suggested that the current approach to NHS finances is unsustainable and has called for a rebalancing of funding towards prevention.[22] Up till now there has been no suggestion from NHSE nor DHSC that efforts to delegate services should lead to either a slowing in the growth in the budget for specialised services or indeed a reduction in total spend. Yet at the same time there is a widespread recognition that unless reforms are taken, current payment models will struggle to deal with new, often very high-cost treatments with curative potential. As we will explore in Chapter 2, policymakers must be willing to initiate a more open and transparent dialogue about the cost and value of services as part of these wider reforms.

22. Department of Health and Social Care. Health and Social Care Secretary Speech on Health Reform. March 2022. [link]

How is specialised commissioning being changed by the integration agenda?

There has been speculation over reforms to specialised services for some time. The wider shift in the system architecture towards integration commenced in 2014 with the publication of the *Five Year Forward View*.[23] At the time, NHSE was criticised by the House of Commons Public Accounts Committee for not making it clear how specialised services would fit within the framework.[24] However, nearly a decade later that framework is providing the vehicle for possible reform. The Health and Care Act includes two clauses (clause 2 and clause 69 which amend existing legislation set out in the National Health Service Act 2006, to allow for the delegation of responsibility for commissioning services to 42 Integrated Care Systems (ICSs) across England. The wording in clause 2 is suggestive of a 'delegation by default' policy, whereby the Secretary of State must specify if NHS England is appropriate to hold commissioning responsibilities. Clause 69 allows for joint working and delegation arrangements that would allow NHSE to delegate responsibility for arranging specialised services to one or more Integrated Care Boards (ICBs).[25] Following Royal Assent on 28 April 2022, these ICBs will come into legal basis in July 2022. Each system will be encouraged to work in a way that makes sense locally; with the wording in the legislation deliberately permissive rather than prescriptive. ICS leaders have been given four initial priorities from the centre:

1. Improve population health and healthcare
2. Tackle unequal access, experience and outcomes
3. Enhance productivity and value for money
4. Ensure the NHS supports broader social and economic development

What is the objective of this exercise?

> *"Giving ICSs responsibility for direct commissioning is a key enabler for integrating care and improving population health. It gives the flexibility to join up key pathways of care, leading to better outcomes and experiences for patients, and less bureaucracy and duplication".*[26]
>
> Amanda Pritchard, NHSE Chief Executive, 2021

> *"No matter how hard you try to integrate something, there will always be an interface somewhere, right? In the NHS we tend to assume that we can just create one integrated commissioner and they will sort out all those problems. The evidence for that is not encouraging"*
>
> Roundtable participant, 2022

23. NHS England. NHS Five Year Forward View. 2014. [link]
24. House of Commons Library. NHS Commissioning of Specialised Services. 2017. [link]
25. Department of Health and Social Care. Health and Care Bill: Integration measures. March 2022. [link]
26. NHS England. NHS England and NHS Improvement's direct commissioning functions. July 2021. [link]

The move towards integration carries potential for patients requiring specialised care. Only in a handful of specialised services (such as cystic fibrosis and haemophilia), the commissioned provider is responsible for most of a patient's care once diagnosed. For most other condition areas, the care provided under the 'specialised' banner represents just one part of the pathway.10 Often care will involve services commissioned by the CCG, local authorities, and NHSE.

These interface boundaries can lead to misaligned incentives. For example, in HIV services, local authorities are responsible for HIV testing, but NHS England is the commissioner for HIV treatment and care. Within neurology, CCGs are responsible for commissioning neurology services provided at local hospitals or in the community, whilst NHSE is responsible for commissioning the services delivered across the network of three neurology centres and 24 neuroscience centres within England. However, the existing neuroscience service specification is not entirely clear on the division between CCG and NHSE responsibilities. This results in practical issues – whereby MS specialist teams are unsure which community team they should refer patients into, and patients find themselves repeating their story as they bounce around the system.

It is obvious that the artificial separation between specialist and generalist outpatient appointments, check-ups and procedures is of no benefit or relevance to the patient. Improving the interface at a local level is therefore sensible, although there are obvious limitations in application to the more specialised services and providers; for example, only 4% of patients at Great Ormond Street Hospital come from within the local ICS boundaries.[27] This will add even greater complexity in the move towards population-health budgets, suggesting that carefully designed reimbursement and clawback mechanisms will need to be introduced to reflect that patients will have to travel regularly across multiple ICS footprints.

"Let's not jump into a definition of things that need to be delegated. We should instead spend our time refining how the systems are developing in ICSs and across ICSs" Roundtable participant, 2022

Policymakers have suggested that an integrated approach can also improve the quality, equity, and value of care. Yet the evidence from twenty years of pilot schemes across England, Scotland and Wales finds that integration policies have made limited difference to patients.[28] It remains to be seen whether these purported benefits can be realised in an environment of constrained resource and competing priorities as we emerge from the COVID-19 pandemic.

In a document published in 2018/19, NHSE set out initial thinking on how specialised services would be planned in collaboration with local systems to ensure more joined up care (see Figure 8).

27. Shaw, M. Provider Voices. NHS Providers report on specialised services. 2020. [link]
28. Reed S, Oung C, Davies J, Dayan M and Scobie S. Integrating health and social care: A comparison of policy and progress across the four countries of the UK Research report, Nuffield Trust. 2021. [link]

Figure 8: Summary segmentation of specialised services. NHS England & Improvement. 2018/19 [link]

Commissioning levels	Population size	Services	Examples	Possible practical application
National or regional	Over 10m population	~80 services ~£1.6bn	Proton beam therapy, specialist mental health services for deaf adults	Remain nationally or regionally commissioned, working with local systems as appropriate
Sub-regional	2.5m - 10m population	~50 services ~£8.6bn	Radiotherapy, children's specialist surgery, CAMHS Tier 4	Greater collaboration with local systems through planning boards
Local health systems (STP/ICS or groups of STPs/ICSs)	1m - 2.5m population	~20 services ~£6.4bn	Adult specialist cardiac services, renal dialysis, chemotherapy	Greater collaboration with local systems

Notably, NHSE indicated that roughly half of all services (70) and nearly 85% the total budget of specialised commissioning (£15bn out of the then £17.7bn) would be delegated to either a sub-regional or local health system level.[29] Since then it is understood that internal ambitions within NHSE have cooled, as senior leadership have responded to concerns from providers, system leaders, and patient representatives over delegating too much, too soon.

Based upon publicly available documents and discussions with those close to specialised commissioning strategy within NHSE, we understand that the move towards more integrated commissioning will involve:

- NHSE will remain the commissioner ultimately accountable for all services.[30]
- A period of joint commissioning following the 'go live' date for ICSs as statutory bodies, including the establishment of ICBs.
- The intention for ICSs to take on delegated commissioning responsibility from April 2023 – albeit with NHSE retaining a 'seat at the table'.
- No immediate changes to the 149 services being classified or delisted as prescribed specialised services.
- An overarching principle that services should be commissioned as close to systems as possible.

NHSE is developing a pre-delegation assessment framework for specialised commissioning which will be shared as part of a wider strategic roadmap. This will be published in the coming weeks ahead of the 'go live' date for ICSs in July. The framework is purported to assess the suitability for an ICS

29. NHS England & Improvement. Integration of specialised services with local health and care systems. Annex E. December 2018. [link]
30. Rt Hon Earl Howe. House of Lords Committee debate. Health and Care Bill. 11 January 2022. [link]

to take on specialised commissioning functions against six domains. It will subsequently be accompanied by a strategic roadmap document which will provide the vision for integration of specialised services within ICS footprints. This is expected to be accompanied by two further, significant changes to:

- **Service specifications.** These will become shorter and more accessible documents, with extra flexibility added so that minor modifications to the service specification can be made more easily.
- **Patient outcomes and quality indicators.** Including a possible consolidation of outcomes with less emphasis on indicators linked to structure and processes, and greater emphasis on the standard of care.

Chapter 2: Considerations

In chapter one we assessed the approach to the commissioning of specialised services, and the possible trajectory under integrated care. Chapter two sets out the considerations which Policy Exchange believe should be front of mind. The insights have been shaped by interviews and two roundtables with health leaders.

> *"It follows almost as night follows day that different regions will take different views about the significance of specialised services. We have struggled with this issue for many decades and not found it easy to come up with a solution."*
>
> Lord Warner, Former Parliamentary Under Secretary of State for Health, 2003-2007.

> *"If you really want to make best use of resources for your population, you need to make sure that the body responsible for that population has as much of that money as possible"*
>
> Roundtable participant, 2022

Our research has identified the following considerations:

Be transparent about the opportunities (and trade-offs) arising from innovating in provision. Pushing responsibility for commissioning services away from the centre and into ICSs makes it possible for local leaders, including providers, to adapt service delivery to suit their populations. This will require careful consideration and an acknowledgement that different condition types will have different thresholds for experimentation.

For example, in rural or coastal communities it might make sense to commission specialist providers who can offer at-home therapies, digital technologies and virtual wards to reduce unnecessary travel time. There are already existing targets in place for certain long-term conditions that fall under the specialised commissioning umbrella to encourage greater adoption of home therapies (for example the NHS Getting it Right First Time (GIRFT) initiative has recommended that a minimum of 20% of dialysis patients should receive their treatment at home).[28] Shifting towards integration at both system and place level may act as an escalator towards meeting such targets, with corresponding benefits for patient care.[31]

In built up areas, pooled budgets may be able to facilitate the merging of two average providers into a single centre of excellence. This approach will

31. NHS Getting It Right First Time. Report on renal medicine. [link]

need to capture the lessons from previous attempts to centralise services—such as the reconfiguration of stroke services in London and Greater Manchester.[32] Any framework will need to strike the right balance between preserving access, the quality of care, and core service specifications whilst allowing 'warranted variation' to flourish. It would also be incorrect to infer that the current system has discouraged provider-led innovation. Within multiple sclerosis (MS), the use of care coordinators and administrators of breakthrough treatments has improved efficiency and freed up clinical time to be patient focused. COVID-19 itself has sparked innovation in service design and delivery - one of the few positives from the pandemic. And within mental health and eating disorders, the creation of provider collaboratives demonstrates the benefits of joint working to achieve better outcomes.[33]

Yet the interrelationship between provider collaboratives and the ICS architecture needs to be worked out (see box 4). With provider collaboratives there is a risk of 'make-or-buy' dynamics taking root, alongside a possible duplication with ICS objectives and muddying of the waters with purchaser-provider responsibilities.

Box 4: Provider Collaboratives

NHS England and Improvement define provider collaboratives as two or more NHS trusts/ foundation trusts working at an appropriate scale across places to join up services.

How we got here: The mental health Vanguard programme in the mid-2010s highlighted the benefits of different providers locally working together to solve problems.[34]

This led to the emergence of NHS-led provider collaboratives in 2020 – groups of providers in specialised mental health, learning disability and autism services. Some benefits have already been felt. In one example – the Eating Disorder Collaborative in the West Midlands – commitments to share residential capacity meant a dramatic reduction in out-of-area placements, with 34 patients moved back within the footprint in 2021 alone. The money saved has been re-invested in community services.

Looking forward: From July 2022 most NHS trusts will be required to be part of a provider collaborative. Broadly these changes sit outside of the legislative proposals in the health and care bill and have therefore attracted little scrutiny. However, our research has identified unresolved tensions between the role and function of provider collaboratives and the integrated care system architecture, including duplication and confusion of purpose. Careful attention will need to be paid to governance, geographical footprints, and culture to ensure that the model is successful.[35]

There needs to be a clear mechanism to evaluate success or failure. Policy Exchange understand that NHS England will remain ultimately accountable for commissioning services. However, it will be difficult, and perhaps intellectually undesirable, to try to retain tight control from the centre on every commissioning choice that the 42 ICS areas take. Yet

32. Fulop, N. Ramsay AIG, Hunter RM et al. Evaluation of reconfigurations of actue stroke services in different regions of England and lessons for implementation: a mixed methods study. NIHR Journals Library. 2019. [link]
33. Devine, J. Provider collaboratives: all win or no win. NHS Confederation comment. 13 August 2021. [link]
34. Naylor, C. Charles, A and Taggart H. Mental health and new models of care. The King's Fund. 2017. [link]
35. Wickens, Charlotte. Provider collaboratives: explaining their role in system working. The King's Fund. 2022. [link]

simply trusting ICSs to deliver against their priorities would similarly be unwise, with a significant risk of a return to the 'postcode lotteries' which characterised pre 2013 care. In setting out a framework for delegation, it will be important for NHSE to establish how they will evaluate success or failure. This should be agreed with ICSs ahead of the first delegations from April 2023.

Rushed reforms could lead to unintended consequences. NHSE is embarking on this process with the overarching principle that services should be commissioned as close to systems as possible. This is sensible in theory, although not in itself a justification for a big reform. From our conversations with patient advocates and specialist providers, there is nervousness about undertaking this change too fast and too soon. Specialised services are complex. Even for relatively common specialist services that were outlined Fig 8. such as (MS) or kidney dialysis – which arguably stand to benefit most from delegation – efforts to integrate must not take precedence over addressing first-order priorities around access, resource and addressing workforce burnout. Being suitable for delegation is not the same as being ready for delegation. Careful preparation is required, both from those in NHS England in designing the overarching framework, and at a regional and system level to ensure the necessary upskilling and capacity building has been undertaken.

We need to accept the variable starting points of ICSs. A small number of ICSs are well established, but the majority are immature organisations adjusting to new ways of working. Indeed, several ICSs have struggled to fill key leadership positions such as Chief Executive and Chief Nurse, with many health leaders seemingly choosing to stay within the Provider sector.[36] There has also been a suggestion that the proposed structure (with two boards) will lead to ambiguity over roles and responsibilities.

Evidence from previous reforms also suggests that too much emphasis is placed on structural change. Most improvement work is done by staff providing services – in NHS trusts, primary care, local authorities, the private sector and the voluntary and community sector.[37] We must therefore be realistic about what the new structures can and cannot achieve. As outlined in Chapter One, history offers useful lessons – the last big attempt to decentralise services in the early 2000s was beset with issues and overoptimistic planning.

There are undoubted risks to choosing to undertake this process in a staggered way. Allowing services to be delegated to a single, or multiple, ICSs in one region, but not in another could result in a confusion of roles and responsibilities. Too many different decision makers at a system, regional and national level involved in too many decisions could have a paralysing effect. These is certainly enthusiasm for trying new ways of working within the NHS – the system architecture as proposed in the Health and Care Act commands the broad support of the health and care community. It will be important for all organisations and actors to approach this new period for the NHS with the best of intentions.

The allocative mechanism is not yet clear. The financial architecture

36. The *Health Service Journal*. ICB jigsaws missing a piece of two. 12 November 2021. [link]
37. Ham, C. Governing the Health and Care System in England. NHS Confederation. 2022. [link]

that will accompany the delegation may seem a lesser concern when compared to pathway redesign and other factors covered earlier in this report. But we would argue that there are likely to be significant practical hurdles associated with NHSE's ambition to move towards a population-based funding approach. Our understanding is that the existing resource allocation formula does not consider deprivation adequately, or particular groups in society who may have specific healthcare needs which are currently provided through specialised commissioning (for example, Ashkenazi Jews in North London). Relying on the current formula may therefore exaggerate current inequalities in accessing care amongst historically underserved groups. We understand that NHSE will be preparing baseline figures for calculating system-based allocations for specialised services spend. It is important that due care and attention is given to service provision which crosses boundaries. This includes open access services, such as for sexual health, which are planned in the assumption that they may cater for patients from different geographies.

The approach could create significant bureaucracy for specialist providers. Alongside the transactional burden outlined above, the governance and reporting mechanisms of having to report to multiple commissioners (under a joint commissioning, NHS-led or ICB-led) frameworks) will carry additional complexity. There is a risk that in a desire to retain central control, the result is too many 'seats at the table' with a dilution of reporting roles and responsibilities. Given that change management is a scarce resource within the NHS, we would like to see an impact assessment of the administrative and managerial burden associated with these reforms. The potential upsides for patient care must justify the behind-the-scenes upheaval.

Within this, there will be important considerations around **responsibility for capital spend.** Specialised services tend to be more capital-intensive in their nature – and providers (particularly large tertiary hospitals) have grown accustomed to managing their own capital programmes and developing business cases for national approval within NHSE, DHSC and HM Treasury. Often these business cases are contingent on treating patients from a wide catchment area. There are clearly attractions associated with ICSs taking on capital responsibilities for the wider system – for example in order to reconfigure the primary care estate, or to accelerate the rollout of Community Diagnostic Centres. However, several specialist providers have built up significant cash reserves which they are no longer able to deploy, as capital budgets are now controlled at a system level as part of three-year settlements agreed following the November 2021 Spending Review.[38]

The regime therefore risks penalising specialist providers. It will be important for decisions to be made in close consultation with the boards of specialist providers – with arbitrary criteria (such as the requirement for all business cases to show how they will serve the ICS population) resisted at all costs.

Difficult decisions lie ahead on the status of the NHS Regional teams.

38. NHS England. 2022/23 Priorities and Operational Planning Guidance. February 2022. [link]

Some senior NHS leaders have argued that the creation of ICSs will negate the need for fully resourced NHSE regional teams. It is certainly true that a powerful 'intermediate tier' between the centre and organisations delivering care was more justified in an environment of 200+ CCGs. With much larger footprints of 1 million – 2.5 million people, and each controlling budgets in the region of £5bn, Integrated Care Boards are expected to take on more autonomy over time, with regional teams working to support their priorities.[39]

In a recent report for the NHS Confederation, Sir Chris Ham called for regional offices to become 'thinner' as ICSs take on more responsibilities, and should work with ICSs as equal partners rather than performing a reporting and performance management function as they have done in the past.34 However – as outlined in earlier chapters – the regional function has an important role supporting the commissioning of specialised services. This sits alongside, but separate to, the region's responsibilities for the quality, financial and operational performance of all NHS providers in their region. Policy Exchange agrees with the Ham report that careful consideration must be given to the distinctive contribution that regional offices can make to the future system architecture. There is a risk that in a desire to empower ICSs, a loss of expertise in the commissioning of specialised services occur as teams are restructured or redeployed. This could exacerbate issues with cost control, and ultimately diminish the quality of specialised care.

The risks of delegation include a dilution of expert patient and clinical voice. Whilst existing patient and public voice (PPV) platforms are likely to continue there are concerns about the extent to which patient advocates will be able to continue to champion their needs and input into service design. Pushing commissioning responsibility to individual or pan-ICS level has practical consequences for the VSE sector, many of whom provide existing add-on services such as running clinical network groups. Their ability to continue to do this will ultimately come down to funding, but it is unlikely that many of the small charities who currently serve their communities through representation to the centre would be able to replicate this approach across 42 different footprints.

Reforms must be underpinned by proportionate political accountability and oversight. Our research has found that the changes to specialised services have been largely overlooked in the passage of the Health and Care Act 2022. This lack of political oversight and scrutiny over such a large and growing area of NHS spending should concern stakeholders. That is perhaps not a surprise. This is a technical area of the NHS, with the Specialised Commissioning Directorate possessing a higher level of autonomy compared to other parts of NHSE. One interviewee described it as a 'fiefdom' with its own organisational silo, culture, and priorities. Previous research has observed that the strength NHSE – by some margin the most complex arm's length body in England – makes it challenging for DHSC to act as an appropriate sponsor for its work.34

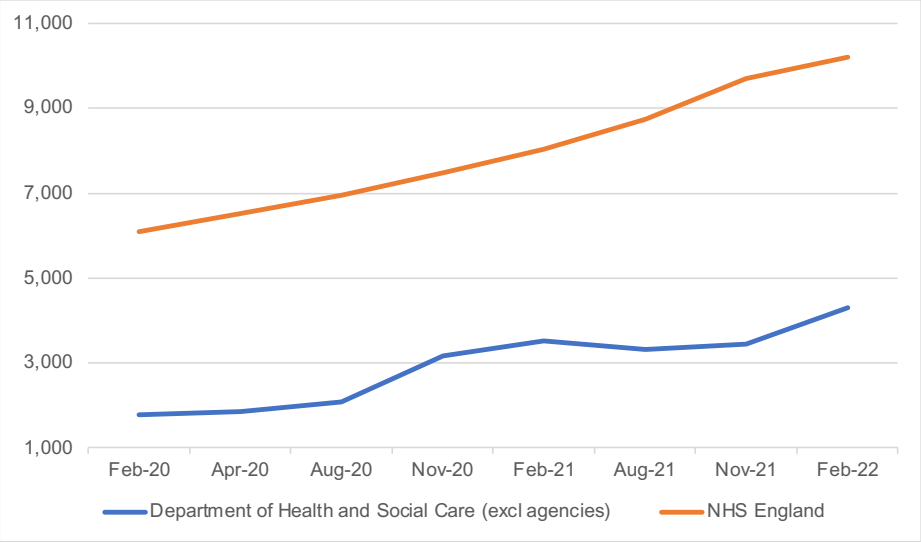
There is a persuasive argument to see more joint working across DHSC

39. NHS England & Improvement. NHS System Oversight Framework 2021/22. 2021. [link]

and NHSE, specifically through joint or merged programme teams. The objectives of this exercise would be to achieve better alignment, streamline existing reporting and compliance functions, and provide improved political oversight on spending. Such an approach is already taken to other priority areas such as the New Hospital Programme.

This should eventually lead to a significant consolidation of roles at the centre. The total headcount of both DHSC and NHSE has also expanded significantly throughout the COVID-19 pandemic (see Fig 9). Total headcount at DHSC (excluding agencies such as the UK Health Security Agency) increased by 141% between February 2020, and February 2022. The total workforce of NHSE staff also grew by 67% from 6,102 to 10,215 in the same period, with particularly significant growth in the proportion of senior roles (see Fig 11).[40] By comparison, the number of nurses working in the NHS in England rose by just 7% from 298,632 to 319,806 in the same period.[41] This continued growth in the size of the centre should not be deemed sustainable as we move from pandemic to endemic. In future we expect to see greater emphasis on collaborative and joint working, especially on priority policy programmes.

Figure 9: Total workforce headcount increases over the COVID-19 Pandemic - DHSC and NHS England[42]



The process should be aligned to the Public Bodies Review Programme recently launched by the Cabinet Office.[43] Any available capacity should be redeployed to ICSs and providers where it can make the most difference.

40. The Health Service Journal. Huge Increase in staff at DHSC and NHS England & Improvement. 19 October 2021. [link]
41. NHS Digital. NHS Workforce Statistics – January 2022 (including selected provisional statistics for February 2022). [link]
42. DHSC workforce management information. Monthly releases. 2020-2022. [link]. We have used total headcount (including non-payroll staff)
43. Cabinet Office. Public Bodies Review Programme. 26 April 2022. [link]

Figure 10: Growth in total wage bill over the COVID-19 Pandemic - DHSC and NHS England

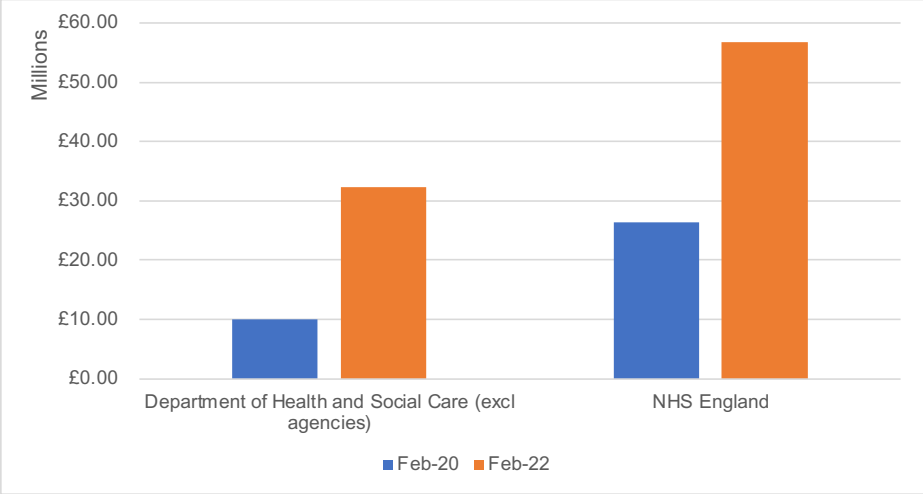
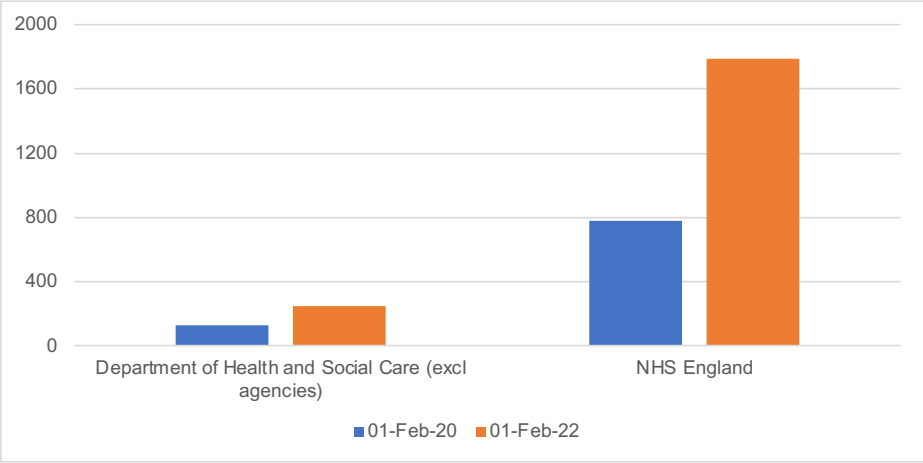


Figure 11: Growth in senior roles over the COVID-19 Pandemic - DHSC and NHS England[44]



There are implications for the clinical workforce. There are widespread and well-documented shortages in workforce within most specialisms. There are more than 100,000 vacancies across the NHS and many think tanks have argued that a lack of front-line staff will be the rate limiting factor that inhibits the recovery of services to pre-pandemic levels.[45] Yet as others have observed, the NHS workforce issue is as much about achieving the correct mix of staff. Equipment matters too; research shows that consultants are more productive in hospitals which have invested in their infrastructure.[46] A return to general physicians, whose breadth of expertise means they can be applied to both acute and chronic health problems, has also been mooted as a possible solution.[47]

There is an important interplay here for specialised services. Several interviewees in our research referred to workforce challenges which have arisen through over-specialisation. As one roundtable participant put it: "do we really need five experts in one area, where the need is for consultants who can work across an ageing population with multimorbidity?"

44. Senior roles are defined as those receiving a Senior Civil Service pay award for 2020 (ranging from £71,000 - £208,100 per annum) [link]
45. The King's Fund. Response to latest NHS staff survey. 30 March 2022. [link]
46. The Health Foundation. A year of plenty? An Analysis of NHS finances and consultant productivity. 2017. [link]
47. Vaughan L. Nuffield Trust comment. "It's not just about the front door of the hospital: lessons from the medical generalism in smaller hospitals study". 2021. [link]

Encouraging providers to work across silos could help achieve more optimal workforce planning for relevant geographies. This must be done with care to not lead to a significant dilution of expertise in specialised areas. However, it should be signalled as the direction of travel in an era of resource constraint, with the Government suggesting that any workforce planning must be funded through existing budgets.[48]

Efforts to strengthen the financial sustainability of specialised services must 'dock' with the wider Government agenda. Previous attempts to wrestle budgetary control have floundered, but there is a consensus that this should be looked at again. Our understanding is that responsibility for setting medicines strategy will remain at the centre, although the budget itself will be delegated to ICSs along with the services. This new arrangement will bring further complexity; including a risk that in-year system budgets lead to perverse incentives. This could lead to an ICB choosing to ration the prescribing of medicines despite the existence of the national allowable growth rate which caps annual growth at 2% with anything above this level paid back as a rebate [see Box 3]. The bargaining power of the NHS is likely to be best achieved if the system can continue to negotiate and spend on medicines as one. The Specialised Commissioning team will therefore need to work closely with the Commercial Medicines Unit within NHSE to assess the growth of in-year budgets and how these relate to the voluntary scheme for branded medicines. Critically, this collaborative approach must 'dock' with other Government priorities, including those set out in the recent Life Sciences Vision.[49] A move towards joint teams and programmes across DHSC and NHSE may be an important facilitator.

The positive case for change must be clearly stated. Whilst there may be a consensus around some of the current issues within specialised services, the NHS needs to communicate clearly what the objectives of this exercise are. The Government has indicated that all specialised services will continue to meet nationally determined standards, although these will be slimmed down and simplified to become more accessible. This is welcome. There has been no shortage of lengthy guidance from 'the centre' in the past six months, with a tsunami of documents, priorities and responsibilities – from the Operational Planning Guidance from NHS England to the annual mandate from DHSC which set thirteen priorities.

We need to find a better taxonomy

Throughout this process, we have been reminded that talking about 'specialised services' is too broad. Each of the 149 services are distinct. Attempting to manage their policy direction for such divergent services as a collective might be the biggest failing of specialised commissioning to date. As policymakers review specialised commissioning as part of the delegation process, there is an opportunity to determine a better and more appropriate taxonomy. This would for example divide services based on their respective needs, from conditions which are episodic and syndromic, to those such as disorders and degenerative conditions which have a greater level of interface with other parts of the system.

48. The Health Service Journal. Javid: No increase in NHS funding to address workforce needs. 8 March 2022. [link]
49. UK Government. The Life Sciences Sector Vision. 2021. [link]

Chapter 3: Conclusion and Policy Recommendations

The decision has already been taken to undertake a major reorganisation of the NHS as we emerge from the pandemic. This report shows that adding the upheaval of specialised commissioning into this equation could be disastrous for patients and the taxpayer if done badly. The upside of any change must justify the short-term disruption.

"I recall there being a lot of lobbying in 2012 to be within the definition of specialised commissioning. It was seen as an important way of elevating a condition's responsibility and priority".
Roundtable participant, 2022

In chapter one, we considered the history of specialised services and tried to explain why it has remained in the 'too difficult drawer' since the most-recent reforms a decade ago.6 In chapter two, we set out a series of areas – from the management of capital allocations to the workforce – where the proposed structural changes could have wide-ranging implications. As with all major reforms of the NHS these will produce both positives and negatives. The challenge will be to deliver against the ambitions whilst ensuring that risks are managed.

Central to this will be the relationship (and buy-in) of various interest bodies that define the specialised commissioning landscape. In 2012, there was a perception that it was in the interests of conditions to achieve specialised designation. This in turn has further strengthened the position of specialist providers within England. Arguably substantial benefits have accrued for those groups over the past decade.

Choosing to unwind elements of this will cause disruption for those groups – for example a charity would need to be structured differently to represent the needs of their patients across multiple ICS geographies. Tertiary hospitals will need to adjust to new ways of working which involve less direct decision making and autonomy. The benefits of the new approach won't also be immediately obvious, so there will be a natural inclination amongst some to lobby in favour of the status quo. NHSE must accept this, and ensure it is as consultative and open in its approach as possible. Forcing the delegation on services too quickly is likely to backfire. Far from a big-bang as ICSs go live in July, what instead is required is a gradual transfer of certain services and functions. History shows us that cracking reform in specialised commissioning won't be easy. But there are big prizes on offer – for patients, for the taxpayer and for the NHS, if we can get this right.

Policy Recommendations

This report sets out a series of recommendations which we would like to see taken forward.

Our summary of these reforms is as follows: the breadth and size of the specialised commissioning portfolio is too large, and this is a good moment to separate it into more logical groupings. However, the delegation process is not without risk, and should therefore be divided into stages.

Initially there should be a focus on devolving commissioning responsibility for the 'dead certs' – more commonly used services such as chemotherapy, specialist mental health, adult cardiology and dialysis where there is a high degree of interface with other parts of the system and a low level of justification for retaining central commissioning responsibility in an era of population-health. Even for these relatively common condition areas, there will still be enormous complexity associated with devolution – as the dynamic between NHSE at the centre and ICBs remains unclear.

These initial delegations should begin from April 2023 and be aligned to the sign-off of five-year system budgets. Services which the case is weaker should retain under central commissioning responsibility, with any delegations deferred until 2024/25 at the earliest. It is important to learn the lessons from previous attempts at reform, such as the over-devolution in 2002.

Our policy recommendations seek to set out steps that should be taken by DHSC, NHS England, ICSs, specialist providers and other bodies to learn the lessons from previous unsuccessful attempts at reform. These are broken down into governance and oversight; delegation approaches; patient input, financial control and workforce.

Delegation framework and approach

1. NHSE should announce its intention to **pilot delegation amongst a small set of services from April 2023 at the earliest**. Suggested services include dialysis, chemotherapy, specialist adult cardiology, and mental health. The NHS should also consider delegating services initially to a small number of 'trailblazer' ICSs which have reached organisation maturity. All delegation must involve close collaboration with the existing NHS regional teams.
2. NHSE should publish its **emerging framework and guidance for the delegation of services in advance of the 'go live' date of ICSs in July** to allow for proportionate scrutiny. This should include a feasibility study and impact assessment.

Governance, and oversight

3. **Both DHSC and NHSE should commit to undertaking a review of their workforce**, with the intention to reduce headcount at the centre. The objectives of this exercise should also include greater alignment of DHSC and NHSE, including through running joint policy programmes, to streamline the policies, strategies, and guidance from the centre. The review should feed into the ongoing Public Bodies Review Programme led by the Cabinet Office. This should in turn enable greater political oversight and accountability for specialised commissioning strategy.
4. **There should be a commitment to redeploy specialised commissioning expertise from NHSE to ICSs or regional offices to support emerging ICSs in their commissioning responsibilities.** This will be gradual and focus initially on the commissioning teams working on services such as dialysis, mental health, specialist adult cardiology, and chemotherapy. Roles could be via secondment or permanent redeployment. Necessary relocation incentives may be required.
5. There should be a **renewed emphasis on data recording and transparency on specialised services**. This should include linkage across primary and secondary care for conditions not incorporated within the NHS Spine (which supports the IT infrastructure in England). Historically, the quality and coverage of specialised services activity data has been poor, and it continues to fail to include the influence of high-cost medicines.
6. As part of the new delegation regime, the NHSE Specialised Commissioning team should announce a **series of accompanying reforms to ways of working**. These should include:
    - Increased transparency over the cost of providers for services. This should be published in the public domain on an annual basis.
    - A commitment to review any service specification which is either older than six years, or where major new treatments or techniques have been introduced within that timeframe. Refreshed service specifications should include mandated data collection as a basic requirement of providers, and ensure outcomes are defined against the latest standard of care as opposed to historic processes.
    - A stocktake of data collection in specialised services, including working closely with relevant GIRFT initiatives and patient representative groups to minimise risk of duplication. The stocktake would assess whether the appropriate data collection is in place to support measurement of progress against the desired clinical outcome.
7. A **Governance framework for provider collaboratives and their relationship with ICBs** should be developed by NHSE and be

published ahead of the 'go live' date in July 2022. The most recent guidance on Provider Collaboratives was published in 2021 prior to the Bill achieving Royal Assent and made only brief reference to the risks and accountabilities that will come with providers playing a fuller role in the designing and planning of services, alongside their traditional delivery role. The new document would contain practical tools and explain how to draw upon the lessons from provider collaboratives in mental health, such as the management of conflicts-of-interests, including over 'make or buy' decisions.

Patient and citizen input

8. Each ICS which accepts responsibility for commissioning a delegated service should **involve patients and their carers in service design**. This would be best achieved through a hybrid approach which draws on the insights from national patient charities and on-the ground service users through the new Integrated Care Partnership. It is unlikely to be suitable for rarer conditions, and all highly specialised services, which will remain under central commissioning control.
9. One specific policy idea would be to ringfence a **proportion of the rebate from the current and future VPAS scheme** to be allocated towards patient and advocacy groups, enabling them to resource activities at an ICS level. Patient and carer input into service design is of critical importance. However, charities are concerned about their ability to engage across up to 42 different geographies. We would suggest that the initial pot is £20m to cover the first two years of ICS implementation, and the remainder of the current VPAS scheme which runs until 2024. This would equate to around £240,000 per ICS per year. Grant requests would need to be made and the pot would be controlled by a steering committee led by a senior former executive within the third sector. The Secretariat would be provided by DHSC, with input from NHSE and the PPV Assurance Group. A weighting criterion would be deployed to ensure that smaller charities would not be disadvantaged. This would exist separately to and independent of any allocation mechanism than pharmaceutical companies have in awarding grants to patient advocacy groups directly.

Financial control

10. **Responsibility for medicines procurement, strategy and policy should remain at the centre within NHSE**, but with greater input and alignment with DHSC and wider Whitehall agendas. Responsibility for medicines spend should be delegated alongside services on a case-by-case basis.
11. **NHSE should proceed with extreme caution in moving to a**

population-based allocation mechanism, to reflect the unique costs associated with delivering some specialised care. A review to the national funding formulary may be required. Initial baseline allocations should be based on pre 2020 figures (adjusted for inflation) to exclude any possible extreme effects of the pandemic on activity.

12. DHSC and NHSE should regularly review the impact of the **introduction of the aligned payment and incentive system across all specialised commissioning contracts,** given the risk that this adds a considerable financial complexity and burden for providers who require funding for multiple geographies. This should include assessment, so that costs borne by one part of the system (e.g., transportation) are factored into assessment of new technologies such as suitable home therapies.
13. DHSC should commission an **independent review of procurement and holistic commissioning in specialised services**. The review would look at all priority areas of spend, including devices, and medicines, and should be led by a former Government official with familiarity of medicines spend but also the interrelationship with industrial strategy. The review should interview patients to understand their experiences of different care, and how improved approaches to procurement can deliver on the 'triple aim' within the Health and Care Act whilst addressing health inequalities. The scope of the review would encompass an evaluation of novel payment mechanisms, to reflect the 'true value' of medicines across the pathway, the interrelationship with integrated care budgets, and the anticipated arrival of very high-cost medicines with curative potential and long-term benefits. The review should be announced this year and report in 2023, to inform ongoing procurement frameworks including the negotiations over the replacement to the existing Voluntary Scheme for Branded Medicine Pricing (VPAS).
14. DHSC and HM Treasury should commit to **greater transparency over the use of the rebate from the existing VPAS scheme within the NHS**. ICS footprints should also have sight on rebate payments with measures introduced to ensure that they benefit from the high-degree of price control achieved through the cap on in-year sales.
15. **Integrated Care Boards must include a specific impact assessment on specialised services as part of their capital and estates plans**. There should be sufficient flexibility in capital programmes to approve projects where the benefits will be derived beyond the given geographical footprint.
16. **NHS England/Improvement and DHSC should introduce a ringfenced capital spending pot for nationally significant specialised projects**. New capital rules set a system-level allocation on capital spending.[50] This is likely to constrain the ability for

50. NHS England and Improvement. Capital guidance 2022 to 2025. April 2022. [link]

hospitals delivering specialised care to make nationally strategic, transformational investments in equipment or facilities, especially when those are designed to serve a broader catchment area than the ICS itself. For the short-medium term, DHSC should consider allowing for an appropriate degree of ring-fencing of capital budgets. This is consistent with other national priority areas such as the New Hospital Programme and reflects that a significant proportion of specialised services will continue to be nationally commissioned.

Workforce

17. The upcoming framework 15 workforce plan being developed by Health Education England (HEE) within NHSE should explore the balance between and prioritisation afforded to **super specialisation and generalist roles in training.**

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