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PRACTICE REVIEW

Delegating specialised service commissioning: will the latest changes establish an effective structure in England?

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Abstract

The history of specialised commissioning in England over the last 40 years has identified several issues that the NHS has attempted, on many occasions, to address. This article aims to place the most recent reforms within their wider historical context; the reforms issued following the Health and Care Act 2022 are just one more approach organising the commissioning of specialised services. Previous reforms will be examined, up to the most substantial changes introduced by the Health and Social Care Act 2012. In 2012, the commissioning of specialised services was one of several commissioning areas centralised within NHS England, but old problems continued and adverse impacts on service delivery and funding emerged. The latest reforms attempt to address both historical issues and those that have emerged since 2012. Whether this new system is likely to succeed in delivering an effective commissioning structure where previous ones have failed is discussed.

Key words: Commissioning; Health and Care Act; Specialised services

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Introduction

Commissioning structures for specialised services in England are being reorganised following the Health and Care Act 2022, with responsibility for some services being delegated from NHS England. Since 2012, NHS England has commissioned all specialised services to integrated care boards. The aim of the new system, set out in the 'Roadmap for integrating specialised services within integrated care systems' (NHS England, 2022), is to strike the right balance between national consistency and universal access, allowing integrated care boards to better integrate specialised services in locally defined care pathways while maintaining national specification of service standards.

The definition of a specialised service has changed over time, becoming broader or narrower depending on the objectives of policy makers and the success of lobby groups in getting their service included (Mullen, 1997). Specialised services cover treatments or specialties required by a relatively low numbers of individuals, usually with scarce specialist expertise and high costs. The variability and high cost of treatments have made specialised services difficult for service planners and clinical commissioners to manage locally. There are over 150 specialised services in England, including high-cost surgery, specialised burn care and the treatment of illnesses such as severe immune deficiency, rare neuromuscular disease and rare cancers (House of Commons Health Committee, 2010; NHS England, 2023a).

In 2023, NHS England agreed that commissioning for 59 specialised services should be delegated to joint regional integrated care boards. In March 2024, it was agreed that integrated care boards in the East, Midlands and North West regions of England should take full commissioning responsibility for these services, plus an additional 25 services deemed suitable for delegated commissioning (NHS England, 2024). For the remaining regions, joint commissioning boards of integrated care boards and NHS England are to be retained until 2025–26. Specialised services constitute approximately £23 billion of annual NHS expenditure, with the proposed delegated services comprising around half the total number of specialised services and accounting for £16 billion (NHS England, 2023a).

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NHS England retains overall accountability for all specialised services and commissioning responsibility for the remaining 50% of service areas, the majority of which are highly specialised services – clinically distinct, nationally coordinated services delivered in one to three expert centres, with small patient caseloads (<500). Arrangements for specialised services and their commissioning differ in Northern Ireland, Scotland and Wales, and are unaffected by the Health and Care Act 2022.

The 2022 reforms constitute a further chapter in attempts to develop the most effective commissioning structures for specialised services. Previous reforms made during the past 40 years have attempted to address issues of national consistency, universal access and the integration of specialised services in local service planning and commissioning. These changes have taken place as part of an ever-shifting relationship between the national, regional and local decision-making bodies in the NHS. The first section of this article briefly examines the history of specialised commissioning in the NHS from the 1980s up to the reforms introduced by the Health and Social Care Act 2012. The changes being introduced following the Health and Care Act 2022 are then described and the extent to which the current changes can address some of the historical issues assessed.

The development of specialised service commissioning up to 2012

Despite their clinical significance and considerable cost, the organisation of specialised service commissioning has not drawn substantial research interest. Over the past 40 years, numerous concerns about commissioning specialised services have been raised, relating to problems such as disjointed services, lack of access for patients, increasing costs and uncertainty regarding how services are designated as being specialised (National Audit Office, 2016; Hammond et al, 2017; Jones and Wyatt, 2020). In 2016, the National Audit Office noted that some specialised services can cover most care for their patients, such as those with cystic fibrosis, but most only form part of a patient's care and treatment pathway (National Audit Office, 2016). Furthermore, some highly specialised services, such as those for rare diseases, are only provided at a small number of centres, while others such as chemotherapy services, are provided by most acute hospitals. In the past 10 years, specialised commissioning has been one of the fastest growing areas of the NHS budget, driven by an expanding definition of a specialised service and rapidly increasing costs, which grew at 8% per year between 2015 and 2020 (Jones and Wyatt, 2020) and in 2023/24 accounted for 14% (£25 billion) of the NHS's operational budget for England (The King's Fund, 2024; UK Parliament, 2024).

Processes for the commissioning and governance of specialised services have undergone several reorganisations since the 1980s, aiming to address growing central and local tensions while establishing a clear governance framework to ensure accountability over decision making and resource allocation. Various developments and reorganisations have sought to identify the right population size for commissioning specialised services, achieve maximum efficiency and value for money and ensure that there are sufficiently skilled staff to plan and commission very specialised areas of care.

Before 2012, a service was considered specialised if a 'planning population (catchment area) of more than a million people' was required to provide sufficient need for a particular treatment or service, and where financial responsibility could be shared (NHS England, 2013). In the 1980s and early 1990s, district health authorities (then, from 2000, primary care trusts) held responsibility for commissioning most services for their patient populations, working in collaboration with each other and their regional health authorities to provide services for populations over broader geographical areas to pool financial risk (National Audit Office, 2016). During this period, specialised services lacked a distinct unified identity, with arrangements determined locally. To increase consistency, the supra-regional services advisory group was established in 1983 to advise the minister (who held ultimate control of specialised service budgets) on which clinical services would achieve greater outcomes for patients and the exchequer by being provided at a population level of 5 000 000 or more (Forsythe, 1993). It was felt that these services should be considered at a national level to avoid over provision in some areas and inadequate access in others. It was also seen as

more efficient to bring together staff with the required expertise at a national level, because of the nature of rare diseases.

This structure was left intact during the 1980s and 1990s, despite some concerns about the introduction of the purchaser provider split in 1990, when regional health authorities devolved some specialist service commissioning responsibilities to district health authorities as the primary purchasers, while retaining responsibility for some highly specialised services to maintain service planning, while opening services to 'market forces' (Donaldson, 1992; Forsythe, 1993). These changes did little to address regional inequality in standards and in 1996 the supra-regional services advisory group was succeeded by the national specialist commissioning advisory group. This body represented an expansion to national oversight of specialised services; while its role was still to advise the minister, it was arguably another step towards national specialised service commissioning.

Following the change of government in 1997, commissioning was devolved to the new GP-led primary care organisations. These primary care trusts consolidated commissioning activities in one local organisation so that resource decisions were taken across funding pockets at a population level (Peckham and Exworthy, 2003; Higgins, 2007). This soon highlighted the mismatch between needs-based population allocations and skewed historic patterns of spending, causing problems for budgetary control. Commissioners whose populations had high rates of service use had no methods for controlling this, especially for medical conditions that were rare and low volume, or delivered outside of their area. In addition, local commissioners could not develop sufficient commissioning expertise and there were limited incentives for them to do so (Featherstone and Storey, 2009; Smith et al, 2010).

In 2003, the government issued guidance that re-affirmed the need for primary care trusts to establish collaborative commissioning groups to coordinate the commissioning of specialised services with strategic health authorities, which took over responsibilities from previous regional health authorities. However, the problems continued (Hansard, 2003). The government then commissioned a review of specialised commissioning by Lord Carter of Coles. This review concluded that primary care trusts were not collaborating efficiently, to the detriment of specialised service users, and that increased collaboration and larger commissioning populations would be beneficial (Carter, 2006). As result, the national specialist commissioning advisory group was replaced by the national specialised commissioning group to oversee the national commissioning of 68 highly specialised services and facilitate collaborative working at a pan-specialised commissioning group, with responsibility transferred from the Department of Health to the NHS. The national commissioning group was established as a standing sub-committee of the national specialised commissioning group. Meanwhile, specialised and local commissioning groups were amalgamated, with the 10 strategic health authorities holding responsibility for coordination and accountability.

While these reforms represented an improvement, they arguably did not address the major underlying issues, with primary care trusts retaining ultimate responsibility and budgets for commissioning specialised services in their areas. Following the review by Lord Carter, primary care trusts still decided which services they would pool and commission at the specialised commissioning group level. As the specialised service commissioning bodies, specialised commissioning groups did not have the required powers to ensure that such services were commissioned efficiently and equitably. The priorities of primary care trusts took precedent over the priorities of specialised services within them, and as ultimate budget holders, primary care trusts were not obligated to follow specialised commissioning group guidance, either individually or collectively. In practice, local decision making remained, with insufficient capacity to effectively commission specialised services and often with little priority given to these services (Featherstone and Storey, 2009; Smith et al, 2010).

Reforms after 2012

The Health and Social Care Act 2012 introduced greater centralisation of many aspects of commissioning, including specialised service commissioning. As part of these reforms, the definition of specialised services was expanded to include 143 services and the budget

was expanded by 40%. This represented a shift away from the population-based approach to commissioning, to assessing four factors (NHS England, 2014):

1. The number of individuals who require the service or facility
2. The cost of providing the service or facility
3. The number of people able to provide the service or facility
4. The financial implications for clinical commissioning groups if they were required to arrange the provision of the service or facility.

The changes made by the Health and Social Care Act 2012 resulted in the fragmentation of commissioning responsibilities (Ham et al, 2015). The was to 'liberate professionals and providers' from top-down control and emphasise localism, to bring commissioning decisions closer to individual patients. This was to be achieved by establishing over 200 new clinical commissioning groups, led by clinicians, with responsibility for commissioning most of the healthcare services in their areas (McDermott et al, 2020). Meanwhile, upper-tier local authorities (county and unitary councils) were given responsibility for commissioning public health services, including sexual health, drug and alcohol services and health checks. Commissioning and contracting primary care services, such as GPs, dentistry, pharmacy and certain aspects of optical services, became NHS England's responsibility via their 10 local area teams. NHS England also took over responsibility for commissioning specialist services from primary care trusts, but rather than commissioning for local populations, NHS England would commission services nationally for the whole population to reduce variation in the services available to patients. As a result, instead of each specialised provider having a geographical 'catchment area', they were contracted for all the relevant services that they provided, regardless of where patients lived. This incentivised specialised service providers to increase their activity levels and accept patients from a wider geographical area (Checkland et al, 2018).

The Health and Social Care Act 2012 also established a more formal structure for developing guidance and commissioning frameworks and aimed to reduce inequalities in standards and provision. The classification of specialised services was undertaken by the Department of Health's clinical advisory group for prescribed services, which comprised healthcare professionals, patient representatives and commissioners, including GPs. This group took advice from the 60 clinical reference groups, each of which was focused on a particular area of specialised service commissioning. The recommendation was for most pre-existing specialised services to retain their classification and for several services that had been removed from the definition of a specialised service to be reinstated.

To consolidate expertise, improve budgetary control and address the fragmentation of commissioning resulting from the large number of clinical commissioning groups, just 10 of the 27 NHS England area teams commissioned specialised services. To reduce costs and simplify organisational operations, area teams were abolished in April 2015. Specialised service commissioning became the responsibility of four NHS England regional teams, working through 10 hubs which contracted directly with providers at a national level. It was thought that having a single structure for commissioning would overcome the more fragmented approach of the national commissioning group, specialised commissioning group and primary care trusts. NHS England developed national standards for the specialised services in its remit, bringing together relevant experts at the national level in a number of clinical groups in a single specialised commissioning directorate, with a national director and clinical lead.

Over the last 10 years, NHS England has sought to establish standards to reduce regional variations by commissioning at a national level. Despite this, inequalities in the provision of specialised services have persisted (Huete and Parsons, 2020; McGill et al, 2024). There is some evidence that the centralised commissioning of highly specialised services was able to achieve a degree of equity of access for patients across England (Coles et al, 2012). The centralisation of specialised commissioning was also seen as an opportunity for more focused and protected funding for specific areas of healthcare, such as adult asthma (Kane et al, 2016). However, expenditure rose more rapidly than the increases in the overall NHS budget. In 2016, the National Audit Office noted that, against the backdrop of increasing pressure on NHS finances, NHS England had not controlled the rising cost of specialised services, which was affecting their ability to provide resources for other services and

achieve the wider health transformation set out in the *Five year forward view* (National Audit Office, 2016).

As well as overall rising costs, the National Audit Office also expressed concern about the cost of the specialised service commissioning process, concluding that 'NHS England will need to get better control of rising costs, in particular drugs costs, improve its management information and manage demand better through service reform' (National Audit Office, 2016). Costs have continued to rise, with average increases of 8% up to 2020, when specialised services constituted a sixth of the overall NHS budget (Jones and Wyatt, 2020). Checkland et al (2018) also found that the new structures established in 2012 for commissioning specialised services created tensions between national and local levels, as national commissioning led to fractured pathways of care. This resulted in a lack of cohesion between prevention and early intervention at one end of the pathway and specialised care at the other, as well as increased pressure on local services, many of which were facing an influx of patients requiring specialised services from outside their local area (Hammond et al, 2017). An example of this complexity occurred in an area where non-specialised child and adolescent mental health services tier 1–3 (community and outpatient) services were commissioned locally to meet the needs of the local population, but with specialised tier 4 (inpatient) services commissioned by NHS England. Because tier 4 services were available for patients from anywhere in the country, capacity for the local population was reduced (Hammond et al, 2017).

The fragmentation of commissioning and the complexity of the new arrangements following the Health and Social Care Act 2012 led NHS England to consider the development of more integrated systems of care, which were initially outlined in the *Five year forward view* (NHS England, 2015). NHS England proposed the establishment of sustainability and transformation partnerships in 2016 to foster collaboration across large geographical footprints (Allen et al, 2020). The National Audit Office (2016) raised concerns about how the commissioning of specialised services fitted within the strategic vision for the NHS set out in the *Five year forward view*, and NHS England subsequently began working on changes to commissioning arrangements to more fully integrate the commissioning of specialised and local services. This would ultimately reverse key aspects of the 2012 reforms.

In 2018–19, planning guidance proposed new regional integrated systems, each with a planning board for specialised services (NHS England, 2018, 2019). These planning boards would provide an advisory function relating to services that could be planned for populations of 1–2.5 million, with collaborative arrangements for services that could be planned for populations of 2.5–10 million. The aim of this was to address concerns that about fragmented care pathways, misaligned incentives and missed opportunities for upstream investment and preventative intervention. However, while specialised service commissioning was to be re-integrated with other commissioning at this new regional level, the national clinical standards framework through the clinical reference groups and the NHS England specialised service commissioning directorate was to be retained. The NHS England (2020) publication 'Integrating care: next steps to building strong and effective integrated care systems across England' took these ideas further by setting out four principles for specialised services:

1. They would continue to be subject to consistent, evidence-based, national service specifications and treatment eligibility policies
2. Strategic commissioning, decision making and accountability would be led and integrated at the appropriate population level: integrated care system, multi-integrated care system, or national
3. Clinical networks and provider collaborations would drive quality improvement, service change and transformation across specialised and non-specialised services
4. Funding would shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place' and thus reversing the changes made in the Health and Social Care Act 2012.

The subsequent white paper 'Integration and innovation: working together to improve health and social care for all' (Department of Health and Social Care, 2021) set out plans for commissioning responsibilities, including a further restructuring of specialised service commissioning. The white paper proposed to:

> **'Enable NHS England to delegate or transfer the commissioning of certain specialised services to [integrated care systems] singly or jointly, or for NHS England to jointly commission these services with [integrated care systems] if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards. Specialised commissioning policy and service specifications will continue to be led at a national level ensuring patients have equal access to services across the country.' (Department of Health and Social Care, 2021).**

The Health and Care Act 2022 formalised these arrangements, setting out the relevant powers of NHS England and the 42 newly formed integrated care boards, which have responsibility for commissioning and service planning. However, final proposals for the structure and landscape of specialised service commissioning were only agreed by NHS England in the first quarter of 2023, just before actual delegation occurred. Clearly, much work had been progressed before this point, but integrated care boards could only ratify proposed changes after the NHS England board approval in February 2023.

The Health and Care Act 2022 provided powers for NHS England to delegate specialised service commissioning to integrated care boards within a framework of national accountability, standards, service specifications and clinical policies, aiming for equal access to the latest treatments and technologies. This delegation would provide the opportunity for specialised services and patients to fully benefit from the focus of integrated care boards on their local population's health:

> **'By integrating the commissioning of specialised services with integrated care boards' wider responsibilities where appropriate… Enabling them to design care that joins up around patient needs, and invest resources where they can have best effect on outcomes.' (NHS England, 2022).**

In 2023, 59 services were approved for delegation to joint integrated care boards based on the seven NHS England regions, as a step towards full delegation from 2024–25, once integrated care boards complied with a new assurance system whereby their readiness would be assessed by a new national moderation panel (NHS England, 2023a, 2023b). The panel recommended that 20 integrated care boards in the East, Midlands and North West regions of England could move to full delegation, while 11 integrated care boards in London and South East regions would be granted delegated powers with conditions and intensive support from 2024–25 (NHS England, 2023b). Integrated care boards in the North East and South West of England requested to maintain their joint commissioning boards for a further year, with delegation from 2025–26.

While funding remained within NHS England, from 2025–26 resources will shift from allocations based on historic funding of providers to a needs-based population model, as with other integrated care board commissioning budgets. The model estimates the needs-based 'fair shares' of revenue required for all specialised services that may ultimately be delegated for commissioning by integrated care boards (NHS England, 2023b). This is based on a similar approach to the established general and acute component of the core services target model, which models the drivers service use at an individual level, with set integrated care board-level targets (NHS England, 2023c). Targets have been adjusted for high-cost drugs and devices that are funded nationally. NHS England have calculated each integrated care board's allocation in relation to this needs-based target and will over time adjust allocations to reduce each integrated care board's distance from their target. However, these changes come at a time when integrated care boards have been under considerable pressure in terms of developing their governance systems and processes, and are addressing severe financial constraints, including having to cut management costs (Sanderson et al, 2023; Page et al, 2024).

Have the post-2022 reforms balanced national and local commissioning?

The history of specialised service commissioning from the 1980s features some persisting issues, including:

- Tensions between system-wide standards of service and access vs local commissioning
- Adequate resourcing leading to future budgetary pressures
- Difficulties ensuring adequate commissioning skills and specialist staff
- Managing tensions between national-level commissioning for services that are also linked to locally commissioned services.

Critiques of the post-2012 system highlighted continuing problems with the process for specialised service commissioning relating to costs and lack of constraint on cost growth, persistent variability of services and lack of integration with wider commissioning processes (National Audit Office, 2016; Hammond et al, 2017). Constant staff turnover in the system has also affected the ability to build expertise in the commissioning of specialised services, further exacerbating problems. Checkland et al (2018) suggested several potential areas for improving specialised service commissioning, including a return to larger-scale geographical populations at a regional tier, with statutory responsibility for a defined budget; avoidance of significant disruption to commissioning teams; retention and development of skilled staff; and removal of perverse incentives for providers. Research has identified the importance of commissioning decisions being made at a sufficient population size to minimise fluctuations in low-volume services (Checkland et al, 2018).

Integrated care boards potentially offer the kind of regional population footprint suitable for integrating areas of specialised service commissioning into local commissioning decisions. Integrated care boards cover larger populations and areas than clinical commissioning groups, but vary in size, covering between half a million to >3 million people (Sanderson et al, 2023). It is uncertain whether smaller integrated care boards are large enough to individually commission specialised services in their areas. Maintaining central standards is likely to be helpful, but guidance and local implementation may continue to vary. Systems will need to balance the need to avoid variations in delivery and standards through a degree of central direction, while recognising that central decision making can be a barrier to planning for local needs. The retention of some service commissioning by NHS England for areas such as adult secure mental health services, specialist gynaecology and tier 4 child and adolescent mental health services may lead to complexity in service delivery and tensions (Checkland et al, 2018).

As well as the highly specialised services, a total of 32 specialised service areas will remain centrally commissioned (NHS England, 2024). Funding for these areas is being proportionately deducted from the new needs-led population funding model for each integrated care board, with an adjustment for historical patient trends. The delegation of budgets to local commissioners and having a local–central budget split may help to contain costs by consolidating services in defined areas. This would remove the previous perverse incentive for providers to increase activity by inflating specialist referrals and thus increase income; previously, payment was through reimbursement by NHS England, resulting in some trusts attracting large numbers of patients from outside their area (Checkland et al, 2018). Nearly £16 billion is being transferred to integrated care boards, with £13 billion allocated for the first 59 services and just over £2.7 billion for the additional 25 services agreed for delegation (NHS England, 2023b). However, preventing future increases for the retained commissioning activity, especially for highly specialised services, will be a challenge. In the author's view, tensions may emerge between integrated care boards and NHS England in relation to the degree of 'top slicing' from integrated care board budgets by NHS England and disproportionate pressures placed on integrated care boards, which receive settlements well below historical cost trends for specialised service commissioning (NHS England, 2023c).

As commissioning becomes more integrated locally, there may also be new tensions related to pathway design, with nationally defined specialised service commissioning standards, local clinical views about service design and integrated care board commissioning priorities being misaligned. Delegating commissioning to integrate with local decision making – a key objective of the 2022 reforms – is not always a straightforward or effective way of improving services (Peckham et al, 2005).

Conclusions

The period from 1983 to 2020 demonstrated a steady evolution from very localised approaches to specialised service commissioning to the more centralised, formal structures

Key points

- The commissioning of specialised services is a scarcely examined area of commissioning, despite the significant costs.
- The delegation of specialised service commissioning to integrated care boards aims to balance the benefits of national standards with those of more localised commissioning.
- Questions remain over whether delegation can achieve greater local integration while ensuring cost containment and avoiding greater inequalities between areas.

established following the Health and Social Care Act 2012. The Health and Care Act 2022 unwinds some of this and appears to be an attempt to strike a balance between the problems associated with the pre-2012 era and those that are emerging with the centralised, post-2012 processes. Very localised commissioning of specialised services can create problems relating to appropriate use of resources and lack of expertise to effectively commission these services. On the other hand, some local focus is valuable, and it is important to align the commissioning of specialised services with wider service commissioning, as part of a local delivery system. None of these are new issues and manifestations of these concerns have arisen in past structural changes. The more embedded structural approach to setting service standards may be an improvement on previous pre-2012 approach of relying on advisory committees. However, tensions could arise as integrated care boards seek to integrate some specialised services into local service arrangements.

At a central level, a key concern remains: can standardisation be achieved when services are delegated? Even with centralised commissioning, variations in services have persisted and these may be exacerbated by integrated care board-led commissioning. Ultimately, the success of delegated powers will rest more on the ability of integrated care boards to develop their commissioning arrangements and expertise in new institutional frameworks. This a wider issue that goes beyond specialised service commissioning alone. The issue of cost is likely to remain area of contention while the NHS struggles with constrained budgets. Whether the key aim of striking the balance between national consistency and universal access can be achieved is still open to debate. It is time that more research attention is paid to this crucial area of healthcare service provision.

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