



Commissioning Intentions 2015/16 for Prescribed Specialised Services

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Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference: 02305

Document Purpose	Guidance
Document Name	Commissioning Intentions 2015/16 for Prescribed Specialised Services
Author	NHS England / Operations / Specialised Services
Publication Date	30 September 2014
Target Audience	Foundation Trust CEs , NHS England Regional Directors, NHS England Area Directors, NHS Trust CEs
Additional Circulation List	CCG Clinical Leads, CCG Accountable Officers, Directors of Finance
Description	
Cross Reference	Commissioning Intentions 2014/15-2015/16 (GW:00505)
Superseded Docs (if applicable)	N/A
Action Required	Use to inform contracts and business plans for 2015/16
Timing / Deadlines (if applicable)	N/A
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Document Status

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Contents

Contents.....	3
Executive summary	5
Purpose.....	6
Context.....	6
Strategic direction.....	6
Changes to the scope of specialised services.....	7
Strategic service review	8
Clinically driven change.....	8
Service development and reinvestment strategy for cost effectiveness	8
Clinical thresholds and unwarranted variation in access to care	9
Clinical utilisation review	9
Service Specifications	10
CQUIN.....	11
Evaluation through Commissioning (EtC).....	12
Networks	12
Individual funding requests and Cancer Drug Fund	12
Contracting for specialised services	12
Prime contractor opportunities	12
Priorities for early engagement for 2015/16	13
Capacity planning and engagement on potential QIPP solutions	13
Coding and counting for services with a national tariff price.....	13
Acute services without a national tariff price	14
Top up payment arrangements and local price modifications to national prices	15
Securing best value for patients from drugs and devices	15
Device spend – reference prices.....	16
Performance monitoring	17
Post-transplant immunosuppressants	17
Chemotherapy drugs.....	18
Consistency in practical arrangements.....	18
Service specific issues	19
Mental health.....	19
Case management.....	19
High secure	20
Offender personality disorder	20
Care pathways	20
Women and children’s services.....	20
Genomic and genetic services	20
Congenital heart disease pathways and services	21
Paediatric long term ventilation	21
Cancer and blood.....	21

Haemophilia tendering & HIV drugs	21
Consistency in Bone Marrow Transplant Service Contracting.....	21
Radiotherapy for Prostate Cancer	21
Hepatitis B & C and HIV	21
PET-CT	21
Radiotherapy.....	22
Proton beam therapy.....	22
Trauma.....	22
Stereotactic radiosurgery and radiotherapy.....	22
APPENDIX	23

Executive summary

Commissioning Intentions serve as formal notice to providers of NHS England's plans in respect of specialised services for 2015/16. They reflect the central challenge of improving patient outcomes whilst constraining levels of spend to match available resources. For NHS England and its providers, collaborating to adopt the most efficient service models through delivering change is a key priority.

The **scope of services** in 2015/16 and beyond will reflect corrections to the Information Rules, and changes to the list of specialised services previously agreed by Ministers. The Commissioning Intentions are also set in the context of future devolution of some services to CCGs and co-commissioning arrangements.

The **NHS Five Year Forward View**, to be published in the autumn, will inform the strategic direction for specialised care. A programme of **strategic service reviews** will inform future plans.

Long term partnership opportunities for tertiary centres will form part of future commissioning arrangements. Service quality and efficiency together with evidence of maturity of relationships in win/win contracting behaviours will inform the selection of providers. Preparations for prime contracting will take place with a small number of area team- led arrangements awarded during 2015/16 where these offer strong benefits.

The **prioritisation round** in December will consider investment and disinvestment to achieve best outcomes for patients within available resources. Providers should not initiate service developments unless these are required as a result of prioritisation.

NHS England is developing a small number of additional **service specifications**, which will be resource neutral. NHS England will monitor service specification KPIs and **quality dashboards** through core quality standards. CQUIN will continue to be used to improve quality and efficiency. NHS England is considering whether provider compliance with core service specification measures should be a condition for attracting CQUIN in some circumstances.

Clinical thresholds are being reviewed and will be audited. NHS England will only make payment where treatment complies with policies so providers need to ensure monitoring systems are in place. **Coding and counting changes** for nationally priced services will be subject to national notification and standard template reporting.

For acute services, NHS England will promote redesign to achieve convergence to prices reflecting **most efficient quartile costs** and subject to national guidance, where contract level **risk share** is not in place, expand marginal cost arrangements for **locally priced services**

For nationally priced services, payments above **mandatory tariffs** will not be made except through local tariff modification applications supported by Monitor.

The **NHS standard contract** will be used, with a uniform standard price/activity matrix and local price list format to improve transparency and benchmarking capability.

Providers have identified that **better value in excluded drugs and devices** is key to protecting available resources for clinical services. NHS England intends to improve reporting and price transparency to ensure NHS England pays the best available price. Reference prices for devices will be introduced reflecting maximum reimbursement, together with updated risk and reward sharing arrangements and consistency in funding **supportive medicines**.

NHS England plans to make **service-specific changes** including: expanding case management in mental health; taking national approaches to stereotactic radiosurgery, genetic laboratories, genomic medicine centres; and procuring PET-CT services.

Purpose

1. These intentions provide notice to healthcare providers about changes and planned developments in commissioning and delivery of prescribed specialised services by NHS England. Together with planning guidance, the NHS contract, National Tariff Document and CQUIN guidance, they form an agenda which will be reflected in contracts, in-year service development plans, service reviews and procurement opportunities for 2015/16.
2. Their prime purpose is to enable providers: to make early preparations; to engage with clinical service leads and commissioners; and to realise change that benefits patients. They should inform providers' strategic, operating, financial, workforce and business plans, and contract negotiation plans.

Context

3. There have been many positive achievements within the sector: extensive national clinical leadership engagement; the adoption of expert-led service specifications; more consistent contract management; and, for the first time, equity for patients through nationally consistent evidence-based treatment policies.
4. However, levels of growth in spending on specialised services have been unaffordable. The specialised services sector of the NHS is operating at a substantial deficit relative to the recurrent money available with growth eclipsing resources. The central leadership challenge for commissioners and providers in the coming year is to achieve the best outcomes possible for patients within the constrained resources available.
5. This means planning for constrained provider income and leading change to adopt the practices of the most efficient clinical services. These changes will need to be reflected in contractual arrangements with early action taken on QIPP plans. For commissioners, it will mean prioritising carefully, identifying the disinvestment required to fund new obligations and working in collaboration with partners where preventive action in upstream services can reduce pressure on complex care.

Strategic direction

6. Building on the Call to Action in July 2014 and the planning framework published in December, the NHS will be publishing a Five Year Forward View in the autumn.
7. On grounds of quality or efficiency for some tertiary conditions, NHS England will choose to work with a smaller number of leading hospitals. The selection of these long term partners will be influenced by the maturity of the relationships these hospitals exhibit, both in terms of win-win contractual behaviours over the next 12-24 months and their shared understanding of the medium term financial context within which the whole NHS is having to operate.
8. NHS England's plan for implementing its element of the 'UK Strategy for Rare Diseases' will inform the strategic approach for specialised services. NHS England 'Statement of Intent' outlines how it intends to achieve the commitments and work with partners on all other commitments in the strategy.

Changes to the scope of specialised services

9. Ministers have already agreed that the following services should no longer be commissioned by NHS England and should be reflected in CCGs contracts from April 2015:
 - specialised wheelchair services
 - outpatient neurology referrals made by GPs to Adult Neurosciences Centres
 - outpatient neurology referrals made by GPs to Adult Neurology Centres
10. Ministers have also agreed that the following services will no longer be commissioned by CCGs; these services will be reflected in NHS England contracts from April 2015:
 - some highly specialised adult male urological procedures
 - some adult oesophageal procedures
 - services for patients with homozygous familial hypercholesterolaemia
 - some adult specialist haematology services
11. NHS England has recommended to the Prescribed Services Advisory Group that the following services currently commissioned by NHS England should in future be commissioned by CCGs:
 - renal dialysis (excluding encapsulating sclerosing peritonitis surgery)
 - surgery for morbid obesity

Once a ministerial decision is confirmed, any change in responsible commissioner will need to be reflected within NHS England and CCG contracts with providers.

12. In addition, the information rules (IR) software and guidance will be updated with technical changes to better reflect the detail of clinical service specifications, and ensure full alignment with the Manual. Subject to confirmation by the HSCIC, it is expected that the IR will be reflected in the HRG grouper software and the replacement for the Secondary User Service to which providers submit data
13. Providers are, through data quality improvement plans, making revisions to data flows in 2014/15 that will enable national adoption of the IR toolkit in 2015/16, which will be mandatory. Contracts should reflect the updated IR to provide national consistency in the scope of services. This will require liaison between providers, NHS England and CCGs to jointly manage the alignment of contracts, activity flows and commissioning budgets.
14. NHS England will be establishing arrangements to co-commission the majority of specialised services in partnership with CCGs. This will enable better aligned decision making to help restore pathway integrity and improve the transition for patients between specialised and non-specialised services. The detailed arrangements for co-commissioning are being developed and will be shared in due course.
15. Regardless of whether services are commissioned by NHS England or CCGs we expect to be able to exemplify for CCGs the usage being made by their populations of specialised services, and to incentivise them to work alongside NHS England in ensuring appropriate prioritisation decisions are made.

Strategic service review

16. In commissioning and sourcing provision of clinical services NHS England, in line with legislation, will act with a view to:
 - securing the needs of the people who use the services;
 - improving the quality of the services;
 - Improving efficiency in the provision of services.
17. The annual contractual review of existing services and providers and reprocurement where contracts are due to expire are two vehicles for doing this.
18. To ensure that services are commissioned from the most capable provider(s), NHS England undertakes Strategic Service Reviews and, where a service review indicates testing a service will bring clinical and/or financial benefits, reviews will inform the procurement plans for services. NHS England has previously agreed to undertake a rolling prioritised programme to assess all specialised service lines, typically over a three year period. This wider programme of strategic service reviews will be published in the spring. The needs assessment and review of stereotactic radiosurgery and the national procurement of PET CT services are examples of early work in this area.
19. Other factors influencing the service review programme priorities include:
 - Strategic solutions to address those services where providers are unable to meet national service specifications
 - Significant interest from potential providers with credible potential to significantly drive greater financial or clinical benefits for patients than incumbents
 - Services where progress towards the adoption of most efficient service models agreed through contract negotiations has been limited
 - Where Quality, Innovation, Productivity and Prevention opportunities are significant.
20. The scope of service review and procurement will have regard to clinical dependencies between services. The programme will assess national priorities, with a regionally co-ordinated area team assessment to add to the programme where there are locally specific issues for services. The work programme will reflect best use of available change management capacity to ensure at all times continuity of services for patients and the involvement of patients and communities.
21. Further details of the process for potential providers of services to provide evidence for financial and clinical advantages compared to existing services to register with NHS England for consideration within the rolling review programme will be published this autumn. NHS England will advertise market testing through the government 'Contracts Finder' website and respect the objectives of proportionality, transparency and non-discrimination for current or potential providers from the NHS, independent or third sector.

Clinically driven change

Service development and reinvestment strategy for cost effectiveness

22. As outlined in its previous Commissioning Intentions, NHS England is developing a transparent prioritisation framework to guide the work of Clinical Reference Groups and Programmes of Care to enable decisions to be made about investment and disinvestment in services to best meet need within the resources available. These proposals are assessed by the national Clinical Priorities Advisory Group, which advises NHS England on all directly commissioned services

23. 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.
24. 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.
25. The prioritisation round for 2015/16 will take place in December 2014 with decisions ratified in January. Where required, contractual notice periods will be observed for any changes except where, by mutual agreement, more rapid implementation is jointly agreed.
26. For the avoidance of doubt, area teams are unable to give support to cost increasing business case proposals outside of the national process. Providers should not initiate in-year service developments unless formally requested by commissioners as a result of the national prioritisation process.

Clinical thresholds and unwarranted variation in access to care

27. A programme of review is being undertaken to ensure thresholds and criteria for access to specialised services are set so as to optimise patient outcomes within the resources available. Work will also ensure that opportunities for prevention, pathway improvement and efficiencies are identified and action taken across the commissioning landscape for delivery.
28. To treat patients equitably, adherence to defined thresholds and criteria for treatment is a condition of payment for services. NHS England will be expanding its work in auditing compliance, so healthcare providers should ensure effective internal clinical governance controls assurance are in place to avoid undertaking activity that cannot be reimbursed.
29. A wider programme within 2015/16 will be developed to review differences in population intervention rates relative to need, involving provider clinical teams, NHS England and CCG commissioners, supported by Public Health England, to understand and resolve the addressable causes of outlying practice.

Clinical utilisation review

30. Clinical utilisation review (CUR) technology is widely used internationally to provide evidence-based decision support for clinicians to ensure patients are cared for in the optimal setting and to address barriers to optimal patient flow.. NHS England introduced a substantial CQUIN to support providers in adopting the technology for specialised admitted patient care and critical care in 2014/15. Building on this approach, CUR will form a central element of the scheme in 2015/16.
31. Providers should register interest with their area team commissioner by 31 October and will be invited to a day where the leading providers of services and clinician leaders with experience in using the technology to underpin hospital care will be available to share learning.

32. Providers should note that the CUR CQUIN scheme is being made for use by CCG commissioners where it fits with local priorities such as underpinning changes to meet the goals of the Better Care Fund and improved Urgent & Emergency care so should discuss CUR opportunities with all commissioners.

Service Specifications

33. Clinical Reference Groups (CRGs) are the primary source of clinical advice to NHS England for the development of prescribed specialised services. CRGs continue to review and develop the clinical service specifications, introduce clinical access policies, define quality measures and build quality dashboards.
34. A range of service specifications will be added or significantly amended for April 2015 and are listed in the appendix. Specifications aim to be deliverable within existing resources, and, for services without a national price, within current resources for efficient service costs. Providers should use the consultation period to identify any issues that need to be addressed to ensure this is achievable. Self-assessment will be required against all new or amended service specifications and action plans to achieve compliance will need to be agreed with area team commissioners. Any new or revised specifications that require investment by NHS England will be subject to agreement via the annual prioritisation process.
35. Some service specifications describe requirements or good practice in pathway elements that are beyond the scope of the Manual and IRs. In these cases, the latter take precedence in determining funding and commissioning responsibility.
36. Where Service specifications contain KPIs, these will be incorporated for routine monitoring through the contract quality schedule. Providers should prepare for regular reporting of the identified KPIs.
37. Since 2013, all services have been required to meet service specification standards. In 2014/15, derogation, (time-limited permission to operate at less than full compliance subject to a compliance plan) has been used. Aside from 'commissioner derogations' (which address structural issues outside of providers' control), unless notified to the contrary providers should be fully compliant before April 2015 so that all patients benefit from consistent standards of care.

CQUIN

38. NHS England is reviewing arrangements for national incentives schemes, including CQUIN, for 2015/16. Detailed arrangements will be published later this year.
39. Providers and commissioners should engage early in the contracting round and include dialogue with local clinical leaders and commissioners to inform stretching but achievable improvement goals. Planning should be on the basis that:
 - Established Quality Dashboards will move to the routine quality schedule. Where previously linked to CQUIN payments, funding will be moved to other priorities.
 - The 2014/15 quality initiatives that were developed by CRGs and which made care more cost effective were mandated for inclusion as an element of CQUIN which thereby also contributed to QIPP goals. The 2015/16 scheme will build on this with earlier engagement and design on QIPP priorities.
 - Where published CQUIN schemes were based on a two year implementation period, such as Clinical Utilisation Review, these will continue to be available.
 - Currently, CQUIN is not payable on certain areas such as excluded drug and devices spend, and this is expected to continue next year. The national CQUIN guidance, published later in the year, will provide more detail about this.
 - NHS England is considering whether provider compliance with core service specification measures should be a condition for attracting CQUIN for those services, other than where commissioner derogation is in place. This will be clarified in the national CQUIN guidance.
40. Recognising the high potential to reduce substantially the cost and improve patient care, NHS England is exploring a number of additional early implementer grants in addition to CQUIN payments, where hospitals commit to roll out clinical utilisation review technology on a whole hospital basis. Whilst every Trust has opportunity to secure a CQUIN, which fully funds the cost of implementation, early implementer grants are likely to aimed at those providers with current specialised contracts above £50m per annum. A decision on early implementer grants will be made by 31 January. Further information will be published alongside CQUIN measures for specialised services.
41. Building on the CQUIN made available last year, NHS England is aiming to identify up to six pioneer sites to implement and evaluate the impact of hand hygiene RFID technology solutions. International evidence of substantial reduction in healthcare acquired infection rates suggests this is a promising intervention. Early implementer grant support per site may be made available over and above the fully funded CQUIN for providers undertaking more substantial deployment. The CQUIN is open to all providers of care who have acute admitted patient care wards that regularly treat a high proportion of specialised patients. The CQUIN scheme is also available for CCGs to commission.

Evaluation through Commissioning (EtC)

42. The Commissioning through evaluation programme, now known as 'Evaluation through Commissioning' (EtC) was established in 2013 as an innovative mechanism to capture further evaluative data to inform future clinical commissioning policy in areas that show significant promise, but with insufficient existing evidence of clinical and/or cost effectiveness. Five schemes are already in progress. Selected participating trusts will be reimbursed for provision at prices agreed through national review. Patient selection and data submission requirements in full are a condition of funding. NHS England will consider the potential for any further schemes as part of the wider resource prioritisation process where these can be delivered within a balanced financial plan.

Networks

43. Strategic Clinical Networks, Academic Health Science Networks, and Operational Delivery Networks (ODN) are a significant resource to the NHS to address the challenging agenda ahead. In particular, providers and commissioners should be satisfied the work programmes address unwarranted clinical variation and secure adoption of most efficient practice in services to free up resources for patient care. ODN membership is mandatory for all commissioned providers of critical care, neonatal care, paediatric neurosciences, burns and major trauma to be compliant with service specifications.
44. For ODNs, providers should review arrangements against the four key success factors for ODNs set out by the Chief Nursing Officer and Chief Medical Officer:
- Improved access and egress to/from services at the right time
 - Improved operating consistency
 - Improved outcomes
 - Increased productivity
45. NHS England has provided supplementary funding for ODNs through setting aside 0.1% of CQUIN funding for the last two years and this will continue in 2015/16. Future arrangements for the funding of ODNs will be reviewed during 2015/16

Individual funding requests and Cancer Drug Fund

46. Arrangements for Individual Funding Requests and the Cancer Drug Fund (CDF) will continue in 2015/16. CDF applications prior to commencement of treatment, (or within 48 hours in exceptional circumstance), invoicing within three months and returns made to the Systemic Anti-Cancer Therapy (SACT) database remain conditions of reimbursement. All CDF drugs will be funded at cost without additional charges and are not within scope of gain-sharing arrangements with providers.

Contracting for specialised services

Prime contractor opportunities

47. During 2015/16, NHS England will lead a process to invite proposals for prime contractor delivery for a whole pathway of care or model of care where tiers of provision are closely networked. Under prime contracting arrangements, activity funding and clinical outcomes are attributed to the lead centre that manages clinical and corporate governance on a hub and spoke basis. Proposals will be taken forward as a result of strategic clinical service reviews and providers are invited to engage with local teams to identify areas of opportunity for clinical and financial benefits from potential arrangements and to identify willingness to partner as a lead or a spoke centre. Development of new arrangements will reflect principles of openness, transparency and non-discrimination for both current and potential providers in line with regulatory requirements.

Priorities for early engagement for 2015/16

Capacity planning and engagement on potential QIPP solutions

48. The 2015/16 contract requires all activity plans and local price lists to be in a mandatory common format. Capacity planning to inform contract discussions will take place in the autumn and should start from a 'no intervention'¹ basis. Area teams will be provided with demographic and non-demographic growth assumptions to jointly build activity plans. There may be local reasons for variation to these national assumptions which will need to be documented and agreed where robustly evidenced. Commissioners will take responsibility for the final decision on these forecasts in line with their responsibilities to determine the level of care to commission.
49. Area teams 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.
50. Initiatives which impact on a 'no intervention' plan, with clear responsibilities and constructive engagement will be vital to ensure that contracts remain affordable. Area teams will discuss a range of QIPP projects which have been developed by clinical reference groups 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

Coding and counting for services with a national tariff price

51. NHS England recognises the benefits of improvements in the accuracy of coding. In the context of an overall reduction to spending within available financial resources, changes in counting may lead to increased expenditure without additional clinical benefit, which will require disinvestment in other services and reduced access to services by patients. It is therefore important that all change proposals are robustly evidenced and a national assessment of the wider system impact of proposals can be made.
52. Commissioners are mindful that consideration is being given to a moratorium on coding and counting changes to ensure service stability. For the coming year:
 - Notice for coding and counting change proposals for services with a national price must be submitted using the standard documentation template and email address, which was issued in August 2014 by circular via area team commissioners. Submissions were requested by 30 September 2014 in line with the requirements in national contract provisions.
 - Additional backing information will be worked through with area team commissioners who will also provide to the national team an initial assessment of validity of proposals that are likely to be supportable, should a decision be made to accept such changes for 2015/16

¹ Forecasting future activity with existing demand management and QIPP measures but prior to incorporating additional QIPP measures or initiatives

Acute services without a national tariff price

53. NHS England will operate in line with the National Tariff Document (NTD) when published. The intentions set out below reflect an assessment from the direction of travel set out by Monitor and NHS England in the Tariff Engagement Document published earlier this year.
54. Current arrangements for locally priced services vary significantly between block contracts, marginal price arrangements and cost and volume pricing. Prices vary widely, and overall spend growth is unsustainable, far exceeding that of nationally priced care, and there is evidence that providers with a larger share specialised services enjoy substantially higher EBITDA² margins than other hospitals. The tariff engagement document proposes options for change to default arrangements for services to avoid rolling over unsustainable arrangements and prices.
55. Unless risk share agreements are in place, full cost and volume contracts create the incentives for services to achieve profitability through growth in activity. This approach is not aligned to the constrained financial resources available to the NHS and results in unintended disinvestment in services such as primary care and mental health. Through marginal cost arrangements, provider fixed costs are covered and the additional variable costs associated with extra activity are provided for, with the benefits of economies of scale being available to preserve access to care in other services. NHS England will look to expand marginal cost arrangements with existing providers for the majority of services.
56. Monitor and NHS England are engaging on options for change to the approach to setting local prices. Where services do not already reflect the most efficient quartile of unit costs, commissioners want to work with providers, who need to engage clinical service leads to:
- Agree a programme of clinically-led service redesign to realise changes for April 2015 and any other changes needed to match the most efficient operating models for services
 - Reflect anticipated improvements in agreed prices for 2015/16 and the timing of when any further benefits realised after April will flow through into prices.
57. Building on previous work last year to assess standards compliance and benchmarks in some areas such as critical care, a range of benchmark costs and prices is being compiled for area team commissioners and providers to use this autumn. Commissioners and providers should identify early areas of opportunity and agree goals for change, which can be confirmed and enhanced by benchmarking evidence once available.
58. Services that remain under block contract arrangements in 2015/16, for example due to poor quality data available to commissioners, will need to demonstrate with transparency equal or greater efficiency improvement than services commissioned using other forms of contracting arrangements including convergence to most efficient costs.
59. For services operating in line with efficient costs, and those where planned improvements can be reflected in prices, enhanced marginal rates may be agreed. These enhanced rates will also be possible for admitted patient care services where providers have committed to implement clinical utilisation review tools. A substantial CQUIN payment is also available to support this approach.
60. NHS England's approach to these services will be informed by an assessment of any further opportunities to achieve greater value for patients once the NTD is published, which should inform local contract discussions

² EBITDA is a recognised measure of operating profitability: Earnings before interest, taxes, depreciation, and amortization.

Top up payment arrangements and local price modifications to national prices

61. The national tariff payment system sets prices based on the average complexity of a group of patients treated with particular diagnoses and procedures. Differences in complexity are recognised for some specialties at designated providers through a top up payment. Even with these adjustments, no payment system perfectly reflects the distribution of complexity. This continues to be the subject of debate between larger and smaller providers.
62. Although NHS England supported some transitional arrangements where above tariff payments were made to some providers, addressing issues in the distribution of income between providers is not possible though the payment of supplements where additional financial resources are not available.
63. Where formal local modification joint agreements were notified to Monitor and approved for 2014/15, these will be reviewed on a case by case basis. NHS England will engage constructively on solutions but no new local modification agreements for above tariff payments will be entered into until commissioner spend is within available resources. Where providers meet the conditions set out in guidance for a local modification application, NHS England will abide by the relevant determination.
64. Commissioners look forward to the outcome of the complex care working group, and the introduction of HRG4+, both of which will inform future arrangements to more accurately account for complexity. Addressing the distribution of funding between trusts based on the available financial quantum of income – and aligning CCG and NHS England purchasing power through a full impact assessment – are needed to achieve a sustainable solution for patients.

Securing best value for patients from drugs and devices

65. Feedback from provider and commissioner reference groups has indicated that, in order to protect limited financial resources for clinical services, more should be done jointly to secure better value from the rising spend on excluded drugs and devices, which represents around a quarter of acute spend. NHS England already invests significantly in supporting this agenda with a Medicines Optimisation Clinical Reference Group, area team commissioner pharmacists and embedded pharmacist support in many trusts. NHS England is looking to expand work in this area as a key shared goal in 2015/16, including:
 - Validating clinical usage decisions at source to address unwarranted variation in prescribing practice
 - Improving transparency in prices paid to better target shared areas on procurement opportunity
 - Best Value Reference prices for devices and some drugs – to ensure all reimbursed payments reflect achievable efficiencies but allow local flexibility for trusts who wish to purchase at different rates and fund the difference
 - Harmonised supportive drug payments to improve consistency
 - Updated risk and reward sharing protocols to provide practical approaches to covering the resources needed where providers and commissioners aim, in addition to usual therapeutic switching, to dedicate additional resources to 'go the extra mile' together on more significant projects

66. Budgets for excluded drugs and devices will be set annually based on the provider's assessment of need through horizon scanning, subject to a 'confirm and challenge' meeting with the provider, with review of any outliers in rates of growth by the national specialised pharmacy lead. 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.
67. Clinicians in a large number of trusts already use the Blueteq system for individual funding requests. NHS England intends to roll out use of such systems to support usage decisions for excluded drugs and devices on a wider basis during 2015/16. All acute trusts with a current contract spend on excluded drugs and devices above £15m will have a CQUIN to support this change. Trusts with lower spend who wish this to be considered as a local CQUIN priority should discuss this with their area team. Once in place, invoices will be authorised based on recorded compliance with commissioned treatment indications.
68. Excluded drugs and device costs charged to NHS England will be reflective of actual product costs to hospitals and will be subject to audit to demonstrate this. Providers will charge all drugs subject to discounts, rebates or other such Patient Access Schemes will to NHS England at net cost.
69. Significant variation is experienced in the prices that commissioners pay for excluded drugs and devices. For specialised indications, these drug and device charges are directly 'passed through' to NHS England. Significant benefits can be obtained from better procurement. NHS England, through the Commercial Medicines Unit in the Department of Health, will continue to support a national process for procurement of high cost medicines. NHS England will maintain a central repository of prices for excluded drugs, updated as national procurements are implemented. This will represent the maximum that commissioners will pay. Trusts are not expected to tender for medicines included in the national framework.

Device spend – reference prices

70. NHS England is working to establish best value prices available to the NHS beginning for 2015/16 with implantable cardiac devices, bone anchored hearing devices and TAVI, with the involvement of Clinical Reference Groups. There are significant variations in prices paid by trusts for the same product. NHS England will agree commissioning approaches for devices within a category of treatment as well as reference prices. Where hospitals purchase at higher cost, the provider will bear the financial risk.
71. NHS England will shortly publish operating principles to inform arrangements for collaborative working on improving value for patients. The principles include identifying standard methods of payment for cash releasing schemes and expectations for when sharing of risk and reward is appropriate. 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.
72. 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.
73. Non-excluded drugs prescribed concurrently with the excluded drugs are not chargeable as these are covered within national tariff. No additional charges above cost will be accepted unless specifically identified in 2015/16 national tariff guidelines, explicitly agreed with NHS England and specifically in advance within the contract.

74. 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 (TAs). NICE approved drugs/ devices recommended within a NICE TA that are excluded from tariff will be automatically funded from day 90 of 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 TAs and be able to demonstrate compliance through completion of innovation scorecard returns.
75. 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 and there is an exceptional ability to gain clinical benefit from the treatment.
76. Excluded drugs/devices recommended within a NICE Interventional Procedures Guidance and/or guideline will not be routinely funded unless endorsed within a national clinical commissioning policy
77. An updated policy covering requests for excess treatment costs for research will be published later this year.

Performance monitoring

78. All providers will be required to fully populate the national (in full) 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.
79. From April 2015, providers of hepatitis C treatments will be required to report a minimum data set to include treatment provided, genotype of patient and whether a sustained virological response has been achieved.
80. Providers will need to submit the national standard minimum data set for drugs and devices expenditure set out in the Schedule 6 of the NHS Standard Contract, which will be enhanced for 2015/16. Providers will be required to provide assurance to commissioners that drugs and devices have been used in accordance with agreed national policy including through 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.
81. Shared access to the data from the Pharmex system by a combined commissioner and provider project group has significant potential to improve transparency and targeting of cost saving opportunities whilst minimising the data collection burden for trusts. Following discussions with user representatives NHS England intend to adopt this requirement for its contracted providers in 2015/16. Where trusts do not use the Pharmex system, regular provision of equivalent information in a prescribed format will be required in line with the standard contract provisions.

Post-transplant immunosuppressants

82. The programme of planned change from primary care to secondary care prescribing of post-transplant immunosuppressants and inhaled antibiotics for cystic fibrosis will continue in 2015/16 once NHS England is assured there is a stable homecare market. The aim is that the process will be complete by April 2016. To ensure changes take place once commissioning budgets with CCGs are aligned, trusts should implement changes in a coordinated way with GPs only once notified to do so by area teams.

Chemotherapy drugs

83. Chemotherapy drugs should be considered for funding via the Cancer Drugs Fund by application to the national chemotherapy panel.
84. All trusts are 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. 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. Reimbursement is conditional on meeting the 90% target.
85. National chemotherapy algorithms will be published for 2015/2016. Only those drugs which are identified within the algorithm will be funded as part of the pass through arrangements. This 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). Where local arrangements that offer better value are not yet in place, a standard ceiling price for supportive medicines will be paid to trusts for each cycle of chemotherapy delivered. Non-chemotherapeutic agents such as bisphosphonates and hormone therapies unless specifically identified as excluded by the national tariff or by agreement with NHS England, are considered in tariff.
86. Where outpatients or admitted patient care is nationally priced, any diagnostic testing and pathology is included prices and is for Monitor and NHS England jointly to take into account when considering annual updates to the national tariff. Where molecular diagnostic testing is used to help optimally target the use of drugs to patients who are most likely to benefit, trusts will need to factor in adoption of NICE guidelines as set out in the NHS Contract duties. Where a new test meets the criteria for exclusion from national tariff arrangements, NHS England will consider separate funding. The management arrangements for the introduction of molecular tests for a cohort of patients potentially eligible for the specific targeted drug will be considered on a drug by drug basis by NHS England following discussion with the relevant pharmaceutical company and other key stakeholders.
87. An agreed price will be paid to trusts for each cycle of chemotherapy delivered to cover pharmacy procurement costs.
88. All trusts are expected to work with area teams to maximise opportunities for dose banding and vial sharing where such activity does not exist.

Consistency in practical arrangements

89. Since 2013/14, NHS England, CCGs and providers have been collaborating to implement the NHS England single national operating model whilst seeking to maintain service and financial stability. Area teams will continue to work with providers to ensure local practice is transitioned to the single national operating model.
90. Mandated currencies will be adopted. For the first two years of introduction, providers will need to provide monitoring information for the baseline year and current year in both the mandatory currency, and previous currency, to assure the accuracy of prices against the new currencies given the financial quantum involved.
91. Contracts will use a standard format indicative activity plan and non-tariff price list, including drugs and devices, providing clarity and transparency. There will be a single stated price per service line in each provider contract.

92. NHS England will normally only hold (or be party to) one NHS Standard Contract with any provider. Secondary care dentistry and public health services from each NHS England area team 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 bill the relevant area team based on responsible commissioner for that population.
93. No national changes are planned to contract arrangements for those area teams commissioning health and justice services and those services used by the armed forces that are normally aligned to NHS England prescribed services contracts.
94. It is likely that the e-contract system for 2015/16 will be focussed on generating the modular content needed for contract documentation. NHS England expect to use the e-contract functions where they speed up the inclusion of standard elements to the contract, whilst making use of standard document management methods (such as PDF and MS Office documents) to make the contracting process easier to deliver in 2015/16.

Service specific issues

95. Service reviews are planned for hyperbaric oxygen, paediatric burns, and vascular amputation with further development of enhanced recovery pathways in cancer surgery.

Mental health

96. In 2014/15 NHS England stated its intention to move towards all inclusive pricing for specialised mental health services, particularly in relation to observations and special packages of care. This remains a priority and it is expected that all providers will move to inclusive pricing in 2015/16.
97. Providers of specialised mental health services will be commissioned with increased consistency of contracting terms. This will include consideration of percentage occupancy rates for child and adolescent mental health services (CAMHS) and adult mental health services as well as activity-related contracts with risk share arrangements and controls between provider and commissioner provided this offers value for money.
98. Further work is required to ensure consistency across the range of outreach services commissioned, which is supported by a service specification for all specialised mental health services.

Case management

99. The function of case management will be widened during 2015/16 to cover all specialised mental health services commissioned by NHS England, to support commissioning and providers and to ensure that patients receive the right level of care, at the right time in appropriate, safe, high quality services.
100. CAMHS Tier 4 and medium and low secure services will be tendered during 2015/16 to ensure treatment offered and location of services best meets patients' clinical needs. The procurement will also achieve increased consistency in pricing and contract terms across regions.

101. For these services, local dialogue and mutual accountability with CCG and local authority commissioners is needed to ensure capacity is aligned and sufficient in less restrictive settings. Service usage per head of population for each CCG and local authority area, along with length of stay and commonly defined delayed transfers of care, will be a key measure developed in 2015/16 to jointly address unwarranted variation in equity of access to both intensive and preventative services and to improve joint planning, This will build on learning from the best examples where CAMHS Tier 3+ services are making a difference for patients.

High secure

102. Currently, a high secure capacity assessment is underway. It is intended that this assessment will inform future commissioning intentions.

Offender personality disorder

103. There will be continued support for the implementation of the Offender Personality Disorder Programme within the overall funding available to the programme. This will be achieved by decommissioning services in hospital settings for offenders who meet the criteria for Dangerous and Severe Personality Disorder (DSPD), and by commissioning new services, mainly in prisons. In 2015/16 NHS England will conclude the decommissioning of the DSPD service at Nottinghamshire Healthcare NHS Trust.

Care pathways

104. A review of gender pathways, including access to treatment, will be undertaken to identify area how existing pathways can be strengthened and improve services for patients.

Women and children's services

Genomic and genetic services

105. NHS England is currently completing preparations to carry out a formal procurement exercise to support the establishment of a stronger, more responsive, modernised and efficient genetic laboratory service. This will provide a new configuration of Central Genomic Laboratories and will affect both current regional, local and speciality-based genetic laboratory services. A public consultation, clarifying the scope and draft service specification requirements of the new service, will begin in the autumn. It is anticipated that the new pattern of service delivery will be in place in 2016, with a current planned 'go live' date of January 2016. NHS England is exploring the potential to use the prime contractor model to commission the tests for which NHS England is responsible via the selected Central Genomic Laboratories.

106. NHS England is a key delivery partner in the Department of Health-led 100,000 genome project. NHS England is currently inviting applications from providers wishing to act as NHS Genomic Medicine Centres, which will help identify suitable patients wishing to consent to participate in the project and provide sample DNA to be sequenced as part of this important national development programme.

107. The medical genetics CRG will continue to identify opportunities to reduce variation and potential duplication in genetic testing practice. A specific proposal for Fragile X testing will be introduced shortly.

Congenital heart disease pathways and services

108. Many providers are already working towards the new children's and adult service standards, which will have been consulted upon and finalised by March 2015. The 12 months following this will be used to ensure progress against meeting those standards, and making clear the intended future form and function of the provider landscape

Paediatric long term ventilation

109. Complexities in putting in place the package of care at home can lead to extended lengths of stay for patients who are fit for discharge from paediatric critical care. Area teams will work with providers and ODNs to ensure early identification through a monthly long term ventilation status report and alerts to the responsible CCG to support timely discharge. Providers will be required to provide information in line with the service specification to improve pathway management for children and their families.

Cancer and blood

Haemophilia tendering & HIV drugs

110. Following a tendering exercise in 2014/15 the national frameworks for the supply of blood clotting factor products are in place. All centres using blood clotting factor products for NHS patients will be expected to purchase factor products in line with these agreed national arrangements. A similar requirement will also apply to the use of regional contract framework agreements for HIV drugs.

Consistency in Bone Marrow Transplant Service Contracting

111. A project on to achieve greater consistency in the scope of services commissioned within BMT packages of care is now underway to inform a more consistent approach to commissioning this activity in 15/16. In line with other acute services without a national price, the aim is to achieve convergence to prices reflecting most efficient quartile costs.

Radiotherapy for Prostate Cancer

112. In line with the emerging clinical evidence an updated commissioning policy may result in a reduced number of fractions being delivered for patients. The policy will be for immediate implementation. Providers should note this significant potential change when assessing demand and planning capacity.

Hepatitis B & C and HIV

113. Increases in blood borne virus testing of offenders are planned by Public Health England during 2015/16 and 2016/17. This will impact on growth rates for these services; commissioners and providers should take this into account when capacity planning these services. An assessment of the scale of impact is being undertaken and further information will be provided to area teams and providers later this year. It is likely that the NHS will embark on a procurement process to identify optimal Hepatitis C treatments from amongst the new therapies becoming available

PET-CT

114. A national procurement is in progress for PET-CT contracts covering over 50% of scanning in England. A mix of static and mobile provision is expected, with transition to new long term contract arrangements in April 2015 to secure new capacity and capital investment. A decision on tendering the remaining arrangements will be taken by September and formal notice will be served to remaining contracts following this.

Radiotherapy

115. NHS England in partnership with Cancer Research UK published "Vision for Radiotherapy, 2014-2024" in March 2014 in order to communicate NHS England's broader ambitions around equitable access to the most clinically and cost effective radiotherapy treatments. Reducing clinical variation is an aspiration of the Vision document and NHS England will continue to support the development of clinical commissioning policies to help address this as well as exploring opportunities to review the coding and pricing structure to ensure best value for money.

Proton beam therapy

116. High energy proton beam centres in Manchester and London are being commissioned. In the meantime care will continue to be commissioned from selected overseas providers where patients meet the published commissioning policy.

Trauma

Stereotactic radiosurgery and radiotherapy

117. Following a needs assessment and national strategic review and consultation in 2014, a national procurement of this treatment will be undertaken during 2015 to address both capacity and equity of access across the country and to ensure prices reflect best value for the NHS as usage increases in line with NHS England commissioning policy. A public consultation on proposals for these services will take place this autumn.

APPENDIX

118. Service Specification additions and amendments for 2015/16:

A06/S/a In-Centre Haemodialysis
A06/S/b Home Dialysis
A06/S/c Peritoneal Dialysis
A06/S/d Acute Kidney Injury
A06/S/e Assessment and Preparation for Renal Replacement Therapy
A10/S/a Adult Cardiac Surgery
D01/S/d Complex Disability Equipment: Prosthetics
E07/S/a Paediatric Critical Care Level 3
E07/S/b Paediatric Critical Care Level 2
E07/S/c Paediatric Long Term Ventilation
E07/S/d Paediatric Critical Care Transport
E08/S/a Neonatal Critical Care
E08/S/b Neonatal Critical Care Transport
E10/S(HSS)/a Gestational Trophoblastic Disease
Paediatric Medicine – Specialised Allergy Services
Paediatric Medicine – Neurodisability
Specialised Services for Pain Management in Adults
Adult Critical Care
Teenager and Young Adult Cancer
Tier 4 Personality Disorder
Gender dysphoria
Fetal Medicine
Children's epilepsy service
Congenital gynaecology anomalies
Recurrent prolapse and urinary incontinence
ACHD surgery
Hepatitis C subsection of infectious diseases
Genomic Laboratory Services