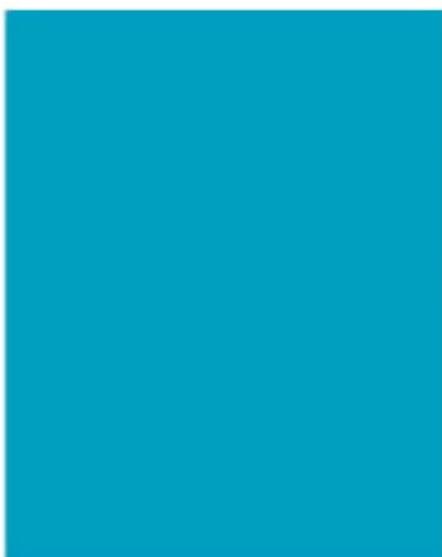


**Prescribed
Specialised
Services
Commissioning
Intentions
2014/15-2015/16**



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NHS England

Prescribed Specialised Commissioning Intentions

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Purpose

1. This document sets out to healthcare providers notice of NHS England's Commissioning Intentions for Prescribed Specialised Services for 2014/15 and 2015/16. They should be read in conjunction with the Strategic and Operational Planning Guidance, the NHS Standard Contract and the National Tariff Document (NTD) which are to be published later this year by NHS England and Monitor.
2. The commissioning intentions provide the context for constructive engagement with providers, with a view to achieving the shared goal of improved patient outcomes and service transformation within the fixed resources available. To support patient-centred care, NHS England is committed to securing alignment across all aspects of NHS commissioning. We shall be working with CCGs, partner NHS oversight bodies and local government to secure the best possible outcome for patients and service users within available resources. We expect all commissioners and providers to be flexible around the service improvements that can be made when opportunities for alignment are realised.

Context

3. Since the last published Commissioning Intentions in November 2012, much has changed. More than 1600 expert clinicians, in 75 service-specific Clinical Reference Groups (CRGs) have developed national service specifications and healthcare providers have assessed compliance with key elements. Many providers now hold a single contract with one area team covering all English patients treated; national clinical policies are in place and access to the Cancer Drugs Fund (CDF) and Individual Funding Requests (IFR) are consistently assessed through a standard operating procedure approach led by four regional teams.
4. Clinical Senates and Strategic Clinical Networks are working to support commissioners and providers in consideration of local challenges and Operational Delivery Networks (ODNs) are working to ensure coherent and co-ordinated cross-provider working to comply with commissioned pathways and standards.
5. Our 2014/15-2015/16 Commissioning Intentions build on the progress that has been made, with an emphasis on addressing the strategic challenges faced by NHS England in delivering improved outcomes for patients and communities within a fixed resource.
6. Significant achievements have been made through the collaborative work of commissioners and providers however it is clear that a step change is needed in our shared pursuit of effectiveness, efficiency and the engagement of patients and staff, if we are to achieve our aim to secure high quality care for all, both now and for future generations.
7. In 2014, NHS England's strategy 'A Call to Action' will set out a long term vision and the critical changes needed in the medium term. For health services to remain sustainable some key changes in support of our future direction of travel need to begin now and these are set out in our commissioning intentions.

The Scope of Prescribed Services

8. At a clinical level, major changes in the scope of services directly commissioned by NHS England are not intended for 2014/15, as we believe a period of stability is required after the major changes in 2013/14. The technical algorithm to align services between NHS England and Clinical Commissioning Groups' (CCGs) commissioner responsibility, "The Identification Rules"(IR), has been refined to improve its precision and will be further updated to align to the update of procedure codes for all NHS services . A summary of the impact of the Information Rules refinement will be provided in the coming weeks to aid forward planning by trusts and commissioners.

The Prescribed Specialised Services Manual

9. The Manual is the technical document that describes the 143 prescribed specialised services. It sets out which elements of services are commissioned directly by NHS England and which by CCGs. It provides details of each service to be commissioned and a rationale as to why a service is commissioned by NHS England and not by CCGs.
10. The Manual will be updated to include any changes in commissioning responsibility agreed by Ministers following receipt of recommendations from the Prescribed Specialised Services Advisory Group.
11. This document will also be updated to take account of any changes in service description and numbers of providers. All material changes will be highlighted.

Clinical Reference Groups

12. Clinical Reference Groups (CRGs) were introduced in 2012 to assist in the transition of prescribed services into NHS England and to support the development of commissioning and contracting products, such as service specifications and clinical commissioning policies. Their inclusion into the structures of NHS England was approved and 75 CRGs have been established for specialised services, with additional groups for Health and Justice, and Armed Forces commissioning. Membership of the CRGs is supported on a voluntary basis by the individual's host provider organisation, with four patient voice members appointed through national selection. The groups are supported by a lead commissioner with access to the Public Health, Pharmacy and Clinical Effectiveness Teams.
13. The CRGs continue to review and develop the clinical service specifications, introduce clinical access policies, define quality measures and build quality dashboards. This will form a key part in the development of the future specialised services commissioning strategy. As voluntary groups they need support from providers, area teams, regions and the national support centre team to develop their work.

14. CRGs are the primary source of clinical advice to NHS England around the development and management of the prescribed specialised services.

Patient & Public Engagement

15. In upholding the NHS Constitution, NHS England is committed to ensuring that patients are the priority in every decision that NHS England makes. Putting patients first needs to be a shared principle in all that we do. NHS England, through the area teams will ensure that this is demonstrated in the way care is provided and monitored through our formal contracting process with providers.

16. We expect all providers to demonstrate real and effective patient participation, both in terms of an individual's treatment and care, and on a more collective level through patient groups/forums; particularly in areas such as service improvement and redesign.

17. It is essential that all providers of specialised services demonstrate the principles of transparency and participation and offer their patients the right information at the right time to support informed decision making about their treatment and care.

18. Providers of specialised services should look to provide accessible means for patients to be able to express their views about, and their experiences of specialised services, making best use of the latest available technology and social media as well as conventional methods.

19. As well as capturing patient experience feedback from a range of insight sources, providers should demonstrate robust systems for analysing and responding to that feedback.

Strategic Direction

20. As part of the 'Call to Action', NHS England is developing a five year strategy for specialised services, which will be published in April 2014. This will address the service specific objectives for the next five years, overarching strategic objectives for the provision of a system of specialised healthcare as a whole and the impact of co-dependency between service areas.

21. Our strategic commissioning approach has six strands:

1. Ensuring consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit:
 - Any potential developments in access to treatments or services with resource implications will be considered and costed by the CRGs. These will then be assessed and evaluated by NHS England's Clinical Priorities Advisory Group and prioritised against NHS England's ethical framework.

National adoption alongside any consequent disinvestment will also be evaluated through the Clinical Priorities Advisory Group and ratified by NHS England's Quality and Risk Committee to ensure resources can be safely released to support innovative development.

2. A Clinical Sustainability Programme with all providers, focused on quality and value through:
 - achieving and maintaining compliance with full service specifications, and making changes to service provision where there is no realistic prospect of standards being met;
 - reviewing and revising service specifications to deliver a continuous incremental improvement in clinical outcomes, service quality, patient experience and value for money;
 - refreshing and focusing CQUIN schemes to directly contribute to improving outcomes with challenging, but achievable goals;
 - providing transparency in service quality through the continued development of service level quality dashboards and improvements in data flows.

3. An associated Financial Sustainability programme with all providers, focussed on better value through:
 - a two-year programme of productivity and efficiency improvement in service delivery which will commence during 2014/15 and will focus on converging local tariff pricing to match the most efficient services, with support and reward in line with commitment to levels of ambition, and shared ownership of risk;
 - agreed improvement goals to ensure that efficient services form part of lean, patient-focused pathways, and that treatment is commissioned by default in the most cost effective setting, adopting and spreading best practice across provider services;
 - securing the benefits of more widespread use of best value prices for drugs and devices with increased transparency of billing;
 - strategic collaboration with providers and other partners to achieve prevention and earlier intervention in specific services;
 - reducing the future burden of demand for prescribed services by managing demand and reducing rates of admission and readmission.

4. A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate to address clinical or financial sustainability issues.

5. Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients in particular services and care pathways:
 - We will select providers with a strong track record in clinical and financial sustainability programmes in 2014/15, to award prime contracts in 2015/16 for a network of care with other providers for selected priority services.
 - We will pilot five specific services initially partnering with CCGs to co-commission full pathways of care.

6. A systematic rules-based approach to in-year management of contractual service delivery, including:
 - transition from local to national data flows as the primary source of payment for services covered by national datasets;
 - the promotion and use of clinical utilisation review tools to identify and address bottlenecks in care and ensure the right treatment in the right settings;
 - the use of commissioner-led clinical threshold audit by the NHS England medical directorate peer review team;
 - the commissioning of clinical coding reviews where needed to establish potential unintended consequences of clinical practice that have not been subject to formal notification of change.

Operating Model for Prescribed Services

22. NHS England continues to build on the single operating model with the national support centre team, five Programmes of Care, CRGs, regional teams and the 10 area teams.

23. The 10 area teams that lead on specialised services contracting across England are:

- a. Birmingham and Black Country
- b. Bristol, North Somerset, Somerset and South Gloucestershire
- c. Cheshire, Warrington and Wirral
- d. Cumbria, Northumberland, Tyne and Wear
- e. East Anglia
- f. Leicestershire and Lincolnshire
- g. London
- h. South Yorkshire and Bassetlaw
- i. Surrey and Sussex
- j. Wessex

The Prescribed Specialised Services Manual

24. In line with the Health and Social Care Act 2012, Ministers take into account four factors when deciding which elements of specialised services should be prescribed and therefore directly commissioned by NHS England rather than by CCGs:
- a. The number of individuals requiring the provision of the service or facility;
 - b. The cost of providing the service or facility;
 - c. The number of persons able to provide the service or facility; and
 - d. The financial implications for CCGs if they were required to arrange for the provision of the service or facility.
25. Ministers take advice from the Prescribed Specialised Services Advisory Group (PSSAG), a multi-disciplinary committee hosted by the Department of Health.
26. The Prescribed Specialised Services Advisory Group will make recommendations to Ministers who will consult with NHS England on any agreed recommendations. Any changes in commissioning responsibility will need to be reflected in the Manual, the Identification Rules and in allocation changes.
27. If NHS England becomes the responsible commissioner, commissioning products such as service specifications and policies will need to be developed. NHS England will also consider the funding priority of the service through the Clinical Priorities Advisory Group and a process for selecting providers. Any highly specialised services that become the commissioning responsibility of NHS England will be discussed at the Rare Disease Advisory Group (RDAG).

Commissioning through Evaluation (CtE)

28. Commissioning through Evaluation (CtE) has been developed by NHS England as an innovative approach to the commissioning of prescribed specialised services for which there is currently insufficient evidence of relative clinical and/or cost effectiveness to warrant routine commissioning. Commissioning through Evaluation is particularly pertinent to specialised and other lower volume procedures or services, where randomised controlled trial evidence is less prevalent, and where an alternative approach to evaluation therefore needs to be available to support commissioning policy decisions.

Strategic Clinical Service Review

29. NHS England directly commissions 143 specialised services and will be developing a commissioning framework for each service. For many of these services, it will be the first time that there has been a single national commissioner and it will be important to ensure that each framework takes into account factors such as patient need, required changes to service provision, technological advancement and the health care provider market. As each framework is developed, NHS England will decide how best to take

forward the procurement of services, in line with regulations and Monitor's final guidance when available. This process will take into account proportionality, best practice and equal treatment. If a competitive procurement process is needed, details will be advertised as required by the regulations in order that all potential providers are aware of the opportunity.

30. In line with the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013, and draft guidance issued by Monitor entitled 'Substantive guidance on the Procurement, Patient Choice and Competition Regulations', NHS England is committed to ensuring that when it procures health care services it satisfies the procurement objectives laid down in the regulations, namely to act with a view to: securing the needs of the people who use the services; improving the quality of the services; and improving the efficiency in the provision of services.
31. NHS England will develop its commissioning framework by prioritising those service lines which most urgently need to be reviewed and that are in the best interests of the people who use the services.
32. This prioritisation work will be informed by system wide strategic plans for the future of health care delivery and specialised service configuration in each region. Each prioritised programme of change will work within a consistent national framework and process. There may be some areas where a national approach to procurement is required due to the incidence of quality or capacity issues arising.

UK Strategy for Rare Diseases

33. The UK Strategy for Rare Diseases will be published by the end of December 2013. NHS England, in line with the three devolved health administrations, will be developing an implementation plan in response to the strategy. The plan will be developed through the Rare Diseases Advisory Group and will be published in February 2014.

Reinvestment Strategy for Cost Effectiveness

34. Commissioners will establish a transparent priority setting framework which enables decisions to be made about investment and reinvestment within a CRG, and between Programmes of Care.
35. A principle will be established for the identification of disinvestment for "better value reinvestment":
 - a. In 2014-15 this framework will be developed and proposals will be consulted upon.
 - b. In 2015-16 this framework will be implemented with a prioritised list of better value interventions.
36. Investments will only be approved where they demonstrate measurable outcome and value improvements and where cash has been released elsewhere.

Co-Commissioning, Trialling New Payment Approaches

37. Although the contracting focus for 2014/15 will be the consolidation of the single national operating model, NHS England is keen to promote innovation that benefits patients, providers and commissioners.
38. Where innovation can demonstrably contribute to improving outcomes, quality and saving money, area teams will work with providers over the next 18 months to gain permission for local variations and agree risk/benefit share arrangements where appropriate. This will extend to innovative proposals from multiple providers working together.

Prime Contractor

39. Commissioners will lead a process to invite proposals over the coming 18 months for prime contractor delivery where this enables either consolidation and networking of specialist provision to achieve the national specification and standards, and/or prime contractor arrangements for a whole pathway of care or model of care where tiers of provision are closely networked. One example of this is neurorehabilitation, where such an approach could enable alignment of incentives and accountability for quality improvement and capacity management.
40. To support this process, tools and guidance will be developed including a national inter-provider contract, specification standards between hub and spoke and incentive structures.

Driving Value

41. The NHS faces a major challenge in that it cannot rely on additional funding to meet the needs of patients and drive quality improvement. If we are to protect the fundamental principles of the NHS, offering comprehensive services on the basis of clinical need, there has to be significant reform in the way that services are provided.
42. NHS England will focus on driving commercial terms to get better value for the taxpayer from suppliers and partners and we want accountability for all partners to reorganise care to improve outcomes and release cash savings.
43. Specialised services are provided at the end of a pathway of prevention and treatment. These are often the most expensive and scarce resources that the NHS is able to offer and therefore must be accessed following pathways of care that seek to actively prevent deterioration and provide levels of care appropriate to the needs and stage of disease. Alignment of the accountability, incentives and clinical leadership around improving outcomes across pathways and programmes, will drive better value.
44. Over the next two years, it is the intention of NHS England to focus on aligning and driving value from specialised services through three programmes:
 - a. Getting value from commercial business

- b. Enabling the right care, providers and pathways for outcomes and value
- c. Reinvestment, with a view to delivering improved clinical outcomes for patients/service users.

Right Care

Collaborative Commissioning

45. Commissioning for NHS funded care is now spread across NHS England, CCGs and local authorities. Over the next two years there will be a drive on joint strategy, planning and collaborative commissioning to ensure there is alignment of our commissioning toward outcomes and how each party works to lead on pathway or programmes of care.
46. Strategies will be developed over the next year to show the future structure of care in each region and the changes in services ahead. The configuration of specialised services will have a critical impact on how services evolve in the acute and tertiary sector. Decisions about how specialised services are configured to meet national standards at best value must be planned, along with a broader strategy including clinical interdependencies. These plans will have an opportunity to drive value and improved outcomes.

Pathways

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

Specialised Programme of Care	Pathfinder
Mental Health	Forensic pathway
Women and children	Paediatric care pathways
Internal medicine	Acute Kidney Injury pathway
Cancer and blood	Haemoglobinopathy
Trauma	Back pain and sciatica

Effective & Focused Commissioning

49. The majority of specialised services form part of a patient pathway and it is important that patients can access more specialised care promptly and also, once clinically ready for discharge, they can move out to intermediate step down or more community based care settings. There are several specialities, such as neuro-rehabilitation, where patients may not be able to either access more specialised care or be discharged once clinically suitable.

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

51. These principles are summarised below:

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

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

discharge planning initiatives and through appropriate incentives with providers to facilitate prompt discharge.

53. This will not only result in improved equity of access for patients, but will also ensure a more effective and focused use of resources.

Strategic Clinical Networks

54. Commissioners will support Strategic Clinical Networks and Academic Health Science Networks to develop work plans which focus on strategic care models and pathway development for key health needs. This will enable integration of care and a shift toward earlier intervention and treatment. Specialised commissioning will benefit from this work particularly where there is a direct link to specialised care such as in obesity, kidney care and cancer.

Clinical and Operational Delivery Networks

55. NHS England has recognised that clinical networks are an NHS success story and have been responsible for some significant sustained improvements in the quality of patient care and the outcomes of treatment. We should build on this progress, moving beyond transition and stability, toward delivery of real value and transformation through strong governance, improvement planning and aligned incentives and supports.

56. Operational Delivery Networks (ODNs) are focused on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise. For more information about Operational Delivery Networks, go to: <http://www.england.nhs.uk/wp-content/uploads/2012/07/way-forward-scn.pdf>

57. ODNs focus on operational delivery; they ensure outcomes and quality standards are improved and that evidence based networked patient pathways are agreed.

58. They focus on an operational role, supporting the activity of providers in service delivery and improvement in delivery of a commissioned pathway. They have a key focus on the quality and equity of access to service provision. This will allow for more local determination, innovation and efficiency across the pathway. ODNs support the delivery of 'right care' principles by incentivising a system to manage the right patient in the right place at the right time.

59. ODNs will be fully established in 2014/15 and all acute providers who provide specialised services under the scope of the ODN will be required to join networks for quality improvement. Networks will operate under a governance framework which develops an annual improvement plan across all members, and publishes results of the network's achievements annually. These will identify how value has been measured and improved for the benefit of the patient and commissioners.

60. These networks will have a host organisation and an agreement with NHS England which sets out the roles and responsibilities of all parties. NHS England is able to seek the advice of ODNs in undertaking strategic service reviews. NHS England will retain a

register of all ODNs and members, together with the annual improvement agreements and annual reports from the ODN on delivery.

61. The governance model for the ODNs comprises of the following:

- a. An agreement with the commissioner (s) which includes open book financial arrangements:
 - i. Roles and responsibilities of the host in managing resources and governance
 - ii. Terms of Reference of the Board
 - iii. Members Agreement
 - iv. Host and Board Service Level Agreement
 - v. Information governance agreements
 - vi. Financial and quality incentive agreements

62. An ODN may have a combination of individual provider, prime contractor, alliance, and joint ventures within its auspices.

63. If at any point an entire ODN responds as a prime contractor to an invitation from commissioners, this would change the nature of the ODN into a provider entity with a contract for services with the commissioner.

64. ODNs will not automatically translate into a prime contractor, and indeed commissioners will manage choice and competition processes in such a way that any invitation to submit proposals is fair and transparent. The ODN however may identify this as an opportunity where there is alignment of commissioning intentions and provider development and consolidation.

65. NHS England recognises that there is still a degree of transition required for ODNs to embed fully within provider contracts, until the tariff and reference costs solutions take effect. The transitional funding approach, which utilised 0.1% of CQUIN monies, will continue throughout 2014/15, whilst future funding options are developed for 2015/16.

66. Due to the nature of the care pathways that are commissioned by specialised services, over time we expect many more to be delivered in an ODN model as reflected in our service specifications. Providers should consider utilising existing ODN structures and consider how these could be aligned to ensure greater efficiency and cross fertilisation of skills, service development and expertise.

Contracts

Standard Contract

67. NHS England has been engaging with stakeholders to inform the development of a revised NHS Standard Contract for use in 2014/15 and this will be published during December 2013. It is likely that there will be considerable continuity with the current

contract, in terms of both structure and content. There will also be some significant revisions, to reflect stakeholder feedback and other important developments, including implementation of recommendations from the Francis report and from NHS England's review of incentives, rewards and sanctions, which will be completed by the end of October 2013.

68. The 2014/15 Standard Contract will be used for all new contracts agreed for specialised services from 1 April 2014 onwards. Where existing contracts do not expire at 31 March 2014, these will be updated for 2014/15 using Deeds of Variation which will be produced by NHS England early in 2014. Forms of contract other than the NHS Standard Contract will not be used.
69. An online system for completing the NHS Standard Contract (the eContract) was made available for the first time in February 2013 and an improved, more robust system will be available for use for 2014/15. The eContract approach has significant benefits, for instance in enabling the tailoring of contract content to reflect the specific range of services being commissioned. We anticipate that use of the eContract approach will become the norm for specialised services contracts for 2014/15.

Single Provider Contract

70. The intention for 2014/15 is that NHS England should normally only hold (or be party to) one NHS Standard Contract with any provider, which includes the five areas of direct commissioning with contract schedules for each area team.

Consistent Contracting

71. 2013/14 was a year of collaboration between NHS England, CCGs and providers to implement the NHS England single national operating model whilst seeking to maintain service and financial stability.
72. Area teams will continue to work with providers to ensure local practice is transitioned to the single national operating model, including:
- a. clear and consistent identification of prescribed specialised services at all providers using the nationally published tools and grouper;
 - b. the eradication of differential prices charged by the same provider to NHS England based on a patient's place of residence by individual providers. There will be a single stated price per service line in each provider contract;
 - c. the implementation of mandatory currencies. This should be accompanied by the production of monitoring information for the baseline year in the mandatory currency, and continued monitoring in the previous currency alongside mandatory currencies, to assure the accuracy of locally set prices against the new currencies given the quantum involved;
 - d. standardised simplified indicative activity plans and non-tariff price lists, including drugs and devices, providing clarity and transparency.

- e. a nationally standardised approach and documentation for coding and counting change proposals to better evaluate and assess the wider system impact of those proposals;
- f. transparency about the application of Section 75 rules and evidenced consideration of “most capable provider” in commissioning and funding decisions.

73. In conjunction with full Payment by Results, NHS England will negotiate marginal rates and capped resource contracts or service lines, which will seek to manage within a fixed commissioning budget and recognise provider cost.

Implementing Commissioning Policies

74. NHS England commissions according to agreed policies and service specifications, which identify where treatments, devices and services are routinely commissioned. Commissioning policies that specify treatment thresholds and criteria act within the NHS contract as group prior approvals for treatment. In some cases, additional audit requirements may be required with regard to individual prior approval by commissioners. Where policies and specifications make clear that treatments, devices and services are not routinely commissioned or where treatment thresholds and criteria have not been adhered to interventions will not be funded.

CQUIN

75. CQUIN arrangements for 2014/15 will be focused on an updated national menu of schemes with associated measures. To reflect an appropriate return for the level of investment, CQUIN measures will be based on achievement of significant levels of improvement, which may require the deployment of provider resources.

76. A CQUIN indicator for adoption across all specialised services providers will be developed. This incentive will only be offered to providers for initiatives which are proven to offer continuous improvement toward best practice, benchmarked utilisation, appropriate care and quality indicators. An example would be the adoption of utilisation management systems across providers and pathways.

77. A national review group drawn from commissioners and CRG leads will establish the indicator for adoption across all specialised providers. The CRGs will be guided by a set of principles in developing the specific CQUINs for their area to ensure these incentives are delivering greater value for the NHS.

CQUIN on Drugs and Devices Excluded from Tariff

78. National tariff pay and price adjustments are not automatically applied to drugs and devices excluded from tariff i.e. NHS England will pay actual costs. These costs are also excluded from the tariff efficiency deflator arrangements. NHS England is committed to consistently adopting the national rules as published in all contracts and therefore will be excluding excluded drug and device budgets from the contract value to which CQUIN applies for all NHS England contracts in 2014/15 and onwards.

Commissioning Resources

79. Specialised services will, as in 2013/14, be funded directly by NHS England. NHS England will set budgets at an area team level for all prescribed specialised services activity undertaken by providers in their geographical area. Allocations will be based on historic baselines adjusted for 2014/15 planning requirements.
80. High quality specialised services will be effectively managed within these finite resource envelopes by NHS England and providers working together.
81. Each area team will be responsible for ensuring the financial and quality performance of the contracts it holds. Growth and efficiency savings will be applied to contracts in line with the 2014/15 planning guidance. This will apply to all elements of the contract but not drugs and devices excluded from tariff.

Financial Sustainability Programme

82. Prices for specialised services are currently subject to wide variation. This does not provide equitable funding to trusts, and could lead to significant financial instability when a single national price is set for a non-tariff service. The financial sustainability programme aims to ensure that local tariff prices for specialised services converge to levels that at least 25% of providers are already achieving and are compliant with national standards of care. In recognition that unit costs may be impacted by the consistency of adoption of the national service specifications, a target range, rather than a specific price level, is being developed. Where current provider non-tariff prices are above the target range, a trajectory for reductions through locally agreed service redesign will be agreed and will inform the contract prices and contractual service improvement programme.
83. During 2014/15 a key element of the programme will be to develop a national benchmark understanding of best practice pricing and standards compliance. This will be shared with providers. Commissioners and providers will identify early areas of opportunity and agree goals for change in the 2014/15 contract. This will ensure early progress on convergence is made whilst more extensive benchmarking is undertaken.
84. In 2014/15 providers will have the opportunity to contribute toward the development of a national pricing framework which manages risks and benefits. This framework will fully apply to all providers in 2015/16. NHS England will work with CRGs, providers, the Payment by Results development team and Monitor to develop a programme of work to deliver national currencies and prices for specialised services. NHS England is open to proposals from provider networks during 2014/15 where alignment of pricing between members retains funding within the best practice range.

Specialist Top Up Payments

85. Specialised top up payments will continue to be paid solely to those providers who are on the list of providers eligible for top up in the National Tariff Document (NTD) guidance, (as defined by the Specialist Top Up Group), and for those services outlined

in the guidance. There will be no extension to other services which now form part of the prescribed list.

86. In future the list of eligible providers will be informed by the strategic clinical service review.

Identification Rules

87. The Identification Rules (IR) is a technical toolkit that enables identification of the 143 prescribed specialised services and supports the detail of the Manual and clinical service specifications.

88. The Identification Rules consist of two elements:

- a. A software version of an informatics rule set that enables automated identification of specialised activity from standard inpatient and outpatient data flows.
- b. A guidance document that outlines how specialised services can be identified in non-standard data flows.

Note: both elements need to be used together.

89. The current version of the Identification Rules is in the process of being updated to address anomalies/omissions reported by stakeholders. NHS England intends to publish a document during early October 2013, outlining the changes to the 2014/15 version of the Identification Rules. NHS England is committed to promoting a stable financial environment by keeping any changes to a minimum, and this revision will aim to address only those changes that are essential.

90. The intention for the 2014/15 commissioning process is that there will be no deviations from the reported Identification Rules and NHS England will utilise contract sanctions where the quality of data is proven to be deficient.

91. A development time line is currently being developed to look at opportunities to incorporate the Identification Rules within the HRG grouper and the replacement for the Secondary Usage Service (SUS) for the future.

Dialysis Away from Base in England

92. The 10 area teams responsible for the commissioning of specialised services will fund dialysis away from base for all English patients who require treatment from a dialysis provider within an area team's catchment area. Payment for dialysis away from base will be made to the dialysis providers by their area team. Further guidance for commissioners, providers and patients is being developed.

Individual Funding Requests

93. During 2013/14, the responsibility for Individual Funding Requests (IFR) for specialised treatments transferred to four regional teams which manage the process on behalf of the 10 area teams working to a single NHS England “Individual Funding Requests Policy and Standard Operating Procedure”. The current management process, the policy and Standard Operating Procedure will be reviewed and revised for 2014/15, strengthening national consistency. A training programme for panel members, commissioners and potentially for providers will be available.

Cancer Drugs Fund

94. The Cancer Drugs Fund will continue during 2014 and will continue to be managed as part of the prescribed services single operating model. The single national consistent policy for the management of the Cancer Drugs Fund will continue and be refreshed as required. This will be operationally managed on a regional footprint by four of the area teams responsible for prescribed services.
95. Trusts must have a process in place to ensure that the Cancer Drugs Fund application is made as part of the decision-making process i.e. patients should be registered prior to the commencement of treatment, except in exceptional circumstances, and in any event within 48 hours of commencing treatment. Failure to do so may result in withholding of payments.
96. Invoices must be submitted within three months of use of the drug. All Cancer Drug Fund drugs will be funded at cost; no additional charges will be accepted and no gain sharing will be allowed with drugs funded via the Cancer Drugs Fund. From April 2014 the Cancer Drugs Fund audit will be undertaken from returns to the Systemic Anti-Cancer Therapy (SACT) database. All trusts will be expected to make complete submissions to SACT for all chemotherapy.

Drugs & Devices

Commissioning and Procurement

97. Significant variation is experienced in the prices that commissioners pay for a range of drugs and devices that are provided to patients but are not covered by tariff. These drugs and devices are directly ‘passed through’ to the commissioner as the responsibility of NHS England.
98. The NHS is not obtaining best value from the opportunity to procure these at scale, with standard terms. It is estimated that savings of up to £400m over five years would accrue from this “at scale” approach. Commissioners will therefore establish a national procurement framework for excluded drugs and devices which provides for a national transparent price list that will be the maximum payable by

commissioners. This price list will not include administration costs and prescribing costs of aligned therapies will not be chargeable.

99. Excluded drugs and devices have historically been passed through as a charge to commissioners without a national standard framework which ensures best value for the NHS. It is acknowledged nationally that significant benefits can be obtained from better procurement. This national process proposes a four regions approach with two tranches of drug procurement over an estimated two year period. Currently homecare drugs are not included within this procurement framework. NHS England is currently working very closely with the Commercial Medicines Unit (CMU) in the Department of Health.

Payment

100. Drugs as detailed in the current NHS England excluded drug list will be commissioned in line with NHS England commissioning policies and NICE Technology Appraisals (TA). NICE approved drugs/ devices recommended within a NICE Technology Appraisal, that are excluded from tariff, will be automatically funded from day 90 of its publication. Some approved drugs and devices may be funded before this time at the discretion of NHS England. Trusts are expected to meet the requirements of NICE Technology Appraisals and be able to demonstrate compliance through completion of innovation scorecard returns.

101. Those excluded drugs and devices that are not NICE approved or endorsed within a national clinical commissioning policy can be considered via an Individual Funding Request, if there is evidence that the patient has clinically exceptional circumstances in comparison with other patients with the same condition presenting at the same stage of the disease. However, where the intervention relates to a cohort, a business case will be required and a national policy will be developed.

102. Excluded drugs/devices recommended within a NICE Interventional Procedures Guidance (IPG) and/or guideline will not be routinely funded unless endorsed within a national clinical commissioning policy.

103. Budgets for excluded drugs and devices will be set on an annual basis. This will be based on the provider's assessment of need through horizon scanning, and agreed through a confirm and challenge meeting with the provider. It is not anticipated that new excluded drugs and devices will be funded in-year unless approved by NICE and/or anticipated funding requirements have been previously identified.

Post-transplant immunosuppressants

104. It is expected that from April 2014 all post-transplant immunosuppressants and inhaled antibiotics for cystic fibrosis will be commissioned directly from trusts; patients receiving these treatments via GPs in primary care should be repatriated to secondary care.

Chemotherapy Drugs

105. Chemotherapy drugs could be considered for funding via the Cancer Drugs Fund by application to the national chemotherapy panel.
106. All trusts will be required to provide Systemic Anti-Cancer Therapy (SACT) data for all patients at each cycle of chemotherapy. This in turn will support the audit of drugs within the Cancer Drugs Fund.
107. From April 2014 all 42 fields of SACT data are mandated for each cycle of chemotherapy delivered. Trusts are expected to audit activity data quarterly and demonstrate that over 90% of activity data maps to the SACT data submitted per month. Trusts must have an action plan agreed with commissioners to address any shortfall in SACT data fields and findings of the audit of activity compared to SACT data submissions.
108. Only those drugs which are defined as a priority within a recognised chemotherapy regimen will be funded as part of the pass through arrangements. It does not include drugs which are provided for symptoms that arise post chemotherapy (e.g. anti-emetics, unless given to all patients as part of the standard regimen) and it does not include longer-term use of non-chemotherapeutic agents such as bisphosphonates. In addition, hormone therapies, unless specifically identified as excluded by the national Payment by Results team or by agreement with NHS England, are considered in tariff.
109. Procurement costs related to chemotherapy will be agreed in line with national principles.

Financial Assumptions

110. Excluded drugs and device costs charged to NHS England will be reflective of actual product costs to providers. NHS England will reserve the right to audit provider costs to demonstrate compliance with this term. Where national procurement terms have been adopted and commercial best price obtained. The cost of these drugs should represent good value for money to commissioners.
111. NHS England will maintain a central repository of prices for all excluded drugs and devices which is updated as national procurements are implemented. This will represent the maximum that commissioners will pay. If trusts obtain better value than this national price then the trust should be offered the national funded level on the condition that it joins the national programme so that the national programme achieves this benchmark level. Gain share opportunities will be considered where they are in line with national principles and endorsed by commissioners.
112. All existing gain sharing arrangements should be identified by 31 October 2013 to the area team pharmacy lead and will be reviewed against national principles developed by the Medicines Optimisation CRG.

113. Where agreement cannot be reached on share of gains or proposals offer limited value, the full value of best price and best prescribing practice will be passed through in line with national guidance.
114. Where drugs and devices are used outside of commissioned services, as defined as nationally commissioned by NHS England, any consequential costs that are incurred will not be funded. This includes the costs associated with the entire treatment.
115. Non-excluded drugs prescribed concurrently with the excluded drugs are not chargeable as these are covered within national tariff.
116. No additional charges above cost will be accepted. The only exception to this will be for those specifically identified in 2014/15 Payment by Results guidelines, explicitly agreed with NHS England and specifically agreed within the contract. Any on cost or additional charges previously added to drug costs must be identified to the area team pharmacy lead by 31 October 2013 and will be subject to review.
117. It is expected that all drugs subject to discounts, rebates or other such Patient Access Schemes (PAS) agreed as part of a NICE Technology Appraisal review will be charged to NHS England at full net cost unless by prior approval.

Performance Monitoring

118. All providers will be required to fully populate the national IVIG data base to ensure patient safety. This includes indication, dose, administration and outcome. Invoices for IVIG will be matched to the national database entries.
119. Excess treatment costs related to National Institute for Health Research sponsored trials will be prioritised in accordance with NHS England's interim commissioning policy which can be found at:<http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-06.pdf>
120. A monthly report on drugs and devices expenditure will be required as set out in the Information Schedule of the NHS Standard Contract. Validation of the use of excluded drugs and devices will be requested by NHS England where there is a reported overspend. This will normally be in the form of an audit. Any use of a drug/device outside the agreed criteria without express authority from NHS England will not be funded. Validation queries will be raised on a monthly basis in line with national payment timetables. Where further action is required validation meetings will be convened on a quarterly basis.

Devices

121. There appears to be significant variation in the recharge to commissioners for excluded devices. A national framework will be established during 2014/15 which identifies the best value and price for funding. This will be informed by procurements at a regional and national level that represent value for money. As this price list is

established by NHS England this will be utilised to challenge and inform agreed budgets.

Service Specifications

122. During 2013 NHS England, via the four regional and 10 area teams has undertaken work with the provider community to assess compliance with service specifications. This work has informed an approach to the formal introducing of these specifications which sees:

- a significant number of specifications moving from the developmental to the mandatory part of contracts in-year, where providers have demonstrated compliance with service specifications;
- the development of provider action plans to achieve compliance with specifications within a defined time period. These provider action plans are supported by a 'derogation'. A derogation is a licence to operate outside of a national service specification for a time-limited period;
- a number of services where local and/or regional analysis has highlighted that commissioner-led work is required to achieve compliance with service specifications (e.g. due to a provider landscape with more providers than can support minimum numbers of cases identified in the specification). In these cases a derogation has been used, but without the requirement for a provider action plan;
- a small number of specifications require further work prior to introduction;

123. Area teams will be performance monitoring the delivery of provider derogation action plans through routine contract monitoring mechanisms. NHS England will utilise contract sanctions where there is significant or persistent non-delivery against these plans.

124. Where commissioner-led service review work is required, this will be undertaken as part of the specialised services work plan. The pace and timing of this work will be communicated at a later stage once assessment of the requirement has been undertaken, identifying the scale at which each of these service reviews would most appropriately be undertaken.

125. NHS England does not expect service specifications to drive any inflation in the overall expenditure on specialised services.

Service Developments

126. NHS England has an interim generic policy on service developments which can be found at <http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-02.pdf>

127. Any service development will be funded from within the existing quantum of specialised services and will be prioritised within the specialised commissioning

strategy. Commissioners will decide, with the advice of the CRGs, which service developments should be implemented.

128. NHS England will not support any service developments which are not aligned to our strategic priorities or developments. This includes the following:
- a. Services that are not defined as prescribed specialised services;
 - b. Services that have been confirmed through policy as not routinely commissioned;
 - c. Services which are not able to demonstrate clinical, patient and cost improvement;
 - d. In year service developments, unless explicitly required by commissioners;

New Market Entrants

129. Discussions have taken place with Monitor to agree a programme of work that reviews all 143 specialised service lines and implements a programme of market assessment over a two to three year period. This will allow NHS England to prioritise the work over a number of years and enables us to share our strategic decision-making framework with Monitor proactively.
130. NHS England intends to move towards a 'fair playing field' for NHS and independent sector providers.
131. For 2013/14 there will be no new market entrants for specialised commissioning across the country unless there are clinical safety or capacity issues. It is unlikely that this position will change significantly in 2014/15 unless the outcome of the review of service lines identified above indicates capacity expansion is required or where market testing a service will bring clinical and/or financial benefits.
132. It will be important that we link the review of current provision and capacity with the implementation of the specifications and the development of the national strategy to ensure that we can demonstrate that we have a consistent and transparent way of addressing new market entry on a national basis.

Service Specific Issues

Mental Health

Secondary Commissioning

133. It is intended that all secondary commissioning of Specialised Mental Health Services will cease from 1 April 2014 and NHS England will contract directly with providers for specialised mental health services. This will help moving in the direction of travel to support Monitor's fair playing field review.

Currencies and Pricing

134. It is intended that NHS England move to all inclusive pricing for Specialised Mental Health Services particularly in respect of observations
135. Information for Payment by Results (PbR) development for Specialised Mental Health Commissioning will be required and incorporated into the Information Schedule.
136. There will be on-going work in 2014/15 and 2015/16 in the development of currencies for high, medium and low secure services. It is anticipated that pilot sites will be established in April 2014 to test the currency, care packages and outcome measures.

Access to Services

137. Standardised Access Assessments will be developed by the relevant specialised mental health CRGs for introduction during the period of these commissioning intentions.

Offender Personality Disorder Programme

138. We continue to support the implementation of the Offender Personality Disorder Programme, commissioning and decommissioning services to improve access and treatment outcomes in line with agreed funding.

Winterbourne View Concordat

139. The work with CCGs and providers will continue to ensure the Winterbourne View Concordat actions are implemented.

Child and Adolescent Mental Health Services (CAMHS) Tier 4

140. Following the Child and Adolescent Mental Health Services Tier 4 review, it is expected that the recommendations to procure appropriate quality, access and capacity will be implemented.

High Secure Services

141. A capacity review for high secure services will be carried out to inform a high secure commissioning plan. Work will continue with providers to align policies and procedures that directly impact on patients.
142. An additional 0.5% efficiency is expected from high secure providers with continued involvement in the benchmarking cost exercise to ensure delivery of future Quality, Innovation, Productivity and Prevention (QIPP).

Innovative Radiotherapy

143. Working with the Department of Health, NHS England is supporting the establishment of a Proton Beam Therapy (PBT) service in England by 2018. During 2014/15 we anticipate a phased increase in access to Proton Beam Therapy through the current overseas programme, whilst equipment is procured for the future centres planned in Manchester and London.
144. Intensity Modulated Radiotherapy (IMRT) is now available in more than 50 sites throughout England and we will require all providers to reach and maintain access to inverse planned IMRT at 24% or more of all radical treatments in each site. This is in line with the Government's commitment.
145. Intensity Modulated Radiotherapy and Proton Beam Therapy are only two examples of innovative radiotherapy and NHS England is therefore working in partnership with Cancer Research UK, clinical leaders and industry partners to develop and communicate NHS England's broader ambitions around equitable access to the most clinically and cost effective radiotherapy treatments as part of its broader strategy work.
146. Work will be undertaken during 2014/15 in collaboration with providers to secure sustainability in workforce and other aspects of service delivery to maintain IMRT services.

Paediatric Cardiology

147. During 2013-14 NHS England is conducting a new review to consider the whole lifetime pathway of care for people with congenital heart disease with the aim of bringing forward an implementable solution by the end of June 2014. This is expected to be a standards driven approach, building on the standards developed by Safe and Sustainable and the ACHD advisory group. All providers are encouraged to respond to the consultation on the standards (expected to take place in 2013/14) and to actively participate in the review. All providers are expected to work collaboratively with other centres in patients' best interests.
148. Until the new standards have been agreed and adopted, the Safe and Sustainable standards remain valid, and all specialist paediatric surgical centres are expected to work with the relevant area team to undertake a baseline assessment of that unit's position against the standards, and to develop an agreed plan for working towards the standards.
149. All specialist congenital heart disease providers should ensure that families, staff and referrers are kept informed of the progress of the review, the unit's participation in the review, and of local plans to enhance quality and safety.
150. It is widely acknowledged that the uncertainty which has been caused by recent developments is one of the greatest risks to the current delivery of the service. NHS England has developed a dashboard to provide early warning of any emerging concerns. All providers are expected to participate in this process.

Genetics

151. NHS England will be considering the future configuration of genetic laboratory services during 2014/15 with the intention of securing specialist testing and analysis skills; associated staffing and facilities; identifying opportunities to achieve efficiencies through economies of scale, and ensuring a strong provider platform upon which to take forward emerging and exciting advances in genomic medicine. Led by a multidisciplinary steering group, a range of options will be considered, with supporting descriptions of levels of service available to test with a wide range of stakeholders before a formal procurement is undertaken.
152. The Genomics UK led 100k genomes project is also expected to get underway during 2014/15, and NHS England will be working with commissioned providers to support the identification of potential participants and to ensure the programme links effectively to clinical pathways.

Haemophilia Tendering

153. The current national frameworks for the supply of blood clotting factor products expire in 2014 the first of these, for recombinant factor VIII, on 31 March 2014. NHS England is working with the Haemophilia CRG, the UK Haemophilia Centre Directors' Organisation (UKHCDO) and the Commercial Medicines Unit (CMU) to make sure that new national supply arrangements are in place through a competitive tendering exercise. All centres using blood clotting factor products for NHS patients will be expected to purchase factor products in line with these agreed national arrangements in order to support this national initiative.

PET/CT

154. The two national independent sector contracts for PET/CT, which deliver approximately 50% of PET/CT scanning in England, are due to expire at the end of March 2015. NHS England is currently looking at the most appropriate re-procurement model to ensure continued access to PET/CT services. It is envisaged that a tendering process will need to commence in 2013/14 and will run through 2014/15.

