Specialised commissioning – assessing value and prioritising investment

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Introduction

- An overview of NHS organisation
- An outline of specialised services and the role of NHS England
- The budget
- What makes up ‘comprehensive commissioning’
- Prioritisation and ethical decision making
- Clinical Commissioning Policy Development
- The role of clinicians
- Getting involved

The NHS Context

- Socialised Health care system providing care free at point of need
- Public funded health spending Consumes about 8% of GDP and is £124 billion in England or £2200 per head.
- Private health spending another 2% of GDP
- Organised into ‘commissioners’ and ‘providers’
- CCGs commission Hospital and community care
- NHS England commissions specialised care and some other services.
- Deficits growing, choices have always been needed

What are specialised services?

- Less common and more complex conditions,
- Some are cutting-edge care, others well established
- NHS England is responsible for a list of 146 services – is set out in legislation.
- Services include; chemotherapy, kidney dialysis, neurosurgery, major trauma, neonatal intensive care, secure mental health services, interventional cardiology, HIV and wide range of ‘specialised’ elements of many specialties

What is NHS England's role?

- Determines best use of resources within a budget
- Sets national standards of quality and access
- Ensures value for money
- Guides configuration / transformation and pathways

Questions

Three questions for you the audience:

1. It is unethical to ration health care? (yes / no)

2. Doctors should play no part in rationing health care (yes / no)

3. Doctors should decide how best to use resources for patient care? (yes / no)

£16.6 billion

Planned spend on Specialised Services in financial year 2017/18

£15.4 Spent on Specialised Services in 2016/17

£130 million

Pounds invested in the modernisation of radiotherapy equipment

77,000

number of patients registered to receive drugs via the CDF since 2013

£340 million

Budget for the Cancer Drugs Fund (CDF)

£25 million

for the Commissioning through Evaluation programme evaluating 8 promising treatments

10,000

Participants expected to participate in the **PrEP clinical trial** over the next three years

146 Number of specialised services directly commissioned by NHS England

45 2-5 year olds with cystic fibrosis to benefit from ivacaftor

16,000

The number of patients treated by oral Hepatitis C treatments so far

33

Newly commissioned treatments agreed in 2016/17

15 The percentage of total NHS spend Specialised Services accounted for in 2016/17 (as well as what we think it will count for in 2017/18)

13

Genomic Medicine Centres created

8,000

Acute ischaemic stroke patients to benefit from mechanical thrombectomy roll-out

How much does the NHS spend on specialised services?

- The budget for specialised services – **£16.6 billion in 2017-18** – has increased more rapidly than in other parts of the NHS,
- The number of patients needing specialised services is rising – more people, ageing population and so more demand for services that are already provided by the NHS
- More money is needed to cover the cost of new drugs, expanded indications of existing drugs, medical devices and new / expanded investigations and procedures

A comprehensive commissioning approach

- Whole range of services, treatment and interventions that are routinely available
- Clinical commissioning policy – clinicians central to this work
- Individual Funding Requests
- Everything else is not routinely commissioned by default.
- Clinicians and horizon scanning identifies potential for investment in new / expanded intervention
- Not all can be afforded, or offer ‘value’

Deciding which new treatments to fund

NHS England sequence for addressing prioritisation

First Order - MUST Do's (e.g. from NICE Technology Appraisals and the appraisals undertaken as part of the Highly Specialised Technologies Programme).

Second Order - There are NHS Constitution delivery requirements which affect specialised services. (e.g. 18 week wait referral to treatment time, and the 14/62-day cancer targets).

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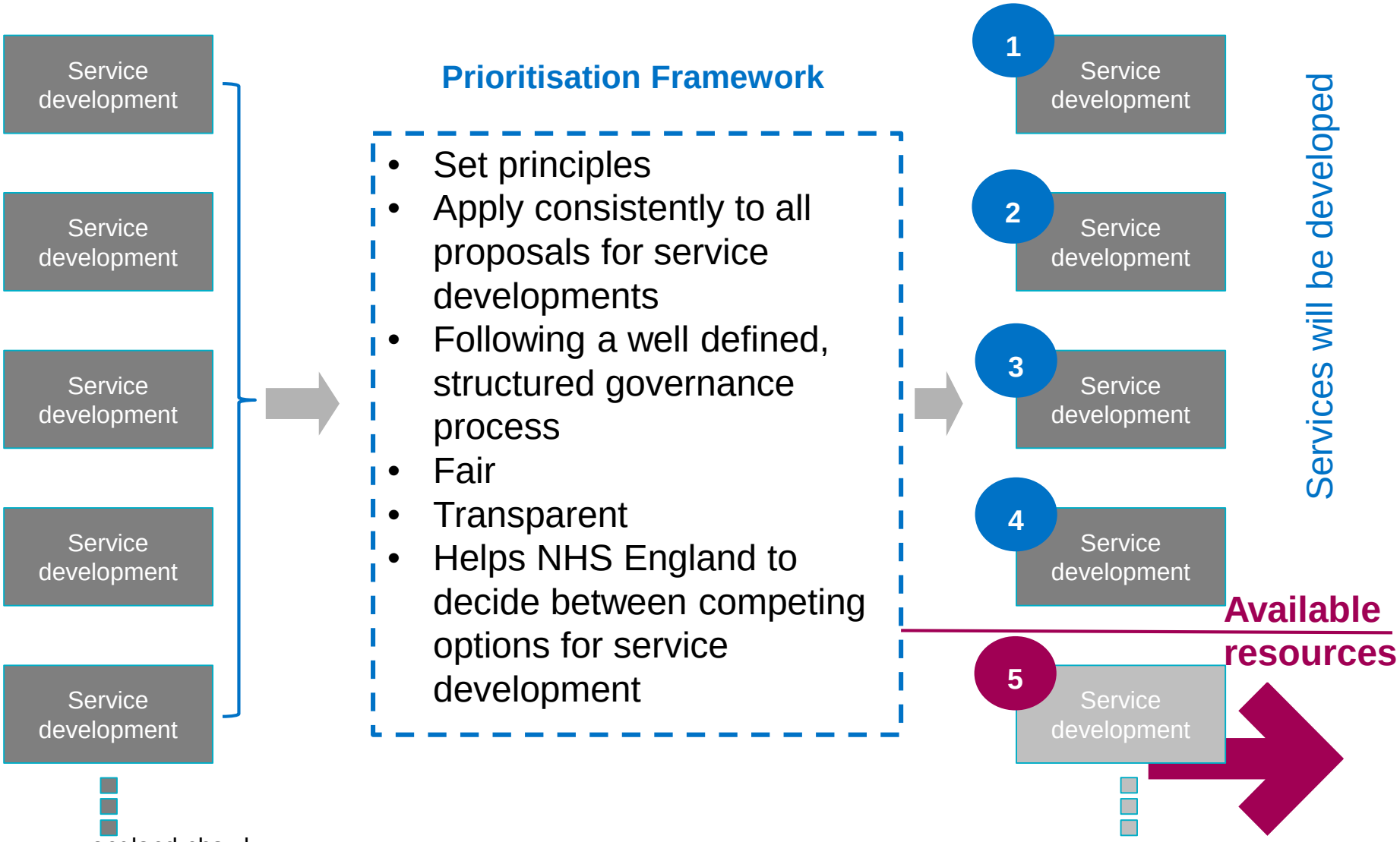
Third Order - Developments to support national service strategies.

Fourth Order - All other specialised services developments.

A prioritisation framework is needed in making discretionary decisions



NHS England's Ethical Framework

Principle 1	Principle 2
NHS England should ensure that all decisions are framed and considered in such a way that **all options for investments are considered** *ie there should not be a parallel system operating, which allows individual treatments or patients to bypass prioritisation*	A commissioner should **not give preferential treatment to an individual patient who is part of a group of patients** with the same clinical needs. A decision to treat some patients but not others has the potential to be unfair, arbitrary and possibly discriminatory
Principle 3	**Principle 4**
Effectiveness and value for money are minimum requirements to enable prioritisation for funding but are **not the sole criteria** that must be met for funding to be agreed	NHS England cannot assume responsibility for a funding decision in which it played no part unless there is a legal requirement to do so. Funding at the end of a clinical trial or after initiation of privately funded treatment can not be undertaken by NHS England

Clinical Commissioning Policy

Needed:

- To ensure clarity about what is provided when
- To allow rational resource allocation decisions
- To be fair and Transparent
- When there is uncertainty over the evidence / net benefit

  or / and
- When currently not funded

  or /and
- Variation in utilisation / uptake

  or / and
- Where there is an additional cost

So how is a new policy developed?

There are three phases of development:

1) **Clinical build:** Clinically lead process;

- Preliminary policy proposal
- Evidence review and Policy Working Group
- Draft policy proposition
- NHS England's specialised services Clinical Panel challenges and confirms whether the policy has a sound evidence base

2) Impact analysis: This stage identifies the financial and operational impacts Policies are also subject to stakeholder testing, and public consultation.

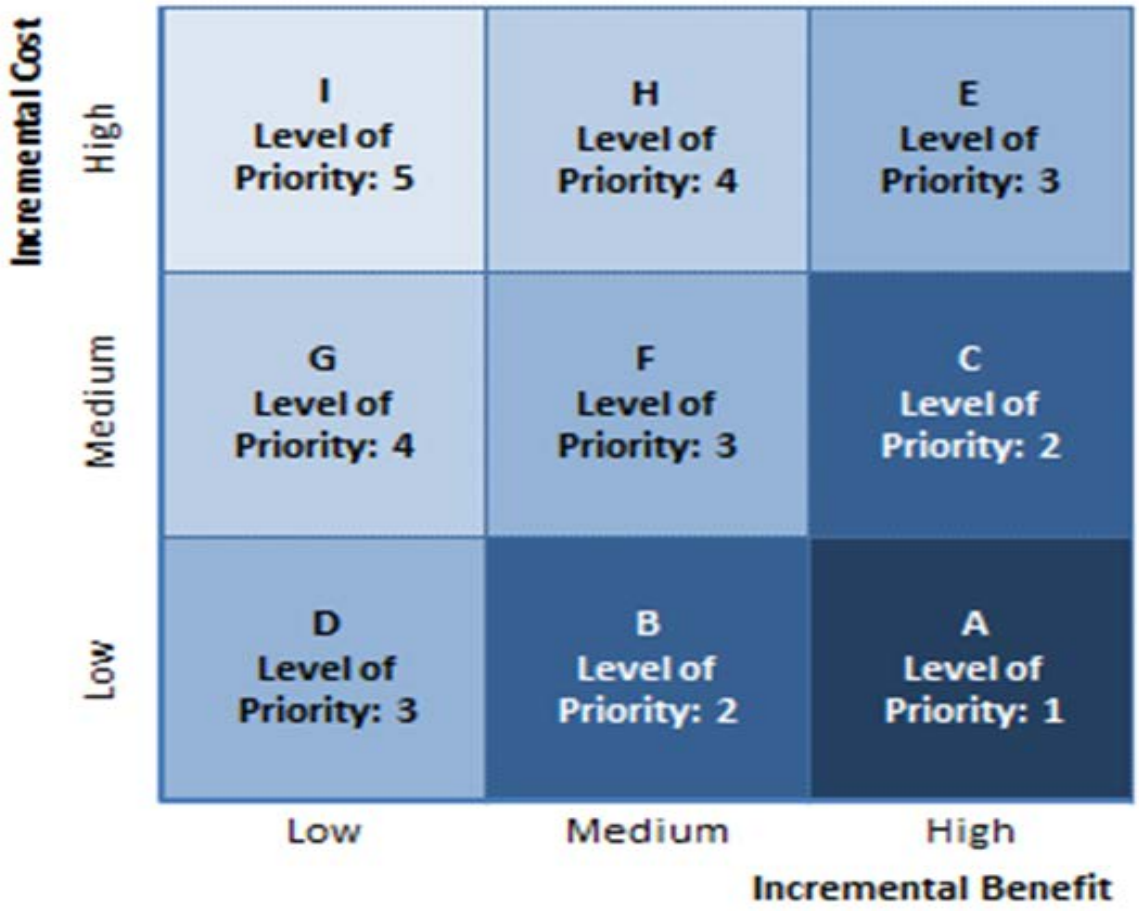
3) Decision: assessed on clinical benefit and cost.

Prioritisation - who makes the decisions?

- All proposed new treatments are independently assessed by the **Clinical Priorities Advisory Group (CPAG)** on their likely relative clinical benefit and relative cost.

- CPAG then makes its recommendations with the final decision made by the NHS England Board,

Prioritisation – how is relative priority assessed?



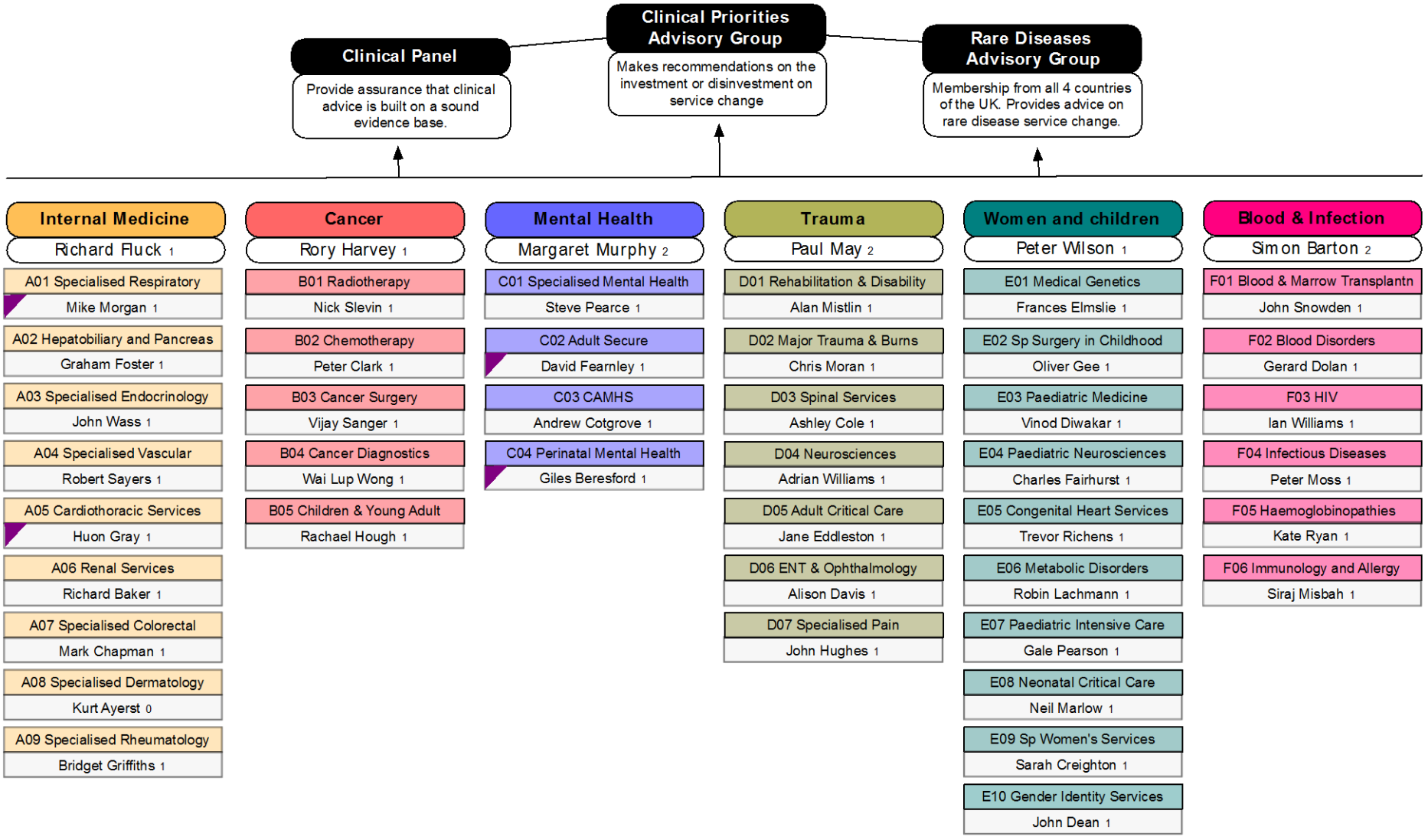
Level of Priority	Grid Position
1 (High)	A
2	B, C
3	D, E, F
4	G, H
5 (Low)	I

The role of Clinical Reference Groups (CRGs)

- Clinical Reference Groups (CRGs). These groups of clinicians, commissioners, public health experts, patients and carers use their expertise to provide clinical advice to NHS England.

- CRGs lead on the development of clinical commissioning policies, service specifications and quality standards. They also provide advice on many other issues.

Clinical References Group Chairs 2017/18



Get involved

- NHS England welcomes the involvement of interested people in the work of the CRGs and is keen to work with all stakeholders including charities, patient groups, staff from service providers and commercial organisations.

- If you would like to get involved you can become a registered stakeholder. You will be kept up to date about the work of the CRGs as well as having the opportunity to get involved in a range of ways.

www.england.nhs.uk/commissioning/spec-services/get-involved/crg-stake-reg/

To find out more about what we do, take a look at our pamphlet

https://www.england.nhs.uk/wp-content/uploads/2017/09/spotlight-on-specialised-services.pdf

For more information

Visit the website:
www.england.nhs.uk/commissioning/spec-services/

Sign up for the specialised commissioning newsletter :
www.england.nhs.uk/email-bulletins/specialised-commissioning-stakeholder-newsletter/

Register as a CRG stakeholder :
www.england.nhs.uk/commissioning/spec-services/get-involved/crg-stake-reg/

Email us:
england.scengagement@nhs.net

Find out more about what we're doing to celebrate our 70th birthday
https://www.england.nhs.uk/nhs70

Questions?

A GUIDE TO CREATING CLINICAL POLICIES

NHS England directly commissions specialised services for the whole population of England to ensure that everyone has access to treatments and services which are effective and a good use of NHS resources. **Clinical policies** are used to determine the commissioning position on new treatments and technologies for patients or revise existing treatments and technologies. They form a critical part of NHS contracts and hold providers (hospitals, healthcare providers) to account for the treatment they deliver to patients. Clinical policies are developed via the work of the **Clinical Reference Groups (CRGs)** following a standard process called the **Clinical Policy Pipeline**, that has three phases.

Phase A Clinical Build

The **clinical build** is the first of three phases to form a national clinical commissioning policy for a directly commissioned specialised service. It concludes through a Gateway managed by the Clinical Panel where a 'Policy Proposition' is confirmed to be built from clinical evidence. The second phase is the 'Impact Analysis' concludes through a Gateway at the National Programme of Care Board. The third and final stage is the 'Decision' through the Clinical Priorities Advisory Group, Specialised Commissioning Oversight Group, and Specialised Commissioning Committee.

A clinician who undertakes to take the proposal through each step is identified to lead each clinical commissioning policy development.

The relevant CRG endorses that the nominated **Policy Clinical Lead** has the support of peers

The Clinical Lead forms the **Preliminary Policy Proposal** (PPP)

The **Clinical Panel** confirms that the policy proceeds and determines the required methodology for a proportional to the complexity of the proposal.

An **Evidence Review** is commissioned guided by the Preliminary Policy Proposal

Working with a **Policy Working Group** the Policy Clinical Lead forms a **Policy Proposition** built from the evidence base

The **Clinical Panel** tests whether the Policy Proposition is built on the Clinical Evidence and whether the policy proceeds either a '**routinely**' or '**not routinely**' commissioned proposal.

The proposal moves to the impact analysis Phase B.

What is a Clinical Policy

- A document **endorsed by NHS England's Board**, that describes the commissioning position how a particular treatment or technology within specialised services and in what circumstances people will receive the treatment, reflecting NHS England's values and principles and taking in to account stakeholder views.
- The contents of a clinical policy are a **mandated** NHS England commissioning position and must be followed by all healthcare providers.
- A policy is developed when there is **no relevant guidance published by NICE** (Technology Appraisal Guidance or Highly Specialised Technology Assessment). If NICE guidance is published on an existing clinical commissioning policy topic, it will either replace, or be incorporated into the policy.

Evidence Review

Evidence Reviews can follow different routes

Licenced Drugs	Commissioning Support Documents (CSD)
Clinically urgent	Rapid Evidence Review (RER)
Medical Technology	Medical Innovation Briefing (MIB)
Limited Evidence Base	Public Health England Evidence Review
Complex Evidence Base	Independent Evidence Review

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Phase B Impact Analysis

The **impact analysis** is the second of three phases to form a national clinical policy. It is coordinated and managed by the National Programme of Care (NPOC) team and concludes through a Gateway managed by the relevant Programme of Care Board. During this phase, the draft proposition is subject to informal stakeholder testing, impact assessment, formal public consultation and an equality assessment. A Commissioning Implementation Plan is developed to consider in advance the timing and method of implementation if the proposition is then approved during Phase C (Decision).

There is a formal handover of the work in Phase A completed by the Clinical Effectiveness Team to the National Programme of Care Senior Team in NHS England

Stakeholder Testing. The NPOC confirms the stakeholders have been identified and tests the work completed by the Policy Working Group (PWG). The responses are reviewed and the Policy Proposition updated. An Engagement Report is completed

An **Impact Assessment** is completed. Key assumptions are debated and captured. The financial Impact is modelled over 5 years.

The **NPOC Board** receives the draft proposition and supporting documentation and considers its readiness for consultation. If approved, the Board determines the appropriate length of time for the public consultation to run

In Year Service Development

The great majority of policy propositions should follow the path to 'relative prioritisation' with decisions of investment being made once a year. Propositions that are cost neutral or cost saving, clinically urgent or low cost can be considered 'In Year'. Those which seek additional resource can be considered 'In Year' if the following three criteria are met:

- It is very likely that the proposed service would have been supported by NHS England in the last annual commissioning round, as it represents as **high or higher priority** than other service developments which were approved
- The proposed service to be developed is both **highly clinically effective and has a cost benefit priority level that is being commissioned by NHS England**; and the evidence is robust enough to achieve a high level of certainty
- The proposed service is **affordable** in the current financial [illegible] for the foreseeable future.

Levels of Consultation

Level 1: Minor changes – no further consultation
Level 2: Medium changes that are broadly supported by stakeholder engagement - up to 6 week consultation, limited engagement activity during the live consultation
Level 3: Significant changes that are broadly supported by stakeholder engagement - up to 10 weeks consultation to include some proactive engagement activities during the live consultation period
Level 4: Significant change with some contentious aspects 12 week consultation to include some proactive engagement activities during the live consultation period
Level 5: Highly contentious/ high volume impact on numbers of stakeholders/ high levels of dissent/ high financial implications/ high media or political profile. 12 week consultation plus an extensive range of pre and during engagement activity

Categories of Consultation Outcome

Category 1. Recommendation for approval with no significant service change or convergence cost to implement product. **Category 2.** Recommendation for approval with potential for service change or convergence costs that requires further analysis and discussion
Category 3. Recommendation for further development as the revisions required are substantial, require service reconfiguration, and/or have a known convergence cost
and may need further consultation before approval.

A **public consultation** is undertaken, and responses collated. Changes are made as appropriate on the basis of the feedback received and a **Consultation and Equality Report** is produced.

The NPOC approves the policy documents as complete, that effective patient and public engagement has been undertaken, and the finance impact of the proposition is fully defined

The suite of papers are handed to the Clinical Effectiveness Team for submission to

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Phase C Decision

The **decision** is the final stage of three phases to form a national clinical commissioning policy. It is coordinated and managed by the Clinical Effectiveness Team (CET) and concludes with the publication of the policy. There are three Gateways within this phase: Clinical Priorities Advisory Group (CPAG); Specialised Commissioning Oversight Group (SCOG); Specialised Commissioning Committee (SCC).

On completion of Phase B there is a formal handover of key documents to the Clinical Effectiveness Team (CET).

The final policy proposition is checked for consistency, accuracy and to ensure that it is written in plain language. A **library pack** and an **evaluation pack** is prepared. **A Summary Report** is populated in preparation for the CPAG.

The **Clinical Priorities Advisory Group** (CPAG) receives the evaluation pack for all the propositions to be considered for relative prioritisation. As a group they determine the relative patient benefit of each proposition in Low, Medium, and High.

The **Cost per Patient** is determined and the propositions equally divided by rank into the highest, medium, and lowest cost.

A 3x3 matrix is then established with cost on the Y axis and patient benefit on the X axis.

Cost per patient

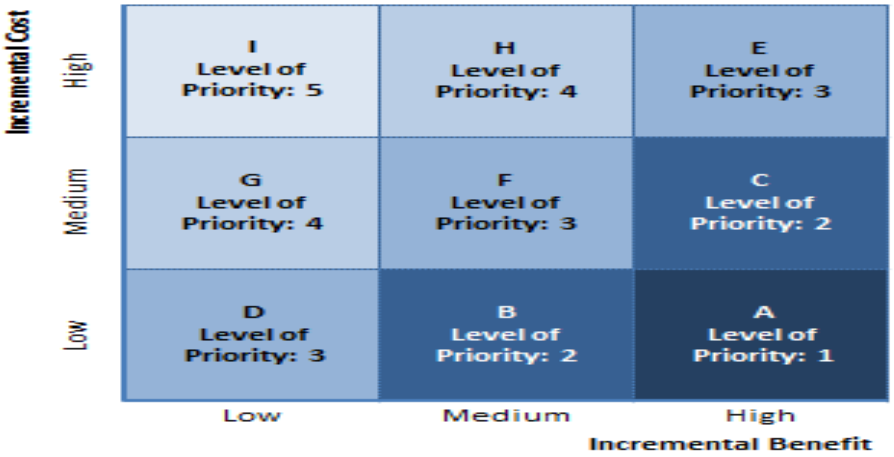
The cost to NHS England over 5 years divided by the number of patients receiving the treatment over the 5 years.

Evaluation Pack

- Summary Report Part I (evidence and service impact)
- Summary Report Part II (finance)
- Clinical Evidence Summary
- Clinical Panel Report
- Consultation Report
- Public Health Lead Report where required
- Equality Report
- Final Policy Proposition

Publication

In Year Service developments are published throughout the year. Relative prioritisation decisions are published as soon after the SSCC as possible. A circular, with a letter to providers, is distributed to the local commissioning teams to support the introduction of the new clinical policy.



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The **relative priority** is determined into 5 levels. Level 1 having the lowest cost and highest benefit, level 5 the highest cost and lowest benefit.

The members of CPAG consider whether the relative priority of any of the propositions should be considered for adjustment based upon NHS England's strategic principles.

SCOG receives the cost-benefit assessment, determines the available resource for discretionary investment, and makes recommendations to the SSCC.

The **SSCC** receives the priority order, and makes the investment decisions.