Paper NHSE121407

BOARD PAPER - NHS ENGLAND

Title:	Investing in Specialised Services
From:	Dame Barbara Hakin, National Director: Commissioning Operations
Purpose of paper: • To propose a set of principles which will underpin the decision making process for investment in specialised services. • To outline the characteristics of the process NHS England will use to make decisions on investment in specialised services.	
The Board is invited to: • Consider the overall approach proposed in this paper; • Review and approve the proposed principles and procedures as the basis for public consultation; • Authorise the Chief Executive in consultation with the Chair to sign off the consultation paper on behalf of the Board; and, • Delegate the future oversight of these arrangements to the Specialised Commissioning Committee.	

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Investing in Specialised Services

1. Before April 2013, commissioning specialised services for the population of England was largely the responsibility of Primary Care Trusts. They acted together in geographical groupings to cover populations of a size more suited for the planning and commissioning of services that typically involve relatively few providers, fewer patients and sometimes unpredictably high costs.

2. From April 2013, NHS England became responsible for commissioning specialised services as defined in Schedule 4 to the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing rules) Regulations 2012. This in effect nationalised the commissioning of a varied portfolio of services and, through the implementation of national service specifications and clinical policies, brought the opportunity to achieve greater consistency and quality for the whole population using these services.

3. NHS England's specialised services portfolio currently costs about £14bn each year, with pressure for substantial growth in activity and costs year on year. Despite the 2014/15 allocation being supported by £400m of non-recurrent funding, the current forecast outturn at month 7 is a deficit of over £150m, mostly associated with the Cancer Drugs Fund. In the context of the Five Year Forward View, the current position and trajectory for spending are not sustainable. The proposed allocation for 2015/16 seeks to eliminate the underlying deficit, however, meeting the needs of the population with the available resources will continue to involve choices and decisions that will be difficult and sometimes controversial.

4. In making its decisions about which specialised services to commission and for whom, NHS England's current process has three principal components. The first is an ethical framework and set of generic commissioning policies. The second is an advisory structure of service-specific Clinical Reference Groups which develop the service specifications and clinical policies to be applied in commissioning. The third is the Clinical Priorities Advisory Group which makes recommendations to NHS England about which treatments and services should be commissioned including priorities for investments.

5. Given that the ethical framework and generic policies were adopted on an interim basis and in the light of a year's experience, in April 2014 work commenced on reviewing our approach to ensure that it is transparent in its criteria and fair in its processes. The work has been shaped with the following in mind:

   - The duty to take investment decisions that are efficient, effective and economically sound, and enable the commissioning of high quality, safe and sustainable services, within the resources available;
   - Our commitment to acting with openness and transparency;
   - The need to make decisions about relative priorities across the whole of the specialised services portfolio; and,
   - The need to meet the needs of the population and reduce inequalities with the resources available.

6. The work has also sought to build on our commitment to good practice with a focus on:

- Clarifying the principles which will underpin commissioning decisions;
- Adopting appropriate and transparent procedures;
- Determining the point in the process where prioritisation assessment is to occur;
- Ensuring timely publication of work plans, decision outcomes, and consultation materials; and,
- Developing further the engagement of patients and the public in the formation of policy proposals.

Proposed principles which underpin decision-making

7. The first step is to establish the relevant principles. To achieve its purpose, the work has been undertaken in partnership with individual patients, patient group representatives, clinicians, commissioners and other stakeholders. A workshop in April 2014 distilled a fresh approach and a reference group was formed to guide and challenge the work. A series of patient and public engagement events contributed to developing the content of the proposed principles to underpin decision-making.

8. The proposed principles fall into four categories:

(i) General principles as to prioritisation:

NHS England will:

- follow its normal good practice in making prioritisation decisions in a transparent way, documenting the outcomes at all stages of the process;
- involve stakeholders including the public in the development of proposals and take appropriate account of their views; and,
- take into account all relevant guidance.

(ii) Does the treatment or intervention work?

NHS England will normally only accord priority to treatments or interventions where:

- there is adequate and clinically reliable evidence to demonstrate clinical effectiveness;
- there is a deliverable and measurable benefit to patients; and,
- they offer equal or greater benefit than other forms of care already in NHS use.

NHS England will not confer higher priority to a treatment or intervention solely on the basis it is the only one available.

(iii) Is the treatment or intervention fair and equitable?

NHS England:

- may accord priority to treatments or interventions for rare conditions even where there is limited published evidence on clinical effectiveness, recognising that the rarity of the condition may make such data unavailable;
- will only prioritise treatments or interventions where these can be offered to all patients within the same patient group (other than for clinical contra-indication).
- will accord priority to treatments or interventions that are likely to reduce health inequalities, and will have regard to any relevant broader equality issues.
- will take into account evidence of the impact of any prioritisation decisions on the wider health and care system, including societal impact.
- will seek to advance parity between mental and physical health.

(iv) Is the treatment or intervention a reasonable cost to the public?

NHS England will:

- prioritise those treatments and interventions that demonstrate the greatest value for money; and
- only commission for those prioritised treatments and interventions that are affordable within its relevant budget, and those that enable resources to be released for reinvestment.

Characteristics of the process for making decisions

9. In prioritising treatments and interventions for the future financial year, NHS England will observe the following sequence.

10. **First Order**. Service investment for NICE Technology Appraisals and the appraisals undertaken as part of the Highly Specialised Technologies Programme. The estimated budget impact for NICE recommended treatments in 2015/16 is in the region of £270M. The decision for this first order is non-discretionary; NHS England is required to fund these NICE appraisals even in the absence of any allocated budget capacity.

11. **Second Order**. There are NHS Constitution delivery requirements which affect specialised services. These include for example the 18-week wait referral to treatment time, and the 14/62-day cancer targets. Most of these requirements are aggregated from local needs analysis building a national investment plan.

12. **Third Order**. Developments to support national service strategies. These may be pre-existing, such as increasing access to transplantation, or nationally or locally defined strategic change. Consideration is given to what treatments and services are provided, to whom and to what level of quality.

13. **Fourth Order**. All other specialised services developments.

14. The Cancer Drugs Fund currently remains outside these arrangements.

15. From the work done since April 2014 to review our current process and practice, we have identified the need to test and develop treatments and interventions that might be commissioned typically using five stages:

- **Environmental Scanning phase,** is coordinated at a Clinical Reference Group level. There are two published outputs from this phase – the list of potential clinical policies that are identified as 'Not being routinely funded' and the list of potential service specifications for commissioning.
- **Planning phase,** where the National Programmes of Care, who coordinate the work of the CRGs into strategic groupings such as Cancer, consider the proposals in the second list and select the ones that most fit the programme's strategic priorities. This will create an Annual Work Programme.
- **Clinical Build phase,** where the Clinical Reference Group works with stakeholders to define the clinical proposal. An independent review of clinical evidence will be commissioned. Finally, a Clinical Appraisal Panel will form a view whether a clinical case is made.
- **Impact Analysis and Consultation phase,** where NHS England will develop, using the defined clinical criteria, a service impact analysis and hence a financial impact analysis. This will result in a final policy or service specification that can be considered for commissioning. The scale and duration of consultation will then be defined.
- **Governance phase,** where the Clinical Priorities Advisory Group assures the Board that the process has been completed and recommends a priority order of commissioning. The NHS England Board approves the prioritisation. Commissioning against the priorities will be overseen by the Specialised Commissioning Committee.

16. The detail of the five phases, including the process step summaries, will be available in the consultation supporting documents. Embedded within the process are a number of steps where decisions will be made. Each of these will be defined as 'Decision Making Events' and detail the elements such as who makes the decision, how the decision is made, and how the decisions are communicated.

17. One of the components under consideration to aid decision-making is the formation of a scorecard methodology. As part of the process for developing a prioritisation framework for specialised commissioning, NHS England will explore in 2015 the extent to which a 'scorecard' would be an appropriate tool to deploy in the proposed prioritisation process. If as a result of this further work a scorecard is considered ready for inclusion in the decision making processes in future years, then a specific consultation will be undertaken before introduction. The prototype scorecard developed and tested earlier this year will not be used in the 2015/16 commissioning round.

The Proposed Consultation

18. We propose to launch a public consultation about the principles and approach to decision-making from January 2015. The Specialised Commissioning Committee will receive the consultation report on behalf of the Board and review the proposed principles and process in light of the consultation responses.

Conclusion

19. The Board is invited to:

- Consider the overall approach proposed in this paper;

- Review and approve the proposed principles and procedures as the basis for public consultation;
- Authorise the Chief Executive in consultation with the Chair to sign off the consultation paper on behalf of the Board; and,
- Delegate the future oversight of the process to the Specialised Commissioning Committee.