Neurological Alliance submission to Specialised Services Taskforce July 2014

The Neurological Alliance is the only collective voice for more than 80 national and regional brain and spine organisations working together to make life better for 10 million children, young people and adults in England with a neurological condition. We aim to raise awareness and understanding of neurological conditions to ensure that every person diagnosed with a neurological condition has access to high quality, joined up services and information from their first symptoms, throughout their life.

This submission to the Specialised Services Taskforce sets out the Neurological Alliance's view of the specialised commissioning issues relating to neurological services.

Summary

- Confusion at Clinical Commissioning Group (CCG) and Area Team level on local commissioning responsibilities for neurological services, arising from inconsistent statements in the current **Manual for Prescribed Specialised Services** and the **Neurosciences Service Specification**. The latter in particular can be, and has been misinterpreted by CCGs to mean that they have no neurological commissioning responsibilities.
- The **lack of outpatient coding** for neurology, meaning that NHS England defines specialised neurological services by the care environment in which they are delivered.
- Growing evidence that due to the confusion around the division in neurological commissioning responsibilities and the lack of neurology accountability and incentive at CCG level, services and treatments that are the commissioning responsibility of CCGs **are not being commissioned**.
- The **specialised commissioning budget** as a whole is too small to meet current demand; NHS England must acknowledge that it isn't possible to prevent people with neurological conditions from needing access to these services given the unpreventable nature of almost all neurological conditions.

1. The lack of clarity on specialised and non-specialised neurological services

There is considerable and ongoing confusion at CCG level about commissioning responsibilities for local neurology services. This confusion is the product of the lack of clarity on the question of what is commissioned nationally by NHS England and what is commissioned locally by CCGs. The current Manual for Prescribed Specialised Services and the Neurosciences Service Specification contradict each other on this point. The latter in particular can be, and has been misinterpreted by CCGs to mean that they have no neurological commissioning responsibilities.

The definition of a specialised neurology service contained within the Manual for Prescribed Specialised Services sets out that neurology inpatient and outpatient services at Adult Neurology and Neurosciences Centres are to be commissioned nationally, while those neurology services provided at local hospitals or in the community are the commissioning responsibility of CCGs. However, the definition of a specialised neurology service presented in the neurosciences service specification goes further than the Manual by incorporating a

three-tiered generic service model. The model appears to encompass all neurology inpatient and outpatient activity, including care provided in the community by all members of a multidisciplinary team and irrespective of whether they are specialists. For example, physiotherapy and community nursing are given examples of specialised local and community primary care services.

> "Local community and primary care services, for example, physiotherapy and community nursing where skills can be developed with the assistance of specialist staff from the Hub centres in order to provide ongoing basic maintenance for people with neurological conditions."
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> *Neurosciences Service Specification, specialised services Tier 1 description, p. 7 for reference*

The result of this contradiction is confusion among commissioners over where specialised commissioning responsibilities lie. There is increasing evidence that specialised services are not being commissioned as a result of this issue, including the following:

- NHS England (South Yorkshire and Bassetlaw) cited the interim neurosciences service specification as evidence that specialist multiple sclerosis nurse posts should be commissioned by NHS England, despite clinical consensus that these positions are the commissioning responsibility of CCGs.
- Birmingham's Queen Elizabeth Hospital, the regional centre for brain surgery, has suspended the refractory epilepsy surgery because NHS England would not pay for it.
- In the past year, tertiary referral rates are down by half at the Sir William Gowers Centre, an NHS unit offering specialised assessment and treatment for people with seizures, which is affiliated to the National Hospital for Neurology and Neurosurgery and part of Epilepsy Society.

Recommendations:

Commissioners at national and local level need a definitive list of which neurology services and treatments are commissioned nationally by NHS England. This needs to be clearly articulated by subspecialty in the neurosciences service specification and the Manual for Prescribed Specialised Services. Both of these documents need to be consistent with each other.

NHS England should:

1. Acknowledge widespread confusion amongst commissioners about the split between national and local commissioning responsibilities for neurological services.
2. Task Area Teams to clarify local neurology service commissioning responsibilities to CCGs.
3. Agree to consult on a revised neurosciences section of the Manual for Prescribed Specialised Services and publish it as soon as possible thereafter.
4. Commit to a timescale for publication of a version of the neurosciences service specification in which the definitive list of specialised neurological services is articulated.

2. The lack of neurology outpatient coding

The ability of NHS England to define precisely which neurological services are specialised is also linked to the current lack of outpatient coding. In its absence, very broad coding is used based on the environment in which a service is delivered as opposed to the service itself. In its most basic terms, any service or treatment provided at a Neuroscience Centre is currently defined as specialised activity while anything provided at a District General Hospital (DGH) or community care environment is non-specialised; however, in practice much activity at neuroscience centres is non-specialised. It is therefore not possible to accurately track neurological activity and spend across the system.

As there is no mandatory tariff for outpatient neurological services, centres are able to negotiate tariffs locally and inflate the cost of non-specialised activity on the basis of the expertise the centres have to provide their specialised services. The upshot of this is that the cost of a non-specialised outpatient appointment, for example, at a neuroscience centre can cost double or triple the amount that it costs for the same appointment at a District General Hospital.

The implications of this are that CCGs are keen to refer non-specialised work to neuroscience centres as NHS England picks up the tab, but this work costs the NHS substantially more than it would if it were done by a neurologist at a District General Hospital.

Recommendations:

Outpatient coding for neurology needs to be developed and introduced as soon as possible. This will ensure that specialised neurological services can be identified and comprehensively commissioned and their outcomes measured.

NHS England should set out and commit to a timetable for the development of neurology outpatient coding, specifying who/which organisation is responsible.

3) Specialised commissioning funding

We are aware of NHS England's push to find savings within the specialised services budget, which will be driven by the five year strategy for specialised services. It is vital that specialised neurological services, the demand for which will continue to grow for this collection of currently predominately unpreventable conditions, are not jeopardised by this savings drive.

The wider budgetary spend on neurological conditions must also be taken into account. As there is no Payment by Results tariff for outpatient neurology activity, there exists significant variation in the amount of money paid for outpatient neurology activity. This is based on the environment in which an activity takes place and regional arrangements. Ironing out these variations in spend has the potential to deliver better value neurological care and avoid direct cuts to the budget for specialised neurological services.

Recommendations

NHS England should acknowledge that it needs to gather information on specialised neurological expenditure before any decisions on how to achieve better value for money can be achieved is agreed.

For more information see www.neural.org.uk or contact Alex Massey, Senior Policy and Campaigns Adviser, on alex.massey@neural.org.uk