Annex E

Integration of specialised services with local health and care systems

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Contents

1 Introduction and case for change

1.1 Integrating specialised services

1.1.1 NHS England is responsible for commissioning £17.7bn[1] of specialised services. Specialised services are prescribed in legislation and support people with a range of conditions, including many that are rare and/or complex. These services tend to be provided in relatively few hospitals and accessed by comparatively small numbers of patients. The 149[2] services that make up the specialised portfolio range considerably from the higher volume services such as renal dialysis or chemotherapy, through to secure inpatient mental health services, and at the other end of the spectrum treatments for rare cancers and life threatening genetic disorders or complex medical conditions.

1.1.2 Many of the specialised services that NHS England commissions are part of broader care pathways that include services commissioned by clinical commissioning groups (CCGs) and local authorities. For example, services for patients with kidney disease are commissioned by CCGs whereas services for patients with kidney failure are commissioned by NHS England. This split in responsibilities and associated budgets can sometimes lead to misaligned incentives, underinvestment in upstream or preventative interventions, and fragmented care for patients.

Box 1: Example of why integration is important for mental health
Too many children and young people are being sent for inpatient mental health care, which sometimes can be many miles from their home. This can make visiting difficult for friends and families, affecting recovery and increasing length of stay. By improving access to community support, preventing avoidable admissions and building capacity locally we can reduce the number of children who require inpatient mental health care and minimise the distance that they are away from home. Mental health new care models have been part of this process, and further joining up commissioning responsibilities may help strengthen the provision of these alternative services

1.1.3 Bringing local systems and national commissioners together for the purposes of planning services is intended to:

- ensure that plans are based on the specific requirements of the local population; and
- give local systems more say in how specialised budgets are spent in their area and make greater use of their insight into local patient needs.

Box 2: Example of why integration is important for cancer
Lung cancer is the most common cause of cancer death for men and women each year and 80% of cases are attributable to tobacco exposures. Upstream interventions such as smoking prevention and cessation are effective forms of preventative intervention and decrease the need for treatment later on. Late or missed diagnosis is a major factor in determining

[1] The specialised commissioning budget for 2018/19
[2] The number of services in December 2018

cancer mortality and delayed diagnosis can have a negative impact on quality of life, with less likelihood that surgery will be effective and greater use of more toxic treatments such as chemotherapy when cancer is diagnosed at an advanced stage. Public awareness, screening programmes and training and support to primary care and other health professionals is needed to improve early diagnosis. Therefore, involving local systems in decision making could enable commissioners to make decisions of where spend adds best value.

1.1.4 Place-based planning helps to ensure the right commissioning environment for these new approaches to provision; setting the strategic direction and expected outcomes whilst enabling providers to respond with their own proposals for person-centred, population-based care.

1.1.5 Moving to place-based arrangements for specialised commissioning does not represent a move away from a fair and consistent approach to specialised service provision throughout the country. NHS England will remain accountable for commissioning specialised services, which will continue to be supported by national standards of care, service specifications and clinical policies determined by NHS England.

2 Specialised services planning boards

2.1 Developing planning boards

2.1.1 Our objective for 2019/20 is for all local systems, through Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), to have an advisory role on NHS England-led specialised services planning boards. Each planning board will decide on the services it will prioritise, but it is likely that they will focus initially on services where there is a clear overlap with locally-commissioned services, which could include cancer, mental health and learning disability, and potentially renal and some cardiovascular services.

2.1.2 A more specific breakdown of which services may be most suitable can be found in NHS England's *Commissioning Intentions for Prescribed Specialised Services 2017-19* which included a segmentation of the specialised services portfolio to determine those that may benefit most from more integrated approaches. Table 1 below summarises this segmentation. We propose that those services that can be commissioned on a population footprint of less than 10 million are most suitable for joint planning.

Table 1: Summary segmentation of specialised services

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

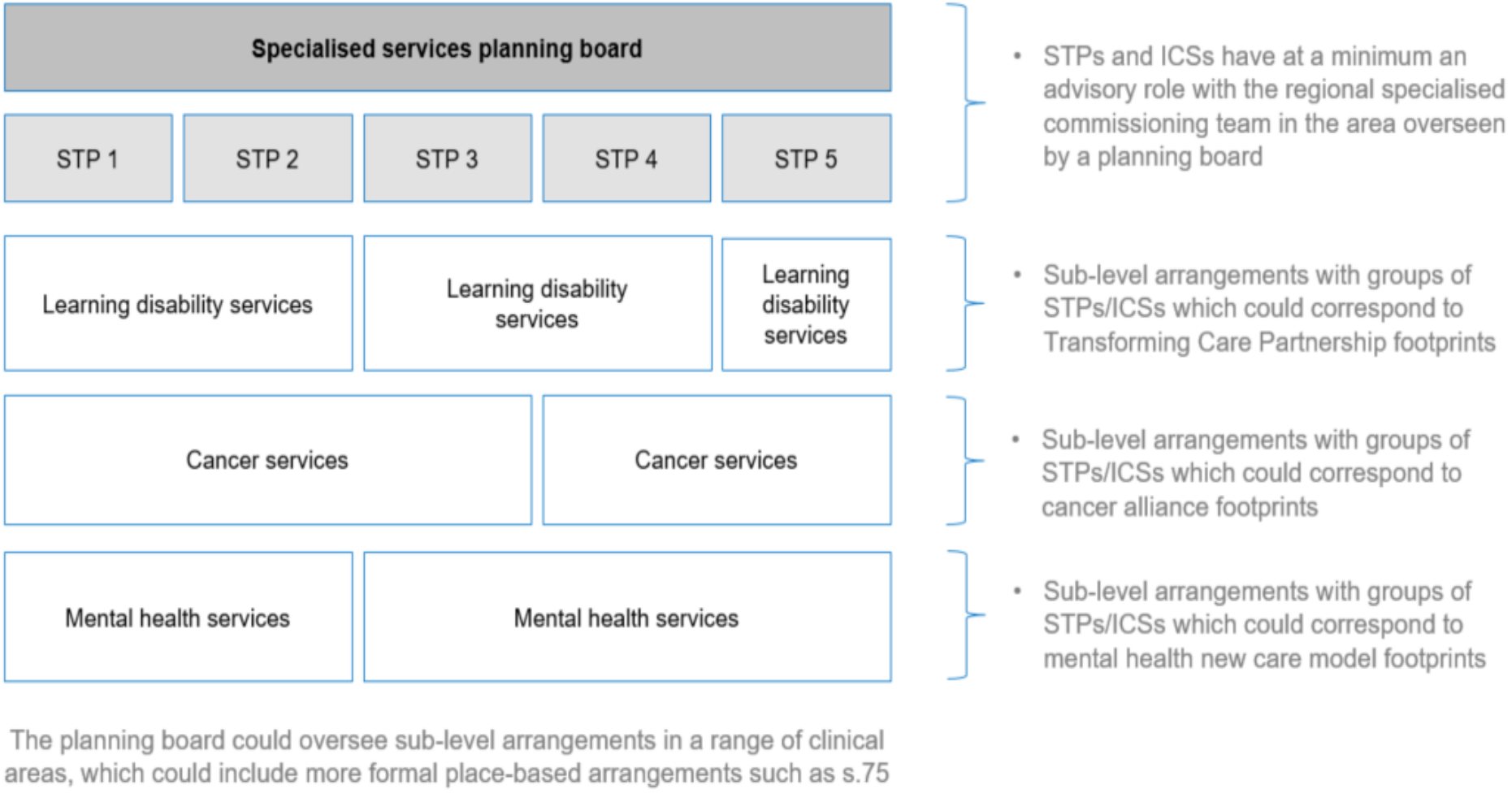
2.1.3 Over the next 12 months setting up or, where they already exist, strengthening these planning boards should be a priority for specialised commissioners and local systems. Whilst accountability and responsibility for commissioning specialised services will remain with NHS England, planning boards should

have real influence over the future shape of services. Specialised budgets will similarly remain with NHS England, but specialised commissioners and CCGs should share information on spending to allow them to make better decisions about how resources are used for their local population.

2.1.4 Whilst NHS England-led planning boards will be the appropriate vehicle for delivering better integration in many areas of the country, in other areas, and in particular where existing relationships with local systems are strong, alternative collaborative mechanisms led by STPs and ICSs themselves may be more appropriate. The type of arrangement pursued will depend on a range of factors such as the size of STP footprint, maturity of plans and the local provider landscape.

2.1.5 Figure 1 demonstrates that the planning board would be developed on a multi-STP footprint that the regional commissioning team determines is practical in relation to patient flows, and would oversee specialised services across several STPs. The arrangements overseen by a planning board are likely to encompass existing partnerships at STP or multi-STP level, such as cancer alliances, transforming care partnerships, or mental health new care models, and may also cover existing operational delivery networks or clinical senates. The appropriate footprint for each arrangement may vary.

Figure 1: How a specialised services planning board could oversee a range of place-based arrangements



2.1.6 Table 2 includes some suggestions for how planning boards could be set up. Their core membership of planning boards should include:

- NHS England specialised commissioners
- STP and ICS representatives (commissioner and provider)
- Clinicians
- Patient and public lay members

Table 2: Suggested specialised services planning board responsibilities

Work area	Role of the planning board
Specialised commissioning strategy and planning	• Oversee and support the development of strategic plans for specialised services in the area. • Clarify how a more integrated approach would improve patient outcomes and experience and system efficiency.
System, service and provider transformation	• Ensure that all plans for system transformation, e.g. the development of new care models, are aligned. • Review and input into NHS England regional service change programmes, and any proposed provider reconfiguration.
Governance and risk management	• Review risk registers and mitigation plans for the services in question. • Clarify any risk/benefit sharing arrangements. • Ensure that planning boards are integrated into wider governance structures (i.e. NHS England regional governance, and the governance structures for collaborations such as Cancer Alliances or Transforming Care Partnerships).
Quality, finance, contracting and performance oversight	• Review quality, finance, contract and performance data, agree remedial actions and review investment cases - reporting to the NHS England regional structures. • Ensure the use of the National Commissioning Data Repository (NCDR) across the geography to support transparency of specialised services spend and activity information.

3 Developing more advanced place-based arrangements for specialised commissioning

3.1 Overview

3.1.1 We know that some local systems want to integrate specialised services even further into local care pathways, for example by pooling budgets, appointing staff to posts that cover both specialised and non-specialised services, or delegating the specialised commissioning budget. Figure 2 below suggests what the process could look like for developing these more advanced approaches to integration.

Figure 2: Development process for advanced place-based specialised commissioning arrangements

3.1.2 In practice, the type of services and the type of collaboration will vary across the country. For example, some STPs may need to collaborate with neighbouring STPs in order take on a greater role in the planning and delivery of specialised services either due to population size or the provider landscape.

3.2 Options for more advanced arrangements

3.2.1 The current legislative framework means, regardless of the collaborative arrangements in place, NHS England retains formal responsibility for the commissioning of specialised services.

3.2.2 We have identified the following three options which are possible within the current legislative framework to support better integration of specialised commissioning with local systems[3]:

1. **Pooled budgets** between NHS England and CCGs, covering specific jointly prioritised service areas, underpinned by section 13V of the NHS Act 2006. This approach can help to create shared incentives for service improvement and requires a joint approach to risk sharing and decision-making.

[3] When we use the term 'local system' here we mean CCGs operating on an STP or ICS (or multiple STP/ICS footprint)

2. **Joint appointments** between NHS England regional specialised commissioners and local commissioners could provide the appointee with responsibility for a range of CCG commissioning functions as well as NHS England's specialised commissioning. This could, in some cases, complement a S13V pooled budget. This approach would ensure that there is an individual or individuals with specific responsibility for integrating services.

3. **Internal delegation** of specialised commissioning may be possible where STP, ICS or devolution areas are proposing to take on responsibility for a wider set of functions that are usually carried out by NHS England, for example other direct commissioning functions. This approach can help to achieve some of the advantages of delegation, such as local ownership of the planning and commissioning of specialised services, and reducing fragmentation, but without formally moving budgets or accountability. In Greater Manchester, for example, the Greater Manchester Health and Social Care Partnership's Chief Officer is an NHS England employee and, as part of the devolution arrangement, has delegated responsibility for a number of NHS England functions, including certain aspects of specialised commissioning.

3.3 Pooled budgets

3.3.1 In many service areas, separate budgets for specialised and non-specialised services can impede the development of effective pathways and contribute to sub-optimal patient experience and outcomes.

3.3.2 A section 13V agreement establishes a pooled budget between NHS England and a CCG or group of CCGs. This enables all commissioners that are part of the arrangement to determine how best to spend the totality of the funds across the specialised and non-specialised elements of the pathway. It could also put commissioners in a better position to work collaboratively with providers to improve overall service planning, efficiency and outcomes.

3.3.3 Local systems that wish to pool budgets using the section 13V provision will need to demonstrate that there is a clear rationale for each service area. This should include demonstrating why the pooling of funds would enable better patient experience and health outcomes.

3.3.4 Section 75 partnership regulations enable budgets to be pooled across NHS commissioners and local authorities as well as establishing joint commissioning arrangements. Section 75 regulations may therefore be most applicable for those pathways that span local authority commissioned services such as social care; they are not permitted to cover invasive treatments and are therefore only relevant to a proportion of specialised services.

Box 3: Example of why integration is important for learning disabilities

The NHS has publicly committed to closing inappropriate and outmoded inpatient facilities for people with a learning disability and/or autism. Transforming care partnerships (TCPs) consisting of CCGs, local authorities and NHS England regional specialised commissioning teams have been

established with this joint ambition. One of the key challenges TCPs face is how to redirect funding from some services (such as specialised, inpatient care) into others (such as community health services or packages of support). The ambition is that pooled budget arrangements will be established to allow resources to be used in the right place.

3.3.5 A section 13V pooled budget does not constitute a delegation of responsibilities and therefore may need additional arrangements to create a joint decision-making mechanism between NHS England and the CCG(s). Each organisation remains responsible for decision making for its functions, but can share financial resources for the purposes of discharging those functions. However, a pooled budget could be combined with a joint appointment to align decision making between NHS England and CCGs.

3.4 Joint appointments and internal delegation

3.4.1 Joint appointments could offer an alternative approach to the integration of NHS England and CCG commissioning functions. Under this model an individual would simultaneously hold contracts of employment with both NHS England and one or more CCGs (such as, concurrent contracts), allowing them to exercise functions on behalf of multiple organisations.

3.4.2 Joint appointments could improve the coordination of decision making between NHS England and a CCG or CCGs on how budgets are spent across the specialised and non-specialised elements of the patient pathway. Where this is combined with a S14Z3 arrangement (which enables collaborative arrangements across any two or more CCGs), this can help bring together decision-making across a wider commissioning geography. Furthermore, joint appointments offer the opportunity for NHS England's regional specialised commissioning function to better align with emerging ICSs and STPs.

3.4.3 Internal delegation involves an individual exercising a function or functions on behalf of NHS England alone. However, that individual would work closely with local commissioners and take their views into account. Although NHS England and CCG budgets would not formally be delegated under this type of arrangement, they could be better aligned through improved transparency of spend across whole pathways.

3.4.4 In Greater Manchester (GM), the devolution of some specialised commissioning responsibilities has taken the form of internal delegation by NHS England to the GM Chief Officer of the GM Health and Social Care Partnership, who is an NHS England employee. In parallel to this internal delegation, GM's health and social care leadership, through the GM Joint Commissioning Board, has an advisory role in respect of the commissioning of those specialised services delegated to the GM Chief Officer. Together these two mechanisms allow for genuine decision making at a GM level with all partners around the same table.

3.4.5 A combination of these two models, through a joint appointee to whom specialised commissioning responsibilities have been internally delegated by NHS England, could enable the integration of NHS England and local

commissioning functions and genuine placed-based decision making. This could be considered as part of the development of a wider ICS or devolution arrangement.

3.5 Contracting under advanced place-based arrangements

3.5.1 The introduction of place-based planning of specialised services could be accompanied by the development of contracting arrangements that support the delivery of joined-up care. This could include lead provider or alliance contracting models. The NHS Standard Contract Technical Guidance will provide more information on these models of contracting.

3.5.2 An example of this is the mental health new care models which, in future, will be commissioned via contracting arrangements that allow provider collaboratives to design and manage services in the best way for their population, and re-invest any savings they make in new services.

3.5.3 Whatever arrangements are put in place, NHS England commissioners retain accountability for the commissioning of relevant specialised services that meet the needs of the population. It is on this basis that relevant operational and quality standards must continue to be met regardless of any contractual or collaborative arrangement. Commissioners should ensure that nationally mandated specialised contract terms and conditions are incorporated as appropriate into contractual arrangements.

Box 4: Key considerations for contracting under advanced arrangements:

Commissioners should ensure that:

- They have decided which provider contracts and/or individual services should be included.
- There are no fundamental inconsistencies between the parties' respective contracting arrangements.
- They have robust governance arrangements to support contracting.
- They know what commissioning support they need to underpin their collaborative arrangements and the source of this support.

3.5.4 For more advanced place-based arrangements, NHS England recommends using a *Model Collaborative Commissioning Agreement (CCA)*. The NHS Standard Contract Technical Guidance 2017-19 provides clear guidance on collaborative contracting in section 13, and model collaborative agreement templates are available on the NHS England NHS Standard Contracts *webpage*.

3.6 Approval process

3.6.1 Local systems that wish to develop more advanced place-based arrangements should develop a proposal setting out the case for change and more detail on how the proposed arrangement would work. Because NHS England will remain accountable for specialised services, national approval should be sought prior to implementation to ensure that there is appropriate support and assurance, as well as a mechanism to share learning. Table 3

provides a summary of the approval route[4]. At a regional level, proposals should be signed off by the relevant Regional Director. Nationally, approval will be required by one of the NHS England Board Committees

Table 3: Approval process for advanced place-based commissioning

Step 1. Proposal developed locally	STP/ICS or group of STPs/ICSs[5] set out case for change, how the place-based arrangement would work for the services in question, how it meets the readiness criteria, and detail of assurance and oversight.
Step 2. Assessment of business case by regional team	Proposals assessed by the relevant region(s) against the readiness criteria, with advice sought from the regional medical director and Patient and Public Voice Assurance Group (PPVAG) where relevant.
Step 3. Review by national panel	National panel reviews the regional assessment and makes recommendations to the relevant committee of the NHS England Board.
Step 4. Formal approval	Final proposals agreed by relevant NHS England Board Committee on behalf of the NHS England Board.[6]

3.6.2 A set of readiness criteria will follow this guidance, which will guide the assessment of proposals for advanced integration arrangements.

[4] Note that there is a separate process for mental health new care models
[5] By STPs or ICSs we mean the statutory bodies that constitute the footprint (i.e. CCGs for advanced place-based commissioning proposals)
[6] For smaller scale proposals the national panel may have delegated authority to approve on behalf of the NHS England Board Committee

4 Ongoing assurance and oversight

4.1 Ongoing oversight

4.1.1 Under place-based arrangements, NHS England and local commissioner assurance and oversight processes should continue to apply to their respective parts of any service portfolio. Where there are more advanced arrangements in place NHS England will seek assurance on the following:

- Will the arrangements support the ongoing clinical and financial sustainability of services?
- Is the transformation on which the business case was predicated being delivered?
- Are leadership and governance arrangements robust?

4.1.2 Assurance processes will need to be in place to maintain quality, financial stability and appropriate contracting mechanisms. These should be designed in the most appropriate way to reflect the place-based arrangements and services within scope, and should be agreed as part of the approval process set out in section 3.6

4.1.3 During 2019/20, regional specialised commissioning teams will be working with local health and care systems to strengthen engagement and join up planning of specialised and non-specialised services through specialised services planning boards.

4.1.4 We will provide support to those local systems that have the appetite to explore more advanced place-based arrangements for specialised commissioning. We expect this to be a locally-led process and therefore the first point of contact should be regional specialised commissioning teams.

4.1.5 For further information please email england.placebased-commissioning@nhs.net.