



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health and NHS England

The commissioning of specialised services in the NHS

Key facts

146

specialised services in
England, in 2015-16

£14.6bn

budget for specialised
commissioning in 2015-16

7%

growth rate in the
budget for specialised
commissioning for 2016-17

Around 300 health organisations provide at least one specialised service

489 full-time equivalent staff working for NHS England on the commissioning of specialised services in 2015-16, compared with 287 full-time equivalent staff in 2013-14

63% of spend on specialised services is accounted for by ten service areas (groups of specialised services)

£2.7 billion total cost of specialised cancer services in 2014-15

£2.6 billion total estimated cost of high-cost drugs in 2015-16

Summary

1 Specialised 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. There are currently 146 specialised services, covering a diverse range of disparate and complex services. These range from services for long-term conditions, such as renal (kidney) and specific mental health problems, to services for uncommon conditions such as rare cancers. Appendix One provides a full list of these services.

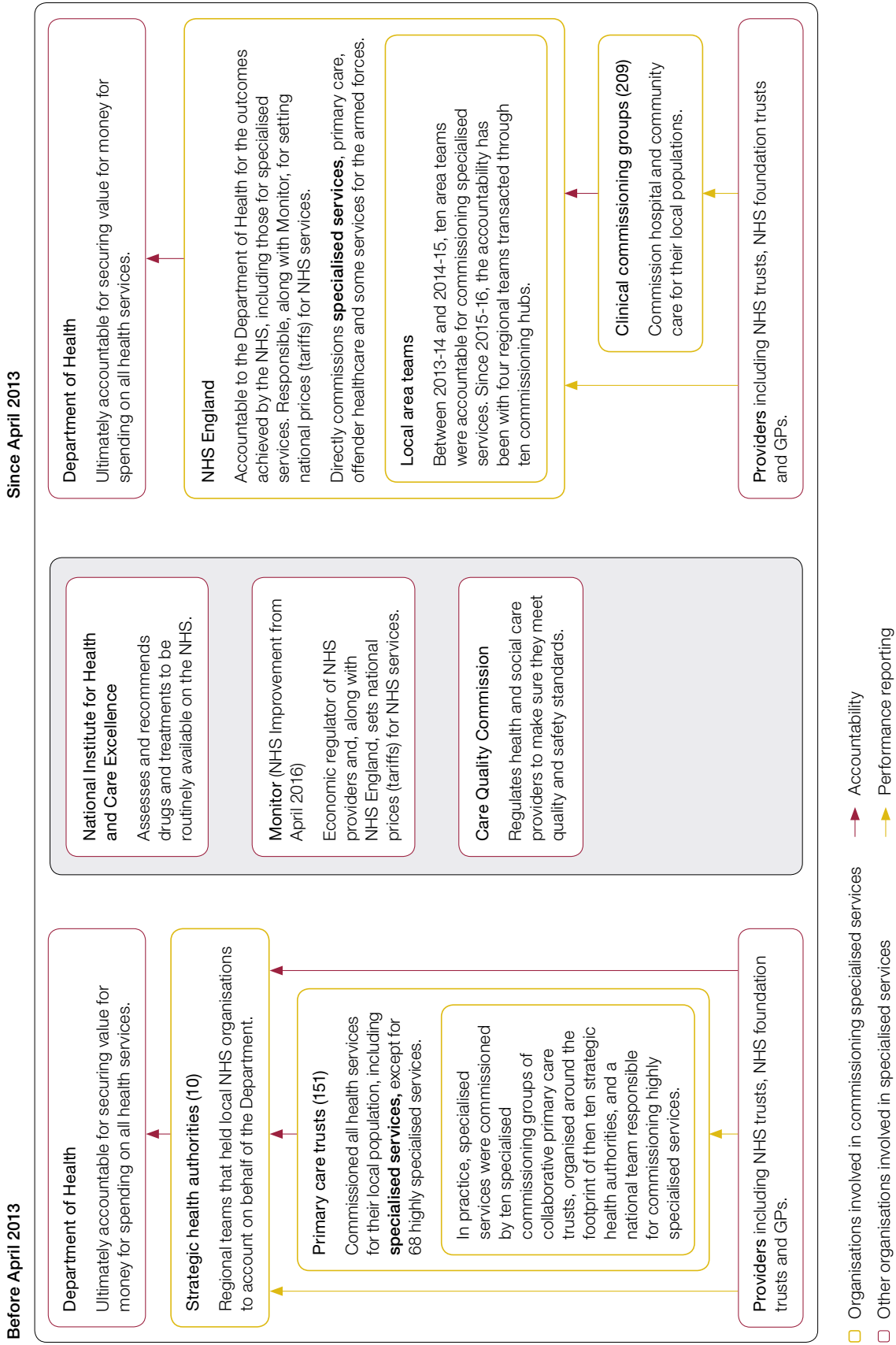
2 Some specialised services, such as those for cystic fibrosis, cover the majority of care for patients with these conditions. However, most specialised services only form a part of a patient's care and treatment pathway. Some highly specialised services, including those for very rare diseases, are only provided at a very small number of centres across the country. Others, such as chemotherapy services, are provided by most acute hospitals.

3 In April 2013, NHS England took on responsibility for commissioning specialised services, including setting the budget for these services (**Figure 1** overleaf). Before this, ten strategic health authorities were responsible for commissioning highly specialised services and 151 local primary care trusts were responsible for commissioning all other specialised services. The Secretary of State for Health is responsible for deciding which services should be commissioned as specialised services by NHS England. Through its commissioning of specialised services, NHS England aims to: improve outcomes for patients; ensure patients have equal access to services regardless of location; and improve productivity and efficiency.

4 Health is an area of public spending that the government has protected in recent years compared with most other areas of government spending. However, finances have become increasingly tight, with health funding rising at a historically low rate of 1.8% in real terms between 2010-11 and 2014-15. The NHS *Five Year Forward View*, published in October 2014, estimated that there would be a £30 billion gap between resources and patient needs by 2020-21 and set out proposed changes to the provision of healthcare services to meet this gap.

5 Specialised services can be expensive to provide. In 2015-16, the budget for these services was £14.6 billion. This is about 14% of the total NHS budget. Commissioning these services effectively will be crucial for enabling the NHS to adapt to increasing patient demand, new treatments and technologies and funding constraints. If NHS England is unable to keep its spending on specialised services within budget, this will affect its ability to resource other services, such as primary care, non-specialised hospital and community services, and wider health transformation set out in the *Five Year Forward View*.

Figure 1 The commissioning of specialised health services before and after April 2013



Our report

6 This report assesses whether NHS England is delivering value for money from its commissioning of specialised services (excluding the Cancer Drugs Fund, which we covered in a separate report)¹ and examines whether:

- NHS England has an overarching vision for the commissioning of specialised services and an effective plan to achieve this vision (Part Two);
- NHS England has the capacity and capability to commission specialised services effectively, including managing the budget and improving productivity and efficiency (Part Two); and
- NHS England is able to gain assurance that it is achieving its objectives to ensure equity of access to specialised services and improve patient outcomes (Part Three).

Part One gives an overview of specialised services in England and the challenges that NHS England faces in commissioning these services. We set out our audit approach in Appendix Two and evidence base in Appendix Three.

Key findings

Managing the budget for specialised services

7 Spending on specialised services is expected to increase at a much greater rate than other parts of the NHS. In December 2015, NHS England announced that the budget for specialised services would increase by 7.0% for 2016-17, compared with an increase in the budget for clinical commissioning groups (which commission the non-specialised acute and community NHS services for their populations) of 3.4% and an increase in the budget for primary care services of 4.2%. NHS England's board noted that keeping within the future budget for specialised services would be exceedingly challenging, as it had limited its cost estimate on potential new drugs and devices to the lowest end of its projected range. Between 2013-14 and 2015-16, the budget for specialised services increased from £13.0 billion to £14.6 billion, an increase of 6.3% a year on average. Over this period the budget for the NHS as a whole increased by 3.5% a year on average (paragraphs 1.8 and 1.9).

8 NHS England has found it challenging to live within its budget. NHS England found it challenging to keep within its 2013-14 budget for specialised commissioning because the original budget was based on poor-quality data. Although it increased its budget during the year, it still overspent the revised budget by £377 million (2.9% of the budget), of which £31 million was for the Cancer Drugs Fund. Improvement in budget management reduced the overspend to £214 million (1.5% of the budget) in 2014-15, £136 million of which was accounted for by the Cancer Drugs Fund. NHS England reported an overspend of £142 million for the first ten months of 2015-16, of which £110 million was for the Cancer Drugs Fund (paragraphs 2.10 and 2.11).

¹ Comptroller and Auditor General, *Investigation into the Cancer Drugs Fund*, Session 2015-16, HC 442, National Audit Office, September 2015.

9 A number of factors are creating financial pressures for specialised services, in particular the increasing volume of effective but expensive new drugs. Factors contributing to the rising budget include: increasing demand, at a faster rate than demand for non-specialised services; increasing use of high-cost drugs and devices to treat previously untreatable conditions or new, more effective products to replace older ones, often at a higher price; and new services being added to the specialised services portfolio. For example, in 2015-16 an additional £191 million (1.3% of the budget for specialised services) was required to pay for new drugs to treat Hepatitis C. It is difficult for NHS England to secure these drugs at lower prices once the National Institute for Health and Care Excellence (NICE) approves them for use. NICE assesses the clinical and cost-effectiveness of new drugs, but does not consider affordability. However, where a drug is not assessed or not recommended by NICE, NHS England has discretion over whether to fund the drug (paragraphs 1.11 and 2.12).

10 NHS England and Monitor have sought to control the cost of services by reducing the prices paid (tariff) for NHS services, but this may have impacted on providers' financial sustainability. In both 2013-14 and 2014-15, NHS England and Monitor required NHS trusts to deliver 4% efficiency savings, set within the price paid to NHS trusts for all NHS services, including specialised services. In 2015-16, 88% of NHS trusts opted for a tariff arrangement that included a 3.5% efficiency saving, and introduced a marginal rate where they were paid 70% of the tariff for specialised services above a level of activity agreed with their commissioners. The remaining 12% of trusts stayed on the previous tariff arrangements. NHS trusts, as a whole, have found these tariff arrangements challenging over the past few years. Trusts that have a high proportion of their income from specialised services are still in a better financial position than those trusts with less income from specialised services. However, despite this, our analysis indicates that their financial position has deteriorated significantly over the past two years (paragraphs 2.18 to 2.21).

Capacity and capability to commission specialised services

11 National-level contracting has strengthened NHS England's position to influence providers and reduce prices but it is not clear whether its commissioning hubs have the skills to manage these contracts effectively. NHS England introduced national service specifications that all trusts are expected to meet. However, in 2015-16, 38% of trusts were not compliant with one or more service specifications. NHS England limits its contracts with providers to 12 months (with a few exceptions). Only 6% of acute trusts responding to our survey reported that their current contract with NHS England enables them to plan services for the long term. NHS England told us that, from 2016-17, it plans to increase the duration of contracts with selected providers to between two and five years. In addition, stakeholders raised concerns that NHS England's commissioning hubs do not always have the commercial skills necessary to manage contracts with providers effectively (paragraphs 2.15 to 2.17 and 3.8).

12 NHS England underestimated the scale of the challenge of commissioning 146 specialised services. In its first year of operation, NHS England focused more on getting clinical commissioning groups up and running, and less time was focused on its own commissioning functions. In 2014-15, NHS England identified a need to increase its resources for commissioning specialised services. It increased the budget from £20 million with 307 full-time equivalent staff in 2014-15, to £38 million with 489 full-time equivalent staff in 2015-16 (paragraphs 2.2 and 2.3).

13 It is not clear how the commissioning of specialised services sits within the NHS Five Year Forward View. NHS England has yet to develop an overarching vision, or strategy, for specialised services. Although NHS England publishes its commissioning intentions for specialised services each year, NHS acute trusts and clinical commissioning groups told us that NHS England had not communicated a clear strategy for specialised services and this had affected their ability to plan services effectively. NHS England told us that, given the level of resources it has had, it has prioritised managing transactions with providers with only limited focus on strategic issues to develop specialised services and improve patient outcomes (paragraphs 2.4 and 2.5).

14 NHS England's original governance arrangements for the commissioning of specialised services were ineffective and stakeholders have raised concerns about the transparency of decision-making. The governance structure for specialised services is complex and has changed a couple of times since April 2013. These complex and changing arrangements may have hindered its ability to develop its specialised commissioning function. Despite repeated requests from various stakeholders, NHS England has not made public most of its meeting notes or board papers relating to how decisions are made as to which new treatments are funded by specialised services. In late 2015, it started publishing meeting minutes of the Patient and Public Voice Assurance Group for specialised services (paragraphs 2.6, 2.7, 3.6 and 3.14).

15 NHS England does not have the information it needs to drive service improvements in specialised services. For some services (accounting for about one-third of total expenditure), payments are based on the level of activity and unit price (tariff) set at national level. In these cases, NHS England knows how much it spends on each service area and what services patients receive. But for the remaining services, including high-cost drugs and devices, and services paid for according to locally agreed prices, there are no consistent national data available because local commissioning teams collect them differently. NHS England told us that it had introduced standard reporting formats for these data in 2015-16 and that this information would be collected consistently from 2016-17. This means that NHS England is currently unable to assess and gain assurance about: how efficiently the services it commissions have been delivered; whether the level of access to specialised services has changed since 2013-14; and whether inequalities in access to services have reduced (paragraphs 2.13, 2.14 and 3.3).

16 Data, where available, indicate that there are variations in access to services, quality of services and prices paid for services. For example, in 2014-15, the number of cancer patients aged between 25 and 74 receiving chemotherapy per 100 new cancer cases varied from 42 to 77 across clinical commissioning groups (excluding the lowest and highest 5%); in February 2016, the level of compliance with national service specifications varied from 74% in the North West to 96% in East Midlands; and in 2014-15, the price paid for a kidney transplant with a live donor varied from £13,000 to £42,000 across the eight centres providing this service (paragraphs 2.14, 3.4 and 3.8).

Patient outcomes and patient experience

17 NHS England does not have the information it needs to assess whether patient outcomes are improving or whether inequalities in patient outcomes are reducing. NHS England is developing 'quality dashboards' for some specialised services. These dashboards collect a range of information on clinical processes, intermediate clinical outcomes and compliance with national service specifications or standards for individual trusts. By April 2016, it had developed dashboards for 41 service areas with six more in development. However, the data in the dashboards were often incomplete (paragraphs 3.11 and 3.12).

18 Some patients, particularly those with long-term conditions, have found their care becoming disjointed. The separation between the commissioning of specialised services and other NHS services can lead to gaps in provision and poor data sharing. NHS England has recognised this as an issue and plans to address it by developing a more collaborative approach to commissioning specialised services with clinical commissioning groups. The NHS *Five Year Forward View* set out NHS England's intention to progressively give clinical commissioning groups more influence over the total NHS budget for their local populations, including specialised services. Most clinical commissioning groups (more than 70%), that responded to our survey, support a more joined-up approach to commissioning services, but they believe more clarity about costs and better engagement with NHS England are needed (paragraphs 2.8 and 3.16).

Conclusion on value for money

19 The growth in spending on specialised services presents an ongoing risk to NHS financial stability. In the three years since NHS England became responsible for commissioning specialised services, spending on these services has increased faster than other parts of the NHS and it has not remained within the budget that it set for itself. NHS England still does not have consistent information from all providers on costs, access to services and outcomes or how efficiently services are being delivered. Without this, it cannot manage the ongoing pressure on its budget for specialised services, make effective strategic decisions or gain assurance that its objectives for these services are being met.

20 Until NHS England significantly improves its strategic and operational arrangements for the commissioning of specialised services we cannot conclude that the current commissioning arrangements are providing value for money. In order to control the future costs of specialised services and put these services on a sustainable footing, 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.

Recommendations

- a NHS England should develop an overarching strategy or vision for commissioning specialised services and communicate this clearly to stakeholders.** This should include how the vision sits within the NHS *Five Year Forward View*, and how it intends to engage with other commissioners, service providers, patients and the public in the development of these services.
- b NHS England should finalise its governance arrangements for specialised commissioning.** It should look to streamline the governance arrangements and make its decision-making processes more transparent, for example by publishing meeting minutes and board papers.
- c NHS England should move quickly to ensure it has the right information to make strategic decisions about commissioning specialised services.** This includes information systems to allow it to link spend, by service provided, to service quality, patient outcomes and patient experience. NHS England should also set out clearly how it is going to ensure that information standards are consistently enforced by its local teams. It should report, on a regular basis, to its board on the quality and availability of this information.

- d The Department of Health (the Department) and NHS England, in collaboration with NICE, should ensure that they consider overall affordability when making decisions that have an impact on specialised services.** For example:
- the Department, NHS England and NICE should work together to establish how the addition of new drugs and devices can be kept affordable within available commissioning budgets;
 - the Department should ensure that NHS England has the flexibility to negotiate the best prices for the high-cost drugs it commissions nationally. For example, by working with providers to guarantee the volumes of drugs to be purchased, the NHS could potentially secure better value; and
 - NHS England should ensure its commercial and financial arms are working effectively with its clinical advisory groups when setting service specifications and service standards to ensure affordability.
- e NHS England should ensure that it has the right skills in the right places to commission specialised services effectively.** Having increased its resources to commission specialised services, NHS England should assess whether it now has the commercial skills necessary to manage contracts with providers effectively. It should also assess whether its commissioning teams have the leadership required to drive service changes.
- f NHS England should work with NHS Improvement to design tariffs which help providers to adopt the most efficient service models.** The various funding arrangements currently in place for specialised services are an obstacle to transparent reporting of performance and lead to variations in prices. NHS England and NHS Improvement should clarify their long-term funding arrangements for specialised services and their intentions regarding the use of national tariffs and local tariffs. NHS England should ensure that it has the data required to enable it to understand how the variations in local tariffs are related to local practices and use this information to design tariffs to support services to adopt the most efficient service models.