Integrated Care Systems Network
NHS Confederation

A vision for specialised commissioning

Lessons for future delegation

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This report is based on interviews and a national stakeholder meeting, co-developed by the NHS Confederation and Boehringer Ingelheim, commissioned and funded by Boehringer Ingelheim.

February 2025

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NP-GB-105318
Date of preparation: February 2025

Key points

- On 1 April 2025, NHS England delegates responsibility for 70 specialised services worth £14 billion per year to integrated care boards (ICBs).

- Delegation of these services is part of a wider shift away from siloed commissioning of individual services towards a more strategic, whole population approach that aligns with the government's priorities for the NHS. Delegation offers new opportunities to increase resourcing for prevention, support shifts in care from acute to community settings, improve integration and staff experience, and design services that better enable underserved communities to access care. Early adopter systems have already begun to transform some services and establish new ways of working to capitalise on these opportunities.

- However, the fragmented approach taken to delegation does not reflect the significance of this shift and the speed of the rollout has caused issues for early adopter systems in their first year. Issues include a need for further capacity and capability, missing data and information and the need to ensure the stability of specialised service providers.

- Early adopters provided suggestions to mitigate these risks for the ICBs taking on responsibility in April 2025, such as allowing sufficient time and focus for the transition, working collaboratively with providers, and prioritising a few areas for initial transformation.

- We recommend that NHS England works closely with systems to ensure they are stable, supported and sufficiently resourced to make these substantial shifts towards strategic commissioning.

Introduction

In April 2025, NHS England will delegate responsibility for the commissioning of 70 specialised services worth £14 billion per year to integrated care boards (ICBs) in England.[1,2] Delegation aims to empower local systems to better manage local population health needs, tackle inequalities and integrate previously fragmented pathways of care.[3] As with the 2023 delegation of pharmaceutical, general ophthalmic and dentistry (POD) services, a subset of early adopter systems have undergone the transfer of some services ahead of the rest of the country.

To support members with these shifts, throughout September and October 2024 the NHS Confederation and Boehringer Ingelheim convened a roundtable of stakeholders from across England and undertook a series of interviews with senior leaders from ICBs, NHS England, provider organisations and other groups with an interest in the commissioning and provision of specialised services. This report is based on those conversations and sets out how local health and care systems and NHS England can ensure the success of delegation and seize the opportunities it offers for integration and patient care.

We would like to thank all those who have been involved in our engagements and contributed to the development of this report. While we have endeavoured to capture and reflect the experiences of our members, this report sets out the view of the NHS Confederation and not necessarily that of any single ICB, provider organisation or stakeholder involved.

Background: from fragmentation to integration

Prior to 2013, primary care trusts (PCTs) were responsible for commissioning specialised services, which they did at a larger regional footprint through collaborative specialised commissioning groups.[4] The 2012 Health and Social Care Act abolished PCTs and gave most of their commissioning responsibilities to 211 clinical commissioning groups (CCGs).[5] As the budgets held by CCGs were intended to serve much smaller populations – too small to effectively commission specialised services for – the act centralised specialised commissioning, centred around providers rather than populations, making NHS England the single accountable commissioner.[4] This was just one part of the fragmented commissioning of care pathways outlined in the Darzi review.[6]

To enable better integration of services, the Health and Care Act 2022 abolished CCGs and gave their commissioning responsibilities to 42 ICBs, responsible for larger populations than CCGs.[7] Ahead of the act in July 2021, NHS England announced its intention to delegate responsibility for the commissioning of some specialised services to ICBs.[8] In April 2023, the first stage of delegation occurred – nine statutory joint committees were established between NHS England regions and the ICBs within them, each tasked with overseeing and taking commissioning decisions for 59 specialised services.[9] These include services for both adults and children, encompassing a range of specialties including cardiology, pain management, foetal medicine services, renal services, specialist cancer services, and specialist palliative care for children and young adults.[9]

Based on ICBs' assessments of their readiness, NHS England agreed that full delegation of the 59 services to ICBs would occur in April 2024 for three regions: the East of England, Midlands and the North West. Joint commissioning

arrangements would remain in the other regions until full delegation in April 2025.[9] NHS England has subsequently agreed for a further 11 specialised services to be delegated.[1] As a result, in April 2025 NHS England will delegate responsibility for the commissioning of 70 specialised services to ICBs.[1]

This shift comes as part of a wider picture of delegations from NHS England to ICBs. The delegation of pharmaceutical, general ophthalmic services and dentistry (POD) services occurred in April 2023, nine months after nine early adopter systems tested the process by taking on responsibility for commissioning some or all POD services.[10] NHS England also announced in July 2024 that responsibility for commissioning vaccination services, suitable elements of screening pathways and child health information services will be delegated to ICBs from April 2026.[1]

Delegating specialised commissioning is therefore part of a much more significant shift that consolidates commissioning responsibilities within ICBs and moves the NHS away from siloed commissioning of individual services towards a more strategic, whole population approach. This is intended to enable ICBs, working closely with providers and other partners, to improve the health of their populations and provide better value, more integrated, and more patient-centred care.[3]

Delivering better outcomes and value from existing budgets is essential. The Darzi review reported that:

"Over the past decade, NHS spending on drugs for specialised services has grown at 8.9 per cent a year, while for devices it has increased at 10.2 per cent annually. This far outpaces the rate of growth of the total NHS budget, meaning that specialised services account for a growing share of expenditure... [and] an inexorable pressure on costs."[6]

Given the growth in budgets, taking on this responsibility creates potential risks which ICBs will need to understand and manage effectively.

The vision for specialised services: opportunities from delegation

Integrated care systems (ICSs) were established to improve integration and collaboration between services and to convene partners to improve population health.[7] Delegation of specialised services is just one step in a wider pattern of consolidating responsibility for a broader range of functions in ICBs, empowering them to more effectively design services around the needs of their communities.[3] The delegation of POD services to ICBs in 2023 has already offered early benefits to some systems in transforming and integrating services, as detailed in our report on the delegation.[10]

Although there have been challenges with the process of delegation so far, it offers clear opportunity to improve patient care and better integrate services. Both ICSs and providers have a clear understanding of the potential benefits and are beginning to take steps towards them.

Increased resourcing for prevention

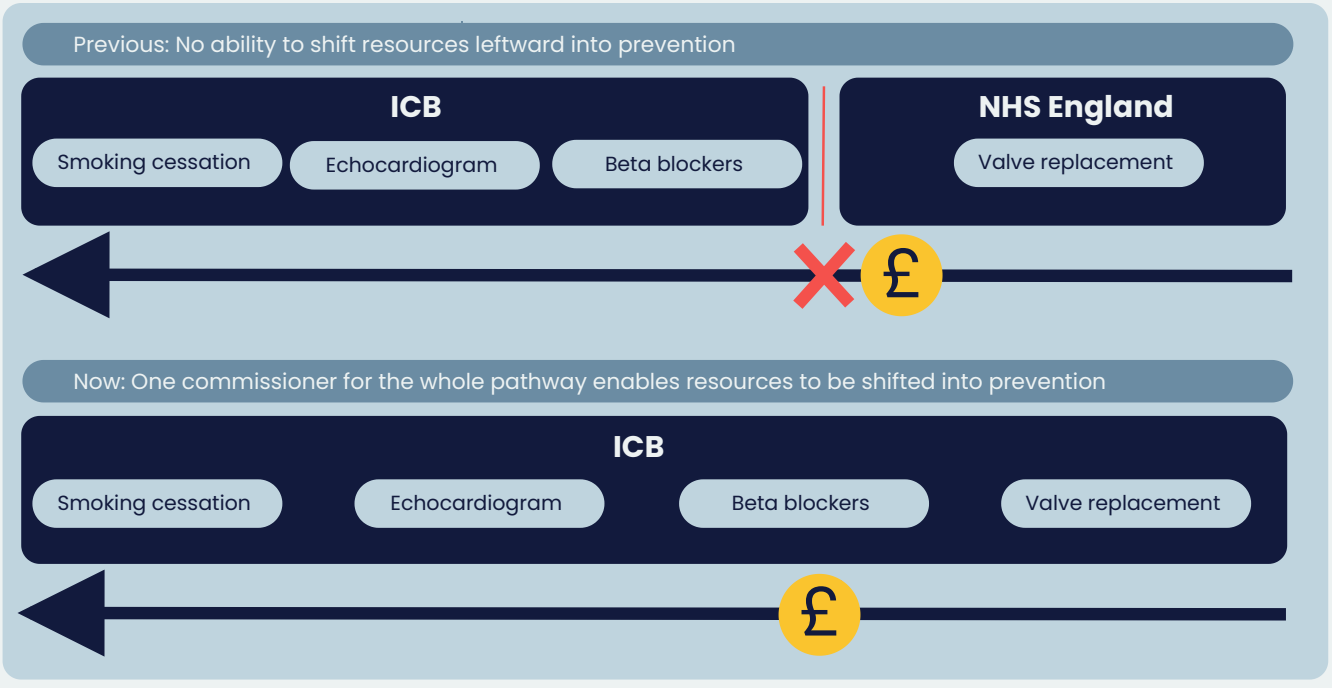
Shifting from treatment to prevention is one of the three major shifts the new government wants to achieve and is essential for helping people live longer, healthier lives and ensuring the performance and sustainability of the healthcare system.[11]

Delegation of specialised commissioning provides commissioning bodies with **oversight of entire care pathways** for the first time since 2013, allowing them to take strategic decisions about resource allocation that most effectively

support those populations.[4] This can include supporting efforts to invest in prevention, by offering new opportunities for systems to move resources leftward along care pathways into primary, secondary, or tertiary prevention.

NHS leaders we spoke with believe that **investing in earlier intervention can reduce demand for specialised services in the long run**, especially when this is delivered at system level. At the moment, services for specialised conditions and the services to prevent those conditions are commissioned by separate entities, NHS England and ICBs, respectively. By bringing these services under the same commissioner, there are significant opportunities to join them up. This includes shifting resources for a condition away from specialist provision into prevention, such as in the example of health valve disease below, but also linking data about how people are using specialised services into wider analyses about unmet need, with the potential to prevent future illness.

Example: **Potential system for a 'left shift' of monies into prevention in heart valve disease**



Improved access, integration and value for money

Despite progress over the past 20 years, we heard from leaders that there is still significant fragmentation and variation in the provision of specialised services. The high proportion of specialist services in some urban areas has driven unequal distribution of services and expertise across the country and led to variation in access. For patients further from specialist sites in big cities, this geographical barrier can be very challenging, particularly for those with conditions that make travel difficult.

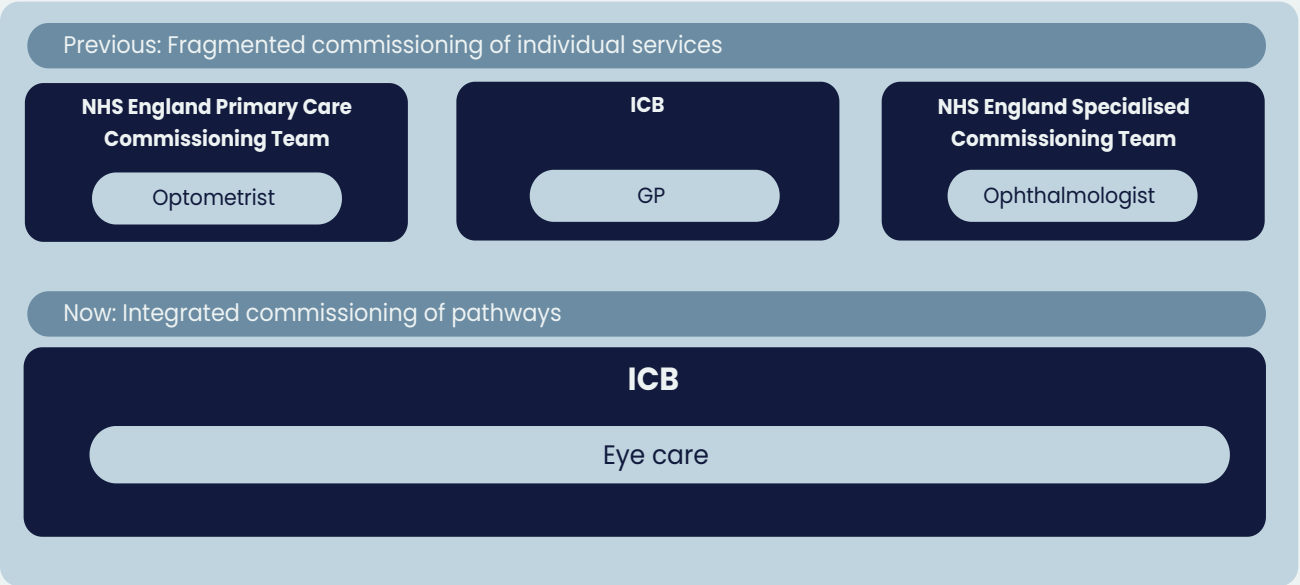
We heard from leaders that **delegation of specialised commissioning offers new opportunities for ICBs to improve their populations' access to specialised care**. For instance, ICBs and specialised providers can organise 'satellite models' where specialists travel and provide specialised care in local district general hospitals for patients who would otherwise have a long way to travel to services. This can both improve access to services as well as expand research trials. Specialised providers can develop training programmes to support local centres with trials and to administer or support the monitoring of innovative therapies. There are also new opportunities to use technology to improve access and reduce cost, such as through remote monitoring.

By holding the budget for whole care pathways, from primary through to specialised services, **ICBs will be better able to commission joined-up care pathways and focus resources where they can be most effective**, rather than having to navigate the transitions where ICB-commissioned mainstream services connect to NHS England-procured specialised services.[4] This is part of a wider change from commissioning individual providers to pathways of care. We heard that in some services, such as renal care, there is a clear logic to joining up specialised and non-specialised services. Over time, depending on the patient population, other services such as chemotherapy could move out of the specialised services portfolio to be considered as part of general care.

Leaders told us that where silos exist, there can be a tendency for decision-makers to prioritise choices which benefit their own budgets at the expense

of wider benefits for the system. The idea behind changing this is allocative efficiency: "Once resources are considered in totality for a population it becomes easier to ensure they are being invested in the most optimal way to improve quality, reduce health inequalities and improve value".[4] Crucially, consolidating budgets across pathways means ICBs can be more accountable for actual health outcomes, not just the volume of activity in individual services, which is key to enabling a wider shift in care towards primary and community services.

Example: **New ability to commission eye care as a pathway**



Working collaboratively at a system level empowers providers and commissioners to think differently, solve collective problems and innovate. **Bringing together commissioners, clinicians and residents across the whole pathway can help improve the knowledge and experience of all parties** involved and enable expertise to be shared between different parties. This offers new opportunities for staff development and empowerment while keeping key people in local services.

Having separate commissioners for different elements of the same patient pathway offers limited incentive for specialised providers to support and integrate with other services. We heard from participants that joining up these services, so that specialised providers can help shape the delivery of other services that their patients access, offers opportunities to improve patient care by embedding specialist expertise in other parts of the pathway. **To be most effective, ICBs should work closely with specialised providers**, given their clinical expertise in specific conditions.

Case study: Improving access to interstitial lung disease care in Morecambe Bay[12]

Interstitial lung disease (ILD) rates in Morecambe Bay, a rural area where agriculture and shipbuilding were historically important industries, are above the national average. University Hospitals of Morecambe Bay NHS Foundation Trust has two main sites, one in Lancaster and the other 50 miles away in Barrow-in-Furness. Until relatively recently, ILD patients, as well as those with severe asthma, have had to travel up to 2.5 hours each way to academic centres in Manchester or Liverpool to access the care they need – a journey made more challenging by their conditions.

Local systems in the region collaborated to join up their services. Specialised service providers in Manchester provide ILD monitoring and support services remotely in Morecambe Bay once patients have been started on treatment. The Morecambe Bay team connected with colleagues at other hospitals in the region to establish the North Lancashire and South Cumbria Interstitial Lung Disease Network, which was awarded specialist prescribing. Morecambe Bay Trust has been given the status of a satellite specialised service.

Patients can now access a tertiary specialised outpost clinic in Barrow where they can receive care from a virtual multidisciplinary team twice a month. Medical staff on site can prescribe drugs not previously available via the site, and patients in Morecambe Bay now have greater access to research trials. In addition, the development of a local integrated care

network (the Morecambe Bay Respiratory Network) has facilitated direct access to specialist tests and opinion resulting in earlier diagnosis and access to specialist ILD medication. Providing the service in this way has led to a reduction in duplication of tests, as well as improving speed and convenience of access for patients.

Tailored provision informed by local need

Delegating specialised commissioning responsibilities to ICBs, who are closer to local communities, should allow local links, present in the PCT era, to be re-established. We heard that **local demographic and geographic factors can better inform service configurations decisions and help tailor services** to patients' needs, improve accessibility and better integrate with non-specialist care.

Linking specialised and non-specialised care data can reveal trends in demand and variations in the nature of provision. Access to this data allows systems to identify areas where there is high growth in the use of specialised services and provide increased support for patients both in terms of prevention and treatment. For example, one leader described how access to specialised services data allowed them to identify localities with higher rates of dialysis use, identify that they were underinvesting in support for chronic kidney disease and diabetes in those areas, and therefore increase investment to support those populations and help reduce demand in the long term.

Leaders told us that **local data can also allow commissioners to better understand the implications of geographical barriers** to patients accessing specialised services. Where pockets of deprivation and unmet need exist in rural and coastal areas, far from specialist providers, which can often be found in large cities, the inability of patients to access care can have flow-on effects for the development of comorbidities or demand on local services. Understanding the uptake of specialist care can therefore help commissioners plan services that address populations' actual health needs.

Case study: OneVoiceILD's Interstitial Lung Disease Care Pathway[13]

OneVoiceILD is a network that aims to bring together people with interstitial lung disease (ILD) and pulmonary fibrosis (PF) to improve care. ILD services are currently designated as specialist, and there are significant challenges for people accessing and receiving care. Based on the lived experience of over 1,200 people and in collaboration with service leads, GPs, commissioners, and researchers, OneVoiceILD's recently developed pathway sets out a vision for how ILD services can be organised across the UK.

The development of new specialist prescribing centres, working within a regional network to bridge the gap between primary, secondary, and community care and specialist ILD services is key to this vision. This model recognises the benefits of delivering high-quality care as close to home as possible to reduce pressure on other services, support collaboration and improve access and quality of care for patients.

What challenges have emerged from delegation so far?

Delegation of specialised commissioning is part of a wider programme of delegations to shift the NHS from siloed commissioning of individual services towards a more strategic, whole population approach. This shift requires a significant change in mindset among commissioners, providers and the public about how services should be designed and delivered.

Given both the opportunities of delegated commission and the challenges of the transition, there have been mixed views over the pace of delegation. Some stakeholders previously warned of risks of unintended consequences to access, resource and workforce morale if delegation did not proceed slowly and carefully, considering the complexity of specialised services and wider pressures in the NHS.[14] While the option to delay taking on specialised services until 2025 was welcomed, many would have preferred a still slower pace and felt that the delegation process has been fragmented and lacked a clear narrative and change model.

Lack of capacity and capability

Top-down pressures on finances and headcount and the fragmented approach to delegation of different services are driving issues with staffing that undermine systems' efforts to make the longer-term shift towards a strategic, whole population mindset. Some NHS leaders would like a clearer change model for delegation that fundamentally values the importance of managing staff robustly and kindly.

Wider shifts aside, just assuming responsibility for 70 new services and establishing the structures and skills to commission these effectively requires significant work that both early adopter systems and those who have yet to take on responsibility have found it difficult to resource. We have heard that delegation has involved umbrella approaches across multiple ICSs, with structures like joint committees, which also include NHS England regional representatives, and with functions generally physically located within one ICB. Although these arrangements are not unprecedented (PCTs used joint committees for specialised commissioning) establishing them and operationalising them can take some work.[4]

Some early adopter systems have found it **difficult to ensure that meetings are as frequent as necessary and that the right people can attend**. In one area, key decisions have been delayed by months because of an inability to convene decision-makers with busy schedules and numerous other priorities. Participants from this region similarly expressed concerns and issues with integrating the NHS England regional specialised commissioning teams, which they told us still felt separate, with agendas and work programmes reflecting NHS England staff's previous roles rather than the priorities of the ICBs. With insufficient headspace to build these relationships and prioritise these key discussions, the process of taking on specialised services has felt distant for many.

This new joint commissioning decision-making must also be informed by, and feed into, the priorities of individual ICSs. Specialised services are by their nature complex, with strategic decisions until now being made by small groups of experts at the national level. Leaders told us their systems **lacked the skills or headspace to critically assess the services they are inheriting**, with some feeling that they are taking on responsibility and risk for services they do not have the expertise to effectively evaluate.

As we found in our report on the delegation of POD services, taking on responsibility for commissioning services is one thing; taking on transformation is another.[10] Some leaders told us they simply did not have the headspace to consider making changes to how specialised services are delivered. Considering the vast portfolio of services being delegated, it is unclear when

ICBs and regions will have enough time and headspace to consider the shifts needed for some of these services, especially those on the more specialised end of the pathway with fewer affected patients.

Missing information

We heard concerns that some important service-level activity **data and service specifications are not yet available**. With less than six months until all ICBs are to take on these services, this information is essential for ICBs to be able to forecast future demand and the financial risk that comes with the new responsibilities they will be taking on. This is particularly important given many systems are struggling to achieve financial balance and are under significant performance management pressure as a result.

Leaders noted that there have been delays in updating national service specifications, and a backlog of these was forming, including specifications for some services that are due to be delegated. They noted this posed a risk for ICBs, many of which do not have significant expertise in specialised services and may be reliant on service specifications to support them with the immediate transition. There is significant lack of clarity about the timeline for updating service specifications and the plans for their use in the future, and a potential conflict between providing consistency and support and limiting local transformation.

In some areas, **lack of detail about funding arrangements have made it difficult for systems to plan for their new responsibilities**. For instance, services commissioned through mental health provider collaboratives are now in scope for delegation from 2025,[15] but we heard that the allocation formula has not yet been released. Leaders reflected on the difficulty of determining how funding streams are to be used for POD services, and noted that, as specialised services are significantly more complicated, there is a risk that accountabilities are unclear and systems could lose financial control.

Risks to the stability of specialised services

Several NHS leaders flagged risks they saw to the stability of specialised services. From providers overall there were concerns that **when ringfencing was removed, potentially moving resources from specialist providers to other parts of the system**, particularly in times of financial challenge, could be destabilising.

There were also wider concerns about how baselines were calculated. **The provider eligibility list (PEL) was a recurrent issue raised by participants**. We heard that the same service can be classified as specialised or non-specialised depending on whether the trust providing it is on the list or not, and that this was most common for outpatient services, where less detailed data is captured. As a result, some systems with higher-than-average numbers of tertiary services may report a higher level of specialised service provision than others simply because a specialised service provider exists in their area. Similarly, systems with particular characteristics, such as a higher-than-average number of prisons and young offender institutions, may have levels of specialised service provision in particular areas that look inflated when these characteristics are not taken into account.

These factors should be considered when determining allocations to specialised services and when creating baselines. Leaders told us there would be risks if national decision-makers begin to set overarching expectations about spend using mechanisms such as the mental health investment standard before baselines have been appropriately established.

Leaders recognised that disease prevention activity in particular yields results over a long-time horizon, meaning that it is unlikely to reduce demand in the short term. This poses a challenge to the idea that large funds can be moved quickly from the treatment of conditions requiring specialised services into activity that prevents these conditions from commonly occurring in the first place. There is also a risk of stranded costs for certain specialised services, which will always require a baseline level of investment regardless of the success of prevention work to reduce demand for them.

Finally, some provider leaders noted that devolving budgets to ICBs could have negative impacts on providers' stability by incentivising ICBs to invest in their local providers rather than specialist centres outside their footprint, even if their populations are using services from that provider. There was some concern that this could encourage local providers to establish 'specialised' services to access specialised funding from their ICB that are less cost effective and more clinically risky.

What can we learn from early adopters?

While wider changes are necessary for systems to fully capitalise on the opportunities from delegation, early adopter systems have made recommendations for ICBs taking on responsibility for specialised commissioning from April 2025, which include:

- allowing sufficient time and focus to take on the new responsibility
- working collaboratively with specialist providers
- prioritising a few areas for transformation.

Allow sufficient time and focus

Leaders highlighted the importance of resourcing the transition. This did not relate solely to funding, but rather **ensuring that senior leadership time was allocated to the transition project**, both on the commissioner side and the provider side. Systems recommended that time is taken to ensure joint specialised commissioning meetings are scheduled early and with clarity of purpose, so that all necessary stakeholders can attend and contribute as fully as possible.

Providers described how by making senior staff capacity available, they had been able to drive plans forward across multiple organisations, as well as unlocking improvements for commissioners in their regions (see Cambridge University Hospital NHS Foundation Trust case study on page 22). Ensuring that staff working on the transition can access expertise in strategy and project

management, but also in areas such as data analysis, is important to ensure that transition projects run smoothly and the right information is available to partners.

ICBs should **manage expectations about the pace of any change in specialised services**. Staff at one system spoke of this as a five- to ten-year project, with the early stages involving "quite small, tactical stuff that wasn't going to change the world but nonetheless is really important to those individual programmes".[12] These small changes improve individual care pathways and allow the teams involved in the transition to build confidence across the system so that they have the capability to deliver the wider programme of change.

Work collaboratively with providers

ICBs are not necessarily experts in specialised conditions and will assume their new functions in a constrained environment with competing priorities. While NHS England's regional specialised commissioning teams can offer support, **understanding of patient need and uptake of specialised services is often best found through specialist providers**. Working collaboratively with these providers offers ICBs the best chance at seizing the opportunities offered by delegation.

Leaders from early adopter systems said that **ICBs and providers taking the time to develop a shared vision for the future was the key enabler for transformation taking place in practice**. We heard from several providers who are increasingly seeing their role as providing strategic advice and expertise in collaborative, system-wide decision-making. One provider described the current spend on specialised services as a "burning platform", and said they saw part of their role as working with the wider system to support shifts in patient care out of hospital into the community.[12]

Clear and comprehensive service data is necessary to identify trends in variation and drive improvement. In some areas with insufficiently granular data, systems have worked with specialised networks to get a better

understanding of the current state of play. We heard this was especially true of providers that provide both specialist and non-specialist services, which already have oversight of the linkages between different parts of the patient pathway that can provide crucial insight to ICBs and help inform service decisions.

Case study: Cambridge University Hospital NHS Foundation Trust[12]

Cambridge University Hospitals NHS Foundation Trust (CUHFT) is part of a seven-trust specialised services provider collaborative in the East of England, which is improving equity of access to specialised services for patients, maximising existing resources and optimising research and innovation. The collaborative is determining what specialised services should look like in future and, in the shorter term, designing different ways of providing care. The provider collaborative is liaising regularly with ICBs to help familiarise them with the specialised services portfolio and provide a clinical perspective to service design.

Delegated responsibility has already allowed ICBs and the provider collaborative to reform some specialised services. For example, CUHFT has expanded its provision of disease modifying drugs for muscular sclerosis, working in partnership with a large district general hospital. It has also digitised seizure patients' engagement with neurophysiologists, so they can digitally upload information about their seizures in advance of remote consultations. Over a wide geography, these changes improve timely access to care for patients who live further away from CUHFT's main hospital site, often in rural areas, within the trust's available resources. Faster access to care and treatment also reduces the number of necessary admissions of patients with more complex conditions in the long run. In this way, delegated commissioning and coordinated planning by ICBs and providers can improve patient care and deliver better value for money.

Prioritise a few areas for transformation

Numerous NHS leaders spoke about the lack of capacity and headspace for them to prioritise transformation work. Where progress has been made, participants described identifying **shared priorities and designing programmes of work around them**. For some regions that has meant working towards better equity of access across multiple ICSs and improving productivity. For others it has meant identifying specific pathways where they see the greatest potential to improve outcomes, including ensuring pathways and services are more patient focused. Identifying **a few priority areas to focus on in the short term can help build momentum and relationships**, and support significant gains for patients in the short term.

Conclusion

The transfer of responsibility for the commissioning of specialised services brings these services back within the remit of local and regional commissioners for the first time in more than a decade, undoing the fragmentation of the 2012 Health and Care Act and supporting a more strategic, whole population approach to the delivery of care that aligns with the government's three big shifts for the NHS.

Delegation offers new opportunities to increase resourcing for prevention, support shifts in care from acute to community settings, improve integration and staff experience, and design services that better enable underserved communities to access care.

However, the fragmented approach taken to delegation and the speed of the rollout is hindering systems' ability to make the shift to strategic commissioning and capitalise on the opportunities from delegation. We have heard of issues for early adopter systems, including significant issues in staffing and resource, missing information, and potential for risks to the stability of specialised services.

Early adopter systems have offered suggestions for how to mitigate these challenges, discussed in this report. We recommend that NHS England works closely with systems to ensure they are stable, supported and sufficiently resourced to make the wider shift towards strategic commissioning.

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Registered charity no. 1090329