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BERKSHIRE WEST CCGs

Commissioning Ambitions 2016-17

Publication Date: 30th October 2015

1. PRINCIPLES

Our commissioning ambitions for 2016/17 outline the strategic interventions we are planning to improve the way we commission, review and transform local services. They respond to both the Five Year Forward View and build on the progress already made through delivery of the Berkshire West CCGs 5 Year Strategic plan and local CCG Operational Plans to deliver sustainable consistent care standards across the CCGs. They also mirror the collective vision of the 10 Berkshire West Health and Social Care partners in our system.

Our message to patients is:

'Together we will support you to stay well and deliver great care when you need us ...'

There will be joined up care and support that meets your needs and helps you to be as independent as possible...

This joined up system, focused on people, will be seamless, and underpinned by an activated, responsible population...'

The priorities set out in the CCGs Five Year Strategy and the NHS England Five Year Forward View remain; the prime focus being on improved quality of patient care provided within a financially sustainable health and care sector. We will reflect national strategies and priorities in all our agreed contracts for 2016/17, and adopt national planning guidance requirements when available.

The following principles will support our commissioning ambitions for 16/17:

- To put a greater emphasis on prevention and putting patients in control of their own care planning including through the expanded use of technology enabled care, multi-disciplinary care planning led by GPs here (under Anticipatory Care CES), and proactive support for carers and families. This will underpinned through CCG Programme Board led pathway redesign, service line reviews and the development of the CCG QIPP programme for 16/17.
- We will commission services which provide our populations with more information and choice about the full range of service providers, ensuring care closest to home is offered wherever possible.
- We will work with providers to explore opportunities to move away from disease specific pathways to care delivery which is person centred and place based.

- We will work with providers to implement new models of care which better support better integration which expand and strengthen the role of primary and out of hospital care, whilst ensuring our acute providers are equipped to treat patients who require in-hospital care.
- We will work with our providers to ensure that appropriate levels of care and diagnostics are available across the week which enable achievement of improved health outcomes for our populations.
- We would want to work with providers to ensure that contracts are delivered within the agreed financial and activity envelope.
- We would want to explore new payment mechanisms which incentivise the delivery of outcome focused care at the right time in the right place, and which support the future sustainability of our local health and care system.
- We will use 2015/16 forecast outturn as the basis for baseline setting unless there is a clear rationale to do otherwise.
- We will only purchase treatments and drugs that are evidenced to be cost-effective, either through NICE TAG or evidence reviews that have been specifically accepted and adopted by Commissioners on the recommendation of the Thames Valley Priorities Committee.
- For non-tariff services, we will uphold the requirements of the National Contract, ensuring that prices paid are transparent, fair and representative of actual costs incurred.
- We will seek demonstrable improvements in quality across all services and will expect providers to implement a range of best practice pathways for specific treatments and conditions within the agreed contract value.
- We will continue to commission Community Enhanced Services from primary care where these support delivery of our strategic vision and will continue to co-commission primary care services with NHS England, exploring the benefits of the fully delegated model.
- We will actively consider decommissioning services that do not deliver the required performance and quality outcomes for patients.

1.1. New Models of Care

We will expect to be in a position to be able to describe our preferred models of care including, actively exploring the feasibility of formally adopting a PACS (Primary, Acute and Community) model where this supports integration with Primary Care and Social Care and offers innovative solutions in the context of the Five Year Forward View (NHS England October 2014) which address both the financial challenges facing our system, and the increasing demand for services.

Having built on the report published by the Kings Fund of our Frail Elderly pathway programme in 14/15, and in partnership with South Central and West Commissioning Support Unit, with Ernst and Young we will accelerate the design of a new model of care for older people as an exemplar cohort, assessing the financial opportunities and setting out the options for future models of care and contracting for delivery from Spring/Summer 2016.

The recently established Joint Primary Care Co-commissioning committee will continue to work to realise the vision for primary care services set out in the CCGs' Five-year Strategic Plan and emerging Primary Care Strategy. This strategy anticipates that primary care will play a pivotal role in a more integrated health and social care system, working to prevent ill-health and support people in the community wherever possible. As such any new model of care will need to interface with general practice. We will continue to assess the benefits associated with the opportunity for fully delegated commissioning of Primary Care.

The increasing number of people with complex health needs is a major challenge and we wish to move to more generic integrated pathways with greater joint working across health and care providers. This will require our main Providers to work together with the public and a range of partners from all sectors including Primary Care, social care the Independent Sector and the third sector to create a fully integrated system delivering new care models.

2. COMMISSIONING AMBITIONS

The prime objectives for the CCGs as set out in our 5 year strategic plan 2014-2019 are:

- Improving the outcomes and experience for people and
- achieving financial sustainability for the health and social care system.

Mindful of the national drive for further financial efficiencies the CCGs will be working with NHS England and other commissioners expecting Providers to continue to adopt recognised national best practice to achieve realistic year-on-year improvements in efficiency, productivity and effectiveness.

We therefore expect to conduct negotiations on our 2016/17 contracts with Providers which enable all parties to:

- Work within the financial envelope available and have a degree of certainty on income and expenditure
- Agree shared strategic priorities
- Improve levels of productivity and efficiency including through the expanded use of technology
- Eliminate any clinical activity that does not offer maximum patient benefit or cost and clinical effectiveness
- Review, reconfigure and re-specify services as appropriate

In line with the points set out above, we will continue to closely monitor and report provider quality achievement and will apply contractual actions as required and as set out by the NHS Standard Contract. We will seek to agree with Providers an appropriate balance of sanctions and incentives to maximise improvements in outcomes for patients.

Key areas for collaborative working include:

- **Better Care Fund:** We have worked with local Health and Wellbeing Boards on the creation of schemes that form our Better Care Fund (BCF) plans and as part of the development process we have engaged with our local providers. In preparation for 16/17 we will be formally reviewing performance against the metrics included in BCF planning requirements to we full understand the impact of the investment in 15/16. As responsible commissioners we will seek to minimise any commissioning risk to the provider in relation to transfer of services or funding into the BCFs. Following discussion at the Berkshire West Integration Finance sub-group, the principles that are proposed to be applied for 2016/17 are as follows:-

(a) Elements from 2015/6 BCF that ***should*** be included in 2016/17:-

(i) Connected Care (value to be determined), on the basis it is a key enabler to integrated working and fulfilment of at least one of the National Conditions specified
(ii) Existing S256 Agreement monies with a review and scrutiny over any funding included for Care Act requirements, with the expectation that any non-recurrent spend for 2015/16 is no longer required. The 2016/17 BCF Plans should also provide greater transparency on the use of funds designated against the Care Act
(iii) Existing DFG and Social care Capital grants (as committed LA spend)
(iv) As a minimum the amount specified by national guidance to be set aside in 2016/17 for the protection of Adult Social Care services, (when known)
(v) CCG and LA Reablement (key to integrated working across social and healthcare)
(vi) Carers funding (existing LA and CCG monies)
(vii) Schemes established in 2015/16 where they can be demonstrated through the evaluation process to deliver their intended outcomes, are assessed as should continue following evaluation using the BCF Self-Assessment tool and are supported locally

(b) Elements currently in the 2015/16 BCF that ***should not*** be included in 2016/17 are as follows:-

(i) Primary care CES re Enhanced Access – although this is an enabler of 7 day working and should probably be continued it is pure health and should not form part of a pooled budget in the BCF. As CCGs potentially move to delegated commissioning CCG Governing Bodies will want to ensure protection of this CCG funding for Primary care.
(ii) Care Act – CCG contributions re Care Act implications will be limited to that required by the national guidance for 2016/17 when known.

(c) Areas of Existing BHFT spend will be considered in collaboration with BHFT and LAs for inclusion in the 2016/17 BCF include but may not be limited to:-

(i) Adult Speech and Language Therapy
(ii) Community geriatricians
(iii) Intermediate care – (night sitting, rapid response, reablement & falls)
(iv) Intermediate Care and Rapid response service
(v) Health Hub

(vi) Hard to reach and homeless service
(vii) Intermediate care
(viii) Care Homes In-reach services

(d) Potential areas for possible future discussion for inclusion in 2016/17 BCF could include but may not be limited to:-

a. Safeguarding (LA)
b. EOL Care (LAs and CCGs)
c. Community Equipment (CCGs and LAs)
d. Prevention/Public Health (LAs)

(e) Areas of BCF spend not budgeted in 2015/16 but which should be considered to be included in the 2016/17 budget

i) Project Management costs
ii) Monthly metrics and data reporting
iii) IMHA Grant
iv) Veterans Grant
v) 7 Day Services as specified by the national guidance to meet the National Conditions

The financial values of the BCFs will be as set out in the NHSE Planning Guidance. For initial planning purposes, and pending receipt of that guidance, 2015/16 guidance will be used.

The finalisation of the 2016/17 BCF budget will be subject to detailed discussions between each Local Authority, its respective CCG and healthcare providers, taking into consideration the anticipated overall financial position of each organisation for 2016/17.

- **Frail Elderly Pathway Redesign:** The Frail Elderly work is system wide across the 10 BW partners. The intention is to determine the optimal pathway for this cohort of the population, identify how investment would need to change to deliver this, identify the optimal delivery model or new model of care, and recommend an appropriate contracting and funding approach. Frail elderly were selected as the cohort following the work by Capita two years ago which should that this group are the biggest cost driver in the system. The rationale was that this group would be an exemplar and the learning could be extrapolated more widely to determine the right model of care across the whole system. A contract has been let to the CSU in partnership with Ernst Young to undertake this work. The outputs of this programme which will be emerging over the

coming months including identified opportunities for "quick wins" will be used where possible to inform commissioning decisions for 16/17 and these will be explored with providers over the coming months.

- **Support for Carers**
  The CCGs, Reading Borough Council and West Berkshire Council will be recommissioning the advice and information service for Carers. Following Carers consultation a new commissioning model was agreed that will focus on developing the market through offering 2 year grants to voluntary organisations. This has been developed from previous discussions and intended to offer a consistent level of service, ease of access/referral across Berkshire West, and the opportunity to draw on local knowledge and expertise. To date, the bulk of our carers information advice and support services have been delivered by a single provider operating across Reading, West Berkshire and Wokingham.
  From April 2016, it the commissioners' intention that carers across Berkshire West (wherever they live) will be able to access local services that adhere to the same specifications and deliver the same high-quality standards, These services will be accessed through a common access number to simplify referrals and signposting into carers support by other agencies.
- **Voluntary Sector Commissioning**
  The CCG is the process of setting up the 2016-17 commissioning process for the Partnership Development Fund. This process will be aligned to the 2016-17 commissioning intentions to achieve health and wellbeing outcomes. The commissioning process will run from November 2015 to January 2016 and 1 year grant agreements will be issued for services to commence from April 2016. The CCG will look to improve the way that its commissions' wellbeing and preventative services from the voluntary sector and will run a fair and transparent process.
- **Berkshire Interoperability Project (Connected Care):**
- Interoperability is key to the delivery of the CCG strategy, underpinning our plans for Integration, our Better Care Fund plans and key programmes. It will enhance patient safety and quality of care, improve patient experience and provide significant opportunity for efficient use of clinical time. We are committed to rapid progress within and between providers and it is our expectation that all providers support the implementation in this critical enabler to all system strategies.
- **Technology Enabled Care:** The Commissioner will take a new coordinating role for the production and implementation of the Local Digital Roadmap as set out by the National Information Board and the Five Year Forward View. All Providers will be expected to participate in the production of Digital Maturity Self-Assessment and the emerging Digital System Board Technology Enabled Care will be key to the roadmap and will include the role of Telemedicine, TeleHealth and Tele Coaching. The Commissioner will seek to maximise the role of the Technology Enabled Care, expanding the role to support patients with Long term Conditions.
- **Personal Health Budgets:** The CCGs are committed to working with our Local Authority colleagues to implement Personal Health Budgets. We have commissioned external support for this work. Scoping work across our three local authorities has

taken place. Areas of focus will include Learning Disabilities / Children with Complex Needs. Pilot sites will be identified and a Berkshire West Personalisation Steering Group is being set up and a co-design Workshop in being held.

2.1. Out of Hospital

Mental Health and Learning Disabilities:

- **Transforming care:** We recognise the scale of change required to transform the care for adults and children with learning disabilities. Our Post Winterbourne Transformation Plan is being delivered through a multi-agency working group including our Local Authorities. The key deliverables include delivery of the 6 elements of the Positive Living Model which includes positive behaviour/support, intensive intervention service, special social care, advocacy, carer support and person led transition plan.
- **Placement Budget and the governance of MH and LD:** We wish to continue to carry out a collaborative review of approaches to the management of mental health and learning disability placements.
- **Mental Health Crisis Care Concordat:** The national Mental Health Crisis Concordat launched in 2014/15, provides a blueprint for an effective pathway for people with mental health problems. We wish to explore opportunities to further strengthen the approach to crisis management across the whole system, and, to that effect expect as part of the signatories of the concordat declaration to continue working collaboratively.
- **Place of safety:** As part of its commitment to improve mental health services, we intend to work with the Provider to review Section 136 place of safety arrangements. The CCGs and LAs have already invested in a one year Street Triage Pilot Scheme which was launched in June 2015, with the aim that this will reduce inappropriate use of Section 136 and decrease use of place of safety; we will evaluate this service in Q3 and with a view to considering funding this service as recurrent investment.
- **New standards for Mental Health Services:** we have been working with the provider to implement the new access standards covering early intervention in psychosis programmes (EIP) and Improving Access to Psychological Therapies (IAPT). These new standards are mandated in 2016/17 and we expect that these standards to be achieved from 1 April 2016. Additional funding has been invested in improving psychiatric liaison service and we will be reviewing the impact this investment is having in terms of counting and coding of people with a mental health diagnosis receiving care in hospital which is currently driving up costs for the CCGs, as well as ensuring we are compliant with the Core 24 service model as recommended by NHSE. We are expecting to access National Funding to support delivery of a Paediatric Liaison Service for those below the age of 16 yrs>.

- **Patient Choice in Mental Health:** Full Implementation of a patients' right to choose any clinically appropriate provider of mental health services. We require the provider to be fully compliant with recognised best practice by April 1 2016, if not before, including full implementation of Choose and Book operational procedures so as to facilitate the introduction of choice. There is no new funding available and any changes to service design and delivery will need to be found within the existing resources. Should a patient chose a provider other than a local provider, the funding will follow the patient and we are in discussions with our main providers as to the mechanics of this. We have agreed with the provider that by end of Q3 the need to refresh the NHS Choice website to facilitate choice to those new patient presenting at their GP surgery with mental health problems to encourage choice of services and service provider.
- **CAMHS (Future in Mind):** The CCGs have worked in partnership with the commissioners and providers of comprehensive CAMHs to develop a 5 year local Transformation Plan for Children and Young People's Mental Health and Wellbeing. The priorities for 16/17 include reducing waiting times; improving access to mental healthcare in a crisis; workforce development across the children's workforce (to include schools, early year's settings, healthcare, social care) to reduce the number of children and young people who require a specialist response; improving pathways to help across the system and implementing the access and waiting time standard for children and young people with an Eating Disorder.
- **Perinatal Mental Health:** The Berkshire West CCGs will continue working with partners to consider the commissioning of a perinatal mental health service in Berkshire West.

Children and Young Peoples Services

- **Transition**. CCGs will work with providers to implement the expected NICE guideline on transition from children's to adults' services for young people using health or social care services (draft for consultation came out Sept 2015). This will improve the planning, delivery and experience of care of young people in their move from children's' to adults' services using person centred approaches.
- **Crisis response and Urgent Care:** CCGs will work with hospital, community and primary care providers to review and improve the effectiveness of local unscheduled care services for children and young people. We will look at ways in which community based healthcare can reduce the number of children and young people requiring admission to hospital and reduce lengths of stay.

Long Term Care

- **Care Homes Enhanced Support.** Further work will continue to address current issues around high admission rates from care home, including early detection of Urinary tract infections and pneumonia through further enhanced support to care homes in the Berkshire West geography.
- **Respiratory.** The option to create an integrated respiratory team across the system will be further explored for patients with COPD and Asthma.
- **Kidney disease.** We will aim to reduce first to follow up ratio for chronic kidney disease through improved education and intervention in primary care
- **End of Life/Specialist Palliative Care.** We will be exploring different models of care which promotes a single point of access to a range of end of life care services.
- **Neurology.** Reviews of current neurology pathways during 15/16 has identified service redesign opportunities to improve patient experience, equality of access and better integration of care, and we will work with providers to exploit these opportunities in 16/17.
- **Cardiology: Cardiology:** We will review the detection, diagnosis and management of Atrial Fibrillation, a major precursor to Stroke and identify opportunities for more effective whole system approach.

Primary Care

- Through the Joint Primary Care Co-Commissioning Committee, we will work to align contractual models with delivery of our strategic vision, aligning payment levels and working to improve quality and sustainability.
- Over the next 18 months we will be re-procuring four APMS contracts using a locally-developed service specification which will reflect our Primary Care Strategy.
- We will also be reinvesting 'premium' funding released through NHS England's review of PMS contracts in such a way as to support sustainable primary care services able to take on enhanced roles and will develop an associated investment plan for GMS practices.
- We will look to review and further develop the new Community Enhanced Services for Anticipatory Care Planning and Enhanced Access, ensuring that all patients have access to these. We will also work to consolidate commissioning arrangements for the other CESs and to develop new processes for supporting quality improvement in primary care.
- As part of the delivery of our Primary Care Strategy we will undertake redesign projects aiming to support providers to address current challenges through new workforce models and new approaches to managing demand and promoting self-

care. In so doing we will link very strongly with the Connected Care, Digital Roadmap and Technology Enabled Care workstreams described above.

- We will also work with NHS England to develop a clearer strategy for primary care premises, supporting providers to access local and national funding streams as appropriate.
- We will continue to work with NHSE to commission primary care services under GMS/PMS and APMS contracts with uplifts applied as agreed nationally.
- We will continue to commission CESs using the NHS Standard Contract with monitoring and payment arrangements as set out in the service specifications.
- We will work with NHSE to monitor the quality of services provided under primary care contracts, and we would look for providers to support delivery of QIPP schemes
- We will be developing detailed requirements around PMS reinvestment as referred to above which are likely to include a new quality-based CES along with transformational funding.

2.2. Urgent and Emergency Care

Our commissioning intentions in relation to Urgent and Emergency Care have been informed by the publication of the following important documents:

- **"Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent care and emergency care. A guide for local health and social care communities":** This is a practical summary of the design principles that local health and social care communities need to adopt to deliver safer, faster and better urgent and emergency care. These principles are drawn from good practice, which have been tried, tested and delivered successfully by the NHS in local areas across England. We will use the guidance to inform commissioning decisions for the coming year**,** alongside the recently published NHSE/Monitor document on new payment models for Urgent and Emergency care.

- **"Commissioning Standards for Integrated Urgent Care"** These standards build on the success of NHS 111 and will help us deliver locally the benefits for patients set out in the Urgent and Emergency Care Review led by Sir Bruce Keogh.

Our local ambition is aligned with these documents and describes an integrated 24/7 urgent care service that is the "front door" of the NHS and which provides the public with access to both treatment and clinical advice.

It is intended that the Urgent Care Co-ordination centre will be in place by October 2016 and in preparation for this we will be developing a Thames Valley wide NHS 111 service specification and a new GP out of Hours Service Specification.

2.3. Hospital Services

- **Elective Services.** We plan to:
  - Continue working with Providers to modernise the provision of elective care pathways optimising the use of technology.
  - To review and transform current pathways in the context of pressures on demand and capacity which will include but may not be limited to dermatology, urology, gynaecology, gastroenterology and diagnostics.
  - Commission the most effective and efficient ophthalmology model to meet our local population needs.
  - Work with providers to review Cancer services to ensure the priorities in "Achieving World Class Cancer Outcomes – A Strategy for England 2015-2020" of prevention, earlier diagnosis, improving patient experience and living with and beyond cancer are implemented and tailored for local requirements through a local cancer framework.
- **7 Day services:** we will continue to work with Providers to achieve the clinical standards for seven day services. During 16/17 we will build on the progress made in 15/16 on those standards we have identified as having the greatest impact locally, within the resources available.

2.4. Capacity Planning

- 2015/16 Activity Plans were mutually agreed as a reasonable reflection of anticipated activity. 15/16 outturn will be used as the basis for 2016/17, except by mutual agreement, or to reflect contract variations agreed during 2015/16
- We will undertake a continuous programme of efficiency benchmarking to ensure value for money and cost effectiveness.
- Key assumptions will include: In the event that non- recurrent or extraordinary patterns of activity are noted, these will be considered for exclusion from the baseline
- Impact of repatriations of patients to local services and clinical pathway redesign will inform contract activity,
- The impact of new technologies and service developments, evidence-based practice, locally developed best practice pathways and national guidelines, Impact of any specific Thames Valley initiatives or changes, including demand management initiatives will also inform activity plans for 16/17

- Where activity is transferring between commissioning organisations, the 2015/16 plan will be used as the basis for this transfer, except by mutual agreement.

2.5. Market Management Activities

- To re-procure the Physiotherapy services procured via an Any Willing Provider model. Current providers will be required to provide transparency of activity and cost information in compliance with the competition and cooperation guidance.
- APMS contracts for Priory Avenue, Circuit Lane, Shinfield and the Walk-in Centre as part of the current co-commissioning arrangements with NHS England. The procurement process for the first three of these contracts will start in 2015/16. The Walk-in Centre re-procurement will take account of the broader work on urgent care described above and is expected to be undertaken in 2016/17.
- To re-procure the current AQP and Tier 2 contracts for Audiology, Podiatry, Ultrasound, ENT, non-sedative flexible sigmoidoscopy, non-sedation gastro endoscopy, Gynaecology, Minor Ops, intraocular pressure refinements and Vasectomy ensuring compliance with the procurement, choice and competition regulations.
- Connected Care: The CCGs are working with the Berkshire East CCGs to jointly procure an interoperability solution which will enable health and social care data to be shared across care settings, thereby supporting delivery of the national requirement that by 2020, all care records will be digital, real-time and interoperable. A full portal solution will be procured using previously identified BCF funding together with funding identified through the Primary Care Infrastructure Fund. It is our expectation that savings benefits identified and realised with provider organisations will be released and utilised to contribute to the funding of this programme. The solution will allow for interoperability and information exchange between organisations as well the creation of a person-held health and social care record enabling the individual to hold and manage information about their care. The procurement exercise is due to be completed by March 2016.
- **Procurement of Thames Valley Urgent Care Centre:** Working in partnership with the other CCGs in Thames Valley we will commission an integrated Urgent Care Co-ordination Centre for Thames Valley. This will handle NHS 111 calls and interface with OOH services. The Centre will provide patients with enhanced clinical assessment from a wide range of health care professionals. It will support patients to self-manage or route them swiftly and accurately to the right part of the system whether this is an ambulance response, primary care, community services or a high street pharmacist. The Urgent Care Co-ordination Centre will interface with a number of GP Out of Hours Providers including Westcall. These OOHs will have a common core specification to ensure that they deliver a consistent interface with the UCCC. It is recognised that there is additional local variation with some OOHs providing medical cover to community hospitals for example and these arrangements will remain. This will lead to a model where GP OOH services are largely dealing with patients who need to be

seen at the base surgery or have a home visit. The UCCC will have GPs within it or in a local hub arrangement and will have dealt with any patient whose problem can be addressed by telephone advice. The concept of the "trusted assessor" will be embedded so that receiving OOH services can be confident that all referrals they receive are appropriate and likely to require face to face contact. This should support the most efficient use of the scarce GP workforce across the Thames valley system.

2.6. Quality and Performance

We expect Providers to engage with the CCGs to develop jointly agreed plans to ensure the effective delivery of Policy and Planning requirements as well as local QIPP/CIP savings which will lead to a more sustainable and equitable health economy. Key areas where providers are expected to provide such support will be detailed in the 2016-17 Service Development and Improvement Plans (SDIP) and may form the basis of our CQUINs for the coming contractual year.

The Commissioners expect all providers to uphold the rights and responsibilities contained in the NHS Constitution and comply with the national quality and performance standards and targets included in the Planning Guidance and Operating and Outcomes Frameworks for 2016/17. In addition, CCGs may wish to agree a number of local performance measures intended to either address particular issues with performance locally, or support delivery of their improvement priorities.

- We will work with providers to ensure that all NHS Constitutional standards are achieved. This will include Referral to Treatment, Cancer wait time and ambulance response time standards that have been particularly challenging during 2015/16. Where constitutional standards are not achieved, we will expect providers to put in place remedial action plans that ensure recovery in performance at the earliest opportunity.
- We will work jointly with providers to deliver the improvements across the five domains in the NHS Outcomes Framework.
- We will closely monitor and report Trust quality achievement to our constituent CCGs.
- Notwithstanding patient choice, where quality concerns are identified and not rectified in a timely manner we will look to redirect CCG activity.
- We will regularly review Provider services to ensure that NICE Quality Standards and recommended pathways are being delivered.
- We will work with Providers to ensure patients who are receiving care out of area are offered the opportunity of repatriation as early as is clinically possible
- We will seek full provision of referral information from Providers in SUS to enable effective demand management strategies.

- We will look to reduce the first: follow up ratios at Providers that remain an outlier against benchmarks and seek performance in the upper 10%.
- We will require Providers to ensure patients are offered a choice of local provider for ongoing treatment and care wherever this is appropriate.
- We will seek to develop innovative shared care arrangements between local secondary, primary and community care services, to reduce the requirement for patients to travel out of area for a range of treatments and drugs.
- We require all Providers to ensure that they adhere to our prior approval and individual funding request process to ensure consistency. Commissioners will not be financially viable for procedures when providers have failed to adhere to those policies.

2.7. CQUIN, SDIPs and Quality Schedule

We expect to reflect national guidance on CQUINs in our contract for 2016/17 and as we have done in previous years, secure a mutually acceptable but challenging agreement around CQUIN that reflects national and local clinical commissioning priorities. Our plan is to identify a list of CQUINs via our Transformation Boards and to use contracting levers to accelerate the adoption of best practice and to drive innovation and improvement where this supports better clinical outcomes.. In reviewing CQUIN proposals we will need to jointly identify those CQUIN targets that should appropriately move from being incentivised through CQUIN to core standards as part of the 2016/17 contract, as well as new priorities for CQUIN development for 2016/17. We would welcome provider input into the development of our proposals for 2016/17, noting that the number of local CQUINs will be relatively limited.

Given the complexity of the contract documentation and supporting schedules our overall objective for 2015/16 is to keep to a minimum the renegotiation of contract terms and schedules, noting that a number of key areas – CQUIN, KPIs, quality indicators, information requirements, SDIP and DQIP plans will require a review and likely renegotiation of targets and indicators, with an expectation that the outcome of our 2016/17 agreements will represent a year on year improvement in efficiency, productivity, effectiveness and quality of care. We will also expect to reflect any nationally prescribed changes to standard terms and conditions, including contract penalties, in agreed contracts for the year. Any nationally revised or newly prescribed measures will be incorporated into contracts accordingly.

2.8. Business Rules/Counting and Coding

All Counting and Coding changes to Contract Terms must be supported by impact data showing the expected activity, and associated costs at least 6 months prior to the proposed effective date unless we have been specifically consulted on such changes, prior to agreement being reached. Commissioners expect that any service changes or developments are supported by a business case and approved by the relevant CCGs together with technical agreement on counting and coding before services commence. The developments and changes must be evidenced to be affordable by the health economy. Where this process is not followed Commissioners will not pay any additional costs or charges

- We will hold Providers to account for their responsibilities in managing activity in line with the overall plan, including withholding of payment for provider generated demand.
- We will agree Contract Terms that mitigate financial risk for both parties, including marginal rates and 'floors and ceilings' where contractually appropriate.
- We will validate all invoices and withhold monies where we believe charges do not comply with the Contract or the rules governing the national tariff payment system, counting and coding.
- We will include thresholds within our Activity plans where national terms permit and require implementation of plans to manage activity where thresholds are breached, to ensure Contracts are managed to the agreed plan.
- We will require providers to have systems in place to routinely alert us to high-cost, long stay patients (>14 days in critical care) (>40 days) who have not been discharged at Month end.

Providers should strive to procure drugs and devices at the minimum cost while ensuring optimum patient outcomes. The commissioners wish to work in partnership with Providers to explore the use of biosimilar and generic alternatives to ensure best value for money is delivered. It is the Commissioners expectation that the Provider will realise the savings, when available, through Patient Access Schemes.

Non-tariff services for Acute Providers

- We will only agree bespoke local prices with Providers where full costings are provided, demonstrating the make-up of those prices and these are agreed to be fully supportable, fair and reasonable. We ask that all Providers provide satisfactory

reassurance to commissioners that they follow relevant national guidance. We will audit Providers against the costings they provide us, to ensure that these are reflective of the true costs incurred.

- Where Providers are unable to provide backing information to ensure that prices are transparent and fair, we will either pay national average price (adjusted for regional price variation) less 5% or the previous year's prices, less 1.9%, whichever is the lower. We will look to apply penalties where data fields essential for commissioning are not provided
- Where a patient is referred on to a different consultant for the same condition the first attendance with the second consultant will be paid as a follow up attendance (although it should be recorded as a first as per NHS Data Dictionary guidance) in line with the locally agreed consultant to consultant policy.
- It is an expectation that providers comply with the recommendations of the Thames Valley Priorities Committee in relation to pricing and agree 'fair' and 'reasonable' prices where tariffs are deemed to be excessive in relation to costs incurred.

2.9. Data Quality and Information

- We require Providers to provide complete, accurate and timely data to support contracts and patient level clinical validation and to examine their performance and put arrangements in place to ensure that they comply with the data and information sharing clauses of the contract and the best practice behaviour set out within the Code of Conduct for Payment by Results. We will raise this as a significant performance issue, with full contractual financial penalties being imposed; where providers fail to provide data and information on a monthly basis, in line with the requirements of commissioners to effectively performance manage the contract.
- In line with the national contract template, providers are expected to comply with the reporting requirements of Secondary Uses Service (SUS) and UNIFY. This includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre guidance and all Information Standards Notices (ISNs) where applicable to the services being provided. As a minimum, providers will be expected to flow admitted patient care, intensive care data extensions and outpatient data to SUS for all activity that can be evidenced in that manner even if the method for payment of the activity is outside the national tariff payment system.
- We expect that the Provider shall meet the NTPS monthly reporting requirements as set out in NTPS Guidance. Where activity is outside national tariff scope, providers should make returns of equivalent data in CDS format through local monitoring direct to the Commissioner by the nationally agreed SUS inclusion dates. If any non-specialised activity is not submitted through to SUS, this should be identified via SLAM monitoring, including all of the fields set out within our SLAM monitoring template

- In accordance with the NHS Standard Contract providers must ensure that each dataset that they provide for monthly reporting requirements contains the ODS organisation code for the relevant Commissioner. We require all data to be submitted on a month actual and cumulative basis each month at flex and freeze.
- To counter issues encountered in 2015/16, where the Provider submits data more than two months after the final reconciliation date the CCGs will not pay against the activity. We expect the variance between first and final reconciliation dates to vary by no more than 1% and un-coded activity at first reconciliation to be less than 5% of the months total activity (in activity terms by POD). In the event this is exceeded, the CCGs will pay 50% of the activity exceeding the threshold.
- In order to validate data, we may also request more information regarding the clinical reasons for admission, outpatient attendances etc. We expect providers to comply with these requests.
- A&E observation ward activity where the bed does not appear on a KH03 return will be paid as an A&E attendance and not an admission. If the patient is subsequently admitted then this should generate a new FCE rather than a readmission.
- Maternity admissions to a nurse led ward will be recorded as outpatients (as per the NHS Data Dictionary) and paid at the appropriate national mandated outpatient HRG tariff or 60% of the national mandated inpatient per diem tariff if no such outpatient tariff exists
- Ward attenders. These will be recorded as outpatients (as per the NHS Data Dictionary) and will be paid at the appropriate national mandated outpatient HRG tariff or 60% of the national mandated inpatient per diem tariff if no such outpatient tariff exists.
- Regular day / night activity should be counted as such and the appropriate locally agreed tariff applied.
- Procedures that take place in an outpatient setting will be reimbursed at either national mandated outpatient HRG tariff or a tariff to be agreed between the provider and the CCGs. The nature of the procedure does not affect the data set the activity is reported in.
- Non-consultant led outpatient clinics will be reimbursed at a tariff of not more than 40% of the consultant-led tariff with the exception of activity that already has a national mandated tariff.

2.10. Specialised Commissioning

From 16/17 CCGs will be responsible for Commissioning Severe and Complex Obesity Services. It is our intention to adopt the current Thames Valley access policy and to undertake an in year review via the Thames Valley Priorities Committee. The commissioning of Specialist Neurology services will also transfer on the 1st April 2016.

It is recognised that discussions are taking place at national level in relation to the co-commissioning of specialised services, and that these include commissioning of Tier 4 CAMHS, Secure Mental Health, Cancer, Adult Critical care, Spinal transformation project . It is too early at this point to assess the full extent to which national guidance or expectation in relation to co-commissioning will impact of 2016/17 contracts.

- We will be participating in the Strategic Services Review Programme and will be working with NHS England to enable collaborative commissioning arrangements for specialised services where appropriate.
- We will be utilising the evidence based Commissioning for Value and Right Care data and reduce unnecessary variation.
- Services previously commissioned by CCGs will no longer be commissioned by CCGs from 01/04/16 include
    - Highly specialist adult male urological procedures
    - Primary ciliary dyskinesia management services for adults
    - Highly specialist adult haematology services

2.11. Contracting Timetable

Subject to any guidance received from NHS England after the date of this letter, the Commissioners will provide the Provider with the intended timelines and framework to be followed for the 2016/17 contracting round no later than the end of November 2015. Commissioners expect to meet national requirements for delivery and completion of contract negotiations and expect the Provider to work towards the same in good faith.

Key Milestones:

- End November 2015 CCGs aim to circulate further details of commissioning intentions, QIPP plans and financial planning assumptions. These plans will be relatively high level with further work undertaken over November and December to finalise definitive and granular level plans.

- End of December agreement of a recurrent baseline plus agreement of methodology for costed proposals.

- Early January 2016 for an agreed joint assessment and interpretation of national policy guidance and implications for the 2016/17 contract and for the submission to CCGs of provider costed proposals.

- Mid-February to secure agreement in relation to key contract issues CCG counter proposals and confirmed financial envelopes. In principle agreements on key contract terms and conditions and key schedule changes (information, quality, CQUIN, SDIP and DQIP) also to be reached for this date.