NHS England

Specialised Services Commissioning Intentions 2014/15

London Region

THE NHS CONSTITUTION
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NATIONAL CONTEXT

Since the last published Commissioning Intentions for Prescribed Specialised Services was published in November 2012, much has changed. More than 1600 expert clinicians, in 75 service-specific Clinical Reference Groups (CRGs) have developed national service specifications and healthcare providers have assessed compliance with key elements. Many providers now hold a single contract with one area team covering all English patients treated; national clinical policies are in place and access to the Cancer Drugs Fund (CDF) and Individual Funding Requests (IFR) are consistently assessed through a standard operating procedure approach led by four regional teams, one of which is in the Specialised Services (London Region) team.

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 transformation within the fixed resources available. Within specialised services we shall be working with CCGs, partner NHS oversight bodies and local government to secure the best possible outcome for patients and service users within available resources.

To support NHS England's strategy *A Call to Action* and to enable health services to remain sustainable some key changes in support of our future direction of travel for the commissioning of specialised services need to begin now and these are set out in our commissioning intentions.

Nationally we said…	1. **Patient & Public Engagement** • We expect all providers to demonstrate real and effective patient participation, both in terms of an individual's treatment and care, and on a more collective level through patient groups/forums; particularly in areas such as service improvement and redesign • It is essential that all providers of specialised services demonstrate the principles of transparency and participation and offer their patients the right information at the right time to support informed decision making their treatment and care • Providers of specialised services should look to provide accessible means for patients to be able to express their views about, and their experiences of specialised services, making best use of the latest available technology and social media as well as conventional methods • As well as capturing patient experience feedback form a range of insight sources, providers should demonstrate robust systems for analysing and responding to that feedback
Locally in London this means…	We will • Map and engage local stakeholders • Support local stakeholders to understand commissioning roles and responsibilities at national and local level • Engage with stakeholders on the local impact of national decision-making

	• Obtain Assurance that providers in their area are meeting PPE requirements • Co-ordinate with other area teams for proposals that affect a wider patient population
Nationally we said…	2. **Strategic Direction** **Ensuring consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit:** • Any potential developments in access to treatments or services with resource implications will be considered and costed by the CRGs. These will then be assessed and evaluated by NHS England's Clinical Priorities Advisory Group and prioritised against NHS England's ethical framework. National adoption alongside any consequent disinvestment will also be evaluated through the Clinical Priorities Advisory Group and ratified by NHS England's Quality and Risk Committee to ensure resources can be safely released to support innovative development
Locally in London this means…	We will • Map how any developments may impact on the local health economy
Nationally we said…	**A Clinical Sustainability Programme with all providers, focused on quality and value through:** • achieving and maintaining compliance with full service specifications, and making changes to service provision where there is no realistic prospect of standards being met • reviewing and revising service specifications to deliver a continuous incremental improvement in clinical outcomes, service quality, patient experience and value for money • refreshing and focusing CQUIN schemes to directly contribute to improving outcomes with challenging, but achievable goals • Providing transparency in service quality through the continued development of service level quality dashboards and improvements in data flows
Locally in London this means…	We will • Develop CQUINs which are consistent with and support the delivery of strategic priorities across London • Monitor dashboard performance and link to CQRM meetings. • Develop dashboard findings to give comparative data on provider performance • Ensure external service specialist work with CRGS to identify and revise specifications that are not fit for purpose and, where necessary, undertake service reviews to distinguish between providers i.e.

	Orthopaedics, ophthalmology, complex gynaecology • Contribute to the development and implementation of CQUIN schemes that are relevant to the services provided in London • Develop a robust implementation programme for dashboard monitoring for key programmes of care – align CQUINs to dashboard compliance • Derogation action plans will be incorporated within provider contracts and delivery regularly reviewed • The service specification assessment exercise has highlighted the need to review and potentially reconfigure services to enable compliance to be achieved e.g. Burns
Nationally we said…	**A Financial Sustainability Programme with all providers, focused on better value through:** • a two-year programme of productivity and efficiency improvement in service delivery which will commence during 2014/15 and will focus on converging local tariff pricing to match the most efficient services, with support and reward in line with commitment to levels of ambition, and shared ownership of risk • agreed improvement goals to ensure that efficient services form part of lean, patient-focused pathways, and that treatment is commissioned by default in the most cost effective setting, adopting and spreading best practice across provider services • securing the benefits of more widespread use of best value prices for drugs and devices with increased transparency of billing • strategic collaboration with providers and other partners to achieve prevention and earlier intervention in specific services • reducing the future burden of demand for prescribed services by managing demand and reducing rates if admission and readmission
Locally in London this means…	We will • Prioritise schemes that reduce waste or excess funding to protect frontline clinical services • Work with CCGs to commission along patient pathways to secure early intervention and prevention strategies that reduce the level of demand in specialised services • Focus on improved productivity and evidence based clinical effectiveness • Review Enzyme Replacement Therapy (ERT) prescribing in Lysosomal Storage Disorders (LSD) services • Consider invest to save initiatives • Review re-admission and infection rates by programme of care and implement QiPP initiatives to drive improvements • Benchmark provider performance across London and peer groups to identify performance outliers and opportunities to develop metrics to improve provider productivity and efficiency

Nationally we said…	**A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate to address clinical or financial sustainability issues:**
Locally in London this means…	We will • Using service specification compliance data identify where services may require consolidation or re-configuration to ensure expertise is concentrated and patients receive high quality care and outcomes • Contract with providers in line with the outcome of planned market reviews • Service changes will be done in consultation with stakeholders and in support of the objective of providing in London world class services and outcomes • Review alternative service delivery methods for primary and secondary provision that reduce the need for specialised service referrals and treatments
Nationally we said…	**Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients in particular services and care pathways:** • we will select providers with a strong track record in clinical and financial sustainability programmes in 2014/15, to award prime contracts in 2015/16 for a network of care with other providers for selected priority services • we will pilot five specific services initially partnering with CCGs to co-commission full pathways of care
Locally in London this means…	• Collaborative working with CCGs, local authorities and providers • Providing local access and where necessary concentrating expertise • Work with the Academic Health Science Networks to ensure research and education support clinical excellence • Review the provision of rehabilitation following specialised procedures to link more effectively with secondary and primary care, including rehab at home options • Work with compliant providers in the five services and the London CCGs to develop comprehensive pathways across primary, secondary and tertiary care
Nationally we said…	**A systematic rules-based approach to in-year management of contractual service delivery, including:** • transition from local to national data flows as the primary source of payment for services covered by national datasets • the promotion and use of clinical utilisation review tools to identify and

	address bottlenecks in care and ensure the right treatment in the right settings • the use of commissioner-led clinical threshold audit by the NHS England medical directorate peer review team • the commissioning of clinical coding reviews where needed to establish potential unintended consequences of clinical practice that have not been subject to formal notification of change
Locally in London this means…	• We intend to move to payment via SUS for all PbR activity
Nationally we said…	3. **Commissioning through Evaluation (CtE)** • Commissioning through Evaluation (CtE) has been developed by NHS England as an innovative approach to the commissioning of prescribed specialised services for which there is currently insufficient evidence of relative clinical and/or cost effectiveness to warrant routine commissioning. Commissioning through Evaluation is particularly pertinent to specialised and other lower volume procedures or services, where randomised controlled trial evidence is less prevalent, and where an alternative approach to evaluation therefore needs to be available to support commissioning policy decisions
Locally in London this means…	• Pilot a Commissioning through Evaluation (CtE) approach to commission the evidence base for Stereotactic Ablative Body Radiotherapy. • Await allocation of centres providing services through CtE • Ensure any service provision in London is compliant with the CtE process and fulfils the requirements of CtE during the evaluation phase • Monitor referrals and ensure equity of access within any nominated centres • This would include the Chemotherapy closer to home agenda, where the current patient pathway will cross organisational & commissioning boundaries. It will be important to see patients are treated in the most appropriate setting, e.g. for many supportive medicines used for cancer patients may be provided in the primary care setting, rather than secondary or tertiary settings (denosumab, bisphosphonates). Providers should work with commissioners to engage in such service model changes
Nationally we said…	4. **Strategic Clinical Service Review** • NHS England will develop its commissioning framework by prioritising those service lines which most urgently need to be reviewed and that are in the best interests of the people who use the services • This prioritisation work will be informed by system wide strategic plans for the future of health care delivery and specialised services

	configuration in each region. Each prioritised programme of change will work within a consistent national framework and process. There may be some areas where a national approach to procurement is required due to the incidence of quality and capacity issues arising
Locally in London this means…	• CAMHS T4 – agree contracts in line with recommendations arising from the national service review • None of the Burns services providing in Southern England meet service specification requirements and a major reconfiguration of services will be required to achieve compliance. ATs in London, East and Midland and South will collaborate to implement the national review of burn services • Engage with the national clinical review of Congenital Heart Disease (CHD). Implement the recommendation from the National Review of Adult and Paediatric congenital heart services. • Implement national quality dashboard for CHD and maintain an overview of the services • Implement recommendations of the Safe and Sustainable review of Paediatric Neurosurgery • We will support the development of the Paediatric Neurosciences ODN in London • Work closely with the Children's epilepsy centres in London and retain an overview of pathways and referrals to ensure that this surgery only takes place in the designated centres • Identify service areas where service review will deliver benefits. E.g. LSD services. Linking up with the national HSS team to ensure a consistent approach is undertaken across the country
Nationally we said…	5. **UK Strategy for Rare Diseases** • We will be developing an implementation plan in response to the strategy
Locally in London this means…	• The outputs from the national implementation plan will be operationalised in London as appropriate
Nationally we said…	6. **Reinvestment Strategy for Cost Effectiveness** • Investments will only be accepted where they demonstrate measurable outcome and value improvements and where cash has been released elsewhere
Locally in London this means…	• Whilst QIPP schemes relating to drugs will focus on securing savings through procurement it is acknowledged that appropriate use of drugs on the patient pathway can deliver improved care and be cost effective

	by preventing alternative more expensive treatment options • There will be continued support for embedded pharmacists who secure savings and reduce waste • Work with Regional pharmacy lead to agree a plan of how to manage prescribing in providers to release efficiencies
Nationally we said…	7. **Co-Commissioning, Trialling New Payment Approaches** • Where innovation can demonstrably contribute to improving outcomes, quality and saving money, area teams will work with providers over the next 18 months to gain permission for local variations and agree risk/benefit share arrangements where appropriate. This will extend to innovative proposals from multiple providers working together
Locally in London this means…	• Explore with CCGs innovative commissioning approaches to facilitate the transformation of CAMHS pathways to promote the safe management of young people with mental health problems outside hospital • We will look to co-commission weight management services with CCGs and local authorities in order to reduce the need for bariatric surgery and support community based non surgical interventions
Nationally we said…	8. **Prime Contractor** • Commissioners will lead a process to invite proposals over the coming 18 months for prime contractor delivery where this enables either consolidation or networking of specialist provision to achieve the national specification and standards, and/or prime contractor arrangements for a whole pathway of care of model of care where tiers of provision are closely networked. One example of this is neurorehabilitation, where such an approach could enable alignment of incentives and accountability for quality improvement and capacity management
Locally in London this means…	• In HIV services we will look to create networks based around a small number of inpatient centres that support outpatient services in the wider community working in partnership with other NHS and potentially third sector providers
Nationally we said…	9. **Driving Value** • Specialised services are provided at the end of a pathway of prevention and treatment. These are often the most expensive and scarce resources that the NHS is able to offer and therefore must be accessed following pathways of care that seek to actively prevent deterioration and provide levels of care appropriate to the needs and stage of disease. Alignment of the accountability, incentives and clinical leadership around improving outcomes across pathways and

	programmes, will drive better value • Over the next two years, it is the intention of NHS England to focus on aligning and driving value from specialised services through these programmes: a) Getting value from commercial business b) Enabling the right care, providers and pathways for outcomes and value c) Reinvestment, with a view to delivering improved clinical outcomes for patients/service users
Locally in London this means…	• We will work with the pharmaceutical industry to promote effective drug use, develop evidenced based pathways that reduce costs and align NHS priorities with industry strategy to deliver mutually supportive arrangements • Use national learning for primary care development for back pain services to reduce unnecessary referrals into the hospital system • Paediatric long term ventilation: London will continue with the development of pathway management utilising a central team to ensure children who require home care packages are transitioned through specialised services to secondary and primary care, working closely where required with education and social care. Savings released from reduced length of stay will be reinvested to manage the pathway management by appointing key workers within the community • London will actively engage with the national CRG paediatric pathways pathfinder projects, long term ventilation and complex disability • Chemotherapy closer to home - the current patient pathway crosses organisational & commissioning boundaries. It will be important to see patients are treated in the most appropriate setting, e.g. for many supportive medicines used for cancer patients may be provided in the primary care setting, rather than secondary or tertiary settings (denosumab, bisphosphonates). Providers should work with commissioners to engage in such service model changes
Nationally we said…	10. **Collaborative Commissioning** • Over the next two years there will be a drive on joint strategy, planning and collaborative commissioning to ensure there is alignment of our commissioning towards outcomes and how each party works to lead on pathway or programmes of care
Locally in London this means…	• Specialised services are at the end of a patient pathway of care that cuts across different commissioners. We will work with CCGs and local authorities to support prevention and early intervention strategies through linked commissioning strategies and common commissioning tools • Work with ATs and CCGs through SPGs to align commissioning intentions and strategies • Consider multiple care packages around the patient rather than the individual treatment programmes

Nationally we said…

11. **Pathways**

- Commissioners will work together across the whole pathway to develop evidence based pathways, from prevention to specialised acre, ensuring clarity in access across commissioning responsibilities. These pathways can be used in contracting with providers, aligning incentives and accountability for outcomes. It is anticipated that the model of engaging commissioners will be the basis for the future whole pathway approaches. The development of this approach will allow the pathways selected to provide evidence of the impact on value of adopting recommended interventions and levels of capacity
- Five pathways will be established for adoption by 2015/16 and will be available for use by early adopters and networked providers. The five pathways are:

Specialised Programme of Care	Pathfinder
Mental Health	Forensic pathway
Women & Children	Paediatric care pathways
Internal Medicine	Acute Kidney Injury pathway
Cancer & Blood	Haemoglobinopathy
Trauma	Back pain and sciatica

- NHS England is committed to commissioning specialised patient care at the optimum time and in the most appropriate care setting. Specialities where there are known to be delayed admissions or discharges will be identified and national work undertaken to both identify and resolve barriers in order to streamline referrals and discharges. This will involve working with CCGs and local authority colleagues in supporting pre-discharge planning initiatives and through appropriate incentives with providers to facilitate prompt discharge

Locally in London this means…

- Paediatric pathways cover long term ventilation and complex disability. London will map the progress of this work to ensure that specialised services and CCGs are working collaboratively to ease blocks in the system and create savings through efficiencies
- Development of Primary care back pain services

Nationally we said…

12. **Effective & Focused Commissioning**

- Six principles, or 'rights', of effective commissioning form the foundation of NHS England's approach to specialised commissioning and these focus on ensuring patients receive the most appropriate care in the optimum care setting with the most effective use of specialised resources. These reinforce and build upon patients' rights under the NHS constitution
- These principles are summarised as:

Right patient	In order for patients to receive optimum care, they need to

	be assessed and referred appropriately
Right provider	Ensuring patients are referred to the most appropriate provider will support achievement of 18 weeks as well as the most effective use of resources
Right treatment	The national service specification compliance process, together with the implementation of national clinical policies, will ensure that only the most effective treatments are commissioned from compliant providers, supported by outcome based evidence
Right place	Patients should receive their treatment in the optimum care setting. This means that patients should receive care within designated centres that meet national clinical standards, and that delayed admission and discharge into and out of specialised care should be considered a priority for action
Right time	This recognises the importance of early referral and prompt treatment, with a particular emphasis on compliance with national waiting times and delayed discharges
Right price	The development of local and national tariffs that represent best value for money whilst ensuring appropriate levels of reimbursement is fundamentally important

Locally in London this means…

- Review of all non-PbR tariff payments e.g. adult critical care
- Implement new PbR tariffs as developed by NHS England and Monitor
- Monitor provider achievement of agreed action plans where providers have contractual derogations for prescribed services so that all services are compliant by the end of September 2014

Nationally we said…

13. **Strategic Clinical Networks**
    - Commissioners will support Strategic Clinical Networks and Academic Health Science Networks to develop work plans which focus on strategic care models and pathway development for key health needs

Locally in London this means…

- Maximise opportunity within London Strategic Clinical Networks (SCNs)/ Academic Health Science Networks (AHSNs) to identify and develop proposals for transformational service improvement across specialised and non-specialised pathways
- Work with Mental Health SCN to develop integrated care pathways for perinatal mental health in London
- Work closely with the SCN and academic health science Networks in NHS England London to streamline ODNs and services with the developing SCNs
- Ensure pathway developments are consistent with current planning and management and incorporate any plans within specialised services contract management
- Working with the SCNs continue to support the development of ODNs to support the delivery of specialised services across London
- Ensure that ODN work plans are consistent with delivery of NHS

	England's clinical strategy • Joint working with the SCNs to help facilitate the development of recruitment clinical leaders
Nationally we said…	14. **Clinical & Operational Delivery Networks** • ODNs will be fully established in 2014/15 and all acute providers who provide specialised services under the scope of the ODN will be required to join networks for quality improvement. Networks will operate under a governance framework which develops an annual improvement plan across all members, and publishes results of the network's achievements annually. These will identify how value has been measured and improved for the benefit of the patient and commissioners • These networks will have a host organisation and an agreement with NHS England which sets out the roles and responsibilities of all parties. NHS England is able to seek the advice of ODNs in undertaking strategic service reviews. NHS England will retain a register of all ODNs and members, together with the annual improvement agreements and annual reports from the ODN on delivery
Locally in London this means…	• Use SCNs to support commissioning decisions. Involve SCNs in decision making around where and what to commission • Develop a programme of implementing service ODNs to ensure collaborative service delivery and quality convergence and to prevent the possible de-skilling of some services • Specialist Services for Pain Management (Adult) – Specialised Pain Services might benefit from an Operational Delivery Network Specialised services in a tertiary setting, should only accept referrals for patients who have been assessed by a secondary care pain management service; in practice, it is difficult to ensure that this pathway is followed, as most tertiary providers are also delivering the secondary care services. The development of an ODN, in conjunction with working with the national Pain CRG, will be explored • Lead on the development of specialised paediatric ODNs and hosting arrangements and appointment of clinical leaders • Oversee the work plan and outcome measures of the networks and work with the SCNs and network teams to ensure the two are aligned • Where service specification identifies the need for a network, ensure that implementation within the current budgetary confines and the ODN governance framework
Nationally we said…	15. **Contracts** **Standard Contract** • The 2014/15 Standard Contract will be used for all new contracts agreed for specialised services from 1 April 2014 onwards. Where

	existing contracts do not expire at 31 March 2014, these will be updated for 2014/15 using Deeds of Variation which will be produced by NHS England early in 2014. Forms of contract other than the NHS Standard Contract will not be used • An online system for completing the NHS Standard Contract (the eContract) was made available for the first time in February 2013 and an improved, more robust system will be available for use for 2014/15. The eContract approach has significant benefits, for instance in enabling the tailoring of contract content to reflect the specific range of services being commissioned. We anticipate that use of the eContract approach will become the norm for specialised services contracts from 2014/15 **Single Provider Contract** • The intention for 2014/15 is that NHS England should normally only hold (or be party to) one NHS Standard Contract with any provider, which includes the five areas of direct commissioning with contract schedules for each area team **Consistent Contracting** • Area teams will continue identification of prescribed specialised services at all providers using the nationally published tools and grouper • The eradication of differential prices charged by the same provider to NHS England based on a patient's place of residence by individual providers. There will be a single stated price per service line in each provider contract • The implementation of mandatory currencies. This should be accompanied by the production of monitoring information for the baseline year in the mandatory currency, and continued monitoring in the previous currency alongside mandatory currencies, to assure the accuracy of locally set prices against the new currencies given the quantum involved • Standardised simplified indicative activity plans and non-tariff price lists, including drugs and devices, providing clarity and transparency In conjunction with full Payment by Results, NHS England will negotiate marginal rates and capped resource contracts or service lines, which will seek to manage within a fixed commissioning budget and recognise provider cost
Locally in London this means…	• We intend to move to the e contract for 2014/15 where appropriate • We will reflect the relevant schedules for all elements of direct commissioning in a single contract • We will consider moving to a single contract management and governance model for all directly commissioned services
Nationally we said…	16. **Implementing Commissioning Policies** • NHS England commissions according to agreed policies and service specifications, which identify where treatments, devices and services are routinely commissioned. Commissioning policies that specify treatment thresholds and criteria act within the NHS contract as group

	prior approvals for treatment. In some cases, additional audit requirements may be required with regard to individual prior approval by commissioners. Where policies and specifications make clear that treatments, devices and services are not routinely commissioned or where treatment thresholds and criteria have not been adhered to interventions will not be funded
Locally in London this means…	• Undertake an assessment to capture impact of commissioning policies and identify outliers • Audit services where activity actuals are outwith the levels expected from the implementation of clinical commissioning policies • The Chemotherapy CRG is about to consult on the production of National Chemotherapy Treatment Algorithms, in order to ensure consistency of patient chemotherapy treatment pathways in England, for implementation in April 2014. The intention is there will be a single algorithm for each tumour pathway where chemotherapy is a major treatment modality. It will therefore be important to ensure clinical engagement within London to the consultation process and once the algorithms are in place, that there is a consistent mechanism in place to ensure compliance with these algorithms
Nationally we said…	17. **CQUIN** • CQUIN arrangements for 2014/15 will be focused on an updated national menu of schemes with associated measures. To reflect an appropriate return for the level of investment, CQUIN measures will be based on achievement of significant levels of improvement, which may require the deployment of provider resources • A CQUIN indicator for adoption across all specialised services providers will be developed. This incentive will only be offered to providers for initiatives which are proven to offer continuous improvement toward best practice, benchmarked utilisation, appropriate care and quality indicators. An example would be the adoption of utilisation management systems across providers and pathways
Locally in London this means…	• Review CQUINS utilised by other Area Teams and assess if a return has been achieved in services London provides and choose those CQUINS for 2014/15 • Align CQUIN schemes to service improvement priorities in London services
Nationally we said…	18. **CQUIN on Drugs and Devices Excluded from Tariff** • National tariff pay and price adjustments are not automatically applied to drugs and devices excluded from tariff i.e. NHS England will pay actual costs. These costs are excluded from the tariff efficiency deflator

	arrangements. NHS England is committed to consistently adopting the national rules as published in all contracts and therefore will be excluding excluded drug and device budgets from the contract value to which CQUIN applies for all NHS England contracts in 2014/15 and onwards
Locally in London this means…	• We will continue the approach of not funding CQUIN on drugs and devices excluded from tariff. This will remove the need to artificially deflate these prices and will overall reduce financial burdens to commissioners and providers
Nationally we said…	19. **Commissioning Resources** • High quality specialised services will be effectively managed within these finite resource envelopes by NHS England and providers working together • Each area team will be responsible for ensuring the financial and quality performance of the contracts it holds. Growth and efficiency savings will be applied to contracts in line with the 2014/15 planning guidance. This will apply to all elements of the contract but not drugs and devices excluded from tariff
Locally in London this means…	
Nationally we said…	20. **Financial Sustainability Programme** • During 2014/15 a key element of the programme will be to develop a national benchmark understanding of best practice pricing and standards compliance. This will be shared with providers. Commissioners and providers will identify early areas of opportunity and agree goals for change in the 2014/15 contract. This will ensure early progress on convergence is made whilst more extensive benchmarking is undertaken. • In 2014/15 providers will have the opportunity to contribute toward the development of a national pricing framework which manages risks and benefits. This framework will fully apply to all providers in 2015/16. NHS England will work with CRGs, providers, the Payment by Results development team and Monitor to develop a programme of work to deliver national currencies and prices for specialised services. NHS England is open to proposals from provider networks during 2014/15 where alignment of pricing between members retains funding within the best practice range

Locally in London this means…	• Continuing the review of new drugs, service specifications and policy changes in addition to those already identified in the Cost of Convergence exercise to prove and identify on-going cost pressures • Developing a pricing framework proposal with our providers which will encourage and secure service change, maintain financial balance and continue to drive up the quality of the specialised services we commission • Continuing to work with the provider organisations to jointly manage capacity in line with affordability • Expecting the continued and full engagement of service providers to lead service innovation and change • Devising QIPP plans which will be complimentary to any agreed quality, service demand and service changes • Introducing CQUIN schemes to reflect national and local schemes where appropriate to our commissioned services • Review of non PbR tariffs
Nationally we said…	21. **Specialist Top Up Payments** • Specialised top up payments will continue to be paid solely to those providers who are on the list of providers eligible for top up in the National Tariff Document (NTD) guidance, (as defined by the Specialist Top Up Group), and for those services outlined in the guidance. There will be no extension to other services which now form part of the prescribed list
Locally in London this means…	• For London the payment of top-ups shall be aligned to the specification compliance outcomes. Only those providers who have demonstrated compliance shall receive top-up payments
Nationally we said…	22. **Identification Rules** • The intention for the 2014/15 commissioning process is that there will be no deviations from the reported Identification Rules and NHS England will utilise contract sanctions where the quality of data is proven to be deficient
Locally in London this means…	• This approach is consistent with the approach adopted during 2013/14
Nationally we said…	23. **Dialysis Away from Base in England** • The 10 area teams responsible for the commissioning of specialised services will fund dialysis away from base for all English patients who require treatment from a dialysis provider within an area team's catchment area. Payment for dialysis away from base will be made to the dialysis providers by their area team. Further guidance for

	commissioners, providers and patients is being developed
Locally in London this means…	• In London we will contract with the providers used by patients when coming to London who need dialysis using the national tariff as the basis for pricing
Nationally we said…	24. **Individual Funding Requests (IFRs)** • The current management process, the policy and Standard Operating Procedure will be reviewed and revised for 2014/15, strengthening national consistency. A training programme for panel members, commissioners and potentially for providers will be available
Locally in London this means…	• IFR teams will work together through regular meetings and information sharing to ensure consistency of decision making • The London IFR team will continue to support the on-going management of the IFR process as one of the four regions leading on this in England • In addition to the centrally provided training programmes London will arrange a workshop for providers to discuss the IFR process: what is working well and challenging issues • Implementation of an electronic database for the submission of requests will release capacity for the IFR Manager and Lead to strengthen the IFR process as a whole • The electronic database will support the nationally required data submissions • Providers will be expected to ensure that a process is in place for applications to be submitted via the electronic web-based system, via nhs.net secure e-mails
Nationally we said…	25. **Cancer Drugs Fund** • The Cancer Drugs Fund will continue during 2014 and will continue to be managed as part of the prescribed services single operating model. The single national consistent policy for the management of the Cancer Drugs Fund will continue and be refreshed as required. This will be operationally managed on a regional footprint by four of the area teams responsible for prescribed services
Locally in London this means…	• The London Cancer Drugs Fund (CDF) team will continue to support the on-going management of the CDF and the ICDFR process as one of the four regions leading on this in England. Implementation of an electronic database for this process and employment of Band 7 CDF manager will release capacity for the pharmacy expertise to be utilised to inform greater understanding of chemotherapy and supportive care expenditure for cancer in London. Providers will be expected to ensure

	that a process is in place for applications to be submitted via the electronic web-based system, via nhs.net secure e-mails • Trust compliance with the SACT dataset must be assured (see section 26), as this will be used for monitoring of the CDF dataset from April 2014, and data provision will be the responsibility of the provider Trusts, i.e. start and stop dates for treatment and whether patients actually start treatment once an approval from the CDF/IFR process has been given. This will be essential for the on-going prediction of actual spend from the CDF in London
Nationally we said…	26. **Drugs & Devices** **Commissioning and Procurement** • Excluded drugs and devices have historically been passed through as a charge to commissioners without a national standard framework which ensures best value for the NHS. It is acknowledged nationally that significant benefits can be obtained from better procurement. This national process proposes a four regions approach with two tranches of drug procurement over an estimated two year period. Currently homecare drugs are not included within this procurement framework. NHS England is currently working very closely with the Commercial Medicines Unit (CMU) in the Department of Health **Payment** • Budgets for excluded drugs and devices will be set on an annual basis. This will be based on the provider's assessment of need through horizon scanning, and agreed through a confirm and challenge meeting with the provider. It is not anticipated that new excluded drugs and devices will be funded in-year unless approved by NICE and/or anticipated funding requirements have been previously identified **Post-transplant immunosuppressants** • It is expected that from April 2014 all post-transplant immunosuppressants and inhaled antibiotics for cystic fibrosis will be commissioned directly from trusts; patients receiving these treatments via GPs in primary care should be repatriated to secondary care **Chemotherapy Drugs** • All trusts will be required to provide Systemic Anti-Cancer Therapy (SACT) data for all patients at each cycle of chemotherapy. This in turn will support the audit of drugs within the Cancer Drugs Fund. From April 2014 all 42 fields of SACT data are mandated for each cycle of chemotherapy delivered. Trusts are expected to audit activity data quarterly and demonstrate that over 90% of activity data maps to the SACT data submitted per month. Trusts must have an action plan agreed with commissioners to address any shortfall in SACT data fields and findings of the audit of activity compared to SACT data submissions **Financial Assumptions** • All existing gain sharing arrangements should be identified by 31 October 2013 to the area team pharmacy lead and will be reviewed

	against national principles developed by the Medicines Optimisation CRG **Performance Monitoring** • All providers will be required to fully populate the national IVIG data base to ensure patient safety. This includes indication, dose, administration and outcome. Invoices for IVIG will be matched to the national database entries • A monthly report on drugs and devices expenditure will be required as set out in the Information Schedule of the NHS Standard Contract. Validation of the use of excluded drugs and devices will be requested by NHS England where there is a reported overspend. This will normally be in the form of an audit. Any use of a drug/device outside the agreed criteria without express authority from NHS England will not be funded. Validation queries will be raised on a monthly basis in line with national payment timetables. Where further action is required validation meetings will be convened on a quarterly basis **Devices** • A national framework will be established during 2014/15 which identifies the best value and price for funding. This will be informed by procurements at a regional and national level that represent value for money. As this price list is established by NHS England this will be utilised to challenge and inform agreed budgets Where drugs and devices are used outside of commissioned services, as defined as nationally commissioned by NHS England, any consequential costs that are incurred will not be funded. This includes the costs associated with the entire treatment
Locally in London this means…	We will • consider re-tendering of homecare contract for ERTs • Consider procurement of some high costs drugs to deliver efficiencies • Consider procurement of some high costs devices to deliver efficiencies (VADS) • Payment - It will be assumed that annual budget setting will apply to chemotherapy too, as 'chemotherapy' is currently PbR excluded. Consequently, monitoring of the algorithm compliance and the consequent budget lines will be reliant on providers providing data on chemotherapy spend, down to drug level on a monthly basis. • As part of the process to understand chemotherapy spend it will be important to unpick current tariffs for providers to provide information to commissioners on how oncology pharmacy services are funded. This is often a hidden cost, bundled with other service tariffs. There needs to be an understanding of these costs so that a strategic plan for oncology pharmacy service provision (from a quality service and supply perspective) can be made for London and consistent approach for funding achieved. To this end providers will need to work with commissioners to unbundle these costs • Chemotherapy Drugs - Trust compliance with the SACT dataset must

	be assured, as this will be used for monitoring of the CDF dataset from April 2014, and data provision will be the responsibility of the provider Trusts, i.e. start and stop dates for treatment and whether patients actually start treatment once an approval from the CDF/IFR process has been given. This will be essential for the on-going prediction of actual spend from the CDF in London • With regards to QIPP, work is currently underway to implement the SSC1321 re SC trastuzumab, which will provide benefits to commissioners (savings on drug costs and attendance tariffs) and providers (release of capacity within chemotherapy day units and pharmacy departments). It will be important to monitor uptake of this initiative, bearing in mind that new clinical trials in breast cancer may impact on some of the predicted benefits. Similarly, it will be important to ensure a consistent approach to implementation of other drug service changes (e.g. rituximab IV to SC) and other patent expiries which bring generics into the market e.g. capecitabine
Nationally we said…	27. **Service Specifications** • Area teams will be performance monitoring the delivery of provider derogation action plans through routine contract monitoring mechanisms. NHS England will utilise contract sanctions where there is significant or persistent non-delivery against these plans • Where commissioner-led service review work is required, this will be undertaken as part of the specialised services work plan. The pace and timing of this work will be communicated at a later stage once assessment of the requirement has been undertaken, identifying the scale at which each of these service reviews would most appropriately be undertaken
Locally in London this means…	• Derogation action plans will be incorporated within provider contracts and delivery regularly reviewed • The service specification assessment exercise has highlighted the need to review and potentially reconfigure services to enable compliance to be achieved e.g. Burns • A few service specifications have not discriminated sufficiently to identify specialised service providers and further work including, where necessary, service review will be required to distinguish between providers i.e. Orthopaedics, ophthalmology, complex gynaecology • The Chemotherapy Services Specifications are being radically revised and condensed, however there will be no surprises, as most issues are already highlighted within this document • With regards to QIPP, work is currently underway to implement the SSC1321 re SC trastuzumab, which will provide benefits to commissioners (savings on drug costs and attendance tariffs) and providers (release of capacity within chemotherapy day units and pharmacy departments). It will be important to monitor uptake of this

	initiative, bearing in mind that new clinical trials in breast cancer may impact on some of the predicted benefits. Similarly, it will be important to ensure a consistent approach to implementation of other drug service changes (e.g. rituximab IV to SC) and other patent expiries which bring generics into the market e.g. capecitabine
Nationally we said…	28. **Service Developments** • Any service development will be funded from within the existing quantum of specialised services and will be prioritised within the specialised commissioning strategy. Commissioners will decide, with the advice of the CRGs, which service developments should be implemented. • NHS England will not support any service developments which are not aligned to our strategic priorities or developments. This includes the following: a. Services that are not defined as prescribed specialised services; b. Services that have been confirmed through policy as not routinely commissioned; c. Services which are not able to demonstrate clinical, patient and cost improvement; d. In year service developments, unless explicitly required by commissioners
Locally in London this means…	• Any service developments approved by NHS England for HSS services should be replicated in all providers for highly specialised services (HSS) to ensure equity and consistency. London will work with Area Teams to ensure this is implemented • We will only consider service developments that meet the principles set out in the NHS England Commissioning Intentions
Nationally we said…	29. **New Market Entrants** • For 2013/14 there will be no new market entrants for specialised commissioning across the country unless there is clinical safety or capacity issues. It is unlikely that this position will change significantly in 2014/15 unless the outcome of the review of service lines identified above indicates capacity expansion is required or where market testing a service will bring clinical and/or financial benefits. • It will be important that we link the review of current provision and capacity with the implementation of the specifications and the development of the national strategy to ensure that we can demonstrate that we have a consistent and transparent way of addressing new market entry on a national basis
Locally in London this	• Assure all services provided in London are safe and have adequate capacity

means…	• The most appropriate procurement route will be adopted to ensure value for money and the competitive environment is maintained to drive quality and efficiency
Nationally we said…	30. **Mental Health** **Secondary Commissioning** • It is intended that all secondary commissioning of Specialised Mental Health Services will cease from 1 April 2014 and NHS England will contract directly with providers for specialised mental health services. This will help moving in the direction of travel to support Monitor's fair playing field review **Currencies & Pricing** • It is intended that NHS England move to all inclusive pricing for Specialised Mental Health Services particularly in respect of observations • Information for Payment by Results (PbR) development for Specialised Mental Health Commissioning will be required and incorporated into the Information Schedule. • There will be on-going work in 2014/15 and 2015/16 in the development of currencies for high, medium and low secure services. It is anticipated that pilot sites will be established in April 2014 to test the currency, care packages and outcome measures **Access to Services** • Standardised Access Assessments will be developed by the relevant specialised mental health CRGs for introduction during the period of these commissioning intentions **Offender Personality Disorder Programme** • We continue to support the implementation of the Offender Personality Disorder Programme, commissioning and decommissioning services to improve access and treatment outcomes in line with agreed funding **Winterbourne View Concordat** • The work with CCGs and providers will continue to ensure the Winterbourne View Concordat actions are implemented **Child and Adolescent Mental Health Services (CAMHS) Tier 4** • Following the Child and Adolescent Mental Health Services Tier 4 review, it is expected that the recommendations to procure appropriate quality, access and capacity will be implemented **High Secure Services** • A capacity review for high secure services will be carried out to inform a high secure commissioning plan. Work will continue with providers to align policies and procedures that directly impact on patients. • An additional 0.5% efficiency is expected from high secure providers with continued involvement in the benchmarking cost exercise to ensure delivery of future Quality, Innovation, Productivity and Prevention (QIPP)
Locally in	• We will cease to include secondary commissioning arrangements for

London this means…	secure services in our contracts with London providers • We will continue to contract with London providers on the basis of all inclusive providers • Providers will be expected to participate fully in the Mental Health Currency & Pricing (formerly PbR) programme of specialised mental health • Providers of specialised mental health services for people of all ages with a learning disability will embed Winterbourne View Concordat requirements in local care planning arrangements • We will agree contracts for Tier 4 CAMHS in line with recommendations arising from the national service review • The additional 0.5% efficiency requirement for high secure services will continue in line with the agreed 10-year High Secure Financial Plan
Nationally we said…	31. **Innovative Radiotherapy** • Working with the Department of Health, NHS England is supporting the establishment of a Proton Beam Therapy (PBT) service in England by 2018. During 2014/15 we anticipate a phased increase in access to Proton Beam Therapy through the current overseas programme, whilst equipment is procured for the future centres planned in Manchester and London • Intensity Modulated Radiotherapy (IMRT) is now available in more than 50 sites throughout England and we will require all providers to reach and maintain access to inverse planned IMRT at 24% or more of all radical treatments in each site. This is in line with the Government's commitment • Intensity Modulated Radiotherapy and Proton Beam Therapy are only two examples of innovative radiotherapy and NHS England is therefore working in partnership with Cancer Research UK, clinical leaders and industry partners to develop and communicate NHS England's broader ambitions around equitable access to the most clinically and cost effective radiotherapy treatments as part of its broader strategy work • Work will be undertaken during 2014/15 in collaboration with providers to secure sustainability in workforce and other aspects of service delivery to maintain IMRT services
Locally in London this means…	• We will work with national programmes to deliver sustainable radiotherapy in London • We will work with London Cancer and London Cancer Alliance in the context of the London Cancer Commissioning Strategy to understand and manage the clinical development of this treatment and ensure demand and capacity are in step with clinical evidence
Nationally we	32. **Paediatric Cardiology**

said…	• Until the new standards have been agreed and adopted, the Safe and Sustainable standards remain valid, and all specialist paediatric surgical centres are expected to work with the relevant area team to undertake a baseline assessment of that unit's position against the standards, and to develop an agreed plan for working towards the standards
Locally in London this means…	• Work closely with the three paediatric cardiology units in London • Monthly meetings with the Trusts to ensure sustainability of the services and review outcomes • Review progress of each unit and ensure governance arrangements are in place based on the current safe and sustainable standards • Review individual baseline assessments and monitor against a work/action plan • Collate action/work plans to gain a London overview of the service, governance, compliance to standards and access to services
Nationally we said…	33. **Genetics** • NHS England will be considering the future configuration of genetic laboratory services during 2014/15 with the intention of securing specialist testing and analysis skills; associated staffing and facilities; identifying opportunities to achieve efficiencies through economies of scale, and ensuring a strong provider platform upon which to take forward emerging and exciting advances in genomic medicine. Led by a multidisciplinary steering group, a range of options will be considered, with supporting descriptions of levels of service available to test with a wide range of stakeholders before a formal procurement is undertaken. • The Genomics UK led 100k genomes project is also expected to get underway during 2014/15, and NHS England will be working with commissioned providers to support the identification of potential participants and to ensure the programme links effectively to clinical pathways
Locally in London this means…	• We will support the process for procurement and work with the national team in identifying the future configuration of laboratory services • As appropriate we will support the multidisciplinary steering group
Nationally we said…	34. **Haemophilia Tendering** • The current national frameworks for the supply of blood clotting factor products expire in 2014 the first of these, for recombinant factor VIII, on 31 March 2014. NHS England is working with the Haemophilia CRG, the UK Haemophilia Centre Directors' Organisation (UKHCDO) and the Commercial Medicines Unit (CMU) to make sure that new national supply arrangements are in place through a competitive tendering exercise. All centres using blood clotting factor products for NHS

	patients will be expected to purchase factor products in line with these agreed national arrangements in order to support this national initiative
Locally in London this means…	• Savings from the tendering exercise will be re-invested in haemophilia services
Nationally we said…	35. **Positron Emission Tomography / Computed Tomography (PET/CT)** • The two national independent sector contracts for PET/CT, which deliver approximately 50% of PET/CT scanning in England, are due to expire at the end of March 2015. NHS England is currently looking at the most appropriate reprocurement model to ensure continued access to PET/CT services. It is envisaged that a tendering process will need to commence in 2013/14 and will run through 2014/15
Locally in London this means…	• London has local provision for these services not impacted by the re-procurement