Appendix 1

NHS
Barnet Clinical Commissioning Group

Building 2
North London Business Park
Oakleigh Road South
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London
N11 1NP

Chief Executive

30th September 2016

Dear (Chief Executive)

North Central London Clinical Commissioning Groups' Commissioning Intentions for 2017/18 and 2018/19

I am writing in my capacity as Chief Officer for Barnet Clinical Commissioning Group (CCG) as lead Commissioner on behalf of the Associate CCGs ('the Commissioners'), party to the current contractual agreement with the Royal Free Hospital NHS Foundation Trust ('the Trust'). This letter sets out the Commissioning Intentions for the coming two years and our approach to contractual agreement for the 2017/19 contract.

As you will be aware, the mandated national approach to agreeing healthcare provider contracts, is for a contractual agreement to be reached before the end of December 2016. It is also stipulated that a two year contract be agreed. The expectation being this will help to provide a solid basis for Sustainable Transformation Plan (STP) implementation.

This letter is not designed to replace current or forthcoming national guidelines and publications and is to be viewed as additional local requirements above and beyond regional and national guidance.

Where there are no specific changes referred to in this letter to the existing contractual terms and conditions, it should be assumed that the CCGs wish for these terms and conditions to continue and that they will form part of the 2017/19 contract. However, this is a two year contracting process and that, as such, changes may take place during the length of the contract.

The letter provides the custom and practice formal notification of proposed changes to commissioned services and contract terms and conditions. Unless otherwise stated, the CCGs expect the requested changes to be implemented from 1st April 2017. However, as this is a two year contract, there are a number of service changes the CCGs are highlighting the intent to change, during the life of the contract.

Given the revised contracting timetable and the requirement to have agreed contracts before the end of December 2016, as per the guidance we feel this is an excellent opportunity to help ensure implementation plans are in place prior to the start of the new contract in April 2017.

Please find set out below the commissioning intentions for North Central London (NCL) CCGs that will impact on contracts for 2017/18 and 2018/19.

Our intentions have been developed through local engagement with our residents, respective councils and voluntary sector, as well as through broader collaborative pieces of work accruing from the NCL STP, the Haringey and Islington Wellbeing Partnership, Royal Free Hospital Pathway Transformation work, and Healthy London Partnerships (HLP).

The financial strategy developed in support of the STP clearly sets out the financial pressure in the system overall and the need to drive up value and remove cost as a result. In addition, system incentives are not aligned to the objectives of the STP to further invest in prevention and primary care, or the introduction of new models of care.

The evolving commissioning strategy being developed therefore places emphasis on developing new contract forms and incentives to underpin the STP, and a set of commissioning principles by which we would want to negotiate contracts for 2017/18 and 2018/19. The CCGs intention is that both the development of contract arrangements and the commissioning principles also recognise the operational and financial pressure that providers in NCL are operating under.

Progress made in developing the NCL STP in 2016/17 will be of great help in agreeing our plans for 2017/18 and 2018/19.

1. Introduction

NCL CCGs commissioning intentions for 2017/18 and 2018/19 are framed within:-

- Local priorities for each CCG to deliver improved outcomes developed through Health and Wellbeing Boards and informed by respective Joint Strategic Needs Assessments;
- Guidance from NHS England (NHSE) and NHS Improvement (NHSI) including the Five Year Forward View (FYFV) and recent publication on improving operational and financial performance in July 2016;
- Collaboration priorities identified through the NCL STP and other collaborative programmes (Haringey and Islington Wellbeing Partnership, Royal Free Hospitals Pathways Transformation, London Health Commission ambitions set out in Better Health for London and HLP workstreams).

2. Strengthening Operational and Financial Performance

On 21 July 2016 NHSE and NHSI published guidance to improve operational and financial performances.

The guidance indicates that there will be a two-year planning round for 2017/18 and 2018/19 with operating plans, and supporting contracts with providers, to be completed by 23rd December 2016. The CCGs would like to work to this deadline and recognise that a settlement for 2016/17 is a precursor to agreeing contracts for 2017/18 and 2018/19.

The NHS England document '2017-2019 NHS Operational Planning and Contracting' (the 2017/19 planning guidance) published on 22nd September 2016 describes the required approach for planning and contracting in the two-year period 2017/19, whilst NHS planning geographies begin to implement the first two years of their STPs. Two-year contracts will reflect two-year activity, workforce and performance assumptions that are agreed and affordable within each local STP. NHSE has issued a two-year tariff for consultation and there will be two-year CQUIN and CCG Quality Premium schemes.

CCG and provider plans will need to be agreed by NHSE and NHSI with a clear expectation that they must be fully aligned in local contracts. The guidance re-iterates that NHSE requires all contracts to be signed by 23rd December. From April 2017 each STP area will have a financial control total that is also the summation of the individual organisational control totals. All organisations will be held accountable for delivering both their individual control total and the overall system control total. It will be possible to flex individual organisational control totals within that system control total, by application and with the agreement of NHSE and NHSI.

2.1 Settlement for 2016/17

The CCGs would like to use the Quarter One reconciliation process for 2016/17 which will inform the two-year contracts to be agreed by the end of December 2016. Initial conversations in each health economy are underway for this purpose.

The CCGs recognise that £60m support for providers in 2016/17 from the sustainability fund held by NHSE is contingent on providers meeting their financial control totals and on the local health care economy's delivery of NHS Constitution waiting time standards.

The CCGs will go as far as possible in supporting provider delivery of respective control totals through a year-end settlement process, and thereby secure sustainability funds. CCGs will therefore seek agreement from NHSE to secure release of the 1% fund held by each CCG to support the year-end settlement process. CCGs will only release 1% contingency funds on agreement of year-end positions for 2016/17.

2.2 Planning guidance for 2017/18 and 2018/19

Planning guidance to support completion of operating plans and signed contracts for the next two years by 23rd December is expected in September 2016.

The two-year operational plans and contracts will also flow from the STP due to be submitted in October 2016, with the STP in turn setting how each organisation will play their part in delivering locally agreed STP objectives including sustainable financial balance across the NCL STP footprint.

Initial guidance for the planning round indicates that:

- There needs to be a more collaborative process to contract agreement than in previous years;
- This will be underpinned by a simplified approach to contracting and flexibility in implementing strategies;
- Partnership working will be incentivised through STP funding streams;
- Local health systems could adopt system control totals for finance, providing opportunities for the transparent sharing of risk.

CCGs ask that we negotiate contracts for 2017/18 and 2018/19 in this manner.

2.3 National tariffs for 2017/18 and 2018/19

Draft tariffs for the next two years have been published for consultation, with the proposals showing:

- Two price lists for 2017/18 and 2018/19;
- A move from HRG4 to phase three of HRG2+;
- Material changes to tariffs for maternity and general medicine.

From the changes to tariff proposed CCGs believe that use of full payment by results for acute contacts in 2017/18 and 2018/19 will add to the risk seen in 2016/17 of inflationary pressure on hospital contracts removing the ability to invest in prevention and primary care.

The CCGs therefore believe that draft tariffs for the next two years confirm the need to set a road-map for realigning incentives and contract form, and commissioning models to support delivery of our STP objectives.

This presents a challenge for both commissioners and providers. Section 4.1 sets out commissioner proposals for alternative contract form and incentives.

2.4 Planning timetable

The table below sets out the planning timetable from NHSE to support the delivery of two year contracts by the end of December 2016. Local planning timetables will be worked up in line with this.

Timetable Item (*applicable to all bodies unless specifically referenced*)	Date
Submission of STP finance forms	16 September
Planning Guidance published	**22 September**
Technical Guidance issued	**22 September**
Commissioner Finance templates issued (commissioners only)	22 September
Draft NHS Standard Contract and national CQUIN scheme guidance published	22 September
National Tariff draft prices issued	22 September
Provider control totals and STF allocations published	30 September
Commissioner allocations published	21 October
NHS Standard Contract consultation closes	21 October
Submission of STPs	**21 October**
National Tariff Section 118 consultation issued	31 October
Final CCG and specialised services CQUIN scheme guidance issued	31 October
Provider finance, workforce and activity templates issued with related Technical Guidance (providers only)	1 November
Submission of summary level 2017/18 to 2018/19 operational financial plans (commissioners only)	1 November (noon)
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November
Final NHS Standard Contract published 4 November	4 November
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	11 November
Submission of full draft 2017/18 to 2018/19 operational plans	**24 November (noon)**
Weekly contract tracker to be submitted by CCGs, direct commissioners and providers	Weekly from: 21/22 November through to 30/31 January
National Tariff section 118 consultation closes 28 November	28 November
Where CCG or direct commissioning contracts not signed and contract signature deadline of 23 December at risk, local decisions to enter mediation	5 December
Contract mediation	5 – 23 December
National Tariff section 118 consultation results announced	w/c 12 December
Publish National Tariff[1]	20 December
National deadline for signing of contracts	**23 December**
Final contract signature date for CCG and direct commissioners for avoiding arbitration	23 December
Submission of final 2017/18 to 2018/19 operational plans, aligned with contracts	**23 December**

Timetable Item (*applicable to all bodies unless specifically referenced*)	Date
Final plans approved by Boards or governing bodies of providers and commissioners	By 23 December
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within two working days after panel date
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January

[1] The National Tariff publication date is dependent upon the completion of a 28-day consultation period

3. Challenges for 2017/18 and 2018/19

Operating plans for the next two years, and the supporting contracts, will need to address the following challenges:

- The clinical case for change set out in the STP including a significant reduction in health inequalities;
- The significant financial gap across the health and care economy in NCL;
- Variable service quality across providers in both primary and secondary care;
- Delivery of NHS Constitution waiting time standards for A&E, cancer and referral-to-treatment, as well as the new mental health standards for psychological therapies and early intervention in psychosis.

The progress made to date in developing the NCL STP will help us to address these challenges over the next two years.

4. Commissioning Strategy

NCL CCGs are developing a commissioning strategy as one the enablers for the delivery of the STP, this strategy sits alongside the emerging financial strategy for NCL. The commissioning strategy recognises that the planning environment for 2017/18 and beyond is very different to the one we experienced in 2016/17. In particular planning for the next two years places a much greater emphasis on system wide sustainability and transformation.

The commissioning strategy, in response to this, considers realigning contract form and incentives that will best deliver the strategic objectives of the STP and investment in prevention, primary care and out of hospital services.

4.1 Contract Form

The CCG believe that the contracts for 2017/18 and 2018/19 need to set a road-map for realigning incentives and commissioning models in support of the STP and system sustainability. As part of this CCGs believe that acute contracts will need to move away from payment-by-result models to ensure the system has the opportunity to invest in STP priorities.

Consideration of alternative contract forms includes a minimum income guarantee to providers, with supporting incentives for activity and cost reduction, in explicit recognition of the financial and operational pressures being faced by providers in NCL.

Initial conversations have been undertaken between commissioners and providers in NCL on alternative contract forms for 2017/18 and 2018/19. Annex 1 to this letter provides greater details for the minimum income guarantee approach to contacts.

CCGs recognise that any contract form needs to be underpinned by a robust baseline and detailed analytical work is underway to support this and will be shared to support contract negotiations.

4.2 Commissioning principles

The NCL Commissioning Strategy includes a set of principles we would like to see underpin negotiations for 2017/18 and 2018/19. We believe that these principles are consistent with the ambition in the recent guidance published by NHSE and NHSI to move to a collaborative approach to contract agreement compared to previous years.

The set of principles by which we want to work together are:

- Partner organisations will work together for the benefit of local people;
- We will involve local people in our design, planning and decision-making;
- Partner organisations will find innovative ways to cede current powers and controls to explore new ways of working together;
- We will be open, transparent and enabling in sharing data, information and intelligence in all areas including finance, workforce and estates.

The minimum income guarantee approach summarised above is designed to incorporate these principles.

National tariffs and Non-Tariff services

Providers will follow all guidance relating to the national and local tariffs. Any nationally mandated deflators/inflators will be applied to non-Tariff prices in line with NTPS Guidance. No other changes to non-Tariff prices will be accepted without the explicit consent of the Host Commissioner on behalf of all Associate Commissioners.

Block items paid without backing MDS are not appropriate for a contract set using NTPS and local tariffs on a cost and volume basis. Therefore any block items remaining in the contract are assumed a double count and will not be included in contracts as the default position.

Counting and Coding Changes

The Trust is asked to set out any identified counting and coding changes from the Provider perspective in order to ensure that the full impact of these are understood by both parties prior to them being discussed and agreed as part of the contract round. Changes to counting and coding will not be considered for 2017/19 unless they are in line with national requirements or the terms of Service Condition 28 of the current Standard Contract.

Claims

As stated by NHSE, all activity identified by the National Identification Rules will be funded by NHSE. CCGs will not fund any activity that are identified as NHSE attributable.

In line with the Secretary of State directive regarding the use of patient identifiable data (PID) and the upholding of type two objections, Commissioners can no longer submit patient identifiable information to Providers. This includes the submission of

NHS numbers. Where queries, validation or analysis is dependent on the use of a unique identifier where available, these will be provided. Providers are requested to co-operate with the National Directive.

It is essential that providers supply a fully populated local submission for the maternity pathway. This lack of supporting information is leading to a lot of disputes over the correct assignment of the lead provider for payment and/or issues regarding the maternity case mix which is currently recorded and charged by providers. In the absence of a National system for Maternity activity and related financial reconciliation of this activity, the CSU will be running some Maternity challenges using Freeze data instead of the normal Flex submissions.

Diagnostic imaging is not being correctly encoded within the outpatient commissioning dataset. It is not sufficient for providers to send separate local submissions for this unbundled activity element, as it does not provide all the information which is required for validation of the data. Therefore, providers will be required to fully encode this data within national Secondary Use Service (SUS) data in line with national guidance, Therefore, commissioners will only pay for diagnostic imaging activity which is recorded correctly in SUS.

Block elements of contracts continue to cause difficulty. Where these are continued, the nature of the service and the rules around which activity is included must be made fully available, and where appropriate, must be supported by Patient Level Data.

The derivation of the national tariff must be possible from SUS data. For example Best Practice Tariffs (BPTs) that rely on access to other datasets or systems e.g. Myocardial Ischaemia National Audit Project (MINAP) must have this data encoded into SUS data flows.

Developing Indicative activity plans (IAPs)

Our suggested approach to the development of IAPs is set out below:

- Analysis is undertaken to compare activity levels each month in 2014/15, 2015/16 and months 1 to 4 in 2016/17 and the percentage increase/decrease of activity levels over this time period.
- A 12 month data set from Month 5 2015/16 through to Month 4 2016/17 is taken as the starting point for agreeing the IAP.
- The 12 month data set is then reviewed by Commissioners/North East London Commissioning Support Unit (NELCSU) and the Trust, to assess the appropriate adjustments to be made based on:
    - Historical growth trends based on the analysis from point 1
    - Predicted waiting list position/RTT backlog position at 31st March 2017
    - Trust known service changes
    - Trust-specific service changes
    - Commissioner specific service changes, e.g. Quality, Innovation, Productivity and Prevention (QIPP) which also needs to take into account whether or not the Trust will backfill the capacity generated from any of

these schemes/de-commissioning of the services to be replaced by the QIPP initiatives
- Any known policy changes that will impact on activity levels, e.g. screening programmes
- Demographic and non-demographic growth
- Adjustments for relevant contractual terms and conditions including re-admissions and Emergency Threshold predicted values

There will also need to be a period of testing the 2017/19 tariffs and refreshing the IAP against the new HRGs.

Information Schedule

National data submissions

Providers are expected to pro-actively monitor and implement all applicable nationally mandated dataset implementations and data standards, and pro-actively highlight to Commissioners should there be risks to these being met.

Automatic upload of data submissions

The NELCSU has developed an automatic upload facility which providers will be expected to use to upload data submissions to the CSU.

Non acute data flows

The NELCSU have agreed a minimum data-set across all care settings which they expect providers to follow which will be shared within Information Schedules.

Block elements of contracts

Where these are continued, the nature of the service and the rules around which activity is included must be made fully available, and where appropriate, must be supported by Patient Level Data.

Unbundled activity

Commissioners will require a separate data flow submitted as part of Service Level Agreement Manager (SLAM) backing data to validate unbundled activity. This should additionally be submitted via SUS according to the rules for identification of such activity as outlined in national SUS submission guidance. Providers will be required to fully encode this data within national SUS data in line with national guidance, Therefore, Commissioners will only pay for unbundled activity which is recorded correctly in SUS in 2017/19.

The Provider is required to submit a list of Outpatient Clinics at the start of the year.

The Provider is required to provide evidence that Best Practice Criteria are being met, where the BPT is charged. Where supporting information is not provided, Commissioners will not fund the additional Top Up tariff.

Information Sharing to Tackle Violence (ISTV)

Over the past year the Mayor's Office for Policing and Crime ('MOPAC'), has been working in conjunction with NELCSU and partner organisations to develop an extended anonymised dataset the Department for Health ISB 1594, which is included in the national standard contract. To support MOPAC and the Royal College of Emergency Medicine's ongoing commitment to reducing violent crime, The London Information Sharing to Tackle Violence Anonymised Sharing Programme brings together an innovative data sharing and analysis methodology between Mayor Trauma Centres and Emergency Departments, Police and Community Safety Partnerships to gain a pan-London view and inform the collaborative response to violent crime in the capital. This extension on the national agreed dataset ISB 1594 to report and provide monthly data and detailed information relating to violence-related injury resulting in treatment is being sought from trusts to ensure the momentum of this important work stream is maintained. To support this work the host Commissioner on behalf of itself and Associate Commissioners would like to request that an enhanced anonymised dataset is collected and sent to NELCSU on a monthly basis.

Productivity metrics

Commissioners will seek improvements in provider efficiency across a number of areas in comparison to peer organisations and any metrics set previously. Building on the work done in 2016/17 it is expected that as a minimum metrics will be more

challenging than those previously set in to comply with the ethos that performance should improve over time. Metrics are intended to cover the following areas:

- New to follow up ratios
- Day Case to Out Patient Procedure ratio
- A&E attendance to admission ratio
- Consultant to consultant ratio

Further work will be undertaken to review and agree APMs and ensure the minimum baseline dataset on which to base targets.

Individual Funding Requests (IFR)

Providers and commissioners will be notified when cohorts are identified through the IFR process so that business cases for service developments can be worked up. Business cases for drugs and public health cohorts must be submitted to the lead commissioner by 31st October 2016 in order that decisions and finances are aligned for 2017/18. Business cases will not be accepted in-year.

5. Priorities for 2017/18 and 2018/19

The sections above set out the national and local framework for developing our commissioning priorities for the next two years, and our recommendations as to how commissioning models and contract form need to change in response to the planning framework and our priorities. This section sets out commissioning intentions that we think will have a material impact on service and contract provision over the next two years.

There is a strong thread of consistency that runs through intentions developed locally in each CCG, and in collaborative work programmes across NCL including the STP, the HLP, and from national guidance from the FYFV and recent guidance on financial and operational performance.

National and local strategies all point to a common set of priorities, that in turn align to how people tell us they would like to see services provided:

- The need to invest in prevention and primary care;
- Better coordination of care for the individual supported by teams around the practice and co-production;
- Improving the quality of, and reducing the variation in, primary care and secondary care services;
- The need to shift system incentives to support these priorities.

5.1 North Central London Sustainability and Transformation Plan

Operational guidance for 2017 to 2019 published on 22nd September makes clear that plans for 2017/18 and 2017/19, and supporting contracts, will be milestones for delivery of our STP.

Our STP priorities are summarised below, as detailed implementation plans for these STP priorities are developed they will require service changes across the provider landscape and in turn to contract baselines for each provider to reflect delivery. We will engage with residents in developing the detail of these plans and formal consultation where appropriate.

The NCL STP identifies the following priorities for joint working across North Central London:

- A focus on population health and in particular in areas that will support improved outcomes and reduced costs within the five-year period of the STP, with these areas being:
    - Smoking with a commitment to reduce prevalence to 13% by 2020/21;
    - Reducing falls by 10% by 2020/21;
    - Taking whole system action to tackle obesity and diabetes;
    - Reducing unwarranted variation in the delivery of population health outcomes by GP practices;
    - Increasing employment support for people with mental health problems and other key groups.
- A focus on developing out of hospital services including urgent care and primary care:
    - Development of primary care at scale and a common offer through investment, development of health and care teams around the practice, delivery of the London Strategic Commissioning Framework, and support for the emerging GP Federations;
    - Ensuring primary care and ambulatory care triage in A&E;
    - Development of out of hospital pathways to support admission avoidance for rapid response, end of life care, and self-management programmes;
    - Begin the designation evaluation for Emergency Centres, Specialist Emergency Centres and Urgent Care Centres (UCCs) to ensure a common offer across NCL;
    - Work to review stroke rehab-pathways to focus on early supported discharge and home recovery based models.
- Development of mental health services:
    - Begin implementation of the NCL perinatal mental health strategy;
    - Consider the pooling of resources to establish a dedicated female psychiatric intensive care unit (PICU) ward for NCL residents;

- Development of primary care mental health services and community resilience;

- Align CCG and NHS England plans for child and adolescent mental health (CAMHs) services by taking on tier four commissioning, currently led by NHS England, for this cohort across NCL.

- Optimising elective pathways including consolidation and specialisation of elective services to improve outcomes. This builds on the Carter Review that has highlighted large amounts of variation in the quality and costs of delivery of care across providers:

    - Work with providers to assess the variability of surgical outcomes and work to define standards and reduce variation with an initial focus on trauma and orthopaedics, general surgery, ophthalmology and paediatrics

    - In 2017/18 we would look to develop co-commissioning of specialist services with NHSE for the following services/pathways:

        - Critical care pathways including a focus on neuro-rehabilitation

        - Bariatric care

        - A psychiatric intensive care unit care with a particular focus on women's care

        - CAMHS tier IV and HIV

        - Sexual health services

- Work on enablers:

    - Estates - considerations will follow clinical pathway planning stages of new care models supported by the opportunities afforded through NCL status as a London estates devolution pilot;

    - Using data better and IT as an enabler by working to ensure technology supports new

    - The realignment of contract form and system incentives as set out above.

The first cut of the STP submitted to NHSE on 30th June 2016 identified the following priorities for joint working across NCL:

- A focus on population health and in particular in areas that will support improved outcomes and reduced costs within the five-year period of the STP, with these areas being:

    - Smoking with a commitment to reduce prevalence to 13% by 2020/21;

    - Reducing falls by 10% by 2020/21;

    - Taking whole system action to tackle obesity and diabetes;

- Reducing unwarranted variation in the delivery of population health outcomes by GP practices;
- Increasing employment support for people with mental health problems and other key groups.

- A focus on developing out of hospital services including urgent care and primary care:
  - Development of primary care at scale and a common offer through investment, development of health and care teams around the practice, delivery of the London Strategic Commissioning Framework, and support for the emerging GP Federations;
  - Ensuring primary care and ambulatory care triage in A&E;
  - Development of out of hospital pathways to support admission avoidance for rapid response, end of life care, and self-management programmes;
  - Begin the designation evaluation for Emergency Centres, Specialist Emergency Centres and Urgent Care Centres (UCCs) to ensure a common offer across NCL;
  - Work to review stroke rehab-pathways to focus on early supported discharge and home recovery based models.
- Development of mental health services:
  - Begin implementation of NCL perinatal mental health strategy;
  - Consider the pooling of resources to establish a dedicated female psychiatric intensive care unit (PICU) ward for NCL residents;
  - Development of primary care mental health services and community resilience;
  - Align CCG and NHSE plans for child and adolescent mental health services (CAMHS) by taking on Tier 4 commissioning, currently led by NHSE, for this cohort across NCL.
- Optimising elective pathways including consolidation and specialisation of elective services to improve outcomes. This builds on the Carter Review that has highlighted large amounts of variation in the quality and costs of delivery of care across providers:
  - Work with providers to assess the variability of surgical outcomes and work to define standards and reduce variation with an initial focus on trauma and orthopaedics, general surgery, ophthalmology and paediatrics;
  - In 2017/18 we would look to develop co-commissioning of specialist services with NHSE for the following services/pathways, critical care

pathways including a focus on neuro-rehabilitation, bariatric care and a psychiatric intensive care unit care with a particular focus on women's care, CAMHS tier IV and HIV and sexual health services.

- Work on enablers:
    - Estates - considerations will follow clinical pathway planning stages of new care models supported by the opportunities afforded through NCL status as a London estates devolution pilot;
    - Using data better and IT as an enabler by working to ensure technology supports new care models. This includes the creation of integrated health and care records;
    - The realignment of contract form and system incentives as set out above.

5.2 Care Closer To Home - Barnet CCG

A key part of Barnet's future commissioning strategy is the move towards 'Care Closer To Home' (CC2H) which is in line with the Five Year Forward View. This approach is where clinical services will be moved from the acute sector to primary and community care where it provides easier access for patients, as well as being safe and cost effective to do so. CC2H is about developing new care pathways and different models of care delivery, which will support effective and efficient patient care.

Developing schemes to move healthcare closer to home will sit alongside other solutions, such as improving existing processes and decision systems within acute providers.

As we develop these new plans and schemes to support CC2H in collaboration with the GP federations, we will ensure we are making pragmatic, evidence-based appraisals of how the benefits for patients and organisations compare with the costs of the various schemes within NCL.

5.3 Haringey and Islington Wellbeing Partnership

The Wellbeing Partnership is sponsored by local providers, Councils and CCGs and therefore the priorities identified have a clear alignment across both health and social care services as well as looking at wider determinants of health and wellbeing with the overall objectives being to:

- Aim for a whole population approach to health and care delivery;
- A simultaneous focus on improving outcomes and reducing costs for population groups who are currently high consumers of health and care;
- Shift care upstream by supporting people to stay and be health, to reduce the level of ill health within our population.

The following population and care pathway priorities have been identified for development:

- A model of care that supports independence in frail older people with health and social care needs;
- An integrated model of care for people with learning disabilities;
- A re-designed musculo-skeletal pathway;
- A model of care that improves prevention, identification and management of diabetes and cardiovascular disease;
- Mental health recovery and enablement.

In 2017/18 the Wellbeing programme will also focus on the following cross-cutting themes:

- Prevention – maintaining independence, early identification and diagnosis;
- Sustaining good mental health;
- Development of primary care;
- Integration of health and care services
- Action on the wider determinant of health including employment, education, housing and environment;
- The One Public Estates Programme to make the best use of public sector estate across health and care services;
- A strategic visioning and planning workstream that will consider options for both commissioning and providing health and care services. This includes consideration of contract form and incentives set out in Section 4 above.

5.4 Healthy London Partnership

In 2013 the London Health Commission examined how London's health and healthcare can be improved for the benefit of the population, with the findings published in the 'Better Health for London' report, published in October 2014.

The report set out ten aspirations and ambitions for London, supported by a series of recommendations to enable London to become the world's healthiest major global city. The aspirations and ambitions are summarised in the table below.

Aspirations for London	**Ambitions for London**
Give all London's children a healthy happy start to life	Ensure that all London's children are school ready at age five; Halve the number of children who are obese by the time they leave primary school and reverse the trend in those who are overweight.

Aspirations for London	Ambitions for London
Get London fitter with better food, more exercise and healthier living	Boost the number of active Londoners to 80% by supporting them to walk, jog, run or cycle to school or work
Make work a health place to be in London	Gain 1.5 million working days per year by improving employee health and wellbeing in London
Help Londoners to kick unhealthy habits	Have the lowest smoking rate of any city over five million inhabitants
Care for the most mentally ill in London so they live longer, healthier lives	Reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 10%
Enable Londoners to do more to look after themselves	Increase the proportion of people who feel supported to manage their long-term conditions to top quartile nationally
Ensure that every Londoner is able to see a GP when they need to and at a time that suits them	Access to general practice 8am to 8pm and delivered in modern purpose-built/designed facilities.
Create the best health and care services of any world city, throughout London and on every day	Have the lowest death rates in the world for the top three killers: cancer, heart diseases, and respiratory illness; and close the gap in death rates between those admitted to hospital on weekdays and those admitted at the weekends.
Fully engage and involve Londoners in the future health of their city	Year on year improvements in inpatient experience for trusts outside the top quintile nationally.
Put London at the centre of the global revolution in digital health	Create 50,000 new jobs in the digital health sector.

In response to the report London CCGs, with NHSE, have established the HLP, with CCGs agreeing to allocate 0.15% of their baseline to establish thirteen London-wide workstreams to help deliver the London Health Commission ambitions.

The transformation workstreams to be delivered across London are summarised below:

- **Upgrade prevention and public health:**
  - Prevent ill health.
- **Design care around Londoner's needs:**

  - Best start in life;
  - Transform care for the mentally ill;
  - Access best cancer care;
  - Transform the lives of the homeless.
- **Transform how care is delivered:**
  - Urgent and emergency care system;
  - Primary care;
  - Specialised care services.
- **Making change happen:**
  - Interoperability – connecting health and care;
  - Engagement and self-management;
  - Align funding and incentives to support transformation;
  - Develop workforce to support transformation;
  - Transform estate to deliver high quality care.

5.5 Clinical Network Priorities

NCL wide Commissioning Intentions:

- Medicine's Optimisation (see Annex 2)
- Maternity (see Annex 3)
- Cancer (see Annex 4)

National / London Commissioning Intentions:

In Annex 5, priorities for national and London Commissioning Intentions have been identified for:

- Public Health and Health in the Justice System
- Mental Health
- Immunisations and screening
- Children and Young People
- Personalisation (Personal Health Budgets and social prescribing)
- Homelessness
- Strategic Clinical Network (SCN) intentions

Annex 6 details the NCL Associate CCGs' commissioning intentions for the Trust.

5.6 Enfield Clinical Commissioning Group

Enfield CCG remains a financially challenged organisation and it will need to identify additional recurrent and non-recurrent initiatives and savings as part of its overall Recovery Plan.

At this time the full extent of its Recovery Plan is still being worked up and therefore the detail within the associate CCGs' commissioning intentions relating to Enfield CCG (Annex 6) is subject to revision. More importantly, the addition of new schemes and initiatives will be designed to bring Enfield CCG and the wider health economy back in to financial balance. Whilst Enfield CCG is committed to giving providers and the public it serves the requisite notice of changes where appropriate,

Enfield CCG reserves the right to introduce new schemes that are not currently heralded within this document at any point.

The commissioning intentions found in the separate Enfield table in Annex 6 should be acknowledged by providers as the most recent.

5.7 Local CCG priorities

Local commissioning intentions focus on delivery the health and improvement priorities agreed through the Health and Wellbeing Board and informed by the Joint Strategic Needs Assessment (JSNA).

The CCG's priorities detailed in the table below are ones that will have a significant impact on provider contracts in 2017/18 and 2018/19 and we therefore want to draw them to your attention. These commissioning intentions relate to Barnet as lead commissioner. All commissioning intentions relating from the CCG's Associate Commissioners to the Trust are contained in Annex 6.

Programme Area	Services	Commissioning Intention
Cancer	Risk Stratification of Prostate Cancer	Prostate cancer patients will be discharged to their GP for the management of their prostate cancer.
Planned Care	Management of patients post prostate Cancer treatment.	Decommission routine follow ups from secondary care for specific cohort of patients, and recommission from primary care via a Locally Commissioned Service (LCS)
Long Term Conditions	Cardiology - End to End Pathway	Implementing an End-to-End Cardiology pathway that includes a community-based heart functioning improvement service, which went live on the 6th June 2016.
Long Term Conditions	MSK - procure new pathway model	The Right Care Value pack has identified Barnet as an outlier, a review of the pathway is currently underway and it is anticipated that a new model of care will be procured.

Programme Area	Services	Commissioning Intention
Long Term Conditions	Neurology	Develop a fully integrated model of care with dedicated Multi-Disciplinary Teams (MDT) working as a system, in community settings, to deliver a responsive and tailored health care service to people with neurological conditions across Barnet. The aim would be to reduce unplanned and avoidable admissions to hospital and to improve medicine's management through changes to prescribing practice
Integrated Care	Discharge to Assess	Ensure the onward care of a patient is prioritised by moving patients out of an acute bed, and moved on to the patients most suited onward care journey in a reasonable timeframe. Important features include the trusted assessment between health and social care, in-house reablement and rehabilitation, and care co-ordinators to support patients and their families throughout the discharge process
Integrated Care	Frailty Pathway	Development of Frailty pathway including review of Rapid Response services and locality based Integrated Teams
Integrated Care	Stroke Services	NCL-wide review of the end-to-end stroke services pathway and a focus on enhanced community capacity (Early Supported Discharge) with an increased skill base. This will include a reduction in Level 3 inpatients, some of which is already taking place at Edgware Community Hospital, where bed capacity is being used for general rehabilitation.

Programme Area	Services	Commissioning Intention
Integrated Care	Tissue Viability	A review of the current pathway as identified a number gaps in primary care provision. 1. New model will support the delivery of care in a community setting. 2. Enable the reduction of unscheduled attendances to A&E due to wound care breakdown. The model will introduce chronic wound care hubs bridging the gap in service provision between primary, community and acute care
Children and young People	Community Paediatrics	Current service specification with RFH is out of date and needs reviewing in the light of new legislation for SEND. The new timeframes in particular, will put pressure on the community paediatrics pathway.
Children and young People	Enuresis and Continence Management	Review of existing service available within primary care, provided by CLCH and RFL to understand what is currently available, the gaps, improve the pathway and possibility of recommissioning from one provider or supporting primary care to provide.
Children and young People	Orthoptics	Move to an integrated service model. On hold. Decommission CLCH and Royal Free. Re-specify and procure during 2017/18
Children and young People	Epilepsy services	To undertake an in-depth review with the intention of enhancing the existing Epilepsy service in line with population growth and NICE guidance
Children and young People	Respiratory services	To undertake an in-depth review with the intention of developing and commissioning of a Children's Asthma service
Children and young People	Allergy services	To develop a Children's Allergy service
Children and young People	Paediatric diabetes	To undertake an in-depth review with the intention of enhancing the existing diabetes service in line with population growth.

Programme Area	Services	Commissioning Intention
Children and young People	Palliative care	To review as to the future needs of Children's that require palliative care
Planned Care	Chronic Kidney Disease (CKD) acute service	To commission a community element to the RFL CKD service including triage and nurse led clinics.
All Areas	All Services	Enablement of Care Integrated Digital Records (CIDR) services across all local health and social care providers. This includes the continual evolution of data sharing for clinical and social care information - access to data at the point of care (part of FYFV - Digital by 2020) All Providers will need to be able to share patient records digitally (their IT systems will have open API capabilities enabled)
Primary Care	Commission anticoagulation services from GPs/Barnet Federation	Support the development of the Barnet GP Federation to deliver list based services to the Barnet Population,
Primary Care	Provision of 7 day 8-8 services out of hours	Commission the Barnet GP Federation to provide additional appointments both bookable and urgent from 6.30-8.00pm Monday to Friday and 12 hours per day on Saturday and Sundays in the 3 Barnet Localities
Primary Care	Commission a new Local Commission Service	Commission one universal local commissioned service from Barnet GP practices/service provider(s) that supports the requirements of the Transforming Primary Care - SCF and health needs of the Barnet population
Primary Care	Future commissioning of existing Local Commissioned Services from GP Practices	Consider decommissioning the following LCSs from Barnet GPs: Anti-coagulation, End of Life Care, Looked After Children (LAC), homeless, methotrexate and medicines management. Conditional on reprovision of services as part of a universal LCS

Programme Area	Services	Commissioning Intention
Urgent and Emergency Care	Walk-In Centre	Review of the Walk-in Centre service commissioning arrangements as part of the wider urgent care review and the Finchley Memorial Hospital development to enhance primary care service
Urgent and Emergency Care	A&E attendance reduction and admission avoidance	To reduce the numbers of patients entering emergency departments (EDs), and to reduce hospital admissions where possible for those whose health needs can be more appropriately met outside of an acute setting. To support these patients to receive the right care in the right place by informing them simply of where they can access the most relevant services to them outside of an ED setting.

We would seek to use the next two years as an opportunity to help shape and ultimately determine between commissioners and providers how these developments outlined in this letter would apply to our local health economy and how they will help address the challenges we collectively face across NCL and beyond.

Please contact me if you require further information.

Yours sincerely

Cathy Gritzner

Accountable Officer

Barnet CCG

LIST OF APPENDICES

Annex 1: Contracting Round 2017/19 Proposal for Providers

Annex 2: Medicines Management and Optimisation

Annex 3: North Central London Maternity Commissioning Intentions 2016/18

Annex 4: Cancer Commissioning Intentions 2017/18

Annex 5: National/London Commissioning Intentions

Annex 6: Associate CCG commissioning Intentions

Annex 1

Contracting Round 2017/19 Proposal for Providers

Overview

The aim of this presentation is to provide an overview of our proposed approach to Acute, Mental Health, Community and Specialist Contracts for 2017/18 and 2018/19.

It sets out the background to this approach in terms of the following:

- National guidance
- Learning from other areas – e.g. Bolton
- Rationale for movement towards capitated budgets
- Local drivers for change – e.g. Sustainability Transformation Plan (STP), Value Based Commissioning (VBC)/Outcomes Based Commissioning (OBC) next steps

The proposed approach is then described, taking the above into account, along with the next steps required to ensure contracts are signed within the timescale of December 2016.

In summary, we are proposing a movement towards **population-based budgets** within a longer timeframe, with the enabler for this being contracts based on a **minimum income guarantee**. This will support joint delivery of STP priorities, whilst providing a forum to remove costs from the system.

This presentation does not include options for potential formal joint ventures with providers, e.g. Accountable Care Organisations, but this is an option to be discussed once contract form has been agreed. However, there is agreement that to ensure the financial sustainability of the local health economy it is vital that we work together to develop and implement initiatives that remove costs from the system. A joint team that works across providers and commissioners is therefore highlighted as one of the key enablers for these plans.

Background: National Guidance

- Strengthening Financial Performance and Accountability published 21st July 2016 (Reset)
- CCGs to agree two year contracts with their providers by December 2016, for April 2017 to March 2019
- Driver for change within the system will be the STP

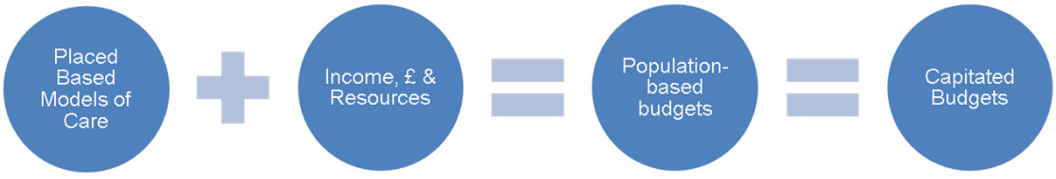
Outline proposal (draft) from NHSE states that:

- To support system stability there will be a number of changes to Tariff to facilitate the move towards population-based budgets (also referred to as place-based budgets or capitated budgets)
- A national template for local variation of payment for emergency activity will be developed
- There will need to be a radical change in the behavioural dynamics of planning / contracting towards a more collaborative process

- This will be underpinned by simplified approaches to contracting and flexibility in implementing strategies
- Partnership working will be incentivised by a number of funding streams, available at the STP level
- Local health economies with robust STPs could adopt system control totals for finance, providing opportunities for the transparent sharing of risk

Background: Place-based Models of Care

- King's Fund focus on 'place-based' models – promotes a geographical focus rather than pathway specific approach.
- Place-based systems of care involve organisations working together to improve health and care for a geographically-defined population, collectively managing common resources.
- Whatever boundaries are chosen, place-based systems of care should focus on the whole of the local population, rather than only focusing on specific medical conditions.
- Within NCL, the CCGs have been piloted VBC approaches across disease specific areas; Placed-based models of care are the next step along this journey.
- Need to consider how we move towards this in NCL – minimum income guarantee contract with an NCL STP risk share are an enabler to achieving population based budgets in the longer term.



Background: Learning from other areas

Bolton FT / Bolton CCG agreed a new way of working to ensure financial sustainability of local health economy. Following principles apply:

- Deficit of either organisation is a failure of both
- Collaborative working
- Aligned incentives
- Open, transparent with no fear
- Enabling and supporting the locality vision
- Risks faced, shared, managed

The contract form to support this approach divides PODs into four different categories:

- Activity reduction incentives
- Cost reduction incentives
- Cost risk share
- Fixed income

Depending on which category a POD falls into, there is either a minimum income guarantee or risk share agreed. An NCL adaptation of this model is shown later in this section.

Background: NCL local issues

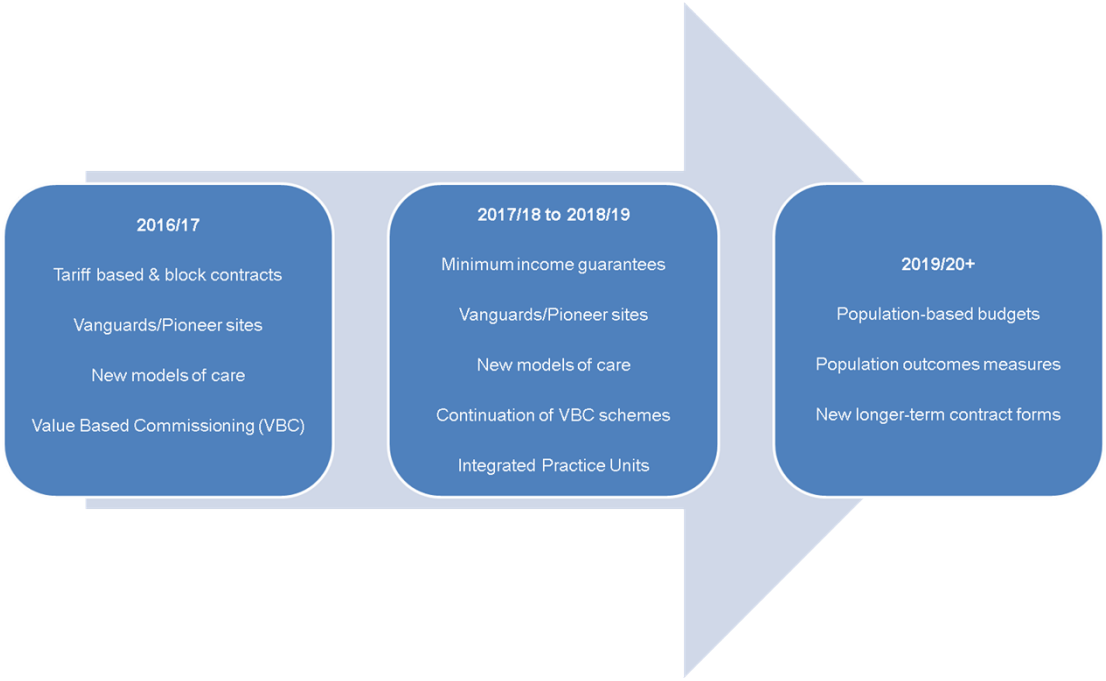
Need to address a number of system wide issues including:

- A significant financial gap in the local health economy
- Silo approach to contracting round
- Lack of collective ownership & responsibility for health economy
- Variable service quality
- Provider longer term viability
- Health inequalities
- Workforce recruitment & retention
- Variable GP Practices
- Increasing patient & public expectations

There is a need to ensure the key driver for change within the system is the Sustainability Transformation Plan (STP), through established workstreams:

- Out of hospital care (Care Closer To Home)
- Elective care
- Provider productivity
- Prevention (Workforce for prevention, Supporting healthier choices, Early diagnosis and proactive management, Tackling wider determinants of health, Workplace wellbeing, Self-management)
- Mental Health (Community Resilience, Out of hospital mental health, Acute pathway, Female PICU, CAMHS, Mental health liaison)

Journey - Current position to population-based budget



Proposals for 2017/19

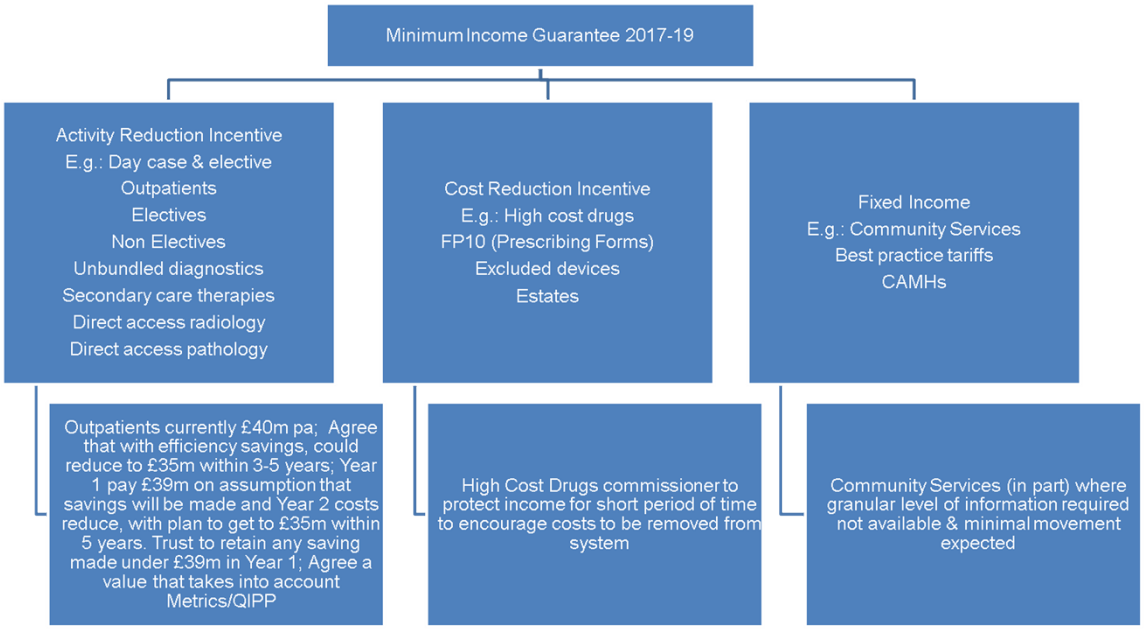
A minimum income guarantee comprised of three main payment mechanisms:

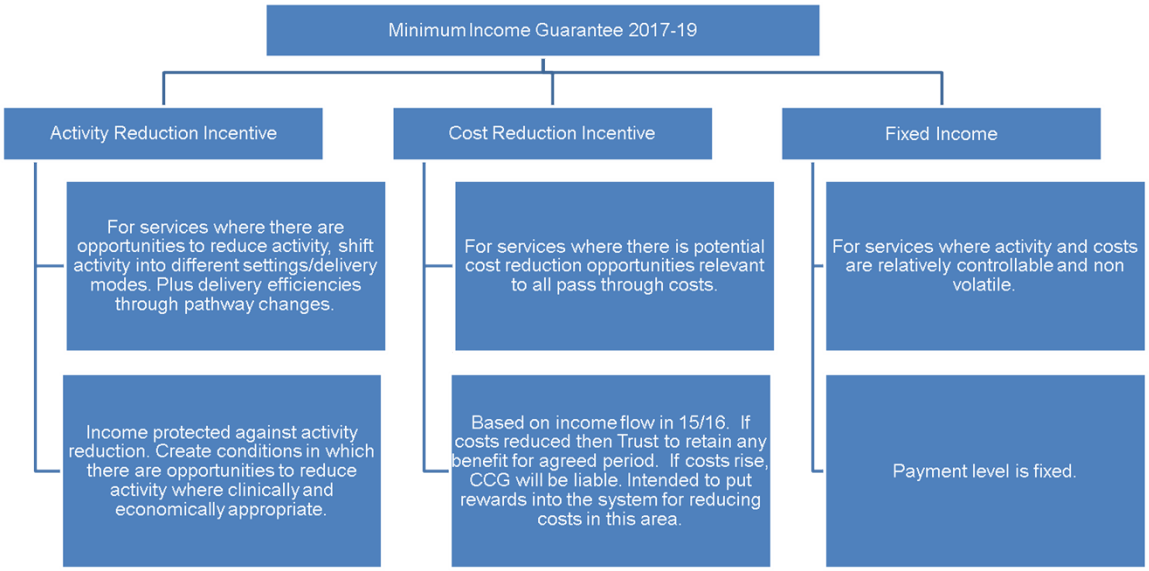
1. Activity Reduction Incentive
2. Cost Reduction Incentive
3. Fixed Income

The following pages describe how this would apply by POD, with examples for each. It is noted that:

- Commissioners and Trusts where deemed appropriate shall consider a Risk Share
- Commissioners and Trusts in setting and agreeing baselines will include an assessment of growth
- Incentives would be paid to encourage a movement towards population based budgets, with suggestion that CQUIN, KPIs and others are used for this
- Underpinned by a joint commitment to reducing costs from the system
- Propose a joint team is put in place to develop and implement schemes that replace CIP / QIPP to ensure a system wide approach linked to the STP

Proposal – Minimum Income Guarantee schematic





Activity Reduction Initiative (An Example)

2017/18 (Year 1):

- Activity Reduction 2.5% Plan vs 5% Actual achievement
- Income Plan (Guaranteed) £9.75m plus Trust savings through meeting and exceeding activity reduction plan (£0.5m)

2018/19 (Year 2):

- Activity Reduction 5% Plan vs 7.5% Actual achievement
- Income Plan (Guaranteed) £9.5m plus Trust savings through meeting and exceeding activity reduction plan (£0.75m)
- Plan agreed to deliver activity reduction of 12.5% by Years 3-5

Years 1 and 2 – the Trust retains any benefits where activity reduction is greater than plan

Proposal for 2017/19 - Contract issues and suggested approach

The following paragraphs set out how we propose to address the following issues in the 2017/19 Contracting Round:

- CQUIN
- KPIs
- QIPP
- Local prices
- Emergency marginal rates
- Readmissions
- Changes to tariff
- Information schedule
- Local quality requirements
- Potential impact of poor CQC reports

For each area, it sets out the key deliverables required by December 2016, and further work required to achieve this.

It also describes the proposed contract form by provider, the rationale behind these proposals, and the risks associated with delivery.

CQUIN / KPIs

Current position:

Range of local and national CQUINs (2.5%) and up to 100 KPIs per Trust. Apart from standard contractual levers, there are no additional financial implications for non-achievement of KPIs

Proposed move for 20167/18:

CQUINs – Agree two to three CQUINs per Trust, with the same indicators across Trusts where appropriate

KPIs – Agree on smaller focused set, with same indicators used across Trusts where appropriate. Link to STP initiatives and for key indicators carve % from contract to add financial consequences

Essential for December 2016:

Agreement of CQUIN and high impact KPI indicators, measurements and percentage of contract value

Desirable:

Agreement of all KPIs, including those with non-financial impact

The following areas are proposed for CQUINs / KPIs for 2017/18 – 2018/19. These support a move towards population-based budgets and outcomes measures:

- Shadow implementation of population-based budgets (capitated budgets)
- Shadow monitoring of agreed population outcome measures – building on what has been implemented through learning from VBC, but moving away from disease specific indicators to those at population level
- Working collaboratively with other providers to implement OBC across acute, community and mental health trusts
- Mental health and community services information (including outpatients) provided at agreed level of granularity
- Activity shifts to community / primary care - could include risk shares where assuming reduction in acute
- Agreement / implementation of pathway changes that will reduce cost in system – linked to Wellbeing Programme
- Establishment of joint Programme Management Office (PMO) that sits across provider and commissioner, responsible for developing and implementing schemes which remove cost from the system. This may not necessarily be included as an incentive, but could be funded through an agreed level of productivity improvements

Issues affecting Contract Value:

QIPP, Local prices, Marginal Rate Emergency Tariff, Readmissions and Tariff Changes

Current position:

Adjustments made to contract value based on agreed values for above

Proposed move for 2017/18

- Block / variable position agreed that takes into account agreed productivity / pathway measures that will reduce overall values, i.e. onus is on providers to make internal changes, with some degree of risk share / tolerance. For each area this would mean:
- QIPP / productivity metrics: Commissioners and provider reach agreement on areas where further productivity gains can be made, or pathways changed to

produce savings. Contract value is based on agreed position, with risk shares where appropriate.
- Emergency marginal rate / readmissions: Contract value is based on current trend, with no adjustments made in year. Contract value for non-elective is either block, block with minor tolerance, or block with variable cost and volume in community services
- Local prices: Contract value is based on current values unless commissioners / providers flag now that a change is required
- Tariff Changes: Contract value takes movements in tariff into account, e.g. maternity remains a variable if providers feel a block does not take into account potential increase in income

Essential for December 2016:

- Agreement of approach, e.g. Areas that will be block / block with tolerance and agreement of tolerance, by Point of Delivery (PoD)
- Agreement of adjustments for productivity / pathways changes that will be made. To be informed by activity and financial trend analysis.
- Value for each of the above agreed
- Timescale for proposed, costed up options – end September.

Service Specifications, Reporting & Information Requirements and Quality Requirements

Current position:

Detailed schedules agreed

Proposed move for 2017/18:

Detailed schedules may not be worked up by December 2016 if Commissioners wish to make significant changes to current arrangements. It is proposed that the following is agreed:

By December 2016:

- Work Plan for update and refresh of Service Specifications to be agreed between Commissioners and Trusts for 2017/19
- New Service Specifications incorporated (where appropriate)
- Roll over of Schedule 6 from 2016/17
- Updated Data Quality Improvement Plan (DQIP) and Service Delivery Improvement Plan (SDIP) to support STP delivery, move to population based outcomes measures and capitated budgets
- No Provider Business Cases to be considered as part of Contracting Round 2017/19; exceptions only where agreed by each CCG
- Quality Schedules to be updated to take into account outcomes of 2016/17 CQC inspections, although CQUINs to focus on incentives outlined on earlier slides, unless there are exceptional reasons

Other benefits

It is anticipated that this approach in supporting STP delivery will also deliver additional benefits in terms of:

- A joint approach to development of population-based budgets and population outcome measures
- Realignment of contract management priorities
- Refinement of the claims and challenges process
- Reductions in audits and deep dives
- Capacity generated to deliver Value Added initiatives

Annex 2

Medicines Management and Optimisation

This section sets out the lead Commissioner's, on behalf of itself and Associate Commissioners, expectations for 2017/18 with regard to high cost drugs.

1.1 New Elements are;

- Gain share/risk share
  - Around the biologics; etanercept, infliximab and use of biosimilars.
  - Around growth hormone
  - Around other biologics coming in the pipeline, please see 'NCL Principles of RISK share document' (actual risk share proportions would be considered on a case by case basis as they come into the pipeline).

1.2 Six months' notice is given to all secondary care providers that NCL CCGs require;

- 50% of the intravenous (latest NICE Technology Appraisals require cheapest acquisition cost infliximab to be used) anti-TNF drug infliximab to be the biosimilar product, and NCL CCGs undertake to agree the Infliximab and etanercept gain-share position in year taking account of prevailing market forces with any agreement based on the difference in price between biosimilar and brand at the current price. Any split in savings share from switching will be agreed according to the principles in the risk share document above on a case by case basis.
- 80% of the anti-TNF etanercept to be the biosimilar product. NCL CCGs will agreed a suitable split of the savings for 2017/18 to between providers and commissioners, based on the current list price.
- 90% of growth hormone to be from the lowest acquisition cost formulation as defined by London Procurement Partnership (LPP)
- Figures will be based on the difference in price between originator product versus recommended biosimilar

Financial Impact	Will there be an impact?	How will activity Change?	What change do we expect in activity?
	Reduction in cost per patient for a treatment course on biologic.	Underlying growth in activity is significantly lower than price reduction, so a volume increase in activity will be seen.	Increase in volume in line with emerging incidence of disease. Overall cost would show a decreased rate of growth compared with when only originator product was available.

Activity Impact	Will there be an impact?	How will activity Change?	What change do we expect in activity?
	Increase in volume in line with emerging incidence of disease.	Increase in volume in line with emerging incidence of disease.	To be quantified

Moorfields:

Following on from work undertaken in 2015-16, the administration price package of £289 currently being charged could not be justified, and is unsustainable. In line with NTPS guidance: "*Local prices for high-cost drugs, devices or listed procedures must be paid in addition to the relevant national price for the currency covering the core activity. However, the price for the drug, device or procedure must be adjusted to reflect any part of the cost already captured by the national price*" we expect the current overall cost of this treatment will be aligned across NCL.

1.3 Six months' notice is given to Moorfields Eye Hospital NHS Foundation Trust that NCL CCGs will agree a reduction to the overall cost of the medication and administration of anti-vascular endothelial growth factor (Anti-VEG) drugs to reflect both NICE guidance and the tariff charge applied by other providers in NCL for the equivalent service.

Financial impact	Will there be an impact?	How will activity change?	What change do we expect in activity?
	Reduction in cost per patient for a treatment course on Anti - VEGF Activity	Increase in volume in line with emerging incidence of disease.	Increase in volume in line with emerging incidence of disease. Overall cost would show a decreased rate of growth compared with when only originator product was available.

Activity impact	Will there be an impact?	How will activity change?	What change do we expect in activity?

	Activity will be charged in line with tariff, and reduced from current price of £289 to £109 plus MFF (code BZ23Z)	Increase in volume in line with emerging incidence of disease.	Increase in volume in line with emerging incidence of disease.

UCLH, Royal Free and BCF:

We would expect that PbR excluded drug cost charges reflect drug acquisition cost only and that these should reflect acquisition cost at LPP agreed price or PAS prices (whichever is lower), and should follow any prior approval process in place for those treatments (e.g. Blueteq, Tick Box Forms etc.).

- This will be an NCL CCGs wide change. NCL CCGs will only pay the actual cost of the drug or technology at which the provider procured the treatment (including any LPP discounts or Patient Access Scheme discounts), in line with NTPS Guidance.
- Any additional (administrative or other) charges applied to drugs or technologies will not be honoured unless specifically agreed otherwise in the contract.
- The same will apply to drugs/technologies which have been approved following submission to the Individual patient Funding Request panel of the relevant CCG.

Financial Impact	Will there be an impact?	How will activity Change?	What change do we expect in activity?
	Overall cost for drugs affected by any excess charges should be reduced	A reduction in the charge made across to CCGs	Decrease in excess charges

Activity Impact	Will there be an impact?	How will activity change?	What change do we expect in activity?
	Activity will be charged in line with agreed acquisition prices minus any administrative tariffs.	Increase in volume in line with emerging incidence of disease, decreased spend per treatment of affected high cost drugs.	Increase in volume in line with emerging incidence of disease, overall decrease in cost per unit of drug used.

Locally Commissioned Services:

We would expect that any locally commissioned services or packages of a care remain cost effective and reflect any efficiencies that become available as a consequence of, but not limited to tariff or drug price changes, or more efficient ways of service delivery using for example telemedicine.

This will be an NCL CCGs wide change. NCL CCGs will only pay the actual costs at which the provider delivers the particular service, in line with the principals set out in NTPS Guidance or local agreements. As components of service provision become subsumed into reference costs for example, a commensurate reduction in activity cost would be expected in locally agreed services where appropriate.

Financial Impact	Will there be an impact?	How will activity change?	What change do we expect in activity?
	Overall cost for packages of care including drugs elements affected by changes should be reduced	A reduction in the charge made across to CCGs	Decrease in cost of package prices or locally agreed prices maintaining cost effectiveness of service.

Activity Impact	Will there be an impact?	How will activity Change?	What change do we expect in activity?
	Activity will be charged in line with agreed prices which will be reviewed as elements within the package reduce in price.	Increase in volume in line with emerging incidence of disease, decreased spend per treatment of affected package of care.	Increase in volume in line with emerging incidence of disease, overall decrease in cost per package of care should be seen.

Carter Productivity Improvements

According to the Carter Review (Operational productivity and performance in English NHS acute hospitals: Unwarranted variations) there is significant variation in the approaches and scale to delivering medicines optimisation;

- Rates of prescribing pharmacists as a proportion of total hospital pharmacists varied between 2.5% and 71% (average 14%).
- Limited digital maturity with regards to medicines information technology.

- Great variation in the deployment of electronic prescribing and administration systems in both inpatient and outpatient.
- Inconsistencies in the way trusts code those medicines classified as high cost drugs.
- Providers will be expected to prescribe and supply in a manner that minimises the potential for waste: examples of prescribing practices that could lead to financial waste include dispensing very large supplies of drugs, in particular high cost drugs with each issue.

NCL CCGs will expect:

- Trusts to take note of the Carter report implications and in particular increase clinical patient facing time for pharmacists.
- Introduce back office efficiencies to free up pharmacy resource for clinical work.

- Improve coding and compliance with minimum data sets and have closer working between their hospital pharmacy and finance teams to ensure correct mapping to the required treatment codes.

- Reduce stock holding in pharmacy departments.

- To improve the Digital maturity of pharmacy and prescribing systems.

Financial impact	Will there be an impact?	How will activity change?	What change do we expect in activity?
	Overall cost for drugs will not be affected by any back office efficiencies, increase in clinical patient facing time, coding etc. Service cost may increase and should settle as this becomes business as usual.	Overall service could increase or decrease (may be due to re-commissioning / transformation etc.)	Overall cost for drugs will not be affected by any back office efficiencies. Service cost may well increase and should settle as this becomes business as usual.
	No expected increase in activity anticipated.	Activity is not expected to change.	Activity is not expected to change.

Financial impact	Will there be an impact?	How will activity change?	What change do we expect in activity?
	Reducing Stock Holding in pharmacy departments will increase efficiency and reduce waste, but the benefits will be to the provider, and the NHS overall. Overall cost for drugs will not be affected, as CCGs will only be charged for what is used in their patients	No change in activity should be seen, though Pharmacy departments will have to ensure they have robust processes in stock for ensuring timely acquisition of stock.	Overall cost for drugs will not be affected by reduction in stock holding efficiencies.

Activity impact	Will there be an impact?	How will activity change?	What change do we expect in activity?
	No expected increase in activity anticipated.	Activity is not expected to change.	Activity is not expected to change.

- NCL CCGs intend to improve the efficiency of treatment pathways in a number of areas including, but not limited to Rheumatology, Ophthalmology and IVF.

- In 2017/18 NCL CCGs seek to assess the opportunity to redesign rheumatology services and will require providers to audit outpatients and provide information around first and follow up appointments for Rheumatoid Arthritis related activity.

- NCL CCGs would expect that devices (both excluded and included in tariff) continue to be acquired at on the best terms and most efficient manner for the local NHS. Therefore we will expect Providers to actively work with us in ensuring device acquisition prices are continually reviewed and opportunities for increased efficiencies fully exploited. Those treatments (e.g. Blueteq, Tick Box Forms etc.).

- This will be an NCL CCGs wide change.

Financial Impact	Will there be an impact?	How will activity Change?	What change do we expect in

			activity?
	Individual cost for devices should see a reduction though overall cost may increase and should settle as this becomes business as usual.	Overall service could increase or decrease (may be due to re-commissioning / transformation etc.)	Overall cost for devices may increase or decrease depending on incidence of conditions treated. Service cost may well increase.

Activity Impact	Will there be an impact?	How will activity Change?	What change do we expect in activity?
	No expected increase in activity anticipated, but incidence, or changed inclusion criteria prompted by local or national need or direction may result in increased or decreased activity	Activity is not expected to change.	Activity is not expected to change.

Planned audits to demonstrate compliance with clinical and/or financial instructions will include but are not limited to Certolizumab and 12 week free supply, growth hormone. Further opportunities for audit identified in year will be discussed and agreed with Trusts.

Perennial Issues for NCL CCGs

All services and medicines will be commissioned in line with the NHSE current '*Manual for Prescribed Specialist Services*' and PbR excluded drug list, including any in-year updates and adjustments. All existing, and new drugs and technologies should be provided within the scope of National Tariff and Payments System guidance unless:

- explicitly excluded through the NTPS 2017/18 and funding agreed with commissioners,
- or as part of excluded services;
- or through local arrangement agreed with the commissioners.

Ensure commissioning of drugs excluded from tariff is in line with principles agreed by NHSE with provider trusts and brings in efficiencies as highlighted in the Lord Carter report. This includes:

- Commissioning of medicines across an integrated pathway.
- Data schedules that assure compliance with commissioned use of these drugs; usage outside these commissioned arrangements will be at the financial risk of the Provider trust.

All CCG commissioned medicines will be charged at acquisition costs that will routinely be no higher than the London Procurement Price or Patient Access Scheme, whichever is lower with no blanket on-costs.

For these drugs that are prescribed and supplied by the hospital optimizing use of the Homecare route, together with applying the governance mentioned in the Hackett report.

Adherence to all medicines management specification documents, i.e. The Principles for Commissioning High Cost Drugs, Red Drug List, Interface policies and the CCG commissioned drug list.

It is the responsibility of providers to inform commissioners of any cost pressures anticipated in the forthcoming year due to NICE technology appraisals, and other developments as per the nationally mandated time frames (between September 2016 and January 2017) for horizon scanning.

Horizon scanning of drugs and respective business cases to support their use must be submitted to commissioners by 30th September 2016 in order that decisions and finances are aligned for 2017/18. New excluded drugs and devices will not be funded in-year unless approved by NICE or previously identified and planned for within the prioritisation round. Business cases will not be accepted in-year.

A full data set will be submitted for all drug charges and any subsequent challenges.

NHS provider Trusts that provide medicines through the homecare route should adhere to all national policy or guidance published as a result of the Hackett Report, including the Royal Pharmaceutical Society's Professional Standards for Homecare Services.

All CCG commissioned medicines will be charged at acquisition costs, with no blanket on-costs or administration charges added.

QIPP projects and initiatives developed as part of a constructive collaborative engagement with Trusts will be vital to ensure that contracts remain affordable. Commissioners and Providers have discussed and agreed a number of schemes as locally identified projects. NCL CCGs will seek to implement agreed plans as outlined in the updated document 'Acute commissioning medicines QIPP plan for 2017/18 NCL CCG'.

Previously discussed and agreed QIPP work includes biosimilar switching, use of lowest acquisition cost HCDs

Emerging opportunities and future plans will be discussed and agreed as opportunities are identified and captured by way of contract variation

The prescribing of care pathways will be reviewed in 2017/18. The areas to be audited will be agreed with providers as part of the commissioning round. Compliance with NICE guidance will be subject to in-year audit.

Where devices / appliances (e.g. erectile dysfunction vacuum pumps / wound care) that are not excluded from the National tariff are required in line with NHS and Trust criteria, Trusts shall ensure a supply for the patient as part of the outpatient tariff.

Where Trusts are using excluded drugs they will provide evidence of compliance with NICE guidance via process of tick boxes, or through use of Blueteq.

Agreements aimed at improved efficiency and cost effective use of PbR excluded High Cost Drugs will be included in the contract.

Annex 3: North Central London Maternity Commissioning Intentions 2016/18

Perinatal mental health

The mental health STP has submitted a funding application to the NHSE Perinatal Mental Health Community Development Fund (September 2016), in order that the perinatal mental health strategy developed over the past year can be implemented. This will enable a specialist community perinatal mental health service to be developed and implemented across NCL, supplementing the services which currently exist and introducing new service provision where they do not. If unsuccessful further funding opportunities are expected to be offered until 2019/20 when allocations will be part of CCG baselines. Therefore planning for the implementation of these services will still need to take place across maternity, mental health, primary care, community and social care sectors.

Maternity providers in NCL will have a key role in ensuring that a future specialist perinatal service is a success. Midwives, obstetricians and neonatal services will need to work in conjunction with commissioners and providers from the mental health, public health, social care and primary care sectors to develop and implement pathways and models of care. Individual maternity providers will be expected to identify a lead obstetrician and specialist midwife with designated time within their job plans to undertake this work.

A service specification has been developed by the London Perinatal Mental Health Clinical Network and will be implemented by CCGs, local authorities and NHSE as specialist services come online.

The commissioning and provision of maternity services in NCL – Implementation of Better Births

In February 2016 NHSE published the National Maternity Review, ‘Better Births’ and in July 2016 the Maternity Transformation Programme which will drive implementation was launched. In preparation for local implementation the North Central London CCGs, in conjunction with the Maternity Network Board will undertake a review of the current systems of commissioning and provision for maternity care. This will seek to identify how services could be delivered across pathways of care, how geographical and organisational boundaries can be minimised, and how women and families can have a greater influence over service review development and change. Organisations will be asked to provide a commitment to full implementation of Better Births including a willingness to review governance and accountability processes which will allow movement of staff across organisational and geographic boundaries.

The maternity network has submitted a bid (September 2016) to NHSE to become an early adopter maternity system. Whether successful or not, implementation will be required to commence over the coming months and certainly no later than the beginning of 2017/18.

Key areas of work include:

- Greater personalisation of care provision, which takes account of women's choices of community or acute settings for antenatal and intrapartum care. This will include increasing births in midwife led settings; home, freestanding (FMU) and Alongside Midwife-led Units (AMU). A more formalised approach to the safe transfer of women which seeks to improve choice and continuity in the antenatal and postnatal period will be developed.
- An increase in the number of women who are offered continuity of carer. This will be delivered through the delivery of care closer to home within community hub settings. Community midwifery teams will have access to named obstetrician support and where necessary deliver care across geographical boundaries. Antenatal clinic services for higher risk women will be reviewed to ensure continuity of carer and choice are a key part of the care that is offered.
- Improved multi-professional working through the community hubs and acute services so that women can access a wide range of interventions through a joined up approach. These will include community midwifery, stop smoking, peri-natal mental health, health visiting etc.
- That professionals can work across geographical, organisational and professional boundaries to deliver safe, effective care. That those professionals have the opportunity to learn together and through joint a competency framework are able to utilise that training across the network.
- The development of a single point of contact / access for women into maternity services in NCL and improved quality of information that enables an informed choice of type of provision as well as individual provider.
- Safer care and improved outcomes for women and their babies through initiatives such as the Stillbirth reduction care bundle (Safer births).
- The development of teams of midwives that are able to explore mechanisms for self-management and governance that are enjoyed by independent providers of midwifery services such as Neighbourhood Midwives. The introduction of new providers into the market e.g. independent providers of midwifery services
- Work with the wider women and children's commissioners and provider workforce to ensure a whole system approach to the early identification and early help for families to ensure a local focus that meets local need and is shared across the STP footprint.

These programmes will be developed through the NCL maternity network over the coming months, however it is likely that the resulting plans will not be available for the commencement of contract negotiations in October to December 2016, and will be implemented across the lifespan of the 2017/19 contract period and beyond.

Review of pathways of care to improve care for women with higher levels of need

The CCGs will work together with providers and others (e.g. primary care, public health and users including the maternity service liaison committees) across the maternity network to examine and review pathways of care and examine how these might be best provided across organisational and geographical boundaries. The way in which enhanced payments for these services are more effectively able to be used to improve services will be considered. Such pathways may relate to rarer medical conditions which attract an intensive pathway payment or high levels of social need which attract the intermediate pathway payment. The possibility of developing teams across provider boundaries will be explored with the intention of commissioning for improved outcomes and quality for women and families as well as improving value for money for the health economy. This will also need to include the opening of the market to other, independent providers.

The CCGs will work with providers to examine the potential impact of tariff changes and the introduction of personalised budgets which were outlined in the maternity review but which have not yet been clarified.

Maternity Specification update

The maternity specification will be reviewed in conjunction with clinician representatives of the maternity network to take account of changes to national and regional policy and updated clinical guidelines. This will include a specific requirement for the provision of postnatal delivery plans for women with gestational diabetes (NICE Ng 3) which has been identified by GPs as an area where improvements in communication are required.

Annex 4

Cancer Commissioning Intentions 2017/18

NCL CCGs will commission cancer services for their population in line with the strategic intentions of the national cancer taskforce [reference: Achieving World Class Cancer Outcomes – A Strategy for England 2015-2020] and the pan-London cancer commissioning board intentions [ref: Cancer Commissioning Intentions 2017/18. Barnet CCG will also, where appropriate, commission cancer services at an STP footprint level as outlined in 'Achieving World Class Cancer Outcomes – A Strategy for England 2015-2020'. NCL CCGs will continue to commission services locally where agreed in 2016/17.

In summary

1. **National/regional intentions**
   - Pan-London Cancer Commissioning Board intentions
     - 2016/17 commissioned services where already agreed
     - Metastatic breast cancer service specification
     - Optimal lung cancer pathway specification
   - The national strategic focus asks that providers must demonstrate:
     - Compliance with 31/62 day cancer waiting times standards - sufficient capacity will be commissioned and use of contract levers will be enacted where not compliant. In particular for urgent GP referrals, providers should:
       - Be able to offer a first appointment within seven days and should be able to achieve a median wait of less than eight days for the first appointment;
       - Be able to transfer patients for treatment, where necessary, by day 38;
       - Be able to treat the patient within 24 days of an intertrust referral (in accordance with national breach reallocation guidance).
     - GP direct access for key investigative tests for cancer – blood tests, chest x-ray, ultrasound, MRI, CT and endoscopy – if not already (as mandated), these should be available from April 2017
     - Development of capability to achieve the 28 day diagnosis standard by 2020
     - Offering of genetic tests for specific bowel, ovarian and breast cancer patients;
     - All patients under the age of 50 receiving a bowel cancer diagnosis are offered a genetic test for Lynch Syndrome.
     - All women with non-mucinous epithelial ovarian cancer are offered testing for BRCA1/BRCA2 at the point of diagnosis.
     - All women under the age of 50 diagnosed with breast cancer are offered testing for BRCA1/BRCA2 at the point of diagnosis.
   - Services for patients living with and beyond cancer, with a view to ensuring that every person with cancer has access to the elements of the Recovery Package by 2020. In 2017/18 service providers will be expected to conform to the NICE service specification to be published in year, building on the Recovery Package.

- Appropriate integrated services for palliative and end of life care, in line with the NICE Quality Standard (2011).

North Central London SPG/STP agreed priorities

- A blended community/acute stratified follow up service for prostate patients
- Compliant 62 day urgent GP cancer waiting times pathways by tumour site for approval by the NCL cancer board that demonstrate compliance with national and regional guidance for:
    - Timely inter-trust transfers
    - Pathway timings

Local priorities

- Migration of SDIP projects into KPI where services are appropriately developed
- Where the 62 standard is not being met and where patients continue to wait a long time for cancer treatment, Root Cause Analysis of breaching patients is expected (as a minimum, for all 104 day waits)
- Improved data quality for breach reasons reporting on the national CWT database (Open Exeter)

CCG specific work programmes where they exist:

- **Camden** – Camden CCG will continue to commission the Camden cancer programme.
- **Islington** – The Islington plan for cancer supports bowelscope sigmoidoscopy screening and MDC multidisciplinary diagnostic centres

Annex 5: National/London Commissioning Intentions

Draft Public Health and Health in the Justice Commissioning Intentions 2017/18

Introduction

The London Commissioning Intentions should be read in conjunction with the flowing three national commissioning intentions;

- Public Health Section 7a
- Armed Forces and their Families Commissioning Intentions
- Health in the Justice Commissioning Intentions

Which are due to be published at the end of September. Set out below are the specific actions that NHSE London commissioners are proposing for 2017-2019 as befits a 2 year contracting round.

These commissioning intensions cover the following programmes;

- Antenatal and New-born screening
- Immunisations
- Child Health Information
- Cancer Screening
- Adult screening
- Health in the Justice
- Armed Forces
- Quality

Where possible we have asked that our commissioning intensions are combined with the plans of other complimentary work such as the Transforming Cancer Services programme, plans for maternity services etc. and are adopted by both CCGs and into the 5 London Sustainable and Transformation Plans

1. Antenatal Newborn Screening Programmes

1.1 Newborn Bloodspot Laboratories:

With the introduction of expanded screening in January 2015, three of the nine conditions screened for present acutely in the neonatal period:

- Medium-chain Acyl CoA Dehydrogenase Deficiency (MCADD)
- Maple Syrup Urine Disease (MSUD)
- Iso-Valeric Acidaemia (IVA).

Without prompt management, they can result in permanent disability and/or death.

In 2016/17 NBBS laboratories were contracted to ensure cover for bank holiday periods to remove the risk of delayed diagnosis of such a disorders due to the day on which the sample was received in the laboratory.

In 2017/18 NHSE London plan to commission NBBS laboratories to ensure staff terms and conditions will accommodate Saturday working in line with nationally agreed timescales for implementation of Saturday working.

1.2 Newborn Hearing Screening:

NHSE to review the fragmented service configuration across Trusts in North West London. Newborn Hearing Screening service providers to work towards centralised model 'Hub & Spoke' as established in South West and South East London. A centralised model has advantages for timely tracking babies within mobile populations, more resilience staffing, efficiencies and economies of scale.

1.3 Sickle Cell & Thalassemia Screening:

NHS E to review current service delivery models for antenatal sickle and thalassaemia screening. Evidence the most effective pathway to ensure timely partner testing and prenatal diagnosis and work with providers to move towards recommended model of service delivery.

1.4 Newborn Infant Physical Examination:

All maternity providers to submit NIPE Key Performance Indicators in line with national screening service specifications.

1.5 Fetal Anomaly Screening Programme (FASP) Biochemical Laboratories:

NHSE to review the complex commissioning arrangements of FASP laboratories. These are currently contracted and funded as part of the Maternity Pathway Payment by CCGs. However, Service Level Agreements with laboratories are negotiated separately by individual maternity units.

In line with the national recommendations, NHSE (London) to consider acting as Lead commissioner for Wolfson Laboratory for all providers.

2 Immunisations

2.1 Hepatitis B

As part of ensuring robust Neonatal HepB within the GP delivery-model, we are reviewing local process with every CCG and will co-draft the London integrated Neonatal Hep B pathway which will be in place across London by 1st December 2016. We will create a resilient weekly failsafe reporting system with our new CHIService hubs for Hep B neonatal vaccinations including recording of results of blood/serology tests from 1st April 2017.

2.2 Bacillus Calmette–Guérin (BCG) vaccine

Whilst there continues to be a global shortage of BCG stock, we will sustain our Neonatal BCG optimisation pathway and referral process for the most at-risk babies and infants. We will ensure our BCG optimisation pathway offers 100% of new births in high-prevalence borough birthing units and that 70% of at risk new born babies are vaccinated. For older infants under 3 months old who might have either missed

the neonatal BCG offer or have moved into London, we will sustain the community-based neonatal BCG referral clinics. We will review stock supplies and usage every three months to understand if we might extend the age range of infant and toddlers eligible for BCG.

2.3 Increasing Immunisations

Following extensive dialogue with practices and key immunisation leads, we will co-draft the London best practice pathway for 0-5s routine childhood immunisation commissioned across London from 1st April 2017. We will ensure that every maternity unit in London is offering maternal vaccinations (including influenza) to pregnant women from 1st April 2017. Following various reviews and a root cause analysis, we will seek to collaborate with all GP practices to send proactive text invites and reactive text reminders using their clinical systems from June 2017. We will collaborate with all practices to ensure that all parents are enabled to make future vaccine appointments at current appointments (i.e. the 12 month one is booked at 4 month vaccination) using Patient Online and other digital technology from June 2017. We will work with CCGs to promote vaccination in young adults up to the age of 19 from August 2017 - this would include uptake of HPV; MenACWY and MMR catch-up and the launching of Patient Online. We will ensure that every Borough and CCG has a joint plan to achieve our influenza aspirations for patient, carers and workforce for 2017/18 from October 2017.

2.4 Child Health Information Service (CHIS)

Following an extensive procurement process London will have four consolidated CHIS Hubs, each of which will produce monthly update their 0-19 age groups with vaccination status from December 2016. As part of our London primary care digital strategy, we will commission alerts to GPs to finish incomplete neonatal HepB pathway from January 2017. With the advent of our CHIS hubs and the technical progress with ITK messaging across clinical systems, we will offer every parent in London the eRedbook from February 2017. The CHIS digital strategy for London also intends to afford HVs and GPs access to the Northgate new born screening portal from June 2017 so they view new born hearing , blood spot and new infant physical examination NIPE screening results. We aim to offer download of the same results by December 2017.

3 Cancer Screening Programmes

3.1 Cervical Screening

3.1.1 The London Cervical Sample Takers Database has now been rolled out across London. Once the database is in a fit state, with all extraction and reporting templates in place and functioning, NHSE will look to outsource the maintenance and management of the system;

3.1.2 Primary Human Papilloma Virus (HPV) testing will be implemented in the NHS Cervical Screening Programme in 2017/18, in line with national guidance and timescales. Samples will continue to be taken using current techniques, however, only those samples which test positive for High Risk HPV (HPV HR +ve) will be screened for cytological abnormalities. This will reduce the workload by an estimated 80 – 90%. In 2014/15 a total of 569,600 women

were screened in London, a reduction of 80% the laboratory cytology workload will result in a drop to 113,920. Working with SPGs and CCGs, NHSE will scope the future requirements for cytology services in line with NHSI's pathology rationalisation programme. We will also scope the requirements for consumables used across London, in light of the reduction in processing of cervical samples, with a view to re-negotiating/procuring a new deal for London;

3.2 Bowel Cancer Screening

3.2.1 Faecal Immunochemical Testing (FIT) will replace the current FOBt test for the NHS Bowel Cancer Screening Programme during 2017/18. It is anticipated that FIT will deliver a 5 – 10% increase in uptake. In 2015/16 at total of 479,054 subjects were invited and of those 220,717 (46.07%) were adequately screened; with a 5% increase in uptake this would increase to 244,670 adequately screened. If cut off levels are set to give the current 2.3% positivity rate this will equate to an additional 307 positive test results which will require follow up through diagnostic testing (colonoscopy) NHSE will be scoping endoscopy requirements for the programme in view of the anticipated increase in activity;

3.3 Breast Screening

3.3.1 Following the recent procurement of a single administrative Hub for the NHS Breast Screening Programme in London, NHSE and the Hub will scope a single NHS Breast Screening Database (NBSS) for London to support introduction of invitation by Next Test Due Date. A change in invitation processes will require all clinical providers to complete a risk impact assessment and state of readiness assessment and either move towards only screening from static sites or at a minimum to implementing live NBSS on all mobile screening units. A single London NBSS will support the scoping and implementation of a centralised film reading service across London;

3.3.2 Following evidence from the breast screening DNA project in Camden and Tower Hamlets, with an additional 625 women from 11 practices in Tower Hamlets screened as a result of direct contact and an increase of 9% in uptake for breast cancer screening during the year in Camden, we will scope the feasibility of a DNA contact service for breast screening across London.

4 Adult Screening

4.1 Diabetic Eye Screening Programme (DESP)

4.1.1 Following the successful pilot with West London CCG, we will roll-out co-commissioning of Hospital Eye Services (HESs) across London;

4.1.2 We will scope the roll-out of Optical Coherent Tomography (OCT) into DESP services to improve patient pathways/care and reduce referrals into HES services.

Providers will need to draw up business cases re procurement of equipment with CCGs commissioning local HESs;

4.1.3 During the year we will establish the DESP screening pathway for pregnant women through engagement with CCGs commissioning maternity services and with SPGs in support of their transitional plans for improving maternity care;

4.1.4 We will support changes to the frequency of screening for diabetic patients in line with national guidance. It is anticipated that patients with a negative screen on two or three successive occasions will move from annual to two-yearly screening, reducing the workload for DESP providers. Patients with abnormal screens or high risk of diabetic retinopathy will continue to be invited annually;

4.1.5 NHSE will support the expected roll-out of GP2DRS to enable the extraction of single collated lists from GP IT systems.

5 Abdominal Aortic Aneurysm Screening (AAASP)

5.1 Contracts with current providers will be extended until mobilisation of services is completed following the London-wide procurement of AAASP services. As part of the procurement we will introduce tariffs into new cost and volume contracts; Targets for uptake and coverage will be included within the new contracts.

5.2 We will work with Specialised Commissioning and the National AAASP to seek clarity on the status of the NWL Vascular Network in relation to the referral of screening patients with an aorta of > 5.5cms

6 Health in the Justice System

6.1 Improving Health and well-being of people in the London Prisons

6.1.1 Prison Reforms: HMP Wandsworth is one of six pilot reform prisons with Executive Governors that have more autonomy over budgets and functions. The prison will be re-roled from April 2017 to be 70% remand and 30% sentenced prisoners (compared to 70% sentenced and 30% remand prisoners currently), and there may be other prison undergoing similar changes. NHSE's Health in the Justice System team will work with all prison reforms and local commissioning stakeholders to design an integrated health service to meet the primary care, mental health and substance misuse needs of the population

6.1.2 NHSE, Health in the Justice System team will develop and implement an improvement plan to take forward the findings of the prison inpatient review carried out in 2016-7. This will include opportunities of working with NOMS, prison governors and healthcare to improve earlier and timely access to care, treatment and support and to reduce escorts and bed watches

6.1.3 We will work with Specialised Commissioning in NMHSE, London and Mental Health Trusts to streamline the pathway for mental health transfers to and from London prisons

6.1.4 We will roll out the GP registration pilot across London to deliver continuity of care for people leaving prisons to maintain their health benefits from prison and to support reducing re-offending

6.1.5 We will implement smoke free prisons by the end of 2017/8 in line with the priorities set by NOMS, PHE and NHSE

6.1.6 BBV opt out testing (Hep B/C/HIV) will be introduced to all London prison by April 2017 as part of the joint priority between NHSE, Public Health and NOMS

6.1.7 We will build on our 2016-17 CQUIN to ensure full implementation against the screening protocol for DESP, AAA and bowel cancer within the London prisons

6.1.8 Health in the Justice team has expanded the TB programme for prisoners and detainees in the Immigration Removal Centres and an additional two prisons (HMP Thameside and HMYOI Feltham). There is an additional business case for HMP Isis for roll out in June 2017. These new sites will be fully operational by April 2017

6.1.9 We will embark on a planned procurement for a pan-London radiology reporting service for all prisons and Immigration Removal Centres for October 2017

6.20 We will work with the NHSE Screening Team to consolidate screening in prisons and looks at ways of improving uptake of screening

6.21 We will re-procure an integrated healthcare service model for HMYOI Feltham with the new contract in place from April 2018

7 Improving Mental Health in the Justice System

7.1 We will develop co-commissioning opportunities with CCGs to develop:

- Integrated mental health pathways from and to Liaison and Diversion services in police custody and courts
- integrated child and adolescent mental health pathways for children and young people in the Justice System

7.2 We will commission equivalent access to IAPT and Early intervention for psychosis services for people in the London prisons. This will be supported by a Mental Health Clinical Reference Group with expertise in justice settings.

7.3 We will continue to support the HLP on their crisis care and mental health programmes to improve pathways and access to approved places of safety and mental health inpatient beds, working with the three police forces, Mental Health Trusts & CCGs.

7.4 We will work with the MPS to evaluate the effectiveness of the enhanced Liaison and Diversion service commissioned to provide mental health support to Counter Terrorism Command.

8 Improving Services for Children, Young People and Adults who have been sexually abused

8.1 We will develop and implement a two year modernisation plan to take forward the findings of the MOPAC/NHSE, London Sexual Violence and Child Sexual Exploitation Needs Assessment working with the Havens, Rape Crisis Centres and other stakeholders. This will include taking forward the findings of the 2016-7 Estates review of the Havens.

8.2 We will review the Children and Young People's (CYP) Haven in order to develop a commissioning plan for 2018/19 and beyond.

8.3 We will work with MOPAC, CCGs and Local Authorities to evaluate the pilot Child Houses funded by the Home Office and develop commissioning options for 2018/19.

8.4 We will build on the work of the Health & Justice CAMHS Transformation programme to ensure that robust pathways to and from custody are reflected within the overall healthcare offer.

8.5 We will align the model of healthcare delivery with any reforms to the Young Persons Estate.

9 Immigration Removal Centres

9.1 We will work with the Home Office to deliver the recommendations from the Shaw report on the management of vulnerability with the Immigration Removal Centre setting, in particular for those detainees with mental health issues.

10 Health for homeless asylum seekers

10.1 We will support Guy's and St Thomas' NHS Foundation Trust to ensure their healthcare premises for patients for Barry House are housed in an appropriate local healthcare facility.

10.2 We will commission an updated health and social care needs assessment for the initial accommodation services that outlines the work achieved following the additional investment given for mental health and maternity services.

11 Patient and Public Participation

11.1 We will ensure all training packages offered to our Patient and Public Participation sub-group and commissioning technicians are NVQ accredited.

12 Armed Forces

Currently the national Armed Forces commissioners are consulting on the national commissioning intentions. This consultation is due to be completed by October 2016.

12.1 Procurement of a National Veteran's Mental Health Service: NHSE is responsible for some veteran's mental health services. Following the outcome of the stakeholder engagement event and our review of existing services NHSE national Armed Forces team is planning procurement to commission veteran's mental health services from April 2017. Further details will be circulated in due course.

12.2 London's plans For our London Armed Forces Network (LAFN), our recently audit demonstrated that London needs a primary care training program for staff which includes Mental Health First Aiders module. We are collaborating with the London Deanery to develop this. The LAFN also intends to establish a mental health sub-group to support further post-traumatic stress service and review drug, substance misuse and alcohol provision for ex-forces and their families. We will continue to liaise with the Ministry of Defence (MoD) to ascertain the effect and implications of any international decant of active personnel back to London garrisons in Hounslow and Greenwich. No date has yet been established.

13 Quality; Management of clinical or service delivery incidents

13.1 Commissioned service providers are, in the majority of cases, accountable for ensuring the appropriate management of clinical or service delivery incidents.

13.2 The management of incidents and serious incidents should be delivered in accordance to available guidance where available and applicable.

13.3 The National Serious Incident framework, the process for completing the appropriate investigation should take no longer than 60 days, unless agreed otherwise by the commissioner.

13.4 NHSE (London) Public Health and Health in the Justice System commissioners feel this timeframe should be applied to all incidents, whether classified as serious or not. This will support the delivery of effective contract management, where concerns around quality and safety are present.

13.5 As such, we will be including in all of our contracts held with service providers that there is an expectation they produce all the required information and reports within 60 days of declaring an incident (irrespective of severity).

Commissioning intentions Statement for homelessness

Homelessness should not be a barrier to accessing and receiving high quality healthcare. We expect all providers to work proactively with commissioners and other partners to help identify and support homeless patients so that they receive holistic care that meets their needs. This includes engaging positively with the work of the London Homeless Health Programme.

Background

HLP CYP programme has undertaken a number of pieces of work designed to support CCGs in improving services for CYP. This document briefly describes those outputs and how they can be used by CCGs within commissioning intentions 2017 – 2019. These should be seen in conjunction to plans described in the STP for the area.

Acute Care Standards for CYP and Peer Review

The HLP CYP Acute Care Standards are a compilation of all standards for in-patient care deriving from Royal Colleges, NICE, the Department of Health and other bodies. They represent the standards of care which should be delivered within paediatric inpatient units.

https://www.myhealth.london.nhs.uk/healthy-london/programmes/children-and-young-people/resources-old

HLP has commenced a programme of supportive peer review using expert clinical panel members in conjunction with local CCG commissioners. The output of the review is an action plan held jointly by the provider trust and CCG.

Commissioning Intentions 2017 – 2019

The CCG will work with the Royal Free Hospital NHS Foundation Trust as lead commissioner to make progress towards achieving the actions described in the agreed plan following the peer review

Level 1 and 2 Paediatric Critical Care

“High Dependency Care for children (Royal College of Paediatrics and Child Health 2014) changed the nomenclature of critical care and proposed that a degree of intensive care (formerly known as high dependency care) should be delivered in all in-patient units (level 1 PCC). Some units should be designated as level 2 units providing level 1 care plus the ability to look after CYP receiving long term ventilation. HLP published a set of standards to support this model.

https://www.myhealth.london.nhs.uk/healthy-london/programmes/children-and-young-people/hospital-care

Bringing all units up to the standards required will be a large leap in quality, requiring extensive development of the medical and nursing workforce. In order to undertake this, HLP has secured funding to develop an educational package with online and face to face elements to support extensive workforce development. In addition, work is underway to develop a commissioning framework for L1 and L2 PCC.

Commissioning Intentions 2017 – 2019. The CCG will work with (INSERT NAME) trust to make progress towards achieving delivery of L1 PCC standards. The CCG will work with other CCGs in the SPG/STP area to determine which trust/s should be commissioned to deliver long term ventilation to CYP.

Paediatric Assessment Units (PAU)

“A PAU is a facility within which children with acute illnesses, injuries or other urgent referrals (from GPs, Community Nursing teams, Walk-in Centres, NHS Direct or Emergency Departments can be assessed, investigated, observed and treated without recourse to in-patient areas” (RCPCH 2009). HLP will be publishing standards for PAUs in September 2016 in response to specific CCG requests as there is much activity in this model development across London.

The CCG will work with its local providers to commission a paediatric assessment unit based on the standards set out in the HLP CYP PAU standards (2016).

Asthma Care

The 2015 pharmacy public health campaign collected data from nearly 10,000 CYP with asthma when they attended their pharmacy. Results for each CCG can be found here https://www.myhealth.london.nhs.uk/healthy-london/programmes/children-and-young-people/london-asthma-toolkit/pharmacy/public-health-campaign.

The HLP CYP asthma standards describe the level of care which should be delivered across the system, from pharmacies to primary, secondary and tertiary care. Consistent delivery of these across London will reduce the high morbidity and mortality associated with asthma in CYP.

https://www.myhealth.london.nhs.uk/healthy-london/programmes/children-and-young-people/resources-old

The CCG will work with primary care providers and (INSERT NAME) trust to make progress towards achieving delivery of the London asthma standards for CYP.

CYP in Mental Health Crisis

All CCGs submitted a Local Transformation Plan (LTP) for CAMHS in September 2015. These will be revised by October 2016 and Tier 4 collaborative commissioning plans need to be in place by December 2016. HLP is publishing a CYP Mental Health Crisis Care document at the end of September to help CCGs. which will be found here:

https://www.myhealth.london.nhs.uk/healthy-london/programmes/children-and-young-people/camhs

The CCG will work with their local providers to make progress towards delivering their local CAMHs transformation plans and delivering any national standards that are developed.

New models of care for CYP

The HLP CYP team have produced a portfolio of products on out of hospital care to drive improvements in quality. These include:

- London’s out of hospital standards for children and young people
- Compendium: New models of care for acutely unwell CYP - which describes a number of alternative models of care provided for CYP across the country, with a particular focus on acute models of care. Many of the case studies included illustrate how these standards can be used to drive improvements in

quality and assist commissioners to identify opportunities within their own areas.

- New models of acute care (in development)
- Opportunities for Pharmacy to support out of hospital care (in development)

This suite of documents will help organisations to develop place-based models of care treating the CYP in the most appropriate location for their needs.

https://www.myhealth.london.nhs.uk/healthy-london/programmes/children-and-young-people/resources-old

The CCG will work with their local providers to make progress towards developing their out of hospital care provision for CYP.

Supporting people to manage their own health, wellbeing and care

2017/18 Commissioning intentions prepared by HLP Personalisation and Self-Care programme

Overview

People who manage their own health, wellbeing and care have improved experience of care, increased choice and reduced demand for high-intensity acute services. The NHS FYFV calls for a radical upgrade in prevention and public health, and greater engagement with people and communities to harness the energy and potential they have. There is a growing body of evidence showing that a diverse and wide range of person-centred and community-centred approaches lead to improved outcomes and significant benefits for individuals, services and communities. This has been demonstrated through improved mental and physical wellbeing, contributing towards NHS financial sustainability and wider social outcomes

A commitment to supporting people to manage their own health, wellbeing and care was clear from the 30th June 2016 London STP submissions with plans to rollout digitally enabled self-care a key part of local digital roadmaps. However, 40% of people have low levels of knowledge, skills and confidence to manage their health and wellbeing; 44% say they would like to be more involved in making decisions about their care; and research shows that people want a multi-channel offer - in achieving personalisation through an online account and making it easier to self-serve.

The health and care system can do much more to support people to make improved and informed choices and to be more active in managing their own health, wellbeing and care.

Success in 2020

Londoners are more proactive in their care and report improved outcomes due to their enhanced role in shared decision-making. Supported by a vibrant and diverse supply market and new digitally-enabled processes, self-care becomes the norm. New Care Models empower Londoners to take control of their health and wellbeing drawing upon a wider network of support made available by family, friends, voluntary and community groups, as well as heath and care services when needed. This results in:

- **Care decisions are shared, helping to reduce unwarranted variation and supporting patients to make informed choices.** Patients are routinely and systematically involved as active partners with clinicians in clarifying acceptable care, treatment or support options and choosing a preferred course of action. Decision aids to help people think are widely utilised to help patients and clinicians think through the pros and cons of different care, treatment or support options.
- **Care planning and self-management is hardwired into how care is delivered**. Meaningful care planning takes place for people with long-term conditions or ongoing care needs which guides the choices and actions of the patient and their professional team. This care plan is digital and can be shared between care settings and is owned by, and useful for, patients, their families or

carers. People living with long-term health conditions or care needs are offered support to improve their confidence and their capacity to manage their own health and wellbeing. This is achieved through greater take-up of evidence based approaches such as self- management education, peer support, health coaching and group based activities

- **Personal Health Budgets and integrated personal budgets, including NHS and social care funding, are available to everyone who could benefit** (in line with Mandate requirements). In each CCG area at least 1-2 people per 1,000 of the population has a PHB or integrated personal budget incorporating NHS funding. PHBs should be in place for NHS Continuing Healthcare and Continuing Care, people with high cost packages of support (e.g. people with a learning disability); and in specific areas where the model will deliver a positive impact (e.g. end of life care, mental health).
- **Social action beyond the NHS helps people improve their health and manage their wellbeing.** CCG and local authority commissioners support the local population in building community capacity and resilience. Social prescribing and Expert Patient Programmes are widely available to the public through primary care and whole population care models. Strong partnerships between the NHS, statutory partners and voluntary groups deliver health prevention and support for patients, carers and their families. Shared leadership promotes community-based activities aiming to strengthen local skills, knowledge and resilience to improve health and wellbeing.

Ahead of the 2017/18 planning round, HLP's Personalisation and Self-Care Programme is encouraging CCGs across London to signal the following commissioning intentions to local providers:

- **Extend an existing CQUIN or agree a new local incentive scheme for shared decision-making**. NHSE's 'where to look' packs can help target local populations. Once local populations have been identified then commissioners should check whether decision aids are available to help patients and professionals reach decisions that take account of the personal preferences of the individual. Commissioners should consider incentivising the utilisation of decision aids for specific populations as well as the appropriate training of staff which could be quality assured by adopting the CollaboRATE measure.
- **Extend an existing CQUIN or agree a new local incentive scheme for person-centred care planning and self-management.** Patients who are frail, reaching the end of their life, are socially isolated or lonely, have dementia or complex co-morbidities spanning physical health, mental health and social care, as high consumers of health and care services, are the most likely to benefit from an **integrated care plan**. Local providers should be incentivised to routinely undertake structured conversations between patients and practitioners to identify individuals' goals and the support needed to achieve them. A single integrated care plan should be outcomes based ("what matters to me"), owned by the individual and, when explicit consent given, key information is accessible through digital channels to other professionals involved in their care and support. In terms of **self-management**, providers should be incentivised to offer tailored support based on need (including anticipatory care planning, social prescribing, health coaching and personal health budgets) alongside ongoing reviews of individuals' support needs to ensure it reflects changing

goals, needs and priorities. There are a number of useful resources available to support health literacy and digital health literacy.

- Negotiate with providers for a proportion of block funding from all out of hospital contracts to be used for personal health budgets which will be promoted through local social prescribing schemes and expert patient programmes. Block contracts present barriers to offering people choice and control. In order to release funds for Personal Health Budgets, CCG commissioners need provider's time and input to review current funding and contracts and how they can be used to help PHBs to be taken up by a wider cohort of people. Provider's concerns about the potential destabilising effect of this on local provision are understood. Commissioners are therefore encouraged to work with all providers of out of hospital services to explore:
  - A local risk-share agreement releasing portions of block contracts.
  - Extending an existing CQUIN or developing a new scheme which will incentivise providers to free up a percentage of the block contract to be prioritised for the wider uptake of PHBs and enable the supported transition to a more diverse local supplier marketplace. Guidance available from Leeds South and East CCG on unblocking contracts in specialist children's services.
- **Increase the existing provision and use of Expert Patient Programmes and Social Prescribing Schemes.** Expert Patient Programmes (or Chronic Disease Self-Management Programmes) have favourable economic evaluations - investment by health services, leads to savings by health services. They promote self-efficacy and greater self-management of health. It may be a quicker win to develop and expand existing programmes such as these, with a review to ensuring they are operating according to best evidence and practice, and effectively measuring the health, social and financial outcomes. They could more explicitly include social prescriptions, and provide information about the range of sources of help and support within their communities. In tandem with this, local Social Prescribing coverage should be extended to mainstream populations (i.e. people who do not have an existing long term condition) and cover the whole life course to include parents and guardians of children and young people.
- Gain a commitment from local providers to work with a range of stakeholders to promote information and access to community based resources and help build local capacity to support vulnerable people. Commissioners should encourage providers to utilise local online directories, which are available in every London borough, with professionals' sign-posting appropriate patients to information on additional resources that can aid their care and support. Mental health and community health providers can also help build local capacity by inviting representatives of voluntary sector organisations and other key agencies like the London Fire Brigade to participate in standard and routinely scheduled training courses (i.e. MECC, Safeguarding, MHFA etc.). The London Fire Brigade carried out 85,000 visits within vulnerable people's homes in 2015 and the Brigade are keen to formally rollout 'safe and well' visits across London in 2017. Local providers should be encouraged to build formal relationships with the London Fire Brigade so that they can access their free resources (building and meeting room space for promotion of local health initiatives), as well as develop processes to receive appropriate referrals from the London Fire Brigade and social housing providers.

Support you can expect from the HLP to implement the above

Personalisation and Self-Care Programme

- Promoting good practice and enablers to support the rollout of Personal Health Budgets and
- Integrated Personal Commissioning across London
- Personalisation and Self-Care Case for Change (April 2016)
- Population health and financial modelling and analysis on the Return on Investment of Social

Prescribing Schemes, Expert Patient Programmes and both combined (September 2016)

- Commissioners Guidance on Operationalising Social Prescribing (November 2016)
- Fire as a Health Asset pilots commence (January 2017)
- Guidance on how to optimise usage of local online directories (March 2017)
- Contributing standards for the development of personalised apps – e.g. integrated digital care plan (2017/18)

London Digital Programme

- Document exchange (structured and unstructured documents) STP pilots commence (Quarter 2 2017/18)
- End of Life Care Plans and Crisis Care Dataset STP pilots commence (Quarter 3 2017/18)
- Online Passport (Passport) STP pilot commence (Quarter 4 2017/18)

Transforming Primary Care Programme (Proactive workstream)

- Strategic Commissioning Framework Financial Model (August 2016)

Commissioning Intentions 2017/18 – Digital Services and Interoperability

Introduction

This briefing is intended to inform the development of CCG Commissioning intentions. It provides key messages and signals to the provider community from both a national and regional perspective on the development and use of digital services (including interoperability). The briefing is provided by the HLP Interoperability Programme.

Context

Following announcements by the Secretary of State in September 2015, CCGs in London (working within digital roadmap footprints) are now collaborating to providing a system leadership and co-ordination role supporting the delivery of the various ambitions set out by the National Informatics Board and in local sustainability and transformation plans.

The recent report by Robert Wachter describes the importance of technology to future transformation plans and highlights key deficits in digital maturity in all settings. Achieving improvements in digital maturity in hospital and other settings is a key area in which improvement is required and CCGs are expected to collaborate with providers residing within and across roadmap/STP footprints to drive up digital maturity in order to support wider transformation plans.

https://www.england.nhs.uk/digitaltechnology/info-revolution/wachter-review/

The NHS settlement includes provision of £1.4b funding to cover informatics development. A proportion of this funding will be retained nationally for the development of national infrastructure, but significant funding will be made available for local use. A number of sources of national funding have already been announced covering primary care (Estates and Technology Transformation Fund), Global Centres of Digital Excellence and Urgent & Emergency Care Transformation.

Health economies wishing to take advantage of national funding will be expected to be 'investment ready'. This will mean they need to have approved roadmaps in place and also to have developed collaborative governance and delivery models at STP level. Economies most likely to attract local funding will have strong collaborative informatics leadership and delivery capabilities in place.

CCGs within footprints containing providers with low levels of digital maturity should be working closely with these providers to develop local investment plans that will drive up maturity. They should already be supporting alliances between providers. In the informatics context, this means exploring options to learn from and potentially utilise technology available in more digitally mature organisations – in particular from centres of global digital excellence.

Local STPs are enabled by and potentially dependent on CCG engagement to create:

- Improved collaboration between all organisations to deliver improved value for money, drive up digital maturity and ensure the safe and efficient functioning of

new models of care. From an informatics perspective, this is likely to mean consolidation of informatics services and platforms around Accountable Care organisations and/or to require interoperability solutions that are able to support clinical workflows that can span existing organisational boundaries.
- Improvements in digital maturity – in particular within provider organisations – to drive down cost whilst streamlining workflow.
- A patient-centric approach to information sharing (recognising that from an informatics perspective, 'place' may mean something bigger than a single STP footprint.
- Digitally enabled channel shift (to reduce demand for face to face care both in primary and secondary care and to increase the proportion of people being cared for closer to home).
- The provision of new capabilities to enable at-scale information sharing between organisations and patients both to support direct care provision and advanced real time analytics/population health management.

Delivery of digital roadmaps and the broader transformation agenda will require collaborative action in at least five domains:

- Access - The development and adoption at scale of digital and telephone based alternatives/enhancements to face to face to care (particularly in the out of hospital and urgent and emergency care contexts).
- Citizen activation – in particular in the realm of self-management and participation in care
- Design – (and collective ownership) of a London-wide, patient centric interoperability infrastructure that enables 'plug and play' apps, provides the means to locate and share data at minimum cost and which enables at scale information sharing to support clinical workflow.
- Assurance - (of provider informatics strategies) by CCGs and of CCG roadmaps by NHSE. The assurance of provider strategies by CCGs will require CCGs to ensure that all providers are making appropriate investments in their informatics strategies and that they are capable of delivering the ambitions set out in the NIB.
- Standards - The development and adoption of information 'standards' to support technical interoperability strategies

Interoperability

Interoperability is a key enabler for wider transformation. CCGs should note that a range of different patterns of interoperability may be required to resolve key STP problems.

Viewing of local care records – can be achieved (in order of sophistication) using portal style technologies, in- context viewing or integration within system workflows. Use of point to point integration to achieve integration between hospital systems and local integrated care records is increasingly discouraged by HLP on the grounds that such integrations are costly and cannot scale. Instead, local strategies should increasingly align around hub models provided locally or regionally as they emerge.

Population health management - will most likely require at-scale aggregation of data to create a data pool against which advanced algorithms can be used to

support local clinical decision making and commissioning activities. The bigger the data pool, the more useful the analysis.

Co-ordination of care - will most likely require real time location, in context viewing and the ability to update structured data and documents that is locally held by each organisation. Given the nature of London, this needs to be supported across organisational and STP boundaries to enable urgent care provision and specialist services such as cancer. The use of subscriber based alerting and notification services will be a key enabler. NB the HLP London Digital Programme will provide capabilities in this space 'once for London' and CCGs should promote and support this 'once for London' London wide initiative.

Activation of patients - Local initiatives to connect patients to their data are to be encouraged. These will require identity management. CCGs should be aware of the recent commitment by the Secretary of State to implement a 'blue-button' style service across the NHS. NB: HLP are working closely with the national NHSE team and Digitalhealth.London to create an online account through which patients can create and use a digital identity to connect to their data using accredited apps. CCGs should promote and support this 'once for London' initiative.

Key signals

It is of particular importance that CCGs signal to existing and potential new providers an expectation that their strategies will support the following ambitions.

- Any new information systems must demonstrably comply with existing national (and potentially locally defined) standards (where these are appropriate).
- Providers should be encouraged to support connectivity to the emerging regional information exchange 'hub' as it emerges.
- Any new information systems must be capable of exposing a comprehensive set of APIs (Application Programming interfaces) to enable the sharing of patient records. Providers must be capable of exposing data based on a common set of standards (e.g. IHE XDS, CDA, FHIR)
- New and legacy systems must demonstrate continuing compliance with published and emergent standards such as those relating to transfers of care from hospital.
- Providers must support the use of electronic solutions for key cross-organisation transactions (e.g. referral, electronic ordering and results reporting)

Annex 6: Associate CCG commissioning Intentions

Enfield CCG specific commissioning intentions (refer to Section 5.6 in the main letter)

Programme Area	Services	Commissioning Intention
Planned Care	Cancer screening in Enfield	Enfield CCG to develop innovative pathway and publicity arrangements to maintain/improve Bowel, Cervical and Breast screening attendances, especially in the most deprived wards. 6 months' notice is given of possible change.
Integrated Care	Care Homes. Care Homes Assessment Team to deliver a further reduction in emergency admissions from care and nursing homes.	Enfield CCG will review the CHAT Team to ensure efficacy and efficiency of service. 6 months' notice is given of change to specifications and KPIs.
Integrated Care	End of Life Services. All palliative care patients to have advance care plans in place and choice of preferred place of death	Enfield CCG expects all providers to be formally signed up to and deliver "Coordinate My Care". 6 months' notice is given of intent to change the contractual statement for End of Life Services from 1st April 2017.
Integrated Care	OPAU at Chase Farm. CF OPAU is a rapid access health and wellbeing hub to support Enfield's older people's health, well-being & independence if their health conditions are at risk of worsening.	Enfield CCG will review the OPAU at Chase Farm to ensure efficacy and efficiency of provision. 6 months' notice is given of service chance.
Long Term Conditions	Long Term Conditions/integrated Care MDT approach in diabetes, COPD/asthma/heart failure	ECCG to review provision for patients with long term conditions. To support patients with co-morbidities/complex needs/more than one long term conditions; To use MDT approach to manage patients with complex needs by keeping patients in the community as long as possible, to reduce frequent re-admissions to the hospital; To encourage clinicians to work collectively in an integrated way to address patients with complex needs in the community. 6 months' notice is given of possible service change.
Long Term Conditions	Locality based hypertension management in primary care	ECCG to develop locality based services in hypertension management in primary care; to reduce outpatient appointments; to reduce hospital admissions; to promote self-management; to be in line with NICE guidelines and local/NCL wide agreed clinical pathway in the management of hypertension in primary care. ECCG gives 6 months' notice of change to pathways which will impact on activity levels.
Long Term Conditions	Locality based COPD/asthma management in primary care	ECCG to develop locality based services in COPD/asthma management in primary care; to reduce emergency re-admissions to the hospital; to promote patient self-management; to have call and recall review at locality level; spirometry testing in primary care; medication review monitoring; to be in line with NICE guidelines and NCL-wide/local clinical pathways in respiratory; integrate further between community respiratory specialist nursing team/ILTs and primary care teams. ECCG gives 6 months' notice of change to pathways which will impact on activity levels.

Programme Area	Services	Commissioning Intention
Integrated Care	Continuing Healthcare. Management of care pathway for frail and elderly patients in transition from physical health and elderly mental health care including patients with dementia, and more complex physical and mental health needs	Enfield CCG gives notice of intent to development of local continuing health care bed provision in Enfield to reduce the number of patients receiving complex care out of area. To improve the effective use of resources by developing a joint health and social care service specification that represents VFM and improves access to local CHC long term care locally.
Planned Care	Community Dermatology. Improving the effectiveness of the Community Dermatology Service to increase volume, performance and service scope.	ECCG to serve 6 months' notice to RFH to develop the Community Dermatology Service in 2017/18. To include: 1. Implementation of a revised Community Dermatology Service Specification 2. Revised Key Performance Indicators with escalation routes where performance does not meet the targets set. 3. Relocation of services to two primary care sites 4. Increased scope to include Paediatrics, Routine monitoring, OP Procedures and other items as determined by the specification.
Planned Care	Community Dermatology - Review	Under review (as part of QIPP transformation for 2017/18
Planned Care	Community Gynaecology	Enfield CCG to review the community Gynaecology service. 6 months' notice is given of decision to re-commission or decommission current provision.
Community	Community Urology	Enfield CCG to review the community Urology service. 6 months' notice is given of decision to re-commission or decommission current provision.
Community	Community Ophthalmology Re-procurement of Enfield Community Ophthalmology Service to improve VFM, access and patient waiting times.	Enfield CCG gives 6 months' notice to all Providers that we are decommissioning all internal routine referrals into Ophthalmology with effect from 1st April 2017. This includes referrals from screening programs that are commissioned by NHS England. All routine GP referrals are required to be sent to the Enfield Referral Service for triage to an AQP provider. Enfield CCG will enter into negotiation with Providers to effect this contractual change from 1st April 2017.
Children and young People	School Aged Children (The Healthy Child Programme)	A greater emphasis on prevention and early identification, resulting in improved outcomes and performance indicators and a decrease in referral to more specialist services. Enfield CCG will work with the London Borough of Enfield on the development of the Early Help Model incorporating the Healthy Child Programme for 5 -19 year olds. 6 months' notice is given that Enfield CCG will expect all providers to implement specified elements of the model.
Children and young People	Early Years Help:- Maternity Services To deliver the 2020 vision for maternity services described in the Better Births Review (2016)	1. Enfield CCG will work with NCL commissioners to develop an NCL plan in response to the Better Births Review 2. Enfield CCG expects all providers to deliver specified elements of the integrated peri-natal mental health pathway subject to additional funding for specialist perinatal provision 6 months' notice is given of change to specifications and KPI's

Programme Area	Services	Commissioning Intention
Children and young People	CAMHS (Future in mind) - Transformation plan. To deliver 'an integrated whole system approach to driving further improvements in children and young people's mental health outcomes'	1. Enfield CCG to review progress of implementation of the Future Mind Transformation Plan against agreed milestones and outcomes. 6 months' notice is given to BEH MHT of potential change to plans, to be supported by a new service specification. 2. Enfield CCG will work with NCL commissioners to review provision for children and young people with Eating Disorders against NICE Guidance 3. Enfield CCG expects that all Providers to embed the THRIVE model of care underpinned by CYP IAPT principles.
Children and young People	LAC: Improved health outcomes for children and young people in care, and young people leaving care with emotional wellbeing and mental health issues	Enfield CCG to review provision for Looked After Children given the increase in number of referrals and revised guidance. 6 months' notice is given to BEH MHT and RFH of a new service specification/potential application of new models of care (BEH MHT SDIP work programme in 2016/17)
Children and young People	SEND and Children with complex health needs: Children and Families Act. Improved outcomes and experience of service for children and young people with Special Educational Needs and Disabilities, and their families. Implementation of the Children and Families Act (2013) and revised SEND Guidance.	1. Enfield CCG gives 6 months' notice is given to BEH MHT and RFH of a new specification for children with disabilities/potential application of new models of care 2. Enfield CCG will work with the Council and providers to develop a local action plan in response to the joint SEND inspection 3. Enfield CCG will review potential to extend personalisation through more flexible contracts and/or personal budgets and 6 months' notice is given of possible change
Children and young People	SEND and Children with complex health needs: Autism. Improved outcomes and experience of service for children and young people with suspected social communication issues	Enfield CCG to review end to end pathway for autism diagnosis against NICE guidance. 6 months' notice is given to providers of change to current services.
Children and young People	Children who are ill: Improved outcomes and experience for children and young people who are ill, including those with acute, chronic and life limiting conditions	1. Enfield CCG to review out of hospital services for children who are ill, including approach to self-management, continuing and palliative care and children community nursing services. 2. Subject to public consultation Enfield CCG will implement outcomes of the review of the Chase Farm PAU (included in commissioning intentions for 2016/17) 3. Enfield CCG will work with Haringey CCG to ensure the effective implementation of NMUH urgent care and PAU pathways 4. Enfield CCG to work with NCL commissioners to review implementation of the Best Practice Diabetes Tariff 6 months' notice is given to providers of possible change to services.

Programme Area	Services	Commissioning Intention
Children and young People	Personal Health Budgets (continuing care and further services to be identified)	The NCL CCGs will review the potential to extend personalisation through more flexible contracts and/or personal budgets. Providers will need to work with commissioners to roll this out. Enfield CCG: 6 months' notice to BEHMT and RFH of this change.
Diagnostics	Pathology. Standardisation of Pathology provision through procurement of Direct Access Pathology Service. De-commission of current acute providers.	ECCG to serve 6 months' notice to Acute Pathology providers of intent to procure a single provider for Direct Access Pathology. To include: 1. Standard pricing schedule 2. Contract and Quality metrics 3. Incentive proposal for demand management 4. Robust IT plan which integrates between primary care and pathology provider 5. Collection of samples from GP Practices and other sites as defined in the service specification.
Planned Care	Teledermatology - Implementation in 16/17, scope expansion in 17/18. Redirection of patients from acute outpatients to most appropriate setting i.e. self-care, primary care or community.	ECCG to serve 6 months' notice to RFH of intent to further develop the Teledermatology service in 2017/18. To include: 1. Implementation of Teledermatology Service via RFH (majority provider) with consultant triage 2. Redirection of activity from acute to primary care following Teledermatology review 3. Patients direct listed to procedure or biopsy following Teledermatology 4. Redirection of all appropriate follow-up activity to Community Dermatology Service 5. Expansion of scope to include rashes, 'urgents', 2WW and paediatrics (subject to clinical case)
Planned Care	Acute Dermatology. Implementation of acute dermatology specification setting out clear thresholds ensuring appropriate reduction in acute capacity to allow transfer to community service and/or Teledermatology.	ECCG to serve 6 months' notice to acute providers of intent to develop and implement an Acute Dermatology Service Specification, the specification will include: 1. Thresholds for activity 2. KPIs including 1st:FUP ratio, outpatient: procedure ratio and waiting time 3. Access to consultant Advice & Guidance
Planned Care	Direct Listing of Endoscopies. Implementation of triage at the point of referral to identify appropriateness of Direct Listed Endoscopy.	ECCG to serve 6 months' notice to existing acute providers to develop an Endoscopy Direct Listing protocol and pathway. Referrals will be triaged using a standard referral form and assessed for appropriateness of direct listed procedure.
Planned Care	PoLCE	Enfield CCG to agree the implementation of an NCL-wide PoLCE policy with effect from 1st April 2017. Enfield CCG with NCL CCGs will open negotiations with Providers to agree a contract variation in 2017/18 informed by the CCG's revised PoLCE criteria for 2017/18. Enfield CCG gives 6 months' notice to providers that PoLCE criteria and a PoLCE Financial Cap will apply from 1st April 2017.
Planned Care	ENT Pathway between Community & Acute	Enfield CCG to review the ENT community to acute away to ensure value for money and that the service provided meets requirements. 6 months' notice is given of possible service change.
Planned Care	Roll bunion service into PoLCE	TBC following GB decision on inclusion of Bunion Surgery within the NCL PoLCE policy.

Programme Area	Services	Commissioning Intention
Planned Care	MSK 1. To develop integrated MSK services in Enfield 2. To review criteria for hip/knee arthroplasty - Hard choices	Enfield CCG gives 6 months' notice of 1. Intent to commission a consultant-led multidisciplinary MSK elective system, which will include a single point of access through the provider hub and spoke model combining all planned Orthopaedics, Rheumatology, pain management and physiotherapy services across Enfield, triage and assessment, guided by evidence based clinical pathways to facilitate referral process; shared decision making tools to help with patient decision, care planning and self-management. Provide learning loop/education with primary care on referral and skilling up primary care on MSK related conditions and reduce referral variation. 2. To develop a set of criteria for hip/knee arthroplasty
Planned Care	Community cardiology	Enfield CCG to review the current community cardiology service specification; question whether it is fit for purpose; is in alignment with NICE guidelines, and consider local clinical pathways in the context of the STP process/as part of whole systems approach to cardiology services in Enfield. 6 months' notice is given of possible service change.
Planned Care	Respiratory	ECCG to review clinical pathways for respiratory with NCL clinical leads, to reduce variation and unnecessary hospital activity, and improve patient outcomes. ECCG gives 6 months' notice of change to pathways which will impact on activity levels.
Planned Care	Revised criteria for Hernia procedures	Review of the criteria to ensure more robust assessments - possible commissioning intention for development
Planned Care	Revised criteria for Haemorrhoids	Review of the criteria to ensure more robust assessments - possible commissioning intention for development
Planned Care	Revised criteria for Male Sterilisations (Vasectomies)	Review of the criteria to ensure more robust assessments - possible commissioning intention for development
Planned Care	Community Sleep Apnoea Service	Enfield CCG to review the Sleep Apnoea Screening pilot in order to help bring activity back into the community and drive down acute activity. 6 months' notice is given of revised Service Specification.
Planned Care	PSA Monitoring Local Enhanced Service	Enfield CCG to agree the implementation of an NCL-wide Urology Local Service: Stable Prostate Cancer and Watchful Waiting Follow-up monitoring. This will provide routine follow ups for patients who have been diagnosed and subsequently discharged with prostate cancer and those men with high PSA levels who do not wish/are able to have a TRUS biopsy. 6 months' notice is given of possible change.
Planned Care	Ear Syringing Local Enhanced Service	Enfield CCG to review the current pathway arrangements and activity. Consider options to develop a seamless ENT pathway for a Local Enhanced Primary Care Service. This will be considered this as part of whole systems joined up approach to ENT services in Enfield. 6 months' notice is given of possible change.
Planned Care	Locality Commissioning	Enfield CCG gives notice of possible reductions in acute activity from increased use of community services, unnecessary referrals & development of care plans for frequent flyers
Planned Care	Ophthalmology secondary care routine referrals	Enfield CCG to decommission all routine direct referrals to Ophthalmology secondary care providers who are not listed under the Enfield CCG Community Ophthalmology AQP Contract.

Programme Area	Services	Commissioning Intention
Planned Care	Procedures of Limited Clinical Effectiveness (PoLCE) Standardise across NCL CCGs PoLCE Policy 2017/18	Enfield CCG to agree the implementation of an NCL-wide PoLCE policy with effect from 1st April 2017. Enfield CCG with NCL CCGs will open negotiations with Providers to agree a contract variation in 2017/18 informed by the CCG's revised PoLCE criteria for 2017/18. Enfield CCG gives 6 months' notice to providers that PoLCE criteria and a PoLCE Financial Cap will apply from 1st April 2017.
Planned Care	AQP Adult Hearing Services Improve access to Adult Hearing Services for patients greater than 50 years and improve VFM at RFL (and BCF) and Adult Hearing Services provided by Any Qualified Providers	Enfield CCG to serve 6 months' notice to Decommission Direct Access Adult Hearing Services for patients over 50 years at RFL. All patients over 50 years will access AQP Providers (including RFL) for direct access adult hearing services from 1st April 2017. Enfield CCG will enter into negotiation to agree a contract variation with RFL for 2017/18.
Planned Care	AQP Termination of Pregnancy Re-procurement of Any Qualified Providers for the provision of Termination of Pregnancy service	Enfield CCG gives notice that these services will be advertised in 2017/18 as part of the CCG's Any Qualified Provider reprocurement policy.
Planned Care	Pathology GP Direct Access Tests Review	Under review (as part of QIPP transformation for 2017/18
Medicines Management	Medicines Management Shift from Lucentis / Eylea to Avastin treatment for Wet AMD.	Enfield CCG gives 6 months' notice of intent to decommission the existing Wet AMD service and for patients who have been treated for Wet AMD in accordance with NICE guidance recommission on the basis of offering Avastin as an alternative to Lucentis and Eylea
Mental Health	De-commission RAID	ECCG to serve six months' notice of the decommissioning of RAID mental health services
Contract form	Non-PbR Price Review Standardise Provider Contract Prices for Non-PbR Activity) across NCL CCGs (based on lowest priced Provider)	Enfield CCG gives 6 months' notice to Providers of intent to implement a standard PbR tariff for: Non-Mandatory PbR tariffs, Critical Care, Direct Access Pathology tests, Mental Health HRGs, RDAs and Non-PbR Outpatient appointment, with effect from 1st April 2017. Lead CCG(s) will work with Enfield CCG to open negotiations with Providers to agree a contract variation to ensure that local prices demonstrate comparative value for money and any that do not, will need to be reduced for 2017/18, from 1st April 2017.
Contract form	Consultant to Consultant Protocol Reduction in Consultant to Consultant referrals	Enfield CCG give 6 months' notice of intent to implement a reduction in Consultant to Consultant Referrals, undertaken in 2017/18. Haringey CCG and Barnet CCG will lead Provider negotiations supported by Enfield CCG with RNMUH and RFL to agree a contract variation for these services from 1st April 2017.
Contract form	Provision of full contract minimum data set for monitoring PbR related activity in 2017/18.	Enfield CCG gives 6 months' notice to all secondary care acute and any other relevant providers that Enfield CCG will commission PbR related activity based on revised national PbR tariffs for 2017/18. Providers will ensure contract reporting schedules include full data MDS to allow monitoring of contracts in 2017/18 in order to improve data quality and timelines for activity reporting in accordance with the NHS standard contract information schedule (schedule 6b) and data quality improvement plan (schedule 6C).
Other	CQUIN payment scheme 2017/19	Enfield CCG gives 6 months' notice to all providers that Enfield CCG will agree the Commissioning for Quality and Innovation CQUIN) payment for the achievement of stretched targets and innovative measurable schemes in line with NHS England guidance 2017/18.

Associate CCG	Programme Area	Services	Commissioning Intention
Camden CCG	Children and young People	Children's Partnership Alliance	Renewal of existing Children's Partnership Alliance Agreement SLA on a rolling one year basis.
Camden CCG	Children and young People	Perinatal mental health service including peer support	Subject to decisions across NCL, a bid for funding from NHS England and local decision-making about proposed investment, Camden CCG's intention is to strengthen perinatal mental health services including peer support. This is likely to include specialist perinatal psychiatry, nurse and peer support for women in the perinatal period
Camden CCG	Planned Care	All	The CCG intends to introduce local timescales for route cause analyses (RCAs) and Clinical Harm Reviews (CHRs) to be completed: a) for RTT, cancer, diagnostics within 4 weeks of the breach (not the future appointment date); b) for discharge issues (e.g. discharge alerts, unsafe discharges) within 7 days; c) for C.Diff within 10 days. The template for these is to be agreed between provider and commissioner. National timeframes will still apply for serious incidents, complaints, and MRSA bacteraemia.
Camden CCG	Mental Health	Psychiatric Liaison	In line with the STP, NCL partners expect to have psychiatric liaison services in place by 2017, which conform to the standards set by NHSE. In line with the evidence base there is a national expectation that these will be provided and funded through Acute providers over an agreed period of time
Camden CCG	Primary Care	London Offer	The CCG intends Commission the London Offer as part of the Universal Offer
Camden CCG	Primary Care	Universal Offer (Including London Offer)	The CCG intends to revise, update and re-commission Locally Commissioned Services from GP practices as part of the Universal Offer.
Haringey CCG	Community	Community Urology Service	Re-procurement of service
Haringey CCG	Community	PoLCE	Procedures of Limited Clinical Effectiveness
Haringey CCG	Integrated Care	Rapid Response	Expansion of the Rapid Response service will take place in 2016/17 using System Resilience funds, which will expire in March 2017 (core service funding will still continue). The impact of service expansion will be evaluated in early 2017 and inform a QIPP proposal to fund further expansion in 2017/18 (provided the expanded service is found to be effective). The service evaluation will also inform how Haringey CCG can work closely with partners in Islington to create a model that works across the both boroughs to best support local hospitals. Rapid Response will also be a key consideration in proposals to develop the system of intermediate care across both Haringey and Islington.

Associate CCG	Programme Area	Services	Commissioning Intention
Haringey CCG	Integrated Care	Stroke Services	Across NCL we have initiated a review of the end to end stroke pathway with a view to establishing appropriate capacity to meet demand and to move away from a predominantly bed-based rehabilitation model. NCL CCGs are committed to implementing the recommendations of the NCL-wide review. This will include a focus on developing a consistent offer of early supported discharge delivered by a skilled workforce. This may lead to the commissioning, as part of an NCL seven day offer, of an ESD spanning the five boroughs as well as a remodelling of the acute stroke and inpatient rehabilitation capacity to ensure improved patient experience and outcomes and effective capacity utilisation across the pathway. The findings of the NCL-wide review will inform the recommissioning of the inpatient rehabilitation beds at Homerton Hospital. As part of our joint commitment to promote independence, choice and control, the CCG and Council will be commissioning a new community support service for stroke survivors and their carers
Haringey CCG	Integrated Care	Better Care Fund and Integrated Care Schemes	There are a number of initiatives contributing to integrated care in Haringey that have been implemented on a trial basis, or are under review as part of the Better Care Fund programme. The aim is to develop a more joined-up approach to integrated care in Haringey. The following services will be evaluated in 2016-17, with a decision on continued funding, re-modelling or re-procurement taken in Spring 2017: • Home Care Reablement • Integrated Community Therapies Team • Falls - Strength and Balance • MDT teleconferences • Locality Teams We are also looking into alternative ways supporting community wellbeing, including social prescribing, this will build on previous work under the neighbourhoods connect service.
Haringey CCG	Children and young People	CAMHS	The CCG is working to establish a Section 75 agreement between Haringey CCG and Haringey Council. It is envisaged that Haringey CCG will be assuming the lead commissioner role for all Haringey CAMHS including LA commissioned services. This will need to be supported by reviewed specifications and a separate finance schedule with CAMHS disaggregated from the adult community mental health budget. Commissioning intentions for CAMHS are to implement our local CAMHS Transformation Plan, and work closely with NCL colleagues to develop a wider approach to perinatal, crisis and eating disorder services, along with the STP priorities.

Associate CCG	Programme Area	Services	Commissioning Intention
Haringey CCG	Children and young People	Transforming Care for People with LD (Winterbourne View). Reduce hospital admissions and length of stay. Tasks include: CTR implementation pre and post admission, identifying populations at risk of admission (risk stratification), up skilling providers and maintain or decrease hospital admissions by 10%.	1. Refer to NCL wide commissioning intentions 2. Enfield CCG expects all providers to deliver the specified elements of the STAY project for Enhanced Behaviour. Project will be subject to review and possible change.
Haringey CCG	Planned Care	Dermatology-Punch Biopsies	Recode as OPD procedures rather than day case
Haringey CCG	Planned Care	NMUH Ophthalmology Service	NCL CCGs will agree a reduction to the cost of administration of anti-vascular endothelial growth factor (Anti-VEG) drugs to reflect both NICE guidance and the tariff charge applied by other providers in NCL for the equivalent service
Islington CCG	Community	Termination of pregnancy	Providers will be contracted from April 2017 for three years under an any qualified provider contract
Islington CCG	Long Term Conditions	Value Based Commissioning - Diabetes	Commissioners and Trusts have committed to shadow-monitoring of capitated budgets and monitoring of VBC outcomes across Haringey and Islington for people with diabetes and for over 75s in Haringey. Trusts have committed, within MOUs, to working together under shared governance. The work that we have initiated through VBC will become part of the wider work that Haringey and Islington are doing together under the Haringey and Islington Partnership.
Islington CCG	Planned Care	Moorfields A&E, acute ophthalmology services	To commission a minor eye conditions service, delivered in the community by optometrists that will impact on the number of minor eye conditions seen in the acute setting.
Islington CCG	Planned Care	MSK community, MSK acute, Rheumatology, Orthopeadics (surgery), Pain services, diagnostics	Complete business case for future of Community MSK service - Haringey and Islington to reach agreement with providers on service commissioning decision. To commission a new model of care for MSK services, across community and secondary care.
Islington CCG	Planned Care	Obesity Services	To commission a Tier 3 Obesity Service for Islington residents in line NHS England guidance.
Islington CCG	Planned Care	Ophthalmology acute service	Commissioners would like to agree that either the Royal Free, or the Whittington repatriate the ophthalmology service that is currently jointly delivered by both hospitals. We would wish to maintain the locations that the service is currently delivered in however, for admin and patient safety reasons - 1 provider should lead the service.

Associate CCG	Programme Area	Services	Commissioning Intention
Islington CCG	Learning Disabilities	All	To ensure people with learning disabilities, particularly those with additional complex health needs, receive equal access to high quality, appropriate and timely interventions across the healthcare system to identify and treat health conditions, improving well-being and preventing premature deaths
Islington CCG	Mental Health	Value Based Comissioning for psychosis	Commissioners expect all parties to work together to achieve the best outcomes and key deliverables for people with Psychosis across Islington and Camden boroughs. Trusts are expected to work in support of Camden and Islington NHS Foundation Trust who are recognised by commissioners as the Lead Provider for the Camden and Islington Integrated Practice Unit for Psychosis and Physical Health Care. Islington and Camden Commissioners will expect all parties to fully participate in delivery of the value based commissioning for psychosis service model and associated contract in 2017/18. Commissioners will work with the Trusts, currently not party to this contract, to support them in preparing to join this agreement. Joining this contract will involve activity relating to care for Camden and Islington's patients with psychosis being removed from the core contract and become part of the value based commissioning for psychosis contract Commissioners will be exploring how the benefits of this model can be extended into Haringey as part of the Wellbeing Partnership. Barnet, Enfield and Haringey - We will continue to move to payment by results / activity contracting for adult mental health secondary care services in 2016/17. Treatment for a first episode of psychosis will go live, and we will extend shadow operation to a wider group of 'clusters', proposed to be the rest of the psychosis clusters
London Borough of Enfield	Children and young People	Early Years Early Help Model: A greater emphasis on prevention and early identification, resulting in improved outcomes and performance indicators and a decrease in referral to more specialist services.	Enfield CCG will work with the London Borough of Enfield on the development of the Early Help Model incorporating the Healthy Child Programme for 0-5 year olds. Co-location to be considered. 6 months' notice is given that Enfield CCG will expect all providers to implement specified elements of the model.

Associate CCG	Programme Area	Services	Commissioning Intention
London Borough of Enfield	Children and young People	School Aged Children: The Healthy Child Programme. A greater emphasis on prevention and early identification, resulting in improved outcomes and performance indicators and a decrease in referral to more specialist services.	Enfield CCG will work with the London Borough of Enfield on the development of the Early Help Model incorporating the Healthy Child Programme for 5 -19 year olds. 6 months' notice is given that Enfield CCG will expect all providers to implement specified elements of the model.
NCL	Mental Health	Specialist community care / crisis care	In line with the STP, all the NCL CCGs will review crisis, acute and rehabilitation pathways, including: Implementation of the crisis concordat; Acute pathways and female PICU; Review of residential and community rehabilitation. This may include the commissioning and decommissioning of services as required in order to deliver this programme of work.
NHS England - specialist	Planned Care	Development of Bariatric Surgery across NCL. NHS England Specialist Commissioning arrangements with CCGs requires future development of Bariatric Surgery in NCL in 2017/18	Development of service specification and business case required to inform future commissioning arrangements and bariatric surgical provision in NCL
NHS England - specialist	Medicines Management	All	To repatriate expenditure on specialist drugs in scope of the NHS England manual for prescribed services that are currently prescribed in Primary Care for 2017/18.
Camden CCG	Community	Adult Audiology Service	Potentially decommission this service from March 2017
Other	Children and young People	Asthma care	All Providers to implement asthma standards (Healthy London Partnership).
Other	Children and young People	Autism Spectrum Disorder (ASD) Services and Pathways	Improved outcomes and experience of service for CYP with suspected social communication issues. Building community-based capacity and early intervention pathways in line with national recommendations. Islington CCG: Implementation of recommendations set out in review of ASD Assessment and Diagnostic Services. To address excessive waiting times within the pathway. Enfield CCG: To review end to end pathway for autism diagnosis against NICE guidance. 6 months' notice given to providers of change.

Associate CCG	Programme Area	Services	Commissioning Intention
Other	Children and young People	Improved outcomes and experience of service for CYP with Special Educational Needs and Disabilities (SEND) and their families. Implementation of the Children and Families Act (2013) and revised SEND guidance.	To ensure professionals provide timely information to inform statutory EHCP processes and deliver robust local offer services Enfield CCG: 6 months' notice to BEH MT and RFH of a new specification for children with disabilities/potential application of new models of care. CCG, council and providers to produce an action plan in response to the joint SEND inspection.
Other	Children and young People	London Paediatric acute care standards (children and young people acute services)	Providers to implement London Paediatric acute care standards (Healthy London Partnership 2016)
Other	Children and young People	London Paediatric critical care standards (children and young people acute services)	Where appropriate levels apply, providers to implement London Paediatric critical care standards levels 1 and 2 (Healthy London Partnership 2016)
Other	Children and young People	National specification for Eating Disorders	Review of commissioned ED services. NHSE require implementation of national service specification.
Other	Children and young People	Personal Health Budgets (continuing care and further services to be identified)	The NCL CCGs will review the potential to extend personalisation through more flexible contracts and/or personal budgets. Providers will need to work with commissioners to roll this out.
Other	Children and young People	Transforming Care for people with LD (Winterbourne View)	Tasks include: CTR implementation pre and post admission, identifying populations at risk of admission (risk stratification) and up skilling providers Enfield CCG: Reduce hospital admissions and lengths of stay. Enfield CCG expects all providers to deliver the specified elements of the STAY project for Enhanced Behaviour. Project will be subject to review and possible change.
Other	Children and young People	Transition (children and young people services)	All providers to implement the NICE quality standards for transition to adult services.
Other	Children and young People	Child Safe House model	To explore options for reconfiguring existing services across providers to support the development of a child safe house in NCL if the model is progressed
Other	Planned Care	Anticoagulation	Growth in the prescribing of newer oral anticoagulant drugs (NOACs) arising from pathway redesign (e.g. primary care initiation) or increased uptake, together with use of anticoagulation self-testing and self-monitoring in line with NICE guidance, may result in reductions in anticoagulation clinic activity due to reduced monitoring requirements.
Other	Planned Care	Rheumatology	To review options for primary and community based management of RA patients and move activity from secondary to primary/community care
Other	Planned Care	Fertility	To review revised package for IVF treatments reflecting Bemfola price.

Associate CCG	Programme Area	Services	Commissioning Intention
Other	Mental Health	Review the Community Eating Disorder Service with Children's and NHS England Eating Disorder Commissioners to inform commissioning intentions for 2017-18	A review of the Community Eating Disorder Service with Children's and NHS England Eating Disorder Commissioners will take place to inform commissioning intentions for 2017-18. Part of the NCL STP