**SHCA Briefing Materials for Westminster Hall debate on national commissioning of NHS specialised services**

**Thursday 15th January, 1.30pm. Led by Stephen Gilbert MP.**

**What are specialised services?**

**Specialised services are those which cannot sensibly be planned, procured and**

**provided at a local level**, typically covering a population of more than one million

people.

Specialised services matter to everyone. The Health and Social Care Act

2012 enables the Secretary of State for Health to prescribe (specialised) services to

be commissioned directly by NHS England having regard to:

* the number of individuals who require the provision of the service or facility
* the cost of providing the service or facility
* the number of persons able to provide the service or facility
* the financial implications for clinical commissioning groups if they were required to arrange for the provision of the service or facility.

Collectively, specialised services treat **hundreds of thousands of patients every year.**

Many specialised services provide for people with rare genetic disorders, while

anyone might need to call upon others, such as those for spinal injuries and serious

burns. In April 2013, NHS England became the sole direct commissioner of all

specialised services. **The budget for these services in 2015/16 is £14.6billion.**

**What is national commissioning?  
  
Specialised services are best planned at larger population levels.**

Funding of specialised services from local budgets previously led to unacceptable local variation in access to treatments, and fragmentation of expertise in commissioning these services.

The most complex services benefit from **centralisation and specialisation** of care, with higher numbers of procedures offered in a smaller number of centres, so that **clinical expertise can be developed to increase patient outcomes**.

National commissioning, with a consolidated budget, can enable sensible planning of these services for the benefit of people in all localities**. This attracted cross-party support during the passage of the 2012 Act.**

* In 2010 the Health Select Committee reported that, when specialised commissioning fell to local Primary Care Trusts it sat **“in a ‘limbo’, where it is not properly regulated, performance managed, scrutinised or held to account.”**

**The threat posed by co-commissioning**

Patient organisations and others representing those with rare and complex conditions have raised significant concerns at proposals published by NHS England in November 2014 on the future funding of specialised services.

* An unpublished NHS England report from March 2014 describes the benefits of the current system of national specialised commissioning:

*“The development of this set of new national specifications and*

*policies, for our services, is a significant achievement given that there*

*was limited national consistency prior to the establishment of NHS*

*England.”*

Despite this – NHS England is pressing ahead with plans to introduce co-commissioning of specialised services with local CCGs.

**While NHS England remains resistant to publishing full details of its proposals for co-commissioning, in recent weeks a number of key pieces of information have emerged which give a clear direction of travel.**

**NHS England’s five principles for co-commissioning include a “move towards population accountability and lay[ing] the groundwork for ‘place based’ or population budgets”. This is inconsistent with continued national budget holding for specialised services. A second principle is to “enable better allocation or investment decisions, giving CCGs and their partners the ability to invest in prevention or more effective services.”   
  
The same Board paper, from November 2014, also pledges NHS England to “devise a model whereby any underspend in a locality’s specialised commissioning budget will result in that funding or a part of it being attributed to the CCG and hence available for local investment at the CCG’s discretion.”  
  
In December, notional allocations of the specialised budget were published for each CCG. Significantly, only £1.08bn of the £14.6bn specialised budget was allocated to national commissioning – or ‘tier one’ services – including the Cancer Drugs Fund. This confirms that the overwhelming majority of specialised services, with the exception of highly specialised services, would fall into co-commissioning.  
  
While NHS England must retain budget and formal responsibility for specialised commissioning in 2015/16, the direction of travel towards local population budget holding in future is clear.**

IVF provides a salutary warning of the risks of returning to local influence in commissioning specialised services. Currently 80% of CCGs provide less than the three cycles of IVF recommended by NICE guidance.   
  
One GP member of a CCG said: *“It might benefit two of my patients. I couldn't look the other 1,998 in the eye if I voted in favour of it.”*

**Patient groups’ views**The Specialised Healthcare Alliance conducted a survey of patient organisations, expert clinicians and industry in late 2014.  
  
The results showed that, with over 100 responses:

* 90% of respondents preferred their service to remain part of specialised commissioning – none favoured leaving specialised commissioning.
* 82% of respondents favoured either no change to commissioning responsibilities for their service or for more of their service to be incorporated within specialised commissioning. 9% opted for more commissioning responsibilities to fall to CCGs.
* On the subject of co-commissioning, while respondents were open to collaboration between NHS England and local commissioners, only 15% of respondents would be happy to see this include pooling of budgets.

**Changes to the National Tariff for specialised services**Members of the Specialised Healthcare Alliance are alarmed by NHS England and Monitor’s proposals to introduce marginal rates of 50% for specialised services above the stated baseline.   
  
The concern is that this will effectively ration access to treatment, especially for the most complex and prospectively expensive patients, where the cost of externally purchased devices and drugs may account for a substantial proportion of total treatment costs and will also be affected.   
  
This effect seems likely to be exacerbated by the matching payment for patients below the stated baseline. In particular, the opportunity to make savings from underspending might prompt providers to shift spend towards less expensive patients, leading to disinvestment in more costly procedures and the rationing of some services. Conversely, CCGs are being promised the proceeds of reduced spending, which may introduce perverse and detrimental incentives around referral.  
  
In considering whether or not to implement the proposals, the pursuit of quality and safety should be paramount. In particular, paying trusts for doing nothing seems to contradict the Five Year Forward View’s commitment to increase patient volumes with providers where the relationship with quality is strong. Indeed, it seems perverse to penalise providers who deliver the best outcomes for patients and who require financial certainty to underpin their investments for the longer term.   
  
**Further information is available on request to** [**team@shca.info**](mailto:team@shca.info) **or by calling 0203 1787 573.**