Appendix 3

NHS SOUTH WEST LONDON COMMISSIONING COLLABORATIVE

South West London Commissioning Intentions 2015/16

V0.15

9/19/2014

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1. Executive Summary

This document sets out to South West London (SWL) acute healthcare providers notice of South West London CCGs' Collaborative Commissioning Intentions for children's, maternity, planned care, urgent/emergency care, integrated care and mental health services for 2015/16. Commissioning intentions are based on the medium-term strategic vision outlined in the CCGs' Five Year Plan, of which 2015/16 represents year two. Commissioning intentions for 2015/16 reflect the content of CCG two-year operational plans. We anticipate that in subsequent years commissioning intentions will be refreshed to reflect progress against achieving the strategy.

In previous years commissioners have developed independent commissioning intentions as single organisations in isolation. However this year the six SWL CCGs have decided to work together under the umbrella of the SWLCC to produce joint intentions for six work areas outlined in the five year strategy to signal our intent to continue to work closely to achieve our vision.

A single set of intentions is being provided to acute providers outlining what is anticipated to be required of them in 2015/16 in relation to the six work areas. This will be supported by an additional set of local intentions that CCGs will produce independently to address wider service development. Local commissioning intentions will be congruent with and supportive of SWL intentions.

The commissioning intentions provide the context for constructive engagement with providers, with a view to achieving the shared goal of improved patient outcomes and service improvement within the fixed resources available. To support patient-centred care, SWL CCGs are committed to securing alignment across all aspects of NHS commissioning. We are working with NHS England, partner NHS oversight bodies and local government to secure the best possible outcomes for patients and service users within available resources.

We have aligned our commissioning intentions to areas of the five year strategy, on which Clinical Design Groups have focused, with the addition of cancer:

- Children's services
- Maternity Services
- Planned Care
- Integrated care
- Mental Health
- Urgent and Emergency Care
- Cancer Services

The commissioning intentions for Cancer Services included in this document are those developed centrally on behalf of all London CCGs. We have excluded commissioning intentions relating to the transformation of primary care as these are being developed by NHS England with support from individual CCGs.

Whilst working to achieve the vision for services in SWL, commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards.

These commissioning intentions have been signed off by CCG Accountable Officers through the Joint Commissioning Group and were agreed in draft form by CCG Governing Bodies in September.2014.

2. Introduction

2.1 Context

There is recognition both nationally and locally that the NHS needs to change if we are to continue to provide high quality services to our local populations. The service must adapt to meet the demands of a growing population with higher expectations and more complex needs. Existing services, which have evolved over many decades, are often fragmented and inconsistent, unable to meet the challenges of caring for a population that has changed fundamentally since the system was designed.

At the same time, we are faced with a significant financial challenge across the local NHS; whilst our budgets have not been reduced in real terms, rising demand from an ageing population and the costs of new technologies and drugs mean we have to address a gap of around £209m a year by the end of 2018/19.

In SWL:

- There is a population of 1.45 million people
- The population is ageing and up to a third of people are living with long term conditions, meaning we need to provide more and better care out of hospital and closer to where people live
- None of our hospitals in SWL meets all the minimum safety and quality standards set out by clinicians based on Royal College guidance – the London Quality Standards
- There is variation in the quality of care between different hospitals and different times of the day, week and year
- The NHS is unlikely to be given extra money in the foreseeable future, yet the costs of providing healthcare are rising much faster than the rate of inflation
- We need to reshape mental health services so that they achieve the highest possible standards and are focused primarily in the community
- We need to ensure that primary care and other community-based services meet the highest possible standards
- We need to do more to prevent people becoming ill and to provide better information to patients about the most appropriate place to get help when they become ill

2.2 Five Year Strategy and Better Care Fund - Why we are working together

The publication by NHS England of *Everyone Counts: Planning for Patients* in December 2013 was a clear indication for local health and social care economies to work together to achieve the transformational change needed to address the challenges facing the NHS. The simultaneous launch of the Better Care Fund by NHS England and the Local Government Association also continues to promote closer collaboration and espouses the merits of integration.

In SWL the six local CCGs, along with NHSE (as commissioners of specialist and primary care services) worked together as the SWL Commissioning Collaborative to develop a common five-year strategy for the local NHS in SWL that aspires to achieve the following vision:

> "People in SWL can access the right health services when and where they need them. Care is delivered by a suitably trained and experienced workforce, in the most appropriate setting with a positive experience for patients. Services are patient centred and integrated with social care, focus on health promotion and encourage people to take ownership of their health. Services are high quality but also affordable."

The five year strategy draws on previous work over the last two years as well as more recent discussions with clinical colleagues across the health system; the initiatives are outlined across eight areas of work. This document includes six of the work areas in the five year strategic plan, excluding the Transformation of Primary Care for which CCGs will take an individual lead on in partnership with NHS England. Cancer services are also included.

1. Children's services
2. Maternity Services
3. Planned Care
4. Integrated care
5. Mental Health
6. Urgent and Emergency Care
7. Cancer

As NHS England is the lead commissioner for Primary Care, our work on Transforming Primary Care is not included in this document.

We believe that our shared strategy and combined BCF plans provide strong foundations on which to build future collaborative success and that issuing shared commissioning intentions is a clear signal of our intention to work cohesively in future to address local health challenges.

Our services are interdependent and the challenges we face cross borough boundaries. We need closer working between our hospitals and also between hospitals, GPs, community services and mental health services if we are to improve the quality of care for everyone in SWL and make the local NHS sustainable. We do not believe it would be possible to achieve the scale of change that is required by working independently at borough level. We have therefore chosen to continue to work together to commission as a collaboration of CCGs to:

- Raise safety and quality standards
- Address the financial gap
- Address the workforce gap
- Confront rising demand for healthcare

3. Strategic Contracting Principles and Intentions

3.1 Strategic Contracting Principles

We will continue to use the national acute contract and to sign up to national schemes intended to promote innovation, improve quality and reduce cost, such as national CQUIN schemes. This letter is notice of our intent to additionally adopt innovative ways of contracting which reflect our collaborative commissioning approach but also require greater collaboration from providers. The specifics of our approach will be refined over the second half of 2014/15 in conversation with providers, but the following ideas are indicative of current thinking.

3.2.1 QIPP and CIP

Commissioners will continue to implement local QIPP schemes, mindful that acute providers are also implementing CIP schemes. Commissioners will seek to liaise with providers to ensure that QIPP and CIP schemes are complementary.

3.2.3 Common incentive framework

We will develop local mechanisms for using CCG funding to creative a common incentive framework that will allow us to take a more strategic whole system approach to the use of incentives to achieve desirable system change.

3.2.4 Common payment structures

We will continue to support the use of national currencies such as PbR, Best Practice Tariffs and the extension of Maternity Pathway Payment. In addition we will develop innovative local payment structures outside traditional block contracts and PbR.

3.2.5 Pathway and outcome-based commissioning

We will consider how best to take forward work in both of these areas, with a focus on reducing fragmentation across pathways and reviewing the way services are commissioned to ensure the alignment of incentives and payment to outcomes.

3.3 Maintaining Operational Performance

Whilst working to achieve the vision for services in SWL, commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards, for example (but not limited to):

- 18 Weeks Referral To Treat (RTT) targets for elective care
- 2 Week Wait targets for urgent cancer referrals
- Four-hour A&E target
- Healthcare Associated Infection (HCAI) targets
- Increasing Access to Psychological Therapies (IAPT) target

4. Acute Provider Collaborative

CCGs recognise that the acute providers are increasingly working together through a collaborative programme to consider how best to respond to the case for change and ambitions described by CCGs in the five year strategic plan. This is a welcome development and CCGs will engage with the programme through a re-scoped governance structure and offer programme management support to enable the acute collaborative to take forward the agreed programme of work.

5. SWL Collaborative Commissioning Intentions

We have aligned our collaborative intentions to the areas of work set out in our five year strategy, six of which are pertinent to acute care and included in this document, in addition to Cancer Services:

1. Children's services
2. Maternity Services
3. Planned Care
4. Integrated care
5. Mental Health
6. Urgent and Emergency Care
7. Cancer Services

For each area of work, this chapter sets out:

1. Key challenges
2. The strategic vision by 2018/19 (as detailed in the five year strategy)
3. 2015/16 SWL commissioning intentions
4. Work in 2014/15 that will support 2015/16 commissioning intentions
5. Work in other areas that will support 2015/16 commissioning intentions

5.1 Children's services

5.1.1 Key challenges

- We do not have a comprehensive understanding across SWL of the capacity and capability of children's services that will allow NHS and Local Authority commissioners to assess needs, plan and coordinate commissioning to ensure that resources are targeted efficiently to secure high quality integrated pathways
- Clinicians are uniquely placed to identify their patients' needs, the standards of care, skills and outcomes required. We need to ensure that improvements in the quality of children's services are supported by strong clinical leadership and collaboration with children and their families, local authorities and public providers, to ensure consistent standards of care across SWL based on a foundation of strong evidence
- Too many children and young people are treated in hospital settings which are often more expensive and stressful to children and their families. Paediatric emergency care consultants feel that services are overwhelmed and that more children could be treated in the community to reduce admissions, improve outcomes and patient experience
- There is not enough focus on ill health prevention and early intervention for children and their families
- There is variable compliance with recommended staffing levels across paediatric units. We need to achieve London Quality Standards and make improvements to the quality of care in children's acute and urgent services

5.1.2 Strategic vision for Children's services in SWL in 2018/19

We will have a service that works efficiently and effectively across settings of care, despite the challenge of increasing demographic and system pressures facing children's services. We want to ensure our children receive high quality care, regardless of where they live in SWL. We want to provide our children with the best start in life to ensure that they remain healthy and achieve their social and educational potential. This means strengthening the whole system, including focusing on prevention and early years intervention.

We want children and young people to receive as much of their care as possible out of hospital, with highly skilled staff able to look after children in their own homes wherever achievable. Our hospitals

will adhere to the London Quality Standards (LQS) and will deliver the same standard of acute care, seven days a week, with senior input 'around the clock'. Where children need to attend hospital as urgent or emergency cases, frontline care will be delivered by consultant paediatricians and trained children's nurses. Some of these children will not need to stay in hospital overnight and a short stay model of care will be promoted as appropriate and safe. We will ensure that there are alternatives in place for hospital care wherever possible.

There will be a focus on the prevention of ill health in children as well as promotion of health education and healthier lifestyles, taking on a family focus where possible and appropriate. To enable this vision for children's care, we will need a highly skilled workforce across community and hospital settings, where generalists and health promotion skills work alongside specialist paediatric care accessible in and out of hospital.

5.1.3 2015/16 SWL Commissioning Intentions

The children's section of the 5 year strategic plan is aimed at improving access to, and the quality of, services and outcomes for children up to the age of 18 years in SWL. It covers acute and urgent care, community services, child and adolescent mental health services (CAMHS), health promotion and ill health prevention. Acute care includes neonatal intensive care and paediatric intensive care.

i. **Children's Network**

Commissioners will continue to support the Children and Young People's Network being created in the second half of 2014/15 in recognition of its pivotal role in developing a model of high quality and sustainable care for children and their families in SWL, in all care settings.

Action Required by Providers

a. Commissioners expect providers to engage fully with the Network as defined by the terms of reference
b. Commissioners expect providers to supply benchmarking data to support the development of a clinical dashboard to provide regular reporting on activity, access and clinical outcomes across paediatric services in south west London.

ii. Workforce

In the second half of 2015/16, in conversation with providers, commissioners will seek to establish the viability of inpatient paediatric and neonatal units across SWL in view of the requirement to

meet LQS and NHSE standards (for neonatal care) within five years. Commissioners will ensure that this is aligned with the Urgent and Emergency Care work.

Actions Required by Providers

To meet LQs within 5 years, providers will need to work with commissioners to review current service provision for inpatient paediatrics and neonatal units across SWL in the second half of 2015/16

5.1.4 Work in 2014/15 that will support 2015/16 commissioning intentions

A Children and Young People's network is currently being created and commissioners anticipate that this group will have a pivotal role in developing a model of high quality and sustainable care for children and their families in SWL. Commissioners expect providers to engage fully with the network and provide appropriate clinical and managerial input as defined by the Terms of Reference.

The Children and Young People's network will lead work to establish a baseline of the provision of and demand for children's services, including community services, in the second half of 2014/15. The baselining of provision will cover both capability and capacity. Commissioners expect providers to support this process by providing an agreed set of metrics in a timely manner.

5.1.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Urgent and emergency care
- Primary care transformation
- Maternity
- Mental health services (including CAMHS)

SWLCC will continue to maintain strong links to NHS England's specialist commissioning team to ensure that SWL commissioning intentions are aligned with NHS England's commissioning intentions.

5.2 Maternity Care

5.2.1 Key challenges

- Outcomes and intervention rates vary widely between maternity units
- Rising maternal age is leading to increasing complexity
- Services are focused on the needs of organisations rather than the needs of women
- Key clinical staffing standards are either not met, or not met consistently
- Continuity of carer could be improved
- Hospital and community postnatal care experience can be poor
- There is variation in the quality and quantity of antenatal care provided by GPs
- Screening programmes are not always well integrated into usual care, and there is variation in uptake and follow up

5.2.2 Strategic vision for Maternity services in SWL in 2018/19

In alignment with the SWL Maternity Network's vision, SWL commissioners want maternity services that provide care to women as individuals with a focus on their needs and preferences. There will be a strong emphasis on improving continuity of carer for all women whilst increasing the proportion of suitable women who receive care within a midwifery led setting. The existing disparity of outcomes and performance between SWL units must be addressed, with all units improving provision, quality and outcomes of care that meet national as well as London Quality Standards.

In SWL maternity services will be designed in a way that:

- Prepares women for pregnancy and becoming a parent through education and up to date evidence based information
- Provides care to women as individuals, with a focus on their needs and preferences
- Invests in improving continuity of care and carer, with a strong emphasis on midwifery led care for normal pregnancy and birth
- Provides care which meets the LQS for women with more complex needs, where obstetric care will be provided in our hospitals, with enhanced on site presence of consultant obstetricians and dedicated obstetric anaesthetists, supported by a range of emergency services, should they be needed

- Values and takes on board feedback from women we look after and their families in order to drive continuous improvement in the quality of care

Commissioners, in consultation with providers, will review and develop a model of care for out of hospital antenatal and postnatal care.

5.2.3 SWL Commissioning Intentions

i. Workforce

Actions Required by Providers

By 1st April 2015 all providers of maternity services are expected to ensure:

- A minimum of 98 hour consultant obstetrician presence on all acute labour wards. (24/7 (168 hours) consultant presence by 1st April 2019.)
- A minimum ratio of one clinical midwife to every 30 births and one consultant midwife to every 900 expected normal births.
- Support for clinicians to work collaboratively via the SWL maternity network with aim of improving outcomes for women, babies and families.

By 31st March 2016 all providers are expected to ensure:

- A minimum of 15% of women's care to be midwifery led and delivered. Includes antenatal, intrapartum and postnatal care.
- A minimum of 2% of births to take place out of hospital/at home
- Women with uncomplicated pregnancies to have no more than 2 midwives providing their antenatal and postnatal care within a community setting

Providers exceeding these standards in 2014/15 are expected to maintain, and not reduce, their performance.

5.2.4 Work in 2014/15 that will support 2015/16 commissioning intentions

Commissioners will begin to develop a model of care for out of hospital antenatal and postnatal care in the second half of 2014/15 with engagement from providers. Progress made in this area may lead to further service developments in 2015/16.

5.2.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Children's Services
- Urgent and emergency care
- Mental health services (including CAMHS)

5.3 Planned care

5.3.1 Key Challenges

- There is a lack of sufficiently integrated end to end planned care pathways for specific conditions
- There are variable outcomes from planned care procedures
- There is variable patient experience across the system
- Planned care services are often disrupted by peaks in non-elective activity

5.3.2 Strategic vision for planned care services in SWL in 2018/19

Clinicians in SWL have developed a vision for a future model of care that responds to regional challenges and meets the needs of people in the area for the years ahead. In SWL we believe that the separation of planned care and non-elective care provided as part of an end to end pathway, with planned care being delivered in a Multi-Specialty Elective Centre (MSEC), will provide safer, higher quality and more convenient care for patients.

The planned care service in SWL will:

- Separate elective and non-elective surgery, reducing the rate of cancellation for non-clinical reasons owing to peaks in demand for non-elective surgery
- Be delivered in a single MSEC for SWL by 2018/19
- Improve efficiency, quality, safety for patients through the centralisation of routine inpatient procedures in a centre of excellence
- Improve patient experience through the use of efficient surgical care pathways, which are predictable, uninterrupted and encourage greater continuity of care
- Optimise post-operative care for the condition provided by senior decision-makers and specialist nurses
- Reduce length of stay in hospital with highly coordinated discharge and after care delivered in the community where possible
- Build easier access to enabling or recovering services into the care pathway, providing continuous and integrated support through the entire patient journey
- Utilise existing estate to maximum effect, with any capital investment focussed on building technology-enabled care pathways

5.3.3 SWL Commissioning Intentions

Actions Required by Providers

Commissioners expect providers to collaborate in the development of an outline business case for the redesign of elective inpatient services, with phase 1 (a single specilaity to be agreed) to be implemented in 2015/16 and subsequent phases refined for future implementation and inclusion in 2016/17 commissioning intentions.

Redesign of a single surgical specialty should be seen as the minimum action required by commissioners, who are willing to consider more ambitious business cases for additional elective inpatient specialties.

Commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards relating to planned care, including RTT.

5.3.4 Work in 2014/15 that will support 2015/16 commissioning intentions

In the second half of 2014/15 commissioners will review existing and planned demand management schemes and local QIPP plans to gauge progress and ensure that schemes are complementary to this area of work.

5.3.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Primary care
- Integrated care
- Urgent and emergency care

5.4 Integrated care

5.4.1 Key Challenges

- The burden and complexity of Long Term Conditions (LTCs) is rising, and patients and service users are experiencing fragmented care which does not meet their needs appropriately
- There is an imperative to implement local BCF plans and improve outcomes at an aggregate level across SWL
- Non-elective (NEL) admissions and urgent care needs are rising, and without the redirection of funds through the BCF, our current community based provision will not meet this demand
- We do not have the inter-organisational systems and infrastructure in place to enable delivery of integrated services
- We have a pressing community and social care workforce gap

5.4.2 Strategic vision for integrated care services in SWL in 2018/19

Our collaborative vision has harnessed common areas of preparation and planning which has been undertaken by each CCG for the delivery of their BCF plans, and other key planning stages such as commissioning intentions and two year operating plans.

We aim to expand and improve services provided outside hospital, up-skill the workforce, increase specialisation in the community and commission high quality care provided out of hospital wherever appropriate. We want people to experience an uninterrupted journey through services, ensure that patients' families and carers receive education and support, and improve connections to the voluntary sector. In addition, integrated services will make better provision for mental health care to enhance overall wellbeing, independence and social capital.

In SWL we believe that people should experience integrated care which:

- Helps people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates. This means that preventative advice is given by their care coordinator and they can access structured education.
- Helps to keep people with one or more LTC and complex needs stable. This means that patients who are at risk have been identified and assigned a care coordinator who intervenes when appropriate.
- Helps people who are at risk of losing their independence to access services which increase their ability to live independently and improve their quality of life. When they are at risk,

their GP or practice nurse is able to signpost them to a care navigator (or equivalent) to help access services.

- Allows people to get timely and high quality access to care when they are ill, delivered in the community where appropriate. Improved signposting to services will ensure people know when and where to access the right services.
- Allows professionals to be familiar with the patient's circumstances, to support their preferences, and to provide continuity where agreed, while including them in making choices about their care through a care plan which is reviewed each time there is contact with their care coordinator.
- Supports people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home. People will know how they will be looked after when they leave hospital and their care coordinator or primary care team will contact them when they are discharged.
- People who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission or promote independence. This means they receive appropriate re-enablement therapy whether at home or in the community; professionals will provide regular care until they are independent again.
- Helps people requiring end of life care to be supported to receive their care and to die in their preferred place. People who are identified as being at the end of their lives are registered on Coordinate my Care which will hold information about their preference of care and place of death and prevent unnecessary admissions to hospital.

5.4.3 SWL Commissioning Intentions

i. Better Care Fund

The refinement and implementation of Better Care Fund schemes that shift activity away from acute settings will be central to commissioners work over 2015/16 and 2016/17. BCF schemes are local to each CCG and Local Authority, however commissioners expect providers to collaborate as needed.

Actions Required by Providers

Commissioners have agreed in discussion with providers to work closely with and support the implementation of BCF schemes, particularly the reduction in NEL admissions in line with the targets of each individual CCG.

ii. Workforce

Commissioners recognise that implementing BCF is likely to require additional capacity and capability in the community.

Actions Required by Providers

Commissioners will work with providers to support the realignment of the workforce to meet new models of care, including 7 day working.

iii. Improving the sharing of patient data

Delivering integrated care requires the sharing of patient information across multiple care settings and provider organisations.

Actions Required by Providers

Commissioners expect providers to engage in the process for resolving information governance issues to facilitate this.

iv. Improving the quality and availability of data

Commissioning genuinely integrated care that improves quality of outcomes and patient experience requires high quality performance data that are shared in a consistent and timely manner.

Actions Required by Providers

Commissioners expect providers to engage in the process for developing and implementing both standardised and ad hoc data reports and adhering to agreed timescales for delivery.

5.4.4 Work in 2014/15 that will support 2015/16 commissioning intentions

Commissioners will share any refreshed BCF plans with providers for their input and support in the delivery of BCF schemes for the remainder of 2014/15 and 2015/16.

5.4.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Transformation of Primary Care and Primary Care Commissioning
- Urgent and emergency care

5.5 Mental Health

5.5.1 The key challenges for this area of work

- Pathways are not systematically integrated to respond to both physical and mental health needs
- There are inequalities in access to mental health care
- Not enough care is delivered outside hospitals; we need improved access to community based services
- We need to ensure that more patients suffering from mental health problems are identified earlier
- We need to improve the wellbeing and quality of life for all patients suffering from mental health conditions, and promote recovery
- We need to ensure parity of esteem, valuing mental health equally with physical health

5.5.2 Strategic vision for mental health services in SWL in 2018/19

People who need to use mental health services in SWL will experience services that:

- Have been developed and shaped with the help of service users and their carers
- Offer patients a choice of provider from within the NHS, the independent sector or the voluntary sector
- Are focused on evidence based recovery models with a greater emphasis on peer led interventions, that continue to support patients into recover
- Are delivered in the locations that best suit service users and their carers, including a greater range of services for patients with dementia delivered in primary care
- Promote social inclusion and parity of esteem by continuing to provide care in a community or primary care setting for those patients who no longer have a secondary care mental health need
- Promote the inclusion of mental health in multi-disciplinary teams that support people with physical and mental health needs, such as those with Long Term Conditions
- Are compliant with the National Crisis Care Concordat (2014) to improve the system of care and support so people in a mental health crisis are kept safe and helped to find the support they need

- Promote community pharmacists, patients and GPs working collaboratively to improve the management of psychotropic medication
- Effectively manage physical health needs, particularly with people who have severe and enduring mental illness to improve the disparity in mortality rates
- Have taken into account and acted on the recommendations set by the Schizophrenia Commission
- Safely manage the transition of young people from CAMHS into adult services and prevent young people from 'falling through the net'
- Engages carers as partners in the care planning process and ensures that their views are taken into consideration

Services will be provided in a system that:

- Facilitates the use of personalised budgets and places greater emphasis on delivering services that have successful recovery outcomes and excellent patient experience
- Continually takes action to address inequalities in mental health services and improvements made, which reflect the needs of Black and Asian and Minority Ethnic (BAME) communities, the socially disadvantaged and vulnerable groups
- Has aligned care pathways to the clustering within the Mental Health Tariff (Payment System) to provide benefits to Service and provider greater clarity to commissioners

5.5.3 SWL Commissioning Intentions

Commissioners recognise that much of the action required to achieve the strategic vision for mental health services in 18/19 sits with mental health trusts, community providers and primary care.

Actions Required by Providers

Commissioners expect that providers will work across organisational boundaries to support implementation of the vision, improve outcomes and deliver services differently as needed.

For example, commissioners expect providers to engage with:

- Improving the inclusion of mental health in multi-disciplinary teams that support people with physical and mental health needs, such as those with Long Term Conditions
- Improving the link between urgent and emergency care and mental health services, including the development of psychiatric liaison services

- Continuing to support the diagnosis of dementia through the national CQUIN, and reducing A&E attendances and NEL admissions for patients with dementia

Commissioners will support providers to understand the process for adoption and impact of the mental health tariff.

Commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards relating to mental health, e.g. achieving IAPT targets.

5.5.4 Work in 2014/15 that will support 2015/16 commissioning intentions

The commissioning intentions set out for 2015/16 are in part a continuation of the work of CCGs in 2014/15.

5.5.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Primary care
- Integrated care
- Urgent and emergency care
- Maternity
- Children's Services

5.6 Urgent and Emergency Care

5.6.1 Key Challenges

- Patients do not always understand how, or feel empowered, to access the right care, in the right place the first time
- Providers do not consistently meet quality standards (national and local)
- There is a projected workforce gap to delivering the LQS
- We need to ensure that our workforce is sufficiently trained to deliver new models of care
- We are not exploiting the full opportunities of ambulatory care pathways

5.6.2 Strategic vision for urgent and emergency care services in SWL in 2018/19

Our vision is to strengthen the urgent and emergency care whole-system service model through improving the quality of urgent care services and ensuring that the provision of integrated urgent care is timely and robust.

In SWL we believe that the urgent and emergency care system model needs to be transformed so people are:

- Supported to manage their conditions in their own homes through improved self-care and shared decision making
- Aware of the different parts of the urgent care system and when and where to access the care they need
- Provided with improved access to a well-connected and clearly defined urgent care system including Urgent Care Centres, Primary Care, GP out of hours, 111, social care, London Ambulance Service, and other health professionals such as pharmacists and dentists
- Diagnosed, treated and able to go home on the same day through wide scale implementation of the Ambulatory Emergency Care (AEC) services as part of our work to improve the overall urgent and emergency care pathway
- Treated in high quality and safe emergency departments that meet the recommended levels of senior staffing and access to specialist equipment, as per London Quality Standards with pathways designed to improve patient flow
- Supported with their health and social care needs in the community, enabled through Better Care Fund schemes
- Able to access emergency departments that deliver high quality specialist care; this will be achieved by implementing the recommendations in the Keogh report (to be published later

in 2014) and taking into account any national guidance on standards for urgent and emergency care services and consistency in the naming of such services. Commissioners will work with providers to understand the local implications of these recommendations, including the introduction of two levels of emergency departments

- Able to access alternative forms of high quality urgent care services which meet LQS and other nominated best practice standards, to alleviate pressure on hospital emergency departments and expedite diagnosis and treatment
- Given access to seven day services in hospitals, complemented by 7 day services across the system to enable timely discharge
- Able to benefit from strengthened links between urgent and emergency care services and mental health psychiatric liaison services

5.6.3 SWL Commissioning Intentions

The focus of this area of work in 2015/16 should be to work towards the provision of services that facilitate 7/7 discharge and meet local and national quality standards.

i. Workforce

Commissioners expect providers to achieve LQS compliance by 20818/19. The roadmap to achieving this will be informed by a baselining exercise to be undertaken in the second half of 2014/15.

Actions Required by Providers

Commissioners will specifically expect providers to support the implementation of 7 day working across the urgent and emergency care system to support delivery of the four hour A&E target.

ii. Ambulatory & Emergency Care Models

Actions Required by Providers

Commissioners expect providers to develop and implement a local model for AEC services in SWL by the end of quarter 2 in 2015/16.

iii. Increasing integration of services

Actions Required by Providers

Providers will work with the UEC Clinical Design Group and local system resilience groups to strengthen integration across the whole system and in particular with London Ambulance Service, community pharmacies, 111 and Out of Hours services.

Commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards including the 4 hour A&E target.

5.6.4 Work in 2014/15 that will support 2015/16 commissioning intentions

In the second half of 2014/15 commissioners will expect to work with providers to baseline compliance against LQS, including workforce capacity. Commissioners will work with the urgent and emergency care CDG to review the current use of AEC pathways and identify areas for wider use.

Commissioners will work with providers to understand the local implications of the Keogh recommendations for the introduction of two levels of emergency departments and implementation of necessary reforms.

5.6.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Primary care
- Integrated care
- Mental Health
- Maternity
- Children's services

5.7 Cancer Services

5.7.1 Key Challenges

The challenges facing cancer services are:

- Increasing the focus on primary prevention
- Improving early diagnosis through promotion of patient awareness and screening uptake
- Addressing the variation in outcomes and patient satisfaction across secondary care providers
- Delivery of chemotherapy in more convenient settings for patients
- Improving utilisation of radiotherapy technology
- Improving access to support for patients living with and beyond cancer
- Optimising delivery of end of life care based around the lives of patients and cases
- Improving patient experience

5.7.2 Strategic vision for urgent and emergency care services in SWL in 2018/19

By 2018 cancer services will focus on prevention of disease, early diagnosis and patient experience. There will be an emphasis on patient choice and the provision of care in the community during active treatment, recovery and, where necessary, the end of life phase. Every patient will be treated as an individual and offered the full support of the healthcare professionals involved.

5.7.3 SWL Commissioning Intentions

Cancer is one of the four priority areas for improvement identified by NHS England (London) to transform the health, wellbeing and lives of Londoners. The Five-year Cancer Commissioning Strategy for London was launched in February 2014. The strategy was developed collaboratively by NHS England with significant input from cancer clinicians, representatives from the Integrated Cancer Systems linking into the clinical pathway groups, CCG clinical commissioners as well as commissioners from Public Health England and NHS England.

These commissioning intentions have been developed from the strategy with the intention of being included in all acute provider commissioning intentions across London.

i. Earlier detection of cancer

To promote the early detection of cancer we will commission:

- GP direct access to diagnostics (chest x-ray, including same day chest x-ray for high risk of cancer, non-obstetric ultrasound)
- GP direct access to flexible sigmoidoscopy, colonoscopy via a diagnostic triage service that will assign the most appropriate diagnostic test. Age of referral for low risk, but not no risk of cancer to service lowered from 55 to 45

In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support US and CA125 concurrently.

We will expect all endoscopy services to be JAG accredited.

Action required by providers

Commissioners expect providers to respond to service changes or tenders that facilitate direct access to diagnostics, specifically chest x-ray and non-obstetric ultrasound, flexible sigmoidoscopy, and colonoscopy.

Commissioners expect providers to respond to service changes or tenders that seek to support the concurrent use of ultrasound and CA125.

Commissioners expect providers to actively engage in the process for defining robust reporting systems, including A&E and UCC attendances and chest x-rays, to support early detection of cancer.

Providers of endoscopy services must achieve Joint Advisory Group (JAG) accreditation.

ii. Reducing variation in secondary care

In order to reduce variation in the quality of services provided by secondary care, we will:

- Ensure that endobronchical ultrasound (EBUS) services are commissioned to an agreed service specification and tariff
- Engage with the London Cancer Alliance to support the development of a best practice timed pathway for lung cancer and encourage providers to implement this
- Engage with the London Cancer Alliance to support the development of a best practice timed pathway for breast cancer, including the provision of a one stop diagnostic service and encourage providers to implement this
- Engage with the London Cancer Alliance to support the development of a best practice timed pathway for colorectal cancer and support providers to implement this – with all

teams completing 60 new surgical cases with curative intent. Providers must ensure that all people who need emergency treatment should be treated by a colorectal cancer team

- Commission prostate cancer services in line with NICE guidance (2014)
- Commission pathways for the management of treatment related fertility issues (NICE Guidance 2013)
- Commission services that manage those with a family history of moderate risk breast cancer to a Pan London specification (NICE Guidance 2013)
- Commission services that manage metastatic spinal cord compression in line with NICE QS56 (Feb 2014).

Action required by providers

Commissioners expect providers to ensure that all services participate in national cancer peer review or other assurance programme defined by commissioners. All cancer MDTs are quorate for 95% of meetings and individual members attend 66% of meetings (in order to support improved MDT decision making).

Commissioners expect providers to respond to service changes or tenders to provide endobronchial ultrasound (EBUS).

Commissioners expect providers to engage with the London Cancer Alliance to develop a best practice timed pathway for lung cancer and to implement this.

Commissioners expect providers to engage with the London Cancer Alliance to develop a best practice timed pathway breast cancer, including the provision of a one stop diagnostic service, and to implement this.

Commissioners expect providers to engage with the London Cancer Alliance to develop a best practice timed pathway for colorectal cancer and support providers to implement this – with all teams completing 60 new surgical cases with curative intent - and to implement this.

Commissioners expect providers to respond to service changes or tenders to provide prostate services in line with NICE guidance 2014

Commissioners expect providers to respond to service changes to ensure the management of those with a family history of moderate risk breast cancer to a pan-London standard (NICE guidance 2013)

Commissioners expect providers to respond to service changes or tenders to provide care for metastatic spinal cord compression in line with NICE QS56 (February 2014)

iii. Living with and beyond cancer - recovery package (National Cancer Survivorship Initiative)

In order to support patients living with and beyond cancer we will:

- Ensure that all commissioned services deliver a recovery package (holistic needs assessments and care plans, treatment summaries, health and well-being events)
- Commission pathways for the consequences of treatment of pelvic radiotherapy, lymphedema and treatment related sexual dysfunction

Action required by providers

Commissioners expect providers to respond to service changes to ensure that all cancer pathways offer a holistic recovery package.

5.7.4 Work in 2014/15 that will support 2015/16 commissioning intentions

The commissioning intentions set out for 2015/16 are in part a continuation of the work of the London Cancer Alliance in 2014/15.

6. Enablers

We have developed a bold and ambitious vision for health and care services in 2018/19 in our five year strategy and recognise that to achieve this we must invest in a number of key enabling schemes. In the second half of 2014/15 as we refine commissioning intentions we will work with providers to scope those enabling schemes that may require investment in 2015/16.

Commissioners recognise that the following areas will require additional focus to ensure progress in 2015/16 towards the vision set out in the five year strategy.

6.1 Workforce

The case for change in SWL is predicated on providers not yet meeting London Quality Standards and recommended Royal College staffing guidelines consistently across SWL. Specifically we know that there is a shortage of obstetric, paediatric and emergency medicine consultants. In addition, General Practice recruitment is becoming increasing challenging and there are gaps in some areas of the community workforce which will make it difficult to integrate services and transfer care in to the community where possible. There is also recognition that the skill mix of the wider workforce requires review and investment.

Commissioners will work with providers and bodies such as Health Education England to understand the impact of commissioning intentions for 2015/16 and the longer term vision for 2018/19 on:

- Recruitment and retention
- Training
- Workforce pipeline
- Transition and succession planning

6.2 Information

Commissioning and delivering integrated care across multiple care settings and provider organisations requires the sharing of information.

To commission high quality services that improve patient outcomes and experience whilst delivering value for money, we need to have better, more timely, access to better quality activity, operational performance and outcome data that can inform the way in which we prioritise resources and scrutinise quality.

Similarly, to deliver joined up patient care across multiple settings and professional and/or organisational boundaries requires the prudent sharing of patient data more widely than is practised currently.

Where providers deliver services across multiple sites, commissioners require providers to share quality and activity data split by site.

Commissioners will work with providers to understand how they can support the adoption of systems that will better facilitate the sharing of information across the whole system.

6.3 IT Infrastructure

Commissioners understand that fragmented and occasionally outdated IT infrastructure is a hindrance to the progression of flexible working practices and innovation in the way care is delivered, as well the sharing of information.

We will work with providers to understand the priorities for investment in this area.

6.4 Estates

Commissioners have committed to providing more care away from hospitals and closer to patients' homes by 2018/19. We will work with providers to understand how best to facilitate this shift, to ensure that there is sufficient capacity in the community and that providers are supported to agree a process for managing potential stranded costs as a result of estates rationalisation.

It is likely that there will be capital costs associated with the development of a Multi-Specialty Elective Centre (MSEC) and this will require further investigation.

Commissioners will continue to liaise with NHS England, commissioners of primary care, to support plans to ensure that primary care estate is fit for purpose and can absorb increased levels of activity.

6.5 Better Care Fund

Unlike the five year strategy, Better Care Fund plans have been developed independently by each CCG to reflect the nuances of each local unit of planning (including local authorities). BCF schemes are expected to be vehicles for delivering the change required to achieve our vision for 2018/19.

7. Stakeholder Engagement

We are committed to working with local providers, service users and the public to develop solutions that will deliver safe, high quality care for everyone. Much public engagement was carried out prior to the establishment of SWL Collaborative Commissioning and we have continued to listen to a wide range of stakeholders when developing the 5 year strategic plan.

We engaged local patients, the public and the voluntary/community sector in the development of the five- year strategy from the beginning, which is in line with best practice engagement. We sought the advice of the Consultation Institute on the best approach to doing so.

Over the past three years a great deal of engagement has taken place with patients, public and partners and we have gathered views and feedback from a range of different stakeholders. In particular, through the Better Services Better Value programme and more recently, each of the six CCGs ran their own local engagement programmes as part of the national 'Call to Action' programme, in advance of agreeing Commissioning Intentions. Focus groups have also taken place across south west London to inform the six CCGs in developing their two year operational plans.

The advice of the Consultation Institute was that the overall approach to engagement in the development phase of work should be to:

i. Build on the engagement activity already completed over the past three years and;
ii. Carry out a listening and learning exercise to test the feedback we had already gathered from the BSBV programme and A Call to Action

During April and May 2014, engagement activity focused on two areas;

i. A listening event/forum for different stakeholders from across south west London
ii. A series of focus groups with a cross section of the south west London community

A number of consistent themes were discussed and fed back both at the listening event and by the focus groups. They were considered and reflected in the final version of the strategy. These included views on workforce, integration of services, patient education and information about accessing services and working more closely with the voluntary sector. Of note, participants in one of the focus groups said that they thought that patient and stakeholder feedback from previous engagement work had helped influence the strategy.

A report on this engagement activity is available at http://www.swlccgs.nhs.uk/documents/listening-and-learning-engagement-report-june-2014/

8. Conclusion

This document has set out the commissioning intentions for SWL CCGs. They are intended to drive major transformation across the services we provide to ensure that patients receive higher quality, more integrated care with an enhanced patient experience. We expect providers to respond positively and proactively to our intentions and work with us to ensure our vision is realised.

Six-month Notice Letter - Cancer

Cancer is one of the four priority areas for improvement identified by NHS England (London) to transform the health, wellbeing and lives of Londoners.

The *Five-year Cancer Commissioning Strategy for London*[1], launched in February 2014. The strategy was developed collaboratively by NHS England with significant input from cancer clinicians, representatives from the Integrated Cancer Systems linking into the clinical pathway groups, CCG clinical commissioners as well as commissioners from Public Health England and NHS England.

The approach taken for 2015/16 is to refine last year's commissioning intentions as they will not all have been delivered by April 2015 and only to add limited additional areas. Commissioning intentions for 2015/16 are outlined below.

Earlier detection of cancer

- GP direct access to diagnostics (chest x-ray (same day chest x-ray for high risk of cancer), non-obstetric ultrasound)
- GP direct access to flexible sigmoidoscopy, colonoscopy via a diagnostic triage service that will assign the most appropriate diagnostic test. Age of referral for low risk, but not no risk of cancer to service lowered to 45 (from 55)
- In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support US and CA125 concurrently
- In order to support the reduction of the risk of delayed diagnosis, all commissioned services will be required to formally report A&E, Urgent care centres and inpatient chest x-rays(CxR)
- JAG accreditation for endoscopy services

Reducing variation in secondary care

- All services will participate in national cancer peer review or other assurance programme defined by commissioners. All cancer MDT's are quorate for 95% of meetings and individual members attend 66% of meetings (in order to support improved MDT decision making)
- Endobronchical US (EBUS) services are commissioned to an agreed service specification and tariff.
- Best practice timed pathway for lung cancer
- Best practice timed pathway for breast cancer – all to provide a one stop diagnostic service. All surgeons to have a minimum caseload of 50 per annum.
- Best practice timed pathway for colorectal cancer – all teams completing 60 new surgical cases with curative intent. All people who need emergency treatment should be treated by a colorectal cancer team
- Prostate cancer services commissioned in line with NICE guidance (2014)
- Agree and implement service consolidation plans
- Services will be commissioned to provide pathways for the management of treatment related fertility issues (NICE Guidance 2013)
- Services will be commissioned for the management of those with a family history of moderate risk breast cancer to a Pan London specification (NICE Guidance 2013)
- Services for the provision of Metastatic spinal cord compression will be commissioned in line with NICE QS56 (Feb 2014).

Living with and beyond cancer - recovery package (NCSI)

- All cancer services commissioned to deliver the recovery package (holistic needs assessments and care plans, treatment summaries; health and well-being events)
- Stratified pathways (breast, colorectal and prostate)

[1] www.england.nhs.uk/london/2014/01/22/cancer-strategy/

- Pathways for the consequences of treatment of pelvic radiotherapy, lymphedema and treatment related sexual dysfunction

APPENDIX 5

The Clinical Commissioners' Approach to Proposed Changes to Coding & Counting Practices for Acute and Community Services from 2015/16

1 Introduction

1.1 The aim of this guidance is to share the Clinical Commissioning Groups' (CCGs) approach to proposed changes to coding and counting practices for acute and community services from 2015/16 onwards. (For nationally mandated changes please see section 3 below).

2 The Process

Area	Requirement
Start Date	In line with NHS Standard Contract 2014/15 Service Condition (SC) 28.10 "any change of practice agreed must be implemented on 1 April of the following Contract Year".
Notice Period	In line with the NHS Standard Contract 2014/15 Service Condition (SC) 28.8 the minimum notice period will be 6 months and correspondingly the last notification date will be 30 September in the current year for the following year.
Materiality	Coding and counting practice mandated by HSCIC or required by the National Tariff will be notified, planned and implemented as required. Proposals for local prices must be cost-neutral to CCGs, ie increases in one service must be off-set by a reduced price in another. Local price proposals that create transactional costs that are disproportionate to the service being delivered and the benefits to patients will not be considered.
Justification	To ensure value for money, all local proposals will have to demonstrate benefits for patients, commissioners and providers in terms of both service provision and data quality.
Implementation	To ensure that any changes of coding and counting can be transacted and effectively monitored, a minimum of 6 consecutive months shadow monitoring should be undertaken and validated by CCGs/CSU before implementation. Proposals will not be considered unless this process is adhered to. Where shadow arrangements are not already in place the exact detail of monitoring requirements will be set out during October to ensure there is a realistic expectation that robust information will be available for all parties. Where shadow monitoring and validation has been undertaken, and implementation agreed this will start from 1 April 2015.
Financial stability	Any cumulative change to the contract value in excess of

	0.25% will be subject to transitional arrangements of up to 3 years depending on the scale of agreed changes (SC28.11)
Assurance	All agreed changes will be subject to clinical coding audit and the results shared with all parties.

Coding and Counting Changes
The NHS Standard Contract 2014/15 Service Condition 28 sets out the high level governance regarding any proposed changes to the coding and counting of NHS activity.

The lessons from 2013/14 and 2014/15 show that a considerable amount of NHS management and clinical resource was used negotiating incomplete and delayed proposals, often without robust financial values and poor implementation plans, the majority of which were not agreed.

CCGs are specifying that all proposals to change the coding and counting of acute services are:

- Presented on the standard template
- Submitted to the Director of Commissioning of the Lead CCG and the CSU Contract Lead

To enable better evaluation of the wider system impact with commissioning partners fully completed submissions must be received by 31 October 2014. Incomplete submissions will be put into a longer-term 18 month process, including the establishment of shadow monitoring where it is not already in place

Providers and Commissioners will be expected to reach pragmatic agreement on the materiality of proposals. Proposals will not be considered where transaction costs to agree, implement, monitor and audit any changes do not offer value for money for the tax-payer.

Proposals must demonstrate benefit for patients in terms of supporting service provision and data quality and this must be clearly set out in the proposal.

There will be a requirement for a minimum of 6 months consecutive shadow monitoring. The standard template and guidance is attached at Appendix D.

2.1 This process will apply to all proposed coding and counting changes for CCG commissioned services. (This includes activity not currently charged for, but where there is an intention to apply National Tariff, and activity for which a local price is proposed).

2.2 All proposals will be shared using the standard template provided by no later than 31 October 2013. Providers should submit proposals to *dboothroyd@nhs.net*.

2.3 Incomplete proposals will be put into a longer-term 18 month process, including the establishment of shadow monitoring where this is not already in place.

2.4 For further information and guidance on the process and completion of the template please email *dboothroyd@nhs.net*.

3 Alignment with National Changes

3.1 National changes mandated by the HSCIC or required by the National Tariff will be implemented in accordance with appropriate nationally prescribed time-line.

3.2 CCGs will expect the impact of these changes to be calculated at individual CCG level for all CCG commissioned services.

Appendix 5a

Standardised Approach to Coding and Counting

Summary of Coding and Counting Proposals

N.B For each proposal use a separate line for different activity type and code as appropriate. Where a proposal shifts activity / costs between NHS England and CCGs, please provide information for each commisisoner type by proposal.

Proposed by:	Name:	
	Organisation	
	Job Title	
	Contact Email	
	Contact Telephone	

Organisation Code :	Provider Organisation Name	Title of Proposed Change	Proposal Number	How Service / Activity (12 months prior to change) is currently coded and charged											Proposed Service / Activity (12 months After Change)								Year on Year Net Impact	Monthly Shadow Monitoring Provided since:
				Commissioner Code	Point of Delivery	Activity Type (s)	Code(s)	Volume(s)	Date From	Date to	Currency(s)	Tariff(s)	Total Value £		Commissioner Code	Point of Delivery	Activity Type	Code(s)	Volume	Currency	Tariff	Total Value		
			1					-				£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
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												£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
Total													**£ -**									**£ -**	**£ -**	

Authorised by:	Name:	
	Organisation	
	Job Title	Director of Finance
	Contact Email	
	Contact Telephone	
	Signature	

Proposals should be shared locally and submitted nationally to the following email address by no later than 30 September xxxxxxxxxx@NHS.net.

Ref MW v1 14-08-2014

APPENDIX 5a

Template for notification of intended Coding / Counting Changes to 2014/15 Contract for 2015-16

Organisation Name and Code	
Proposal *(Title, reference number & date)*	

☐ **Justification for the proposed change**
Summarise the benefits of the change for patients, the commissioner and provider.

Does the proposed change constitute (tick all that apply)	
☐	Coding change
☐	Counting change
☐	Local quality requirement / Local incentive scheme
☐	Agreed service development
☐	Agreed pathway change

Current Service / Activity	**Proposed Service / Activity and how this differs from current provision**
Narrative description (service code e.g. TFC and/or HRG code(s) must be used where relevent)	**Narrative description** (service code e.g. TFC and/or HRG code(s) must be used where relevent)
Activity type(s) (e.g. IP / DC / OP, etc., and whether consultant-led or other)	**Detail of proposed new activity type(s)**
How is activity currently coded? (Please include specialty codes, as well as clinic codes for out-patients and HRG or other coding)	**How will proposed activity change be transacted / coded? (Please include specialty codes, as well as clinic codes for out-patients and HRG or other coding)**
What is the current contractual arrangement?	**Proposed contractual arrangement**
Cost and volume - national tariff ☐	Cost and volume - national tariff ☐
Cost and volume - local price ☐	Cost and volume - local price ☐
Cost and volume - with marginal rate ☐	Cost and volume - with marginal rate ☐
Block ☐	Block ☐
Indirect funding (within other tariff / funding) ☐	Indirect funding (within other tariff / funding) ☐
Other - please specify ☐	Other - please specify ☐
Annual volume of activity by activity type	**Proposed annual volume of activity by activity type**
Current unit price paid (excluding MFF & CQUIN) for activity by activity type at 2014/15 prices (please include unit currency i.e. spell, year of care etc.)	**Proposed unit price paid for activity (excluding MFF and CQUIN) by activity type at 2013/14 prices (please include unit currency).**
Current annual quantum of income received for activity (volume x price, including MFF but excluding any CQUIN) at 2014/15 prices	**Proposed annual quantum of income received for activity (volume x price, including MFF but excluding any CQUIN) at 2014/15 prices**
	Net change in quantum at 2014/15 prices (including MFF but excluding CQUIN)
	£0

Are there any implications for other services, drugs, devices etc.?	
Other services that will change or cease (include current activity and finance)	**Other service after changes (include proposed activity and finance levels)**
	Is any activity moving between providers as part of a planned service change? If so give full details.
	Is any activity moving from or into specialised services? If so give full details.

Ability to transact the proposal - For how long has monitoring been provided?	
☐	6 consecutive Months? (minimum requirement)
☐	12 consecutive months? (recommended time period)
Please confirm that any coding changes will be included in the Trust's coding audit programme and the results shared with all parties.	

Any other relevant information?

Required supporting information
Please append the following information: - Last 3 years reference costs appropriate for the relevant service(s) - Service expenditure (current year-to-date and previous 3 years) - Supporting analysis files

Template completed by (name, job title, email, phone number and date)
Approved for submission by (name, job title, email, phone number and date)

Ref: Coding change template 240914

APPENDIX 6

South West London Trust notification letter (23/09/2014)

This section sets out the expectations for 2015/16 with regards to high cost drugs and devices by the lead CCG commissioner, on behalf of itself and associate commissioners.

1. We expect Trusts to adhere to the following documents which are included in the existing contract and are reviewed and agreed by the SWL Medicines Commissioning Group (which has representation from all SWL Acute Trusts, community services providers and CCGs) on an annual basis:
    - "SWL Interface Prescribing Policy" and associated appendices and
    - "Commissioning Principles for PbR excluded drugs and devices" and associated appendix

    See link for 2014/15 version. We intend to review these documents for 2015/16, also including the information set out below.

Horizon scanning

2. In view of (annual and in-year) updates and adjustments to the "NHSE Manual for Prescribed Specialist Services" and NHS England's PbR excluded drug list, we intend to vary CCG commissioned PbR excluded drugs and associated services accordingly. CCG commissioned drugs will be listed in the SWL CCG Commissioned PbR excluded drug list 2015/16 which will published on www.swlmcg.nhs.uk and included in Trust 2015/16 contracts.

3. It is the responsibility of providers to inform commissioners of any cost pressures anticipated in the forthcoming year including those relating to NICE technology appraisals within prioritisation round timescales. We would expect the Trust to horizon scan implications of NICE approved drugs / technologies, those in development and other developments and set out financial and service implications and the pathway they are proposing to use. New excluded drugs and devices will not be funded in-year unless approved by NICE or previously identified and planned for within the prioritisation round.

4. London CCGs intend to commission treatment pathways in line with NICE guidance and will recognise charges derived from NICE costing templates. NICE costing templates include information on activity charges used to cost the full treatment pathway (this includes cost of drug, price of activity associated with the drug, price of activity when patient is followed up). We would expect the Trust to implement these charges (or less) unless specifically agreed otherwise.

Notification and invoicing for high cost drugs

5. In order to secure funding for PbR excluded drugs or drugs not routinely commissioned, PbR excluded drug funding application forms ("tick box forms") and Individual Funding Request (IFR) forms should be screened by suitably trained Trust pharmacy staff before submission. This is to ensure that only valid applications are submitted that meet all contractual requirements for PbR excluded drugs or the IFR policy (for IFR applications) and that applications are not submitted where this is not the case. We have noticed deterioration in the quality of applications for some Trusts, resulting either in delays of processing or a return of applications to the Trust.

6. For PbR excluded drugs, Trusts are reminded to notify the CCG/CSU within 2 weeks of starting treatment. Invoices for PbR excluded drugs without notification and funding approval will not be paid until such time that an application is made in which case only future (not retrospective) invoices will be paid. This reinforces and further clarifies contractual arrangements already specified in "Commissioning Principles for PbR

excluded drugs and devices". The same will be applied to patients for whom initial or subsequent funding has expired.

7. Patients who have been receiving PbR excluded drug treatment for a while without any record of approval, require submission of an initial PbR excluded drug application form (submitted with Blueteq) with data reflecting the situation prior to starting treatment. If treatment has been given beyond the initial approval period as specified on the application form, the Trust should also apply for a re-approval at the same time in order to seek approval for continued funding.

8. Drugs which are subject to IFR approval must be invoiced monthly separately from the main contract.

9. London CCGs will only pay the actual cost of the drug or technology at which the provider procured the treatment (including any LPP discounts, Patient Access Scheme discounts or other discounts), in line with PbR guidance. Any additional (administrative or other) charges applied to drugs or technologies will not be honoured unless specifically agreed otherwise in the contract. The same will apply to drugs/technologies which have been approved following submission to the IFR panel of the relevant CCG. CCGs will reserve the right to audit provider costs to demonstrate compliance with this term.

10. Trusts are required to respond to challenges raised for PbR excluded drugs in a timely manner (within 10 working days). If no response is received within this timeframe, Trusts will be required to credit the challenged amount.

High cost drugs- post verification audits

11. Trusts are reminded that information provided to request (initial and ongoing) funding for PbR excluded high cost drugs (usually via Blueteq) is part of and should mirror patient clinical records.
    As part of the quarterly review process we will visit the Trust on an agreed audit day to jointly carry out post verification audits comparing submitted data for requesting funding for PbR excluded high cost drugs versus patient's clinical records. This will be on an ad hoc basis (maximum 2 audits per year). Data will have to be extracted from patient's notes by Trust staff on the audit day on a pre-set representative sample of patients. This information will be checked by CCG/CSU staff against data submitted to the CCG/CSU when requesting funding (with honorary contracts in place to cover patient confidentiality regulations).
    If the sample of the audit identifies that there are discrepancies, an appropriate action plan will be agreed between the Trust and the CCG. If the discrepancies are showing that funding for PbR excluded drug applications are not filled in honestly, this may ultimately result in a applying the % breach identified in the sample across the total high cost drug charges for that year and a rebate payment will be expected from the Trust.

Better Procurement, Better Care, Better Value

12. In line with the DoH Better Procurement, Better Care, Better Value strategy we ask Trusts to suggest proposals to further increase quality and cost- effectiveness of using CCG commissioned PbR excluded high cost drugs. Any proposals on sharing benefits will be considered in line with NHSE "Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices" and expected guidance from NHS England Specialised Commissioning Medicines Optimisation Clinical Reference Group (CRG).

13. The provider will work with the commissioner when contracts are negotiated for the procurement or supply of items which may require ongoing prescribing in primary care.

This includes procurement of incontinence and stoma products, glucose monitoring devices, dressings and feeds (including oral nutritional supplements).

14. As per current contractual agreement, Trusts should only supply enteral feeds on discharge if accompanied with a nutritional management plan including MUST score. For clarification, Trusts are requested to ensure measures are in place to ensure that all patients discharged and supplied with oral nutritional supplements have:
    - been properly assessed as needing ONS on discharge
    - clear communication sent to the GP explaining the reason (including MUST score) and, whether any further supplies are needed once hospital supply runs out
    - a future follow up plan i.t.o targets, reviews etc.
    - been changed on the most cost effective product for primary care on discharge. Note that SWL CCGs intend to work with SWL Trusts to ensure that preferred formulary products in primary care will be available to the Trust for suitable patients on discharge.

Other

15. Providers will be expected to prescribe and supply in a manner that minimises the potential for waste.

16. If chemotherapy commissioning is transferred back to CCGs in the future, robust systems and processes must be put in place to manage the entry of new drugs and chemotherapy protocols in the preceding year to ensure that there is appropriate governance in place and that evidence based, clinically safe, cost effective decisions are made.

17. Providers are expected to put active systems in place to ensure that the interface prescribing policy is adhered to by all clinicians. This would include measures to ensure that the policy is brought to the attention of new clinicians and that breaches are followed up as a matter of urgency within clinically appropriate timescales. To avoid delays to continuity of care, named contacts for resolution of these breaches must be in place