Bracknell and Ascot, Slough and Windsor, Ascot and Maidenhead CCGs Commissioning Intentions 2017/18

Version control

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Index to be added to final version

1. Introduction

This document sets out at a high level the commissioning intentions of the 3 East Berkshire CCGs for the period April 2017 to March 2019. This document has been informed by NHS England planning guidance, the emerging Frimley Sustainability and Transformation Plan (STP) (Appendix 1) and key transformation programmes such as New Vision of Care (Appendix 2. These commissioning intentions reaffirm our collective commitment to improving outcomes and delivering sustainable, consistent standards of care within the resources available. It is important to note that the CCGs detailed plans will be set out within the Operating Plan for 17/19 which will be submitted to NHS England in December, and that some sections of the document, including the business rules and finance sections will be reviewed and amended following publication of the NHS England Planning Guidance (expected towards the end of September 2016), and to reflect ongoing discussions with our partners within the STP as the priorities and work streams articulated within it are progressed .

We will reflect national strategies and priorities in our Operating Plan for 2017/19. We will translate our plans into delivery through collaboration with our partners, striving to achieve for transformation at scale and at pace. Our plans will continue to be underpinned by ongoing engagement with patients, users and key partners, and seeking to exploit opportunities to pool collective resources where this achieves better value across our health and care system.

2. A message from our Chief Officer and Clinical Chairs

Our aim is to commission person centred and integrated care, particularly for those most frail and vulnerable in our communities. The emerging Frimley Sustainability and Transformation Plan provides an exciting opportunity to work with a range of partners to realise system level changes that ensure the long term sustainability of the health and care sector in both East Berkshire and across the Frimley STP footprint.

During 2017/18 we will be taking on further commissioning responsibilities for general practice, with Windsor, Ascot and Maidenhead CCG becoming fully delegated commissioners from 1 April 2017. At this stage Bracknell and Ascot and Slough CCGs will be continuing with the joint commissioning arrangements with NHS England, however this situation may change over the coming months. We will be publishing our strategy for a sustainable model of Primary Care later in the autumn following extensive engagement with member practices, partners and our patients.

Principles which will underpin our commissioning ambitions for 17/19

3.1 Our approach is to:

- Put a greater emphasis on prevention and putting patients in control of their own care planning
- Ensure our plans explicitly align with the CCG Strategies and Programmes such New Vision of Care, and the STP vision and priorities
- Use the Right Care programme as a basis for identifying opportunities for reducing unwarranted variation
- Exploit opportunities for expanding the use of technology enabled care
- Commission services which provide our populations with information and choice, ensuring care closest to home is offered wherever possible
- 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
- Only purchase interventions, treatments and drugs that are evidenced to be cost-effective, including through NICE TAG or evidence reviews that have been specifically accepted and adopted on the recommendation of the Thames Valley Priorities Committee
- Commission additional services from Primary Care where these support delivery of our strategic vision
- Actively consider decommissioning services where there is limited evidence of improved outcomes for patients and value for money for the taxpayer
- Evaluate the impact of the current Better Care Fund arrangements and consider greater pooling of resources with our three local authorities, ensuring alignment with the Sustainability and Transformation Plan for the Frimley Footprint;
- Use quality incentives effectively and consistently across the health economy to focus on improving outcomes for patients;
- Use 16/17 Q2 forecast outturn as the basis for baseline setting unless there is a clear rationale to do otherwise

3. Financial resources and system risk

In 2016/17 the three CCGs in East Berkshire received a combined funding allocation from NHS England of £490 million. Although a significant increase, this was less than anticipated. Changes in the funding formula and target allocation resulted in the East Berkshire CCG's not receiving as much additional funding as was previously anticipated. Coupled with growth in acute hospital activity, this has put the CCG budgets under pressure with a significant QIPP requirement in 2016/17 and going forward in order to maintain financial balance and deliver the level of surpluses required by NHS England. All three CCGs are required to deliver surpluses in excess of the standard 1%, with Bracknell & Ascot CCG's requirement being more than 2%. We do not expect to be able to 'draw down' and utilise these additional surpluses in 2017/18, but plan to do so over the strategic planning period (ie to 2020/21). The indicative funding allocations for the next two years, through to 2018/19 are:

Year	Bracknell and Ascot CCG	Slough CCG	Windsor Ascot and Maidenhead CCG	All Berkshire East CCGs
	£m	**£m**	**£m**	**£m**
2016/17	153.4	171.8	165.1	490.3
2017/18	**157.3**	**175.9**	**168.7**	**501.9**
2018/19	**160.7**	**180.2**	**172.2**	**513.1**

The Frimley Sustainability and Transformation Plan Footprint (which includes Surrey Health CCG and NE Hampshire & Farnham CCGs) has been told to expect an additional £47m of funding from the national Sustainability and Transformation Fund in 2020/21, but at the time of writing these Commissioning Intentions it has not been notified of any additional funding above the published allocations for the intervening years.

4.1 Key national business rules

NHS England has advised CCGs that the business rules set out in the 2016/17 Operating Plan guidance should be assumed to continue to apply for future years:

- A minimum 1% surplus (or mirroring current year surpluses if greater than 1%) which can be carried forward to future years.
- In order to provide funds to insulate the health economy from financial risks, a further 1% of allocations should be set aside for non-recurrent expenditure , and this must be uncommitted at the start of the year (and will only be available for investment later in the year to the extent that it is not required to secure the overall national financial position). As a consequence of creating this reserve, commissioner plans are inherently riskier than in previous years.
- A minimum requirement to show 0.5% contingency

4.2 Current financial position

As at month 5 (August) of 2016/17, increases in demand and acuity have put the CCGs under significant financial pressure, and the first call on any increase in funding next year will again be to rebuild a modest level of contingencies. This year each CCG has contributed about £8m into 'Better Care Funds' with our local authorities. These comprise a range of existing health and social care budgets, plus additional monies for new community based services. This has provided some support from health into challenged social care budgets, but the overall financial position for our three local authorities remains extremely challenging. We have also seen a reduction in public health budgets, which, in the longer term, is likely impact on overall health and social care costs.

We also recognise that the position of our main health providers, although improved, remains challenging. Frimley Health Foundation Trust is still operating with an underlying deficit and they need to return to financial balance by 2020. We believe this can only be achieved through extensive collaboration with CCG commissioners. We know our other key providers also remain financially challenged – Berkshire Healthcare Foundation Trust, Royal Berkshire Foundation Trust and South Central Ambulance Service. The collaborative approach of the STP with Commissioners and Providers is therefore of primary importance as we move into the next planning round.

4.3 Summary financial analysis from the Frimley Footprint STP

- The system is experiencing increasing pressure and our modelling of the demography and financial challenges clearly shows that we need to respond with much greater transformation if we are to address our 'do nothing' gap of £249m by

2020/21

- The Frimley system will spend c£1.4billion on health and social care in 2016/17.
- Although there are modest increases in funding over the period to 2020/21, demand will far outstrip these increases if we do nothing.
- We have assumed health providers can continue to make efficiency savings of 2% per annum, and demand can be mitigated by 1% per annum. This is in line with historic levels of achievement. Including broader efficiencies from Social Care will deliver about £176m by 2020/21.
- If a further £28m can be saved across our five priority areas, this coupled with an allocation of £47m from the national Sustainability and Transformation Fund (STF) will bring the system into balance by the end of the period

STP 2020/21 Summary			
	Do Nothing £m	**Solutions £m**	**Do Something £m**
Commissioner Surplus / (Deficit)	(78)	81	3
Provider Surplus / (Deficit)	(135)	102	(33)
Footprint NHS Surplus / (Deficit)	(214)	183	(30)
Indicative STF Allocation 2020/21	-	-	47
Surplus /(Deficit) after STF Allocation	(214)	183	17
Social Care Surplus / (Deficit)	(35)	21	(14)
Total Surplus / (Deficit)	(249)	204	3

5 Our approach to Engagement

We want our public, patients, carers, partners and other stakeholders to be involved in our work and to help us design services that are high quality, affordable and sustainable for the future. This includes supporting self-care and helping people stay healthy Our strategy for communications and engagement is based on the principle of open and continuous communication with patients, the public, member practices, staff and key stakeholders. It also acknowledges our statutory responsibilities and the NHS commitment to involve patients in the way in which health services are planned and managed.. Engagement is delivered in different ways for each CCG through separate action plans.

Our three objectives are:

1. To proactively engage with stakeholders and enable people in east Berkshire to contribute to shaping future health services commissioned by the CCGs.
2. To develop a culture that promotes open communication and engagement with patients and the public.
3. Ensure member practices and staff are informed, engaged and involved in the work of their CCG and participate in commissioning activities for the benefit of patients.

Our principles for communications and engagement are:

- Be accessible and include all sections of our community.
- Be honest and transparent.
- Use different ways to communicate to reach more people
- Be open and clear from the start about what our plans are, be realistic about what is and what is not possible and why?
- Make sure people have the right information at the right time.

- Inform and involve people as early as possible
- Listen to people as well as provide information
- Use plain language that people understand.
- Work with other organisations

Aside to public Governing Body meetings, we have active patient participation groups, a Patient Panel and Community Partnership Forum which are regular and structured channels through which we can engage with the public. We also use digital technology such as social media and HealthConnect, our online consultation tool to make sure we are reaching out to hear from those who cannot attend meetings. We have a number of websites which we manage and the CCGs are well-linked to community and partner organisations, and work across the patch with these organisations to ensure strong engagement.

6 Urgent and Emergency care

6.1 Our strategy for urgent and emergency care is to:

- Prevent crisis through improved access to Primary Care to avoid the escalation of health issues
- Improve urgent on the day services responsiveness through helping people easily navigate services, offering direct access to clinical advice, and which enables people to have their care needs met outside of a hospital setting where clinically appropriate
- Patients only to stay in hospital as long as they need to, supported by an integrated model of community health and social care services

6.2 Our focus will be on the following 5 national priority areas:

- Streaming at the front door – to ambulatory and primary care
- NHS 111 – Increasing the number of calls transferred for clinical advice
- Ambulances – Directory of Services and code review pilots; Health Education England increasing workforce

- Improved flow – ‘must do’s that each Trust should implement to enhance patient flow – SAFER Bundle
- Discharge – mandating ‘Discharge to Assess’ and ‘Trusted Assessor’ models

6.3 Commissioning Intentions 2017/18 - Urgent and Emergency Care

We will:

- Mobilise a new Integrated NHS111/Urgent Care contracted service model from 1 April 2017 including a clinical hub with access to patient records and development of extended clinical services and social care support.
- Review the Bracknell and Maidenhead Urgent Care Centres, the Slough Walk-in centre and East Berkshire Out of Hours Services, as current contracts come to an end, undertaking market testing (subject to procurement advice) and commission new service models which align with our future vision for Primary Care during 2017/18
- Review of the impact of the recently commissioned AIRS service in Bracknell, Ascot, Windsor and Maidenhead populations with a view to extending the service to Slough from April 2017.
- Work with our local Acute Providers to expand the use of ambulatory care pathways, and explore new payment arrangements with a view to agreeing a local price for this activity.
- Review the impact of all of our resilience and out of hospital investments from 15/16 and 16/17 with the aim of continuing to invest only where there is clear evidence that this has had a positive impact on system performance including reducing non-elective admissions, attendances at A&E and reducing delays in discharge from hospital.
- Revise our approach to the management and use of the directory of service (DOS) to enable a comprehensive real time support service. In doing so we will review the current contractual arrangements with the CSU as our DOS provider including agreeing a new specification.
- Work with South Central Ambulance Service to implement the recommendations from the national review of Ambulance Services.
- Work with all out providers to ensure that national quality indicators, best practice and standards associated with effective urgent and emergency care are embedded within the contracts for 17/19.

7 Integrated Care

7.1 Our Strategy for integrated care is to:

- Reflect our New Vision of Care Programme through all of our commissioning activities (see Appendix 2)
- Work with the public and a range of partners from all sectors including Primary Care, Social care, and the third sector to create a fully integrated system delivering new care models.
- Use shared care records and the recently commissioned interoperability solution; joint commissioning arrangements, pooled budgets and the development of common care principles across the STP footprint to accelerate the opportunities for integrated care delivery.
- Work closely with our partners to commission care that supports people with complex needs and those who are frail to live independently for as long as possible.
- Work to realise the vision for primary care as central to the development of local integrated clusters/hubs
- Work with partners to improve the way that we commission wellbeing and preventative services

7.2 Our focus will be on:

- Extending the CCGs personal health budgets offer, focussing initially on people with a learning disability
- People approaching the end of their lives
- People who are at risk of or in an early stage of frailty and giving them access to a team of people who can provide proactive help, with one person known to them co-ordinating their care
- Community capacity and sustainability in particular care homes and carers provision with local authority colleagues
- Expanding the use of social prescribing, care navigators, and health makers.

7.3 Commissioning Intentions 2017/18 – Integrated Care

We will:

- Increase the number of personal health budgets in line with national policy.
- Expect all providers to adopt and work to the New Vision of Care principles and its approach to frailty identification and management. This includes adopting a locally agreed frailty tool within their services and applying the principles of “Making every contact count”.

- Review key service lines and agree revised service specifications including the Mobility Service, Community Hospital in-patients, and Community Nursing through the remainder of 16/17 and with a view to having new service specification in place by April 2017.
- Review community services currently provided by Virgin Care for our registered population living in Surrey with a view to re-procurement during 17/18
- Explore with our local authority commissioners opportunities for joint commissioning for individuals who are eligible for funding from CHC, voluntary sector provision, and learning disability and mental health placements.

8 Mental Health, Learning Disability and/or Autism

8.1 Our strategy for mental health, learning disability and autism in line with the national Transforming Care agenda and is to:

- Improve the physical health outcomes of people with mental health, learning disability and/or autism
- Provide opportunities for people with mental health a learning disability and/or autism to live and be treated in a safe environment as close to home as possible
- Ensure those in crisis receive the rapid support they need
- Support people with long term conditions and dementia
- Support people to maintain or secure employment
- Develop our joint commissioning capacity with local authorities
- Provide people with opportunities to be supported by their peers

8.2 **Our focus will be on**

- Implementing our Transforming Care Plan.
- Improving dementia diagnosis rates and post diagnostic support
- Improving response rates for those in a crisis
- Commissioning enhanced psychological support for people with long term conditions
- Reducing the number of care and treatment beds for people with a learning disability and out of area placements through the commissioning of care for people closer to home

8.3 Commissioning Intentions 2017/18 - Mental Health, Learning Disability and/or Autism

We will:

- Work with providers to reduce the numbers of Learning Disability assessment and treatment unit beds
- Implement the Learning Disability Community Intensive Support service
- Re-scope the role and function of the Learning Disability Community Teams.
- Develop the market for local placements and support for people with mental ill health, LD and/or autism thereby reducing the number of out of areas placements.
- Expect a Learning Disability liaison nurse function to be provided at Frimley North in line with other providers
- Expect the prescribing of antipsychotics to be reduced in all care settings.
- Develop a locally commissioned service to improve the quality of Learning Disability health checks in primary care
- Commission consolidated mental health liaison services to ensure delivery of the one hour response access target and a core 24 service standard through the development of an integrated service specification.
- Review Community Mental Health Teams, and work with partners to jointly commission a transformed model of community mental health provision.
- Work with our provider and key partners to review the current Crisis Response Home Treatment Teams, and commission a new model of urgent and emergency care for Mental Health users.
- Expand the IAPT service with support from national pilot funding, increasing the number of employment advisers and integrate the service with primary care. Expanding the psychology intervention community nursing pilot across the 3 CCGs in line with the IAPT expansion programme and continuing to meet national targets for access and recovery
- Continue to increase dementia diagnosis rates and review post diagnostic support for people with dementia. Developing dementia friendly practices and expanding the service for younger people with dementia from a 2 to 5 days.
- Review the existing Friends in Need service and if it demonstrates it is delivering value for money results with good outcomes expand this to Slough and Bracknell and Ascot CCGs
- Review the Street Triage pilot and explore the potential for continuation in conjunction with Local Authorities
- Undertake a review of the requirement for further places of safety by April 2017.

9. Childrens and Maternity services

9.1 Our strategy for childrens and maternity services is aligned to the delivery of the Childrens and Young Peoples and Better Births Plans and we will commission jointly with our local authority partners

9.2 Our focus will be on:

- Ensuring NICE compliant services
- Providing children and young people with faster access to mental health services
- Understanding the needs of asylum seekers
- Ensuring the CCGs meeting their obligations for children with Special educational needs and disabilities

9.3 Commissioning Intentions 2017/18 – Childrens and Maternity Services

We will:

- Commission a fully NICE compliant community eating disorder and perinatal services
- Work with our providers to implement the recommendations from Better Births
- Review the Children's and Young Persons Transformation pilots and make recommendations on future commissioning
- Continue to reduce Child and Adolescent Mental Health Service (CAMHS) waiting times across all pathways
- Identify the needs of new asylum seekers and commission additional capacity once we have agreed options for delivery in conjunction with partners
- Work with partners to ensure that our collective responsibilities for children with special educational needs and disabilities are met.

- Commission upstream support to children and young people and their parents before they develop a mental health disorder

10 Planned Care

10.1 Our strategy for planned care is to:

- Reduce unwarranted variation in both outcomes and activity using the Right Care Programme methodology to identify priority specialties

10.2 Our focus will be on:

Exploring service redesign opportunities which add value to review and transform current pathways in the context of our Right Care priorities which will include but may not be limited to:

Gastroenterology,	Musculoskeletal
Neurology,	Cardiology
	Respiratory

10.3 Commissioning Intentions 2017/18 – Planned Care

We will**:**

- Commission new ambulance pathways for the management of hyperglycaemia
- Introduce a new specification for an Integrated Diabetes Service across community and acute services to support uncontrolled diabetics and the proactive management of diabetic patients.

- The current diabetes service to work with General Practice and other healthcare professionals/clinicians to develop the necessary skills, competencies and confidence to improve the quality of routine diabetes management
- Review the current dietetic service as part of the implementation of an integrated Diabetes service and work with providers to ensure an effective service for newly diagnosed diabetic patients to support patients to self-care for both their mental and physical wellbeing
-
- Engage in the STP wide Unwarranted Variation programme, influencing service and pathway changes as these are developed
- Review all current locally commissioned services from Primary Care associated with Cardiology to ensure consistency and the expected outcomes to increase the reported prevalence of atrial fibrillation, hypertension, heart failure, and chronic kidney to expected levels and reduce current variation.
- Aim to address the inequity of provision of cardiac rehabilitation across the three CCGs through evaluation of the benefits of the service. All providers must adhere to or working towards the NACR accreditation of service standards.
- Work with providers to develop an integrated community heart failure nursing team expanding the use of telehealth and working towards best practice caseload levels.
- Commission an IV Diuretic lounge with all our Providers
- To improve management of patients with hypertension by promoting active case finding and titrating medication to optimal levels.
- To improve management of patients with CKD by promoting active case finding and titrating medication to optimal levels.
- *C*ommission a new model of dermatology services which enables faster diagnosis and improvement in the two week cancer pathway performance, yet recognises the national shortage in consultant Dermatologists. Access will also be improved for those patients not on the two week pathway.
- Work with providers to review Cancer services to ensure the priorities in “Achieving World Class Cancer Outcomes – A Strategy for England 2015-2020” are implemented and tailored for local requirements through a local cancer framework. Continue to deliver the national performance standards for Cancer.
- We will be evaluating local demand management pilots, with a view to defining a future strategy for the commissioning of MSK services to include increased use of shared decision making in particular in respect of hip and knee replacements, direct access Physiotherapy for East Berkshire, and an integrated community Pain and Spinal service

- De-commission the existing GRACE service and develop a new specification to re-commission a service which will provide triage and update all referral forms and pathways on DXS.
- Work with general practice to reduce unwarranted clinical variation in primary care, extending the use of DXS, and reviewing variation in activity levels with individual practices where this is identified.
- Expect general practice to utilise e referral to agreed levels: and for all providers to ensure that the DXS system is notified of and changes to pathways and referral forms. Our aim is to increase the number of directly bookable slots on E-Referral and that at least 80% of referrals to clinics that are available on E-referral to be made via the E-referral system

11. Primary Care

11.1 Our strategy is to:

- develop a transformed and sustainable model of General Practice for East Berkshire
- Improve overall access to general practice appointments
- Realise the opportunities and benefits set out in the general practice forward view through delegated commissioning

11.2 Our focus will be to:

- Develop an agreed strategy for Primary Care across the CCGs
- Review all locally commissioned services
- Improve prevention and screening uptakes
- Improve engagement and communication with patients
- Develop the seven day service infrastructure

11.3 Commissioning Intentions 2017/18 – Primary Care

We will:

- Work, through the Joint Primary Care Co-Commissioning Committee, to align contractual models with the delivery of our strategic vision, aligning payment levels and working to improve quality and sustainability.,
- Invest in such a way as to support sustainable primary care services and enable practices to take on enhanced roles.
- Look to evaluate and consolidate locally commissioned services from April 2017 through a single quality scheme, ensuring that all patients have access to these, and developing new processes for supporting quality improvement in primary care.
- 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. As part of the delivery of our Primary Care Strategy we will link very strongly with the wider estates review, the Connected Care programme and Digital Roadmap.
- Work with HEE Thames Valley to develop the new workforce
- Work with practices to understand address workload, workforce and capacity challenges and opportunities to take on out of hospital work
- Work with NHSE to improve and monitor the quality of services provided under primary care contracts, and we would look for providers to support delivery of QIPP schemes

Specifically we will

- Commission a single quality scheme to replace the current locally commissioned services to include but not exclusively, AF, Complex case management, and Near patient testing
- Support the use of technology in primary care to support self-care, patient communication, reduction in DNAs and public health screening/prevention improvement
- Commission a visiting service to ensure proactive care for housebound and care home patients using appropriate skill mix on a population basis
- Develop social prescribing across general practice to widen the support for patients and carers
- Commission a practice resilience task force to support practices in crisis,
- Commission specimen collection to support 7 day services, support interoperable primary care/general practice records and identify professional resources to support the realisation of the estates and other infrastructure proposals being considered by NHSE – creating capacity in general practice

12 .Specialised Care

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

It is recognised that discussions are ongoing at national level in relation to the co-commissioning of specialised services. 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 2017-19 contracts.

12.1 Commissioning Intentions 2017/18 – Specialised Care

We will:

- Participate in the Strategic Services Review Programme and will be working with NHS England to enable collaborative commissioning arrangements for specialised services where appropriate.
- Utilise the evidence based Commissioning for Value and Right Care data to reduce unnecessary variation.

13. Policies and Protocols

The CCGs will only contract with Providers that abide by our policies and protocols. These include, but are not limited to local clinical policies and access criteria (including procedures of limited clinical effectiveness, prior approval thresholds and pathways for BMI and smoking) as determined by the CCGs, which may be different to the Provider's host CCG. Referrals will clearly specify when patients are being referred for clinical opinion and patients will only be treated if they meet the CCGs criteria for treatment.

14. Quality and Performance

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 2017-19. In addition, the 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 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.

We will:

- work with providers to ensure that all NHS Constitutional standards are achieved. This will include Referral to Treatment, Cancer waiting and ambulance response time standards that have been particularly challenging during 2016/17. 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.
- work jointly with Providers to deliver the improvements across the five domains in the NHS Outcomes Framework.
- closely monitor and report Providers quality achievements to our constituent CCGs.
- look to redirect CCG activity where quality concerns are identified and not rectified in a timely manner, notwithstanding patient choice.
- regularly review Provider services to ensure that NICE Quality Standards and recommended pathways are being delivered.
- 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
- require Providers to ensure patients are offered a choice of local provider for ongoing treatment and care wherever this is appropriate.
- seek full provision of referral information from Providers in SUS to enable effective demand management strategies.
- look to reduce the first: follow up ratios at Providers that remain an outlier against benchmarks and seek performance in the upper 10%.

- 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.
- 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 liable for procedures when providers have failed to adhere to those policies.

15. Capacity Planning

2016/17 Activity Plans were mutually agreed as a reasonable reflection of anticipated activity. Month 6 outturn will be used as the basis for 2017/18, except by mutual agreement, or to reflect contract variations agreed during 2016/17.

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 17/18.

Where activity is transferring between commissioning organisations, the 2016/17 plan will be used as the basis for this transfer, except by mutual agreement.

16. Equality and Diversity

Section 149 of the Equality Act 2010 places a public Sector Equality Duty (PSED) on all statutory public authorities and those who act on their behalf. Our general duty and one which the CCGs are committed to is to eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity between different groups and foster good relations between different groups. We recognise and value the diversity of our communities and believe that equality is pivotal to the commissioning of modern, high quality health services.

17. 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.
- Agree Contract Terms that mitigate financial risk for both parties, including marginal rates and 'floors and ceilings' where contractually appropriate.
- 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.
- 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.
- 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.

18. 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.

19 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.

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.

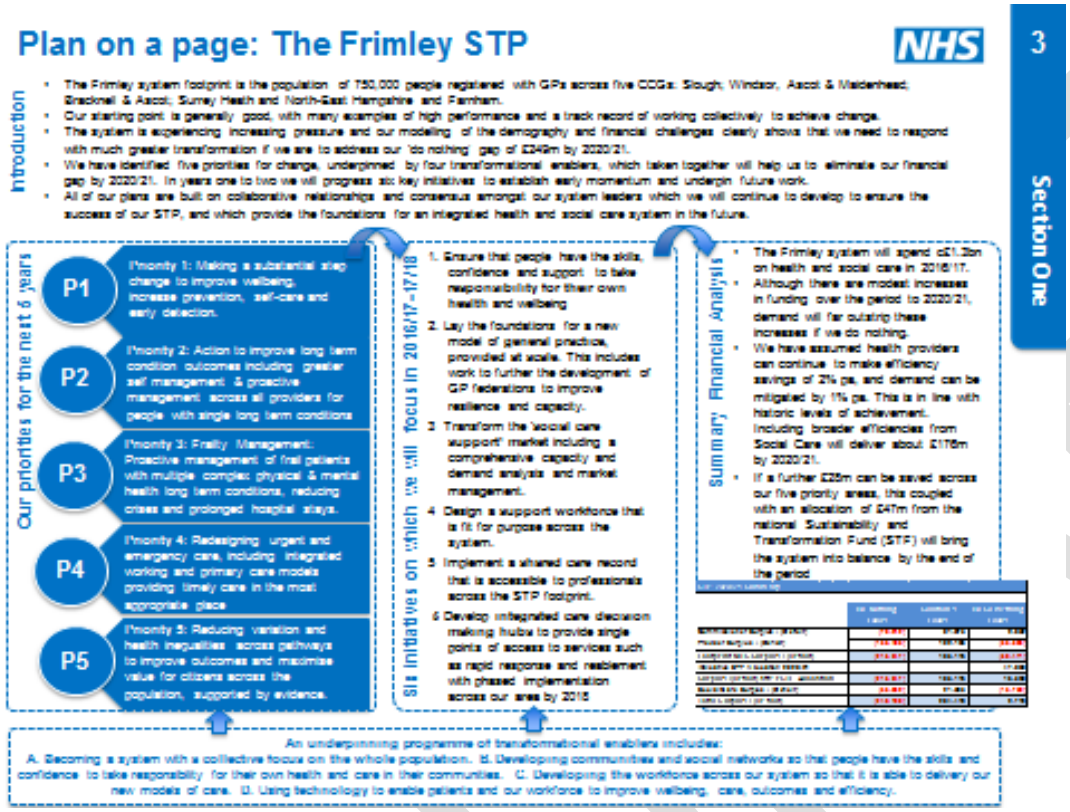
Regular day / night activity should be counted as such and the appropriate locally agreed tariff applied.
Procedures that take place in an outpatient setting will be reimbursed at either national mandated outpatient HRG tariff or a tariff to be agreed between the provider and the CCGs. The nature of 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.

20. Concluding remarks

This letter has outlined the current known commissioning expectations for 2017/18 and I trust that you will recognise many of the issues highlighted as either work in progress our areas for development, the underlying objective being to improve the quality, effectiveness and efficiency of the services we commission and the care you provide. You will see that there are clearly a number of work areas that will require our joint commitment and engagement.

Appendix 1



Appendix 2

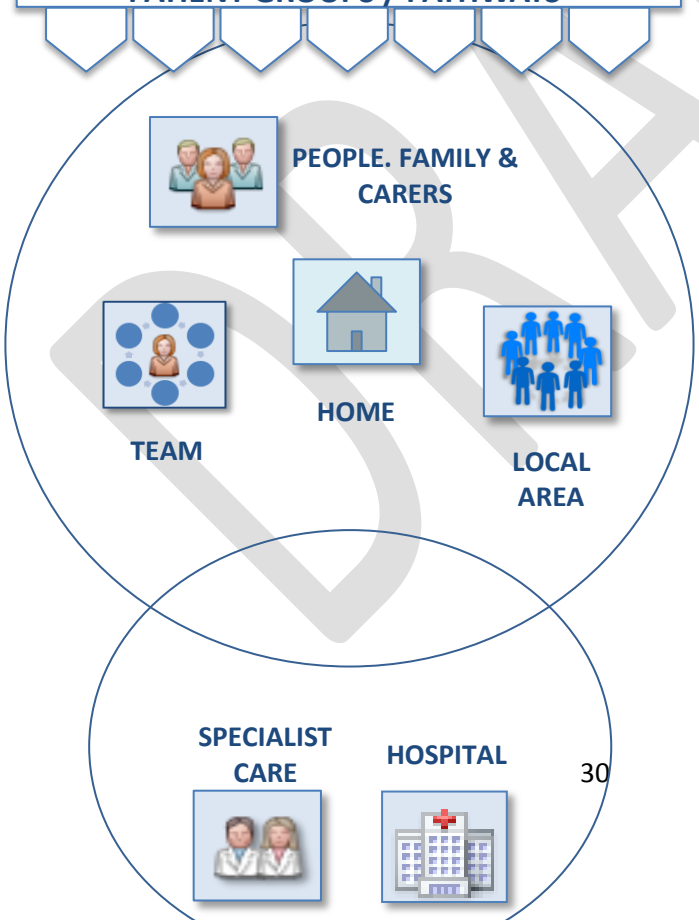
THE NEW VISION OF CARE

Towards better health & independence

THE STAGES

- Self care and prevention to support healthy active aging and independence
- Support to live well with simple or stable long term conditions
- Support to live well with complex co-morbidities, dementia &
- Good hospital care when needed with good transfer planning
- Good transfer of care support, rehabilitation and reablement
- High quality nursing & residential care when needed
- Choice, control and support towards end of life

PATIENT GROUPS / PATHWAYS



Coordinated & Integrated Care System with Care Planning

Aligned Incentives outcomes & resources

Workforce development

System governance & decision making

Shared information

Collaborative Leadership

Communications & engagement

ENABLERS

FEATURES

- Person centred promoting prevention, wellbeing and early intervention
- Information and multi-media sign-posting
- Identifying those who need care by using shared risk processes, case finding, & shared assessment
- Using a single care plan within a formal care planning process
- Delivering care plans using agreed protocols & processes through integrated multi-skilled teams
- Co-ordinated and monitored care delivery with care co-ordinators
- Enhanced localities working