Secretariat Office
32-34 Great Peter Street
Westminster, London
SW1P 2DB
Telephone: 07815 798855
Email: will.warburton@shelfordgroup.org
Website: www.shelfordgroup.org

John Stewart
National Director of Specialised Commissioning
NHS England
Skipton House
80 London Road
SE1 6LH

18 March 2022

Dear John,

We are writing to you on behalf of the Shelford Group Chief Executives on the proposed reforms to the commissioning of Specialised Services in England.

The ten Shelford Group members are major providers of specialised patient care, research, and education, accounting for around a quarter of the total spend on specialised services by NHS England. Our clinicians lead service delivery, research studies, commercial partnerships, education and training programmes and clinical networks across the breadth of specialised services.

The Shelford Group welcomes the policy intention to improve the co-ordination of patient pathways between primary, secondary, and specialised care, and the intention to develop specialised care policy and commissioning in a way that engages and involves stakeholders across the whole care pathway. We also welcome the policy focus on early intervention, prevention and health promotion to reduce demand for specialised care where possible, and the aim to provide more equitable access to specialised services for patients, particularly those who live further away from specialist providers.

With Integrated Care Systems operating on a footprint larger than CCGs and smaller than regions, we agree that there are now some services where delegation of commissioning to ICS level makes sense, and can contribute to these policy goals, even given the significant variation in ICS population footprints.

However, we have concerns that a policy of delegating all but a small proportion of services to ICS level may go beyond what is helpful, and may have implications in terms of quality, equity, value and system complexity that we do not yet see being fully taken into account.

While we continue to welcome and value the opportunity to participate in the helpful Reference Group you have established, we are writing now to request an opportunity to discuss our concerns in more depth, and put forward our ideas on how the goals we share for patients might be better achieved. We set these out in the appendix to this letter, and look forward to an opportunity to discuss with you and your colleagues.

Yours sincerely,

Professor Ian Abbs
Chief Executive, Guy's & St Thomas' Hospitals NHS Foundation Trust

Tim Jaggard
Deputy Chief Executive and Chief Financial Officer, University College London Hospitals NHS Foundation Trust

On behalf of the Shelford Group CEOs:

Roland Sinker, Chief Executive, Cambridge University Hospitals NHS Foundation Trust and Shelford Group Chair
Sir Michael Deegan, Chief Executive, Manchester University NHS Foundation Trust
Dame Jackie Daniel, Chief Executive, Newcastle Hospitals NHS Foundation Trust
Professor Clive Kay, Chief Executive, King's College Hospital NHS Foundation Trust
David Probert, Chief Executive, University College London Hospitals NHS Foundation Trust
Kirsten Major, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust
Professor Tim Orchard, Chief Executive, Imperial College Healthcare NHS Trust
Professor David Rosser, Chief Executive, University Hospitals Birmingham NHS Foundation Trust
Dr Bruno Holthof, Chief Executive, Oxford University Hospitals NHS Foundation Trust

cc
Prof. Stephen Powis, National Medical Director, NHS England
Will Warburton, Shelford Group Managing Director

Appendix: Our areas of concern

The aims for the reforms have been articulated as improving quality, equity and value. We set out below risks we would like to work with you on in each of these areas. We also set out some further areas where we see there may be unintended consequences for innovation, life sciences, research and education, as well as some practical examples of the administrative complexity that the current proposals would create, particularly for those services that operate across larger population footprints than would typically be contained to a single ICS.

1. Quality

- ***The case for the majority of services to be devolved is not yet made***: our trusts see the case for devolving commissioning in aspects of many services, where there is a clear case for integration with local care – for example, in renal dialysis, or the provision of HIV screening in Emergency departments. We do not see however that these examples justify the wholesale move of commissioning of 80-90% of specialised services to an ICS footprint, particularly for those services where the numbers and evidence base supports the planning and provision of care being done at a population size larger than a typical ICS footprint. A taxonomy of specialist services that distinguishes between those that are clearly highly specialised, those that have strong potential for local commissioning and those that sit between these would enable more fruitful discussions. We look forward to seeing the metrics being applied to assess service suitability and service readiness, and would welcome an opportunity to feed our insights into these.
- ***Safeguards to prevent proliferation of providers need strengthening***: We appreciate the proposals you are developing on strengthening service specifications and ensuring national standards are in place, which we see as playing a critical role. We do however still see a risk of derogation from these locally leading to increased variation by postcode, unless the governance mechanisms and resources required to audit compliance are in place. There is a risk that ICSs will focus on high volume services for their local population, leading to a deprioritisation of specialised services, and/or an inclination to support development of services within that ICS's footprint as opposed to at the optimal level for ensuring clinical quality.
- ***In the medium-term, changes to commissioning that foster inappropriate local provision could risk undermining the well-evidenced relationship between volume and quality, and patient preferences***: We are particularly concerned by a narrative voiced to one of our members that care closer to home should always be seen as the preferred option for specialised services if value for money and service specifications are met, given evidence that volume is often strongly associated with better patient outcomes, and that for certain services such as specialist cancer or neonatal care, research shows that patients and families are prepared to accept longer travel times to achieve better outcomes. Delivering services with critical mass also ensures the development of expert staff who treat sufficient numbers of patients to maintain safe, high-quality care, supports patient recruitment to the research trials essential to improving treatment and care, and maximises the use of scarce, expensive physical and human resources.
- We would therefore welcome the opportunity to provide input to the service suitability and readiness assessment, as well as greater clarity on the gateway process to decide which elements of which services should be devolved and when.

2. Equity

- ***The reforms risk exacerbating inequitable access***: We support the imperative to provide more equitable access to specialised services. We do not however think that changing the level of commissioning and providing incremental uplift over a 5-8 year period to ICS allocations for areas with poorer access is likely to lead to the change intended. These reforms could just as easily have the opposite consequence; there is a significant risk that in those ICSs where there is limited or no voice at the table for patients and providers of specialised services, that attention and resources focus instead on general care for the local population.
- We think there are more effective ways to spur innovation in service of improved access, such as a duty on specialist providers to improve equity of access. Many leading centres are already developing stronger links to providers in areas where patients have less access through provider collaboratives and clinical networks. Advances in data and technology are opening up new possibilities for remote care, such as this work in Cambridge on Cystic Fibrosis, which could reduce the need for patients to travel to routine outpatient visits. Many of our trusts run satellite clinics, for example Imperial's HTLV services in Birmingham, York and Manchester.

3. Value

- ***Achieving better value is a shared goal***: We share the goal to achieve best value for money and recognise the challenge of the growth in expenditure in specialised services, while noting the preventative value of many treatments, and that this expenditure can bring wider economic and as well as health benefits through the role specialised services play in generating inward investment in the UK's life science industry.
- ***The reforms risk loss of negotiating expertise and leverage, and the ability to hedge risk***: We are not yet clear however on what the assumptions are behind a theory of change that says that changing the spatial level at which commissioning is undertaken will deliver better value. We note that the 2016 NAO report on specialised services found that national-level contracting had strengthened NHS England's position to get better value for money, and reported concerns about the capacity and capability of local commissioning teams to manage contracts effectively, which in our view remains a risk to date, particularly given the very wide range of functions and responsibilities that ICSs will be asked to take on over coming years. We also see considerable risk to ICSs in terms of their ability to hedge against peaks and troughs in expenditure.
- As an alternative, we think there are ways in which provider payment and risk sharing between commissioners and providers could be developed that would be worth exploring.

4. Other potential unintended consequences:

- ***Specialised Services will not receive a fair allocation of capital investment***: The scarcity of capital available means that specialised services are likely to receive lower than their appropriate share of capital investment, given that investment decisions taken at ICS level are highly likely to prioritise capital for the local care used by many in that population at the expense of specialist care used by few. Many specialised services are capital intensive, and it is unclear how this will be appropriately accounted for in the approach proposed.
- ***Reforms risk negative impact on Innovation, Research and Life Sciences***: The UK is one of the best places in the world to do biomedical research, and Life Sciences are a centrepiece of the government's plans for economic recovery. The concentration of specialised services in centres of excellence enables strong connections and joint roles across the NHS, academia and industry, with research infrastructure and expertise enabling efficient recruitment to clinical trials. The clinical academics and specialists in tertiary care, who act as nodal points between industry, academia and care delivery are vital to innovation in secondary as well as tertiary care. Reforms of commissioning that risk resulting in more fragmented provision of specialist care over time may inadvertently undermine that concentration of talent, critical mass and capability.
- ***Reforms need to take account of the impact on workforce, education and training***: any changes in provision as a result of changes to commissioning would need to be assessed against education and training footprints to ensure there is alignment and that specialists can still access the training opportunities they require.

5. Delivery and timelines

- ***Devolution introduces multiple actors and far greater complexity into specialised commissioning***: The administrative complexity of the proposed reforms for both providers and ICBs is highly concerning, and we would like to see some assessment of the impact on administrative complexity, given the wider stated policy aim to reduce bureaucracy. We also would like to see the opportunity cost of diverting clinical and managerial time to these changes considered as the benefits case for devolution of each service is assessed.
- ***Expertise and relationships will be diluted, and individual ICBs will have insufficient capacity and capability to commission individual services well***: While hard to quantify, the knowledge, expertise, relationships and ways of working in these specialised areas of care take many years to develop and form, until all stakeholders are able to have informed conversations and take collaborative decisions about service development. There are few individuals with deep expertise and knowledge, and the disaggregation of commissioning means their expertise will be spread more thinly. Our view is that proposals that seek to rearrange or reset these relationships that have evolved over decades should be approached with caution, and only proceed for services where there is a strong consensus view on the case to devolve commissioning.
- ***Regional variation introduces further complexity***: The interplay between commissioners, specialist providers, general hospitals, patient groups and clinical networks is already complex and varies across

geographies, and will be made more so through the introduction of integrated care boards, provider collaboratives and joint commissioning bodies. For services that deliver across multiple ICSs, we risk months and even years of inaction as new parties learn their new responsibilities, agreements are made about who will lead on which service, and stakeholders try to co-ordinate change across multiple ICS and regional footprints. For example, one Shelford provider estimates that for its specialist cardiac services (a service requiring a population of 2 million and over and therefore neither an obvious candidate for local or solely national commissioning), it has five ICSs that currently regularly commission the service with occasional patients from beyond those. The District General Hospitals within its 'home' ICS refer to three further specialist centres as well as the Shelford provider in question. The number of relationships and the difficulty of bringing together all parties to develop services will be exceptionally challenging if this service is devolved to ICS level.

- ***Variation in clinical network footprints will need to be take in to account***: As well as ICS footprints ranging from 500,000 to 3 million populations, there is also variation in clinical network footprints across the country, which are often not well understood. For example, the North West Neonatal ODN covers beyond ICS/provider collaborative boundaries - Greater Manchester, Lancashire and South Cumbria and Cheshire & Merseyside – whereas in London North East/North West and South London each has their own Clinical Oversight Group aligning with some provider footprints. What may work well in terms of boundaries in one part of the country can't be assumed to be the same elsewhere.
- **Contractual complexity will multiply**: Colleagues have also raised the potential complexity of contracting with multiple ICSs. The solution to have a lead ICS is not a straightforward one, and will require some oversight and negotiation to ensure that all commissioners remain engaged and decisions are taken on the grounds of what is best for the patients served by the service. The practical load on a lead ICS for any given service needing to co-ordinate multiple ICSs and providers is likely to be considerable.
- Looking again at the proportion of services to be devolved and timescales, factoring in the organisational and system complexity relating to any given service, could help mitigate this complexity and risk.