Armed Forces and their Families Commissioning Intentions – 2016/17
The commissioning intentions provide notice to healthcare providers about changes and planned developments in the commissioning and delivery of Armed Forces and their families’ healthcare services by NHS England.
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Executive summary

Our commissioning intentions for 2016/17 outline the strategic intentions we are planning to improve the way we commission services for the Armed Forces and their families.

The single operating model will be applied to all contracts in 2016/17. NHS England will normally only hold one NHS standard contract with any provider and will use mandated formats for activity and local price plans. NHS England will only make payment where treatment complies with relevant published policies.

We are undertaking a strategic review, informed by a stakeholder engagement exercise, of those veterans’ mental health services currently funded by NHS England.

Purpose

1. These commissioning intentions provide notice to healthcare providers about changes and planned developments in the commissioning and delivery of services for the Armed Forces and their families registered with a Defence Medical Services (DMS) practice by NHS England.

2. Together with planning guidance, the NHS contract, National Tariff system and CQUIN guidance they form a plan to be reflected in contracts, developments, service reviews and procurement opportunities for 2016/17.

3. The prime purpose of these intentions is to enable healthcare providers to make early preparations, to engage with clinical leads and to make changes that benefit patients, with improved outcomes. These intentions should inform providers’ plans at all levels.

Our population

4. NHS England has been commissioning services for the Armed Forces and those families registered with a DMS practice in England since 1 April 2013.

5. Our vision is to obtain the best health benefit within available resources by commissioning high quality, safe and effective care for Armed Forces personnel and their families, in accordance with the NHS Mandate, Armed Forces Covenant and the NHS Constitution.

6. The following services are normally commissioned by the NHS England Armed Forces commissioning team for the DMS registered population (including DMS registered families) in England:
   • Secondary care services, including emergency care;
   • community services;
   • mental health services (only for families registered with DMS).

Community and mental health services are currently transacted through a national risk-share agreement between NHS England and local CCGs.
7. NHS England also provides lead commissioner or similar support arrangements for other services such as cervical screening for those DMS registered patients overseas, or out of hours primary care services.

8. DMS commissions or provides the following services in England:
   • Occupational health for military personnel;
   • primary care for serving personnel and GP services for DMS registered families;
   • all health care when on active operations and prior to return to UK;
   • rehabilitation services for musculoskeletal (MSK) and some neurological patients for serving personnel;
   • mental health in community and inpatient for serving personnel (but not families).

9. The following services are also commissioned for the Armed Forces community by NHS England:
   • primary care for families registered with NHS practices;
   • dental, pharmacy and optometry services for families;
   • secondary care dental services;
   • specialised services;
   • public health services covered by Section 7A.

10. Most services for veterans are commissioned locally by clinical commissioning groups (CCGs). The Royal British Legion estimates that there are currently 2.32 million veterans in the England, 46% of who are over 75 years of age. There were over 800 very seriously or seriously injured personnel from recent conflicts such as Afghanistan and Iraq.

11. NHS England has specific duties and separate funding to commission the following veterans’ services:
   • A small number of veterans’ mental health services, including on line and specialised residential services and veteran specific psychological therapies in response to “Fighting Fit”.
   • Veterans’ prosthetic services including the Veterans’ Prosthetics Panel (VPP) in response to “A Better Deal for Military Amputees”.
   • Assisted conception services for those in receipt of compensation for loss of fertility.
   • On line psychological support services for veterans and families.
   • Inpatient post-traumatic stress disorder (PTSD) services for veterans.

12. Armed Forces personnel and families returning from overseas for treatment in the UK are covered by Overseas Visitor (OSV) regulations and are the responsibility of the local CCG in which the provider of the care that they receive is located.

13. A grid detailing the responsible commissioner is at the end of this document.
Our priorities

Strategic service review

14. In commissioning and sourcing the provision of clinical services, NHS England, in line with the Procurement, Patient Choice and Competition regulations will act with a view to:
   - securing the needs of the people who use the services,
   - improving the quality of the services, and
   - improving efficiency in the provision of the services.

15. The annual contractual review of existing services and providers and the procurement for new services or where existing services are due to expire, are two mechanisms which support this.

16. Whilst CCGs are the responsible commissioner for mental health services for their population, which includes veterans, NHS England currently retains responsibility for some veterans’ mental health services. We are undertaking a strategic review to improve access to veterans’ mental health services, which will be informed by engagement with our stakeholders. The objective is the development of a sustainable model for veterans’ mental health services, which it is intended will go live early in 2016/17.

Service developments

17. NHS England has a prioritisation framework to guide the work of its direct commissioning functions and a clinical reference group (CRG), which enables decisions to be made regarding investment and if necessary dis-investment in services to best meet healthcare need within available resources. These proposals are assessed by the Armed Forces CRG which advises NHS England on all Armed Forces health commissioned services.

18. Investment in new services and interventions will be prioritised using the prioritisation framework. This will ensure that the range of services and interventions are optimised to best meet the needs of patients within available resources.

19. Service developments with a financial impact for existing providers of a given service will only be approved where they were initiated with NHS England’s formal agreement. They will need to demonstrate measurable outcome and value improvements and will need to be agreed as part of the national prioritisation process and where resources have been released from elsewhere within an achievable balanced national financial plan. Where development or changes to the clinical eligibility policy for a treatment would warrant new provider entry or revisiting the assessment of existing providers as the most capable to provide a significantly changed service, this will be managed through the service and commissioning review process with existing and potential providers considered for procurement.
20. For the avoidance of doubt, the regional commissioning team is unable to give support to cost increasing business case proposals outside of the national process. Providers should not initiate service changes or developments without prior commissioner approval.

Meeting the commitments of the Armed Forces Covenant

21. NHS England as the commissioner of health services for the Armed Forces and families registered with DMS need to ensure that it upholds the commitments of the Armed Forces Covenant. Specifically this means that:
   - Armed Forces patients should not face disadvantage compared to other patients in the provision of healthcare.
   - Special consideration is appropriate in some cases, especially for those who have given most such as the injured

22. In practice this means that we:
   - have a set of common access policies to ensure equity of access for service personnel and their families across England;
   - expect our providers to have due regard to the Armed Forces Covenant in managing their waiting lists and inter-provider transfers;
   - expect our providers to offer priority treatment to veterans, for service attributable conditions, subject to the clinical priorities of other patients;
   - commission some bespoke services for veterans, where we have been funded to do so – for example veterans’ prosthetics.

Clinically driven change

23. The Armed Forces CRG is reviewing all 37 clinical commissioning policies, which will be completed by April 2016.
24. The CRG has agreed, with partners, the following priorities for review in 2016/17:
   - extended primary care and better integration with community in secondary care, possibly in partnership with vanguard sites, and in line with the intentions set out in the Five Year Forward View;
   - improved continuity in secondary care dental services;
   - musculoskeletal pathways, especially rehabilitation;
   - spinal pathways;
   - reviews arising from the Strategic Defence Security Review (SDSR);
   - improved care for veterans with mental health issues particularly:
     - those with complex PTSD, including co-morbidities in relation to substance misuse;
     - where stigma is a barrier to accessing care.
Our approach to contracting

Practical arrangements

25. NHS England will normally only hold (or be party to) one NHS Standard Contract with any provider. Armed Forces health services requirements will be included as separate contract schedules within specialised service provider contracts, in a similar way that providers hold schedules for lead and associate CCG commissioners and, for those services, providers should invoice the South Central regional team.

26. NHS England has previously adopted a commissioner hierarchy amongst its directly commissioned services for the purposes of determining who the responsible payer is. This hierarchy has been developed into an algorithm and associated guidance (the Commissioner Assignment Method (CAM)). It is proposed that the guidance becomes an information standard and it is expected that this will be implemented as a mandatory standard on 1 April 2016.

27. NHS England expects that providers will implement HRG4+ and the new ICD10 codes from 1 April 2016.

28. All contracts will use the existing standardised format for Schedule 2B Indicative Activity Plan and Schedule 3A Local Prices. There will be a single NHS England Information Schedule (Schedule 6) encompassing all direct commissioning requirements. Further national standardisation of schedules will be reviewed.

29. Capacity planning to inform contract discussions will take place in the autumn and should start from a ‘no intervention’ basis. There are some demographic changes associated with the rebasing of service personnel and their families from Germany; if these are significant, the regional team will advise providers to inform local capacity plans. Commissioners will take responsibility for the final decision on these forecasts in line with their responsibilities to determine the level of care to commission.

30. The regional team and providers will have early discussions to inform the affordable contract envelope for services, and develop solutions to ensure continued delivery of care within available resources.

31. Initiatives which impact on a ‘no intervention’ plan, with clear responsibilities and constructive engagement will be vital to ensure that contracts remain affordable. NHS England local offices will discuss a range of QIPP projects which have been developed by CRGs on a national basis, as well as locally identified projects. In many cases, provider clinical teams are in a good position to identify local opportunities and should add to the portfolio of planned change, to ensure that the volume growth and efficiency of pathways and episodes of care are addressed in plans.

32. Mandated currencies and tariffs will be adopted.

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1 Forecasting future activity with existing demand management and QIPP measures but prior to incorporating additional QIPP measures or initiatives
33. NHS England will operate in line with the National Tariff Document (NTD) when published.

34. NHS England will only make payment where treatment complies with the relevant published policies.

35. Payments for high cost drugs and devices excluded from National Tariff should, if approved, be made on the basis of a pass through of the actual price charged to providers (prior to consideration of any contract level risk sharing mechanisms). Auditable information to validate payment of excluded drugs and devices will be required, in line with the NHS Standard Contract.

Prior Approvals and Individual Funding Requests

36. There are a number of clinical commissioning policies that are subject to prior approval. These include the assisted conception policy and a number of policies for procedures that may be considered to be cosmetic. Treatments that have not secured prior approval will not be funded. [Link to policies]

37. Requests for prior approval should be made on the appropriate form and sent to [Email]

38. Arrangements for Individual Funding Requests (IFRs) will continue in 2016/17. Further details on IFRs, including the application form, are available at: [Link to application form]

CQUIN

39. Armed Forces personnel and their families move home more frequently than the general population due to their military commitment. In seeking assurance that providers of NHS services are compliant with the Armed Forces Covenant in relation to ‘no disadvantage’ as a result of these moves, we intend to focus our 2016/17 proposed CQUIN on ensuring that patients who move:
   • whilst on a waiting list, join the waiting list at their newly identified provider at the same point on the waiting list;
   • during a treatment programme, are able to continue to access this treatment at their new provider without a break in their programme of care.

40. This proposed CQUIN will address these issues by completing an access policy review with providers and the inclusion of these explicit elements of the Covenant within a revised version of the policy to be confirmed within the 2016/17 contract year. Providers will also be required to demonstrate how this will be delivered operationally.

Quality, Innovation, Productivity and Prevention (QIPP)

41. There are a number of strands to our approach to QIPP. These are:
   • Ensuring we spend our resources in the most effective way.
• Working with CCGs to design and implement QIPP schemes that impact on the services we co-commission and ensuring that the elements of savings accrued from acute trust based QIPP schemes agreed with co-commissioners of the service are drawn down proportionate to the caseload.
• Working with the Ministry of Defence (MoD) to ensure that there is a tax payer benefit to our actions, for example commissioning services to increase deployability.

42. We will work with our colleagues in DMS to consider what QIPP opportunities may exist through delivering care in a different or more efficient way:
• repatriation / movement of minor procedures to out of hospital settings where this is both clinically and cost effective
• reduction in did not attend (DNA) rates
• reduction in the ratio of follow ups to new out-patient appointments where clinically appropriate
• increased work up / access to care in primary care settings to prevent hospital referral
• direct access for diagnostic testing
• improved immunisation and screening take up and recording.

Key contacts
Regional Team
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Richard Swarbrick, National Lead for Armed Forces Networks and Transition,
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### Responsible commissioners

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