



**Commissioning Intentions  
2017/2018 and 2018/2019  
For Prescribed Specialised  
Services**

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## Executive summary

These commissioning intentions outline the strategic interventions to improve the way we commission and contract, review and transform specialised services. They build on progress already made to deliver consistent care standards across the country. They are based on the new strategic framework for Specialised Care set out in May 2016 which builds on the Five Year Forward View goals of a fully integrated health service delivering the best possible outcomes, within the resources available, for the population of England. To realise vision we will enable place and population-based care through much closer collaboration between NHS England and local commissioners on specialised service commissioning, as well as between commissioners and providers in the design and delivery of services. This new approach, to be reflected in all 44 Sustainability and transformation plans complements national clinical changes from Cancer, mental health, learning disability and maternity strategies and service reforms in the 6 specialised programmes of care including delivery of new, more networked models of care

This approach is delivered in a changing NHS context: Improvements for patients and sustainability of services have to be delivered within more constrained expenditure growth in the two years ahead. This provides a shared requirement for greater efficiency and productivity across the NHS for both commissioners and providers. The systematic year on year approach to productivity benefit realisation plans set out in the Carter review will form a key element of provider plans from 2017-2021. Specialised commissioning intentions support key areas of accountability for Trusts, ensuring they also deliver commissioning objectives for patients and tax payers:

- A clinical service redesign programme using operational practice and cost benchmarking will converge local prices to efficient levels and enable Trusts to deliver the planned reductions in resources per Weighted Activity Unit.
- Focusing support for our key providers as they progress implementation of clinical utilisation review and ensuring achievement together of multi-year benefit realisation plans using data to right size community services in STP footprints will enable providers to meet the Carter recommendations to deliver reduced length of stay and improved discharge and step down
- By April 2017 the NHS Supply Chain e-catalogue will be the single point of ordering for specialised high cost devices from all contracted hospitals, enabling leverage of the NHS purchasing power, with a clinically led review of the range and specification of devices from 2017 contributing to Carter procurement transformation plans, and improved performance on the purchase price index.
- Bringing together national work on cost-effective dispensing channels, high cost drugs optimisation, e-prescribing and work of the commercial medicines unit will ensure the NHS gets better value, with annual savings goals embedded in hospital pharmacy transformation plans, and reflected in CQUIN, planned contract expenditure and service development improvement plan milestones.

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New specialised acute tariffs and top ups more accurately reimburse efficiently delivered complex care. The adoption of nationally consistent information rules provides a new enabler to systematically address unwarranted variation.

As NHS England supports the 'Getting it right first time' programme, a reduction in occasional practice and consolidation to expert centres will be reflected in updates to contract schedules. To maintain appropriate centres to achieve best quality for patients NHS England will only fund specialised services activity not reflected in contracted service lines by prior approval, and will only make payment where treatment complies with relevant published policies, and contracted datasets allow patient level validation of payment. NHS England will not make payments above national tariffs except where resulting from published national guidance.

The two year period of stability in tariff prices will be used to shadow and build evidence to support a range of changes to future reimbursement approaches, including service specific facility and infrastructure payments to reflect fixed costs, and alternatives to per-diem contracting for critical care and mental health. In secure Mental Health services, re-procurement following the current service review will enable transition to a new more recovery oriented payment model, with improved discharge and resettlement and user-led patient reported experience and outcome measures embedded in all contracts from 2017.

NHS England's single operating model will continue apply to all contracts. A provider specific CQUIN package with up to 10 nationally developed schemes will be offered to all contracted providers and will enable significant improvements in both quality and efficiency for patients. Existing ODNs funded through CQUIN monies will continue. Unless otherwise notified NHS England will normally only hold one NHS Standard Contract with any provider. Contracts will be for a minimum of 2 years with renewal options to support longer term transformation.

Substantial improvements in data quality are needed to drive the reforms set out in these intentions and the NHS has committed to driving compliance with national standards. There is continuity in contractually mandated formats for activity and local price plans. Provision of nationally defined datasets is a condition of reimbursement and accurate, patient-level itemised high cost drug expenditure is an immediate priority. Information flows are a key marker of and contribution to driving excellence in care that we expect from all those providing specialised services and contract sanctions will be applied systematically where needed to ensure all providers deliver on-time-in-full high quality data.

We are looking to achieve considered but prompt contractual agreement reflective of these priorities with clearly set goals for the coming years to ensure specialised services deliver the ambitions set out in the five year forward view for patients and provider service reforms achieve clinical excellence and financial sustainability.

## 1 Section 1: National Intentions

### 1.1 Purpose

These intentions provide notice to healthcare providers and partners about changes and planned developments in commissioning and delivery of prescribed specialised services. They should be read in conjunction with national planning guidance, the NHS standard contract, the National Tariff Payment System, and CQUIN guidance.

The aim is to enable providers to make early preparations and focus engagement with commissioners and clinical service leads for the 2017-19 planning process.

### 1.2 Context

#### 1.2.1 Strategic Framework

In May, NHS England set out a new strategic framework for specialised services. The framework articulated NHS England's vision for specialised services building on the Five Year Forward View goals of a fully integrated health service delivering the best possible outcomes for the population of England. Achieving our ambition will require changes in how services are commissioned and provided, with specialised care as a fundamental part of more integrated care for patients.

The framework sets out three key areas we will focus on for implementation:

- **Delivering place- and population-based care:** Local level collaboration to agree patient and service priorities, identify sustainable provider configuration and develop options for commissioning.
- **Providing national level support:** National support to enable local flexibility, including reform of clinical advice, improving data and information, support for innovation, and improving the prioritisation of new drugs and treatments.
- **Ensuring financial sustainability and value for money:** Putting in place financial controls in ways that provide clear incentives to transform provision and integrate specialised elements with the whole care pathway.

Over the last three months we have been working with a wide range of stakeholders to test and develop this framework. As part of this engagement we will also be closely working with four STP areas – South East London, Greater Manchester, Hereford and Worcester, and Cornwall – fast track progress in delivering this ambition.

Our Commissioning Intentions represent an important step in implementing the framework. They set out in particular how we will begin to move towards more place- and population based commissioning, supporting integrated care and promoting new models of provision, while also improving quality of care and ensuring financial sustainability.

### **1.3 Delivering place and population based care**

The development of Sustainability and Transformation Plans (STPs), local health and care strategies, provides us with the opportunity to develop greater collaboration and explore opportunities where local leaders can join-up the design and delivery of specialised services.

The transition to place and population based commissioning is challenging. Services are contracted directly by NHS England on a provider basis rather than population footprint, and the portfolio of 149 services is highly diverse in terms of both patient numbers and provider landscapes.

We are taking steps to strengthen the way in which services are commissioned, developing a more collaborative approach with local commissioners based on the shared priorities of the STPs. To support this more collaborative approach, we have been working with local commissioners to develop the approach, as set out in section 5.1. We are not expecting all services to use more collaborative commissioning arrangements from April 2017. However, we would expect to see progress on the national priorities of cancer, mental health and learning disabilities.

Some services will need to be commissioned on either a national or regional footprint. Although this means STPs will not systemically be invited to collaborate on the commissioning of those services NHS England will continue to work closely with STPs on achieving future provider landscape sustainability and enabling required transformation within those footprints.

### **1.4 Providing National Level Support**

To support place-based commissioning we will need to take action nationally:

- National clinical leadership –fundamental for all specialised services is providing national standards of quality and access. The recently revised remits of the national CRGs will mean our national clinical expertise can increasingly focus on setting standards on the outcomes that matter and highlighting models that deliver best quality and value;
- Information – central to driving service change and improving quality will be the better information on the cost and quality of services. A key part of the strategic framework will be improving information for commissioners, providers and for patients;
- Proactive management of new treatments pipeline - For population and place based approaches to be feasible, local health economy system leaders require stability and confidence in the resources they have available for the services they have planned to deliver; and

- Research & Development and Innovation – Innovation should be a systemic part of how specialised services are delivered. Major providers, most of whom have direct access to world-leading clinical research facilities, should be ‘designing in by default’ R&D to more of our care pathways and opening up new paths for innovation. This should include the use of “real world data” and quality improvement as well as formal clinical trials.

## 1.5 Ensuring financial sustainability and value for money

Underpinning the changes to way services are designed and delivered will be financial sustainability. Specialised services makes up over 15% of the NHS spending, and judicious stewardship will be crucial to meeting the financial challenges facing the NHS, both nationally and locally.

This document sets out how we will begin to meet the challenge over the next two years, in terms of managing new cost pressures and improve efficiency. It also sets out how we will put in place the foundations for service transformation.

## 2 Changes to the Scope of Specialised Services

Ministers have agreed that the following services should no longer be commissioned by CCGs; NHS England is working to put in place arrangements to commission these services on a national basis, including ensuring that an appropriate level of resource is transferred from CCGs:

- Some highly specialist adult male urological procedures (these are included in the revised Identification Rules and NHS England will contract for these procedures from April 2017);
- Primary ciliary dyskinesia management services for adults (the commissioning responsibility for this service will most likely transfer during 2017/18 through a contract variation);
- Some highly specialist adult haematology services, most likely services for patients with thrombotic thrombocytopenic purpura (the commissioning responsibility for this service will transfer between 2017 and 2019); and
- Patients with placenta accrete (the commissioning responsibility for this service will transfer between 2017 and 2019).

Ministers had previously agreed that there were certain additional elements of paediatric critical care services that should be commissioned by NHS England rather than by CCGs, including some aspects of patient retrieval. NHS England is in the process of undertaking a review of paediatric critical care services, the scope of which includes patient transport. Once this review is concluded, NHS England will put in place arrangements to enact any changes in commissioning responsibility as a contract variation after giving notice.

A service for patients with alpha-1 antitrypsin deficiency is being considered for prescription as a specialised service. If Ministers agree that the service should be commissioned by NHS England, a more detailed timetable for transfer of commissioning responsibility will be developed. Given that NHS England would need

to develop a service specification and select a small number of expert providers, it is unlikely that commissioning responsibility would transfer before 2017/18.

The Information rules (IR) baselining work undertaken in May and July 2016 will be used to secure the transfer of budget allocations to the appropriate commissioner. As a result all providers will be required to adopt in full the national identification rule set for contract activity from April 2017.

### **3 Strategic Intentions: Improving value for Patients from Specialised Care**

#### **3.1 Strengthen the way we commission**

Many services in the portfolio will need to be commissioned at a national or regional level. However, many would benefit from being planned on an STP or multi-STP footprint. Central to achieving the move to place-based commissioning will be maintaining both national service standards, outcomes and accountability for specialised services while providing local to flexibility in design and deliver services.

For contracts agreed for April 2017 NHS England is not intending to transfer commissioning responsibilities and budgets for any of the 149 services to CCGs. NHS England will remain accountable. However, we are looking for CCGs to take a greater role in planning and commissioning specialised services with NHS England.

For those services identified as potentially benefiting from being commissioned on an STP or multiple-STP footprint we are inviting STP leaders to explore how NHS England and STP partners can more formally collaborate on the commissioning of those services. To support this more collaborative approach, we have been working with local commissioners to develop:

- Clearer articulation of the services that might be most appropriate for locally led commissioning - See Annex B;
- Improved financial information at CCG level to support planning and monitoring;
- Governance options for greater collaborative commissioning, ranging from joint planning through to full devolution; and
- Continued financial incentives for CCGs to help drive efficiencies through collaboration on the whole patient pathway.

We are not expecting all services to use more collaborative commissioning arrangements from April 2017. For 2017/18 and 2018/19 we expect all STP footprints to focus on implementation of collaborative commissioning arrangements covering at least one of the following priority service areas: Cancer, Mental Health and Learning Disabilities.

We expect to see STP plans set out how the specialised commissioning spend can be increasingly joined up from April 2017 with the wider local health system spending to improve outcomes and value across the whole care pathway for those services. For more advanced and higher performing CCGs and STP footprints we will test feasibility of joint commissioning and delegation arrangements with NHS England

### 3.2 Reviewing and reshaping Specialised Services provision

Last year NHS England set out our approach to ensure that services are commissioned from the most capable providers through a rolling Strategic Service Review Programme with priorities published in commissioning intentions. This strategic programme complements regional and local programmes to address significant local service issues with collaborative commissioning colleagues.

From service reviews and from locally led change through sustainability and transformation plans, we expect there to be more networks of specialist providers and re-shaping supply models and contracting approaches to integrate care around patients. Service reviews will also provide opportunity for providers to propose sustainable solutions in line with clinically developed requirements. Service review implementation will also enable new payment approaches in order to incentivise improvement in care quality and patient experience.

Where the relationship between quality, value and patient volumes is strong we expect there to be consolidation of some services as a consequence of undertaking reviews.

NHS England will continue to undertake reviews using a structured programme methodology with provider selection carried out in an open and transparent way.

NHS England intends to use the service review programme to maintain and validate the assessment of commissioner requested services on a service line by service line basis, and as an input to the acute specialised service top up methodology, although as set out in national tariff payment system no changes beyond those announced for April 2017 are planned before April 2019.

Service reviews in progress that will have a transformational impact in 2017/18 include: Hyperbaric Oxygen Therapy, Prosthetics, Spinal Cord Injury, Paediatric Burns, Children's Epilepsy Surgery, Metabolic Medicine and Intestinal Failure. It also includes the Paediatric review of critical care & transport, surgery and ECMO which we expect to lead to a change of service specifications, formation of guidance and policy, revised quality metrics and an accompanying commissioning strategy. A further range of nationally and regionally led reviews planned for the coming year are set out in sections two and three

NHS England aims to build on the recommendations of the Cancer Taskforce and the progress already made to achieve its goals, such as changes to the Cancer Drugs Fund, Cancer Vanguard and the emergence of Cancer Alliances. Therefore, during the next two years an ambitious programme of cancer national service review will be completed. This will enable the development of innovative new care models and strengthened provider networks across the specialised commissioning cancer portfolio, closely linked to the Cancer Alliance population footprints. Our national service review programme will include radiotherapy, chemotherapy, cancer surgery, children's and young people's cancer services and a second phase of PET CT.

NHS England will build on the recommendations of the Mental Health Taskforce and will work with national, regional and local partners to ensure that we have a

consistent and integrated response to the 'Five Year Forward View for mental health'. Key areas of work will focus on the secure pathway, children's mental health services, perinatal services and the pathway of care for people with a learning disability. For all patient cohorts our intention is to ensure that people are cared for as close to home as possible in services that are as least institutional as possible. We will support the new models of care work that is delivered through the co-commissioning pilots and will stretch our ambition to move as swiftly as possible to integrated services near people's homes. We will continue our work on modernising how we pay for mental health services, ensuring that payment methodologies match clinical ambition for excellent care. Our work will be delivered through the Five Year Forward view for mental health ensuring that in policy development and service change we have a single way of monitoring progress and accelerating change.

### **3.3 Supporting the Development of New Models of Care**

Most of the initial STP plans submitted in July set out ambitions for more integrated approaches to the delivery of whole care pathways for these service areas. A number of plans also built on new models of care vanguards including development of 'whole population budgets' and 'lead provider contracts' with service providers, both inclusive of the specialised service element.

Such arrangements could enable both improved outcomes and improved value, and we will work with STP leaders to support transition in delivering their service priorities. In addition we would like invite groups of providers, who collectively deliver a specialised service across a whole national or regional footprint to develop proposals to ensure future sustainability and improve quality of that service. We would expect these proposals to build on models pioneered through the Acute Care Collaboration and other vanguard programmes i.e. moving to network, chain or franchise models.

Where groups of providers do come forward with collective and feasible proposals, NHS England will explore directly with them options around contracting and bespoke payment models, as well as how on we can assure again standards that are focussed more on the quality outcomes we expect to be delivered for out-patients.

### **3.4 Clinically Driven Change**

Two year commissioning intentions create a platform for a substantial programme of clinical service change. A refresh of the clinical advisory arrangements brings 42 new clinical reference groups combining national and regional clinical leadership, patient and public voice, the related colleges and associations, public health and commissioning leaders. The six national programmes of care are strengthened to lead and maintain the momentum of change.

National working groups are being established to deliver a series of clinical connections joining key organisations to the Forward View task of aligning national leadership. A 'Research' group will form links with NIHR to bring closer research strategies to service delivery strategies. A 'Guidelines' group will support the work of NICE helping inform their appraisal priorities and provide detailed service feedback on their work. A 'Data and Resource' group will forge effective links with NHS Digital and NHS Improvement as clinical service change thrives with high quality information and the enabling acceleration effects on change of well-constructed tariff. A 'Value'

group will link the innovation of Right Care, GIRFT, and other streams of work seeking enablers for at scale adoption.

NHS England will continue to prioritise potential new interventions for patients within available funding building on recent reforms to the policy and process, and will explore ways to align policy development more closely to the annual prioritisation process for future years.

We expect to see evidence that provider Executive Quality Leads are seeking to establish work programmes in their organisations in response to evidence of outlying performance from Quality Dashboards, self-declared service specification compliance, national audits and other sources of quality information such as surgeon specific outcomes. Provider derogations from service specifications will only be used to allow service contracts to be let if there is a well-defined work programme to achieve all service specifications approved by the Regional Clinical Director. In turn the national specialised commissioning team will establish a programme of simplifying service specifications.

Specialised services have a key role in the delivery of the World Class Outcomes in Cancer with a focus on the modernisation of radiotherapy equipment and workforce shortening treatment times and implementing care pathway changes including the impact of proton beam therapy will have particularly in children's cancer. Accelerating access to cost effective chemotherapy and guiding clinicians with algorithms that deliver best value, and taking action over occasional specialised cancer surgery that fail to deliver best patient outcomes are key changes we are implementing.

In Mental Health population based commissioning budgets will enable local decisions for care provision maintaining a national focus on the unfinished business of ensuring CAMHS capacity matches demand, seeking service development and payment reform in Adult Medium and Low Secure, and mobilise additional capacity in perinatal care.

Through the National Programmes of Care we continue to maintain attention on the broad portfolio of the services outside of published strategies in cancer and mental health. This includes enabling innovative medical interventions such as mitochondrial donation, developing commissioning through evaluation, forming access policies to new service developments, delivering commissioning plans for obesity surgery in children, and continuing to reduce the burden of liver disease caused by hepatitis C.

### **3.5 Reducing Unnecessary Variation**

The improving value programme brings together the actions of providers and commissioners to deliver improved value from our commissioning expenditure, and helping address the annual growth in costs of specialised services. The programme delivered £350m of efficiencies in 2015/16 and is on track to deliver a further £400m this year. The programme will need to deliver an additional £400m in each of the next two years.

Our CRGs will each have named clinical leads that act as champions for improving value and play a lead role in identifying and developing opportunities with the

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potential to deliver significant improvements for patients, whilst achieving a reduction in the overall cost of services.

Variation is also substantial in the prices paid for, (and in some cases unit costs to deliver), specialised services where national tariff prices do not apply. A pre-requisite to contracts with local prices will be a provider-specific agreed plan for service reform of those services which are above the most efficient levels of cost. As recommended by the House of Commons Public Accounts committee, local prices agreed will reflect planned transition to reflect those lower costs over the 2 year period with an agreed programme of service areas and milestones for review. As well as being reflected in service development and improvement plans a dedicated CQUIN is being made available to ensure programme and specialist resources can be employed by trusts to enable local clinicians to benchmark practices and implement change. This programme will deliver efficiencies in commissioner spend, ensure prices cover provider cost, and deliver the improvements in cost per Weighted Activity Unit set out in the Carter productivity programme reflected in each provider's benefit realisation milestones.

We will continue to adopt and develop "RightCare" processes, delivering reform and improvement in a robust and systematic way, ensuring that our effort and that of our partners is focussed on transforming services to deliver improvement.

Existing Improving Value initiatives which will continue in 2017-18 include:

- Reducing variation in cost and activity associated with high cost devices and procedures, including complex cardiology devices and procedures;
- Delivering best value prices for the NHS for drugs and devices;
- Ensuring the delivery of radiotherapy for patients with prostate cancer is in line with the very latest published evidence;
- Expanding dose standardisation in chemotherapy;
- Working to ensure cost effective prescribing of Anti-Retrovirals and use of Intravenous Immunoglobulin;
- Implementing best practice across the spinal surgery pathway;
- Reducing delayed transfers of care in Critical Care services;
- Extending the use of Blueteq and securing benefits of Clinical Utilisation Review;
- Expanding Enhanced Supportive Care for patients with advanced cancer; and
- Standardising costs of Home Parenteral Nutrition.

We will also introduce new initiatives for 2017-18 including:

- Standardisation drug continuation criteria for patients with MS;
- Optimising value through appropriate use of new generics and biosimilars;
- Reducing Waste in Chemotherapy Services;
- Early Intervention in Premature Infants on Long Term Respiratory Support;
- Implementation of best practice in Anti-Fungal Stewardship; and
- Exploring reform in Renal services – including using technology to facilitate remote monitoring, and utilising shared decision making.

### 3.6 Clinical Utilisation Review

NHS England will continue to support the clinical utilisation review (CUR) programme, providing evidence-based clinical decision support to ensure patients are cared for in the setting most appropriate to their needs. Over the next two years we will focus support for the 5 Acute Early Implementer Sites and the 29 Acute providers who are now implementing CUR or currently undertaking a Local Learning pilot as they continue to access the multi-year CQUIN incentive payment to rollout the approach in admitted patient care and critical care,

Whilst NHS England is not actively further expanding the providers implementing CUR through the CQUIN scheme in the next two years, the expertise of the national programme support team and learning network will be made available where locally determined STP plans have included implementing CUR as an element of transformation across the wider health system. The national framework of 4 internationally proven CUR systems, from which providers can call off contracts for CUR technology, remains available to Trusts for this purpose. The use of evidence based decision support through recognised CUR systems provides strong assurance of consistent quality delivery ensuring providers are well placed to respond to future opportunities for service delivery.

Working with providers over the next two years provides a major opportunity to gather data to support a large scale evaluation of the benefits for patients commissioners and providers. As part of this approach an enhanced nationally standard patient level dataset will be incorporated at all commissioned sites. We are looking to agree 4 year benefit realisation plans with providers complementing and contributing to the approach set out in the Carter review. All Trusts and health communities implementing CUR will be supported to be able to evidence both financial and patient quality benefits. NHS England continues to build on the clinical learning community with national leaders and international practitioners to underpin this approach.

### 3.7 Improving Quality

#### 3.7.1 Better Information

Specialised services quality is underpinned by quality dashboards and a Quality surveillance system for providers and commissioners accessed via secure portals which will continue to be developed to deliver better information on patient outcomes, cost/value and quality to enable and inform change.

Current specialised services quality dashboard metrics covering 52 services are now available on the NHS England Internet site and following the CRG review in 2015/16 will be reviewed by exception in the next 2 years where doing so would provide significant benefit. The focus will be on extending dashboards to cover 80% of specialised services with clinical outcome data.

Providers continue to be required to have an overall registered gatekeeper and service level lead for each dashboard, and to continue to submit data via the portal in line with information requirements.

### **3.7.2 Service Specification Compliance**

The Quality Surveillance Team (QST) will work with the six Programmes of Care Boards to identify the priorities for quality indicator development, particularly where service specifications are introduced or revised. Where indicators have not yet been developed providers will be expected to continue to self-declare (using the Quality Surveillance Information System portal), against the key requirements from the service specification compliance process. The self-declaration, annual assessment and production of service profiles underpin the service specification compliance process and signposts commissioners to where they need to work with providers to address gaps in compliance.

### **3.7.3 Self-declaration**

Providers are required to complete by 30<sup>th</sup> June 2017 the self-declaration against a defined sub-set of indicators for all specialised services they are commissioned to provide with relevant approvals signed off by the chief executive of the provider.

### **3.7.4 Annual Assessment**

An annual assessment will be undertaken on services that are flagged as outliers as a result of either a declaration of non-compliance, or as a result of a flag from other data sources including local intelligence. This will be undertaken in collaboration with regional commissioners and the outcome recorded on the QSIS.

### **3.7.5 Quality Profiles**

A quality profile will be generated for each specialised service delivered by any given provider, summarising information from quality surveillance and identifying national outliers. The profile is updated in real time from in-year portal provider submissions. It is also captured at given point annually, as part of the annual assessment, and reviewed by QST and regional commissioners to determine the level of quality surveillance for the following year. Where the process identifies gaps in compliance a meeting will be held between commissioners and providers that will give rise to agreed resolution actions.

Where the process identifies gaps in compliance a meeting will be held between commissioners and providers that will give rise to:

- Agreement that a derogation should be sought and there is assurance that a time limited action plan will deliver compliance; OR
- Agreement that a gap in compliance exists and that this gap is not amenable to a time-limited action plan. Commissioner and provider discussion will continue to find a long-term sustainable solution to compliance gaps. The commissioner will, within six months of identification of the compliance gap, inform the provider of the action that they will take to ensure long-term sustainable compliance.

### **3.7.6 Peer Review Visits**

The annual programme of peer review visits takes into consideration the current priorities in the NHS England service review programme, services with significant compliance issues and where variation has been identified, either in quality or access.

The 2017/18 national programme is likely to include Neonatal Intensive care, Paediatric Intensive Care, Paediatric Surgery, Hepatitis C network providers, and Vascular services. The Neonatal Intensive care, Paediatric Intensive Care, Paediatric Surgery are one element of the wider service / transformation reviews being undertaken.

The national programme will be complemented by a regionally agreed programme and rapid response visits where regional commissioners identify significant risks which require urgent further investigation.

## 4 The single Operating Model

### 4.1 Contractual Requirements

NHS England will normally only hold (or be party to) one NHS Standard Contract with any provider unless explicitly advised during any given procurement. Prior approval should be sought for any elective specialised services activity not commissioned via a signed contract, reimbursement will be based on agreed contracts

Whilst pathway design work is increasingly aligned with CCGs, NHS England will remain the contracting body for all patients across England treated for services within the scope of specialised commissioning for Contracts awarded from April 2017. Such contracts would novate in whole or in part to reflect any legal changes in commissioner accountability implemented as a result of new governance options such as full devolution.

All contracts will use the following national standardised documentation:

- Indicative Activity Plan standardised formatted template;
- Local Prices standardised formatted template;
- Local Quality Requirements (Acute and MH respectively);
- Information Requirements (already in the NHS Standard Contract);
- Service Specifications; and
- Generic and clinical commissioning policies.

To support continued reductions in local transaction costs further national standardisation of schedules will be considered over the next 2 years.

Increasingly as part of networked provider arrangements subcontracting will play an important role in commissioned services. In line with the NHS Standard Contract providers will be expected to agree and obtain written approval in advance from the commissioner to enter into any material sub-contracts. This will include pharmacy services with particular reference to the Carter Review medicines optimisation recommendations. Existing sub-contract arrangements should jointly reviewed and documented within the 2017-19 contract as per the terms of the NHS Standard Contract. NHS England requires full transparency of sub-contracting pricing agreements including where these inform pass through payments, to be set out in the local price schedule. For the avoidance of doubt providers cannot enter into

agreements with an implication on reimbursement from NHS England without commissioner agreement.

NHS England will advertise intended contract awards and any market testing or procurement through the government 'Contracts Finder' website meeting the objectives of proportionality, transparency and non-discrimination for current or potential providers from the NHS, independent or third sector in line with the new Public Contract Regulations.

The introduction of HRG4+ and refresh of specialist top ups is a significant improvement in the accurate attribution of costs relative to patient complexity. NHS England does not expect to make payments above mandatory tariffs for services.

NHS England will only make payment where treatment complies with relevant published policies, and based on priced patient activity reflected in contracts. No resources are available for transitional financial payments. Providers will be expected to provide sufficient data to enable NHS England to validate invoices to ensure that all payments for specialised services are compliant with commissioning policy and are as per the rules of the National Tariff Payment System. The invoice validation process supports the delivery of patient care across the NHS and is vital to ensure NHS England fulfils its statutory duties of fiscal probity and scrutiny.

NHS England will also explore the opportunities for longer than 2 year contracts (including contract term and option to extend) with tier 1 and 2 providers where this affords opportunities for significant improvements in service quality and efficiency, and builds on effective existing contractual arrangements.

All new investment decisions will be subject to the national CPAG prioritisation process. As set out in previous years providers should not initiate specialised service changes and developments without prior commissioner approval as cost impacts will not be funded unless considered in advance through this process.

## **4.2 Contracting for Excluded Drugs and Devices**

Improving the value that the NHS gets from our significant investment in high cost drugs and devices continues to be a shared priority across the NHS. We have ambitious goals in terms of the contribution our high cost drugs and devices service reviews can make to the financial sustainability of services going forward. We intend to work closely with clinical colleagues and partners to bring forward system-wide benefits realisation through:

- Innovative procurement;
- Aggregation of demand;
- Clinical consensus underpinned by evidence based policies for the most effective and best value products;
- Optimisation tools and support;
- The promotion of effective new technologies and products; and
- Minimising unnecessary on-costs and levies on available investment resource

At the national level we are developing agile responses to improve cost effectiveness across the lifecycle of products, from market entry, through new indications and substitutes, to the end of patent. This will include a range of interventions from innovative procurements and supply chain arrangements, commercial access agreements, and clinical commissioning policies. However, the key-stone for improving value is local development, in particular hospital pharmacy transformation programmes, contract and Pharmex data quality improvement, policy compliance, best value from dispensing, clinical networking and the uptake of biosimilars and generics. In recognition of this we will be supporting local development through:

- Close alignment with the Carter Review recommendations, particularly in relation to hospital pharmacy transformation, reforming procurement and delivering purchasing price index improvements;
- Digital developments such as E-prescribing, E-catalogue supplies ordering, electronic prior approvals and standardised contract reporting;
- Completing the centralisation of the high cost device supply chain;
- Empowering clinically led efficiency improvements to maximise the benefits of new and existing technologies and reductions in unwarranted clinical variation including in the range and specification of devices; and
- Important CQUINs to support medicines and devices optimisation.

#### **4.2.1 Hospital Pharmacy Transformation Programme**

NHS England will continue to work closely with NHS Improvement to align priorities and to improve efficiencies relating to medicines optimisation and the Hospital Pharmacy Transformation Programme (HPTP). Trusts will be incentivised to undertake the work required by a medicines optimisation CQUIN during the two years of this contract, after which time it is expected that all schemes will be fully implemented.

#### **4.2.2 Aligning clinical and commercial priorities**

We are working alongside the Commercial Medicines Unit (CMU) to maximise the value for the NHS from drugs procurements going forward. This includes exploring the on-going relationship between the CMU, NHS England and the wider NHS.

Providers of specialised services that utilise high cost drugs will participate in CMU therapeutic tenders and comply with Pharmex data collection requirements as a condition of reimbursement.

NHS England is also working with NICE and the newly reformed CRGs to ensure that treatment algorithms for drugs commissioned by NHS England reflect optimal use of the most cost effective treatments. Trusts will be supported to address unwarranted variation.

#### **4.2.3 Commissioning from specialised centres**

In order to provide assurance that high cost drugs are being used appropriately and in line with commissioning policy, specialised centres will be required to act as gatekeepers to ensure appropriate use of resources and reduce unnecessary risk to patients. Where it may be more appropriate for drugs to be administered closer to

home, specialised centres will be required to establish formal clinical network arrangements with local services to provide appropriate assurances.

#### **4.2.4 Innovation**

NHS England is working with Pharmaceutical Industry colleagues to expedite early access to innovative medicines. Trusts will be required to comply with the commercial arrangements associated with each scheme.

#### **4.2.5 High cost drug data improvement**

Improving data quality associated with high cost drugs remains a priority for NHS England. A standard drugs minimum dataset (MDS) was introduced to all NHS England specialised services contracts in 2016/ 17 and work with NHS Improvement and NHS Digital on improving data quality will continue to allow improved benchmarking and identification of unwarranted variation. All patient access scheme rebates and all drugs supplied through homecare are required to be reported. Trusts will be required to provide dm+d drug codes as part of the MDS which aligns with the requirement for Trusts and system suppliers to implement the dm+d information standard by June 2017. Dashboards will be developed to monitor MDS data quality from each provider and these will be published on the NHS Improvement Model Hospital portal.

#### **4.2.6 Best value from dispensing**

Providers are expected to ensure VAT efficient dispensing methods (e.g. outsourced pharmacies, homecare etc.) are used where clinically appropriate in order to ensure maximum cost efficiencies and to align with the recommendation from the Carter Review to consider alternative supply routes. Following work undertaken in 2016/17 NHS England will propose a cost per item approach to recompense Trusts for work/ activity not reimbursed by the national tariff. This funding mechanism will ensure consistent reimbursement across providers, replacing various previous inconsistent arrangements regarding VAT savings (e.g. % gain sharing agreements).

#### **4.2.7 Medicines optimisation**

The Medicines Optimisation CRG will continue to develop and implement schemes to improve value from high cost medicines, e.g. reducing waste by increasing uptake of a standardised chemotherapy doses and standardised parenteral nutrition; purchase of standardised products as recommended by national advisory groups; development of incentive schemes; expediting implementation of biosimilar products; ensuring value from patient access schemes.

#### **4.2.8 Faster uptake of biosimilar and generic medicines**

In order to allow NHS England to continue to invest in new developments we will require all Trusts to use more cost effective generic and biosimilar products where these are available and in line with product licenses. We expect Trusts to have an active improvement programme to implement use of these products with all new patients being initiated on the biosimilar/ generic product within 3 months of them becoming available and all existing patients to have been moved to the biosimilar/ generic product within 12 months.

#### **4.2.9 Individual Funding Requests (IFR)**

IFRs for cancer-related treatments are now subject to the same process as non-cancer treatments. Trusts must ensure that appropriate internal governance arrangements are in place to assess appropriateness of requests prior to submission to NHS England. IFRs will be subject to an increased level of financial scrutiny to ensure that actual costs reflect those agreed.

#### **4.2.10 Chemotherapy**

Compliance with the SACT database is mandated and will be monitored. All Trusts must have fully implemented e-prescribing for chemotherapy by April 2017 (adults) and September 2017 (paediatrics). All Trusts will be required to report cancer drugs funded via the CDF using the drugs MDS taxonomy. No additional costs associated with the provision of cancer drugs funded by the CDF will be permitted. Trusts must purchase cancer drugs funded within the CDF at the confidential price/access agreement agreed between NHS England and the relevant pharmaceutical supplier.

#### **4.2.11 Reference Prices**

NHS England will continue its work with the NHS pricing team to identify drug categories where spend is predictable across a patient cohort which could be included in tariff from 2019. NHS England will be introducing maximum reimbursement rates in some specialities to reduce the data burden on Trusts and to ensure clinical engagement with use of cost effective medicines.

#### **4.2.12 Centralisation of the Supply Chain for High Cost Devices**

The centralised ordering, supply chain and procurements arrangements will be concluded during 2017/18 to deliver the full year impact of the efficiencies available from aggregating national demand. Further clinically led efficiency improvements will be realised through:

- Greater utilisation of the most effective and best value products;
- Improved service specifications;
- The adoption and spread of new technology;
- Reduced unwarranted variation; and
- Effective networking and consolidation.

The intention is to support clinicians to design the second phase of this initiative with partners and industry to utilise the centralised supply chain to deliver Right Care in high cost devices across the country. This will also include reviewing the options to extend the initiative to other high cost device category areas.

### **4.3 Resolving Significant Local Service Issues**

NHS England will continue to use the collaborative process detailed in the 2016/17 Commissioning Intentions in partnership with CCGs to address significant local service issues through a three step escalation process.

#### 4.4 Reforming the Payment System

The adoption of the new Tariff and Top up payments in 2017 represents a significant change to the revenue flows associated with specialised care, more accurately reimbursing complexity. We have worked closely with providers to understand the impact on service line finances and to inform ongoing plans for efficiency and service redesign to ensure care can be delivered within nationally determined funding levels.

Following the adoption of HRG4+ and the associated revisions to specialist top ups, services will be eligible for top ups when the treatment provided attracts a top up and the provider is contracted to deliver it, unless otherwise stated.

Reforming the payment system for NHS services: supporting the five year forward view' published in December 2014 set out the long-term strategy for the payment system. This included an ambition "To develop a comprehensive set of currencies (units of healthcare for which a payment is made), including new currencies, particularly for specialised services." For those with long term conditions or extended treatment pathways this often involves introduction of year of care or pathway currencies. Adoption of such currencies is particularly helpful for services that have local prices, as they create the basis for benchmarking of prices and outcomes.

Objectives in more detail were set out in the 2016/17 commissioning intentions and developed in the Tariff engagement Document (TED) published by NHS Improvement and NHS England. NHS England intends to move forward with non-mandatory pathway currencies for Bone Marrow Transplant, Prosthetic services, and a year of care tariff for Cleft Lip and Palate services. For HIV and Spinal cord injury we aim to develop non-mandatory prices. We also intend to develop a solution, depending on evidence of the adequacy of HRG4+ for intestinal failure consistent with the current service review.

Further progress will be made in 2017/18 and 2018/19 in the development of these currencies, building upon the improvements in the collection of cost information and shadowing the impact of new payment approaches mandated in 2016/17. For services with a shadow currency it will be mandatory to collect and to report information on activity, costs and other metrics (including outcomes) as specified, and to estimate how payment would flow according to the payment mechanism associated with the currency. But it will not be necessary to pay for services according to the currency unless jointly agreed by commissioners and providers.

The two year period of stability in national tariff prices will be used to shadow and build evidence to support a range of changes to future reimbursement approaches, including service specific facility and infrastructure payments to reflect fixed costs. Work is continuing to improve currencies for adult critical care, paediatric critical care and neonatal critical care. In all these services, also, the option of facility and infrastructure payments to reflect fixed costs will be developed for 2019 but where earlier implementation is consistent with local health system goals there is opportunity to do so, with learning from early adopters informing national developments.

A two year CQUIN in 15/16 provided support to providers to expedite discharge, in year one within twenty four hour of patients being clinically ready, and in year two with four hours of patient clinical readiness in line with national standards with the intent that in future stays beyond this point would not attract reimbursement. In line with this direction, from 2017/18 stays beyond twenty four hours after patients are clinically ready for discharge from critical care will be reimbursed at an excess bed day rate. For 2018/19 this approach will apply to patients staying beyond four hours after clinically ready for discharge from critical care in line with national standards. Where bed days with zero organs supported are currently funded at critical care rates the intention is to revert to funding at excess bed day rates in the same way, as an element of the two year planned transition of local prices and costs.

In secure mental health services, re-procurement following the current service review will enable transition to a new more recovery oriented payment approach with improved discharge and resettlement and user-led patient reported experience and outcome measures embedded in all contracts from 2017.

The Tariff Engagement Document also provides details regarding the implementation of reforms to the payment for chemotherapy services (removing the link to individual regimens, and 're-weighting' the current chemotherapy delivery tariffs to better reflect clinical practice), and to more accurately reimburse automated red cell exchange in patients with sickle cell disease.

The objective in all cases is to provide funding that enables providers to optimize care across the patient's treatment pathway, to achieve best affordable outcomes, and that encourages benchmarking and accountability for outcomes. In secure mental health services, re-procurement following the current service review will enable transition to a new more recovery oriented payment approach.

#### **4.5 Next Steps**

These national intentions for the commissioning of specialised services are complimented by the programme of care specific and regional intentions in the next sections, and will also be supplemented by provider specific notice communications where appropriate.

Please contact your nominated supplier manager if you require any assistance in contacting the relevant regional or programme of care lead about the programmes and initiatives outlined.

## 5 Section 2: National Intentions for Programmes of Care

### 5.1 Mental Health Programmes of Care

Plans for major reforms have been published with implications for Specialised Mental Health Services. The publication of the Mental Health Task Force report in February 2015 and “Building the Right Support for the people with Learning Disability” in October 2015 emphasise out-of-hospital care and the need for patients to have greater ability to determine the care they receive. Pathways of care are critical to the whole patient experience as they travel through specialised mental health services, and the role of local community based capacity is key to minimising use of specialised settings. Services need to be high quality and importantly the local capacity is there when needed. The commitment and investment at a CCG level into community services will strengthen the ability to deliver these objectives.

Our published commissioning intentions in 2016/17 signalled the intention to re-procure T4 CAMHS and Adult Low & Medium Secure Services with the expectation that this work needed to have local ownership and outputs embedded within local systems. NHS England has revised its approach to ensure local ownership under the umbrella of national co-ordination as a Strategic Service Review. This approach delivers commissioning interventions for the matters that need to change, such as location of beds, quality and financial requirements including new ways of reimbursing care. Right sizing capacity and care delivery in this way will ensure patients, their families and tax payers’ benefit and fewer patients have to travel for care due to local capacity mismatches. By autumn of 2016 the needs assessment and capacity modelling will be concluded. This work will require local commissioning hubs, CCGs, providers and other stakeholder support to reshaping service provision. 2017-19 will be years of transition and mobilization into new arrangements.

NHS England will further support the work of localisation by:

- Moving from 1<sup>st</sup> April 2017 to the 10 specialised commissioning hubs holding budgets for their resident populations, rather than provider geography;
- Ensuring where contracts (such as those with independent sector providers) cover large geographies each commissioning hub resident population will have their own activity schedule. These price and activity matrixes will covered under the overall terms and conditions of a nationally negotiated contract;
- Ensuring full compliance from all commissioned providers of the Mental Health Minimum dataset to support co-ordinated planning and delivery of services
- Concluding mobilisation plans resulting from the Service Reviews into CAMHS T4 and Adult Low and Medium Secure Services;
- Concluding transfer arrangements with the Transforming Care Partnerships for the specialised commissioning patients supporting the planned levels of reduction in patients within inpatient secure services;
- Conclude procurement and mobilisation process for the additional Perinatal Units as defined within the Task Force implementation plans;
- Continuing to actively support the roll out of the New Models of Care for tertiary mental health services and lessons learned;
- Continue to deliver against the approved business cases for the Offender Personality Disorder Programme;

- Working with the DH and the High Secure Services providers implement the changes resultant from the review into the Safety and Security Directions for High Secure Services, in line with the Ministerial time frame; and
- Working with the DH and the High Secure Services providers define the future clinical model for High Secure Services.

## 5.2 Cancer Programmes of Care

Linked to changes made during 2016/17 to centrally commission six molecular cancer diagnostics, the programme of care team are working with colleagues across NHS England to develop implementation plans for panel and genome testing, ensuring alignment with the genetic laboratory procurement and the 100,000 genomes programme.

During 2015/16, the Prescribed Specialised Services Advisory Group approved the transfer of three new procedures into Specialised Commissioning. The transfer is due to take place from 1 April 2017 and as a result the following procedures will be commissioned nationally as part of Specialised Urology Surgery service specifications and in accordance with nationally agreed clinical commissioning policies:

- surgical sperm retrieval for male infertility;
- urethroplasty for benign urethral strictures in adult men; and
- penile prosthesis for end stage erectile dysfunction.

Following work undertaken during 2016/17 to ensure greater alignment between the prescribed services manual and Identification Rules from 01 April 2017 the funding flows for prescribed cancer surgeries and cancer multi-disciplinary teams (MDTs) will sit with NHS England. Over the course of 2017/18 and 2018/19, we will use these changes to implement Cancer Taskforce recommendations, as follows:

- ensure optimally efficient delivery of cancer surgery across England, taking account of innovative surgeries such as robotics;
- implement recommendations for more efficient MDTs, as outlined within the Cancer Taskforce, alongside the development of consistent local pricing arrangements; and
- develop arrangements for national rare cancer MDTs.

As part of the two-year Tariff arrangements, the programme of care team are supporting the development of new chemotherapy delivery and radiotherapy planning and delivery prices as part of the on-going work to implement cancer Taskforce recommendations, such as enabling the replacement of linear accelerators where appropriate.

Work will also begin to support the implementation of a revised service specification for sarcoma. This will include a review of the current local pricing arrangements in order to ensure greater consistency in pricing and explore the potential to move to national arrangements.

Work will continue to be done to embed and enhance arrangements supporting the new Cancer Drugs Fund. In particular NHS England is now implementing plans for off-label cancer drugs and is working with Public Health England to strengthen the SACT database through the development of chemotherapy algorithms.

As part of the work to address the cancer taskforce recommendations 38 (MDT effectiveness) and 39 (30 day mortality) the QST, in partnership with a number of leading cancer providers and in alignment with Cancer Research UK work in this field, have been reviewing the current working practice of MDTs, identifying variation and best practice. This has culminated in the development of ten recommendations which have been endorsed by the Cancer Programme of Care. Over the course of 2017/19 these recommendations will be tested, refined and implemented.

With the opening of Proton Beam Centres in Manchester (The Christie) and London (UCLH), NHS England will begin to phase out the overseas service, eventually only commissioning activity from these two centres; in line with NHS England clinical commissioning policies. It is anticipated that the Manchester service will open during 2018/19 and the London service will open during 2019/10, however, because of the need to carefully ramp-up service provision, overseas activity is not expected to significantly decline until early 2020/21, with some exceptional cases potentially still being referred overseas.

## 5.3 Trauma Programme of Care

### 5.3.1 Service Review priorities

Three services are identified as priorities for review and may lead to changes in models of care and/or configuration in 2017/18:

- **Hyperbaric Oxygen Therapy** - NHS England is completing a review of Hyperbaric Oxygen Therapy and the current indications where it is used. The review is currently considering the feasibility of running a series of research projects to evaluate specific indications. It is anticipated that the outcome of the review will result in a procurement or tendering process where all providers will be asked to tender and assure compliance to the service specification to be able to continue to be contracted to provide the service.
- **Prosthetics** - A review of prosthetic service during 16/17 and the development of a shadow currency may impact on the future provision and configuration of prosthetic services.
- **Spinal Cord Injury** - Spinal Cord Injury services are facing particular challenges including delays in admissions and equity of access and this is having an impact on patient experience and also having an impact on other services such as Major Trauma and Critical Care. A review of SCI services is nearing completion and it is anticipated that during 2017/18 this will identify where there are capacity and demand issues. An option appraisal of solutions will propose ways to improve both the level and location of provision in some regions.
- **Paediatric Burns** - A national review of Paediatric Burns services is proposed to commence in 2017/18 this will consider issues around fragmentation of services, critical mass of patients, clinical interdependencies and co-location of PICUs and out of hours rotas. The service review will recommend the national configuration of services which addresses these issues.

### **5.3.2 Complex Rehabilitation Commissioning**

NHS England will commission according to the complex rehabilitation service specification all units are expected to be using the mandated currency with full Reporting to UKROC.

## **5.4 Women and Children Programme of Care**

### **5.4.1 Planned Commissioning Changes**

#### **Congenital Heart Disease**

Congenital Heart Disease services will be commissioned against the national service specification and standards and focus on early detection. This will include implementing any necessary service changes following consultation on proposals announced in July 2016; performance management of improvement plans for all Trusts that do not meet our requirements; and ceasing to fund occasional practice.

#### **Genetic lab procurement**

A revised service specification for NHS Genomic Laboratory Services has been agreed and through a planned procurement exercise we reconfigure genetic testing services to a nationally co-ordinated network of Genomic Central Laboratory Hubs partnered with local laboratories, Genomic Laboratory Hubs, providing a broad spectrum of tests.

### **5.4.2 Strategic Service Reviews**

#### **Paediatric Critical Care**

The recommendations arising from the national review of Paediatric Intensive Care services commencing in 2016/17 will likely progress to implementation in 2017/18. This review will encompass Extracorporeal Membrane Oxygenation, Paediatric Burns and Paediatric Transfer/Transport and will also be linked to the Specialised Surgery for Children review. This review also includes a review of pricing.

#### **Neonatal Intensive Care**

The case for change in Neonatal Services is linked to the combination to start NIC in the best place to promote survival and minimise morbidity, and to keep families as close to their home as possible. This review also includes a review of pricing.

#### **Specialised Surgery for Children**

To develop recommendations with stakeholders across specialised and non-specialised surgical services in order to ensure a sustainable network approach to paediatric surgery. The review will clarify procedures that should be defined as specialised and co-dependencies.

#### **Children's Epilepsy Surgery**

NHS England will make a decision on the proposed changes to the Children's Epilepsy Surgery Services (CESS) which would mean that surgery for all children would be undertaken in a designated CESS centre. If agreed, the proposed changes will be implemented from April 2017.

### **Adult Gender Identity Services**

In 2017/18 NHS England will adopt new service specifications for adult gender identity services. The specifications will address the various patient pathways from the point of referral into specialised gender identity clinics through to further treatment including surgical procedures. The process for developing the specifications will begin in 2016, including further stakeholder engagement and public consultation (building on the considerable engagement and consultation to date).

NHS England expects to implement the new service specifications via a process of national procurement, covering non-surgical and surgical providers.

### **Highly Specialised Services**

The programme of care team will support the work of the HSS team on services for Metabolic Services.

Lysosomal Storage Disorders – Drugs and Homecare for LSD services will be re-procured in 2017/18 for 2018/19.

### **Metabolic Medicine**

Policies for Wilson's disease and for the treatment of inborn errors of bile acid which are being developed in 2016/17 and will be implemented in 2017/18. A desktop review of metabolic services commenced in 2016/17 and will report in 2017/18.

### **Developing Payment approaches to best support patient care**

NHS England is working with its partners to develop a consistent and transparent national currency and payment system for neonatal services and paediatric critical care services across the whole pathway in support of the wider commissioning framework which encourages the right baby / child in the right place at the right time. It is also the intention during 2017/18 to shadow test a payment model along-side existing contract models. All providers of neonatal and/or paediatric critical care services (including critical care periods that are delivered outside of an ICU) must submit both the relevant data sets (NCCMDS and/or PCCMDS) to SUS as part of the Commissioning Data Set messages. This is a mandatory requirement under [Information Standards Notice 0092](#).

The work being undertaken to develop the next iteration of neonatal and paediatric critical care HRGs and progress these into tariff will require complete and high-quality data to be available in SUS.

### **Opportunities to work with STP footprints**

The programme of care team will work with STP footprints to agree service priorities and support achievement of those priorities for local populations over the next two years. Collaborative work with CCGs will focus on neonatal services and parts of the paediatric intensive care pathway and the team will support the collaborative commissioning vanguard to pilot joint working between CRGs and CCGs through the complex obstetrics work programme linked to the Cheshire and Merseyside Women's and children's services partnership, and input into the Maternity Review.

## **5.5 Internal Medicine Programme of Care**

### **5.5.1 Planned Commissioning Changes**

Procurements to commission services to meet the national caseload for Cytoreductive Surgery with HIPEC for peritoneal carcinomatosis and primary ciliary dyskinesia.

The commissioning plan for obesity surgery for children will be determined and taken forward in 2017/18.

A work programme of policy and service specifications will be undertaken.

### **5.5.2 Transformation and Strategic Service Reviews**

#### **Intestinal Failure**

The procurement process for Intestinal Failure will be taken forward and implemented in 2017/18.

#### **Cardiac Services**

A review of Cardiac Services is being scoped with a focus on commissioning for value and variation in quality.

#### **Liver transplant pathways**

A review of Liver Transplant Services is being considered with a focus on variation in access.

#### **Mechanically / Ventricular Assisted Devices**

A review of the approach to commissioning and pricing given the low availability of organs compared to need.

To support development of Urgent and Emergency Care Networks and 7 day working as part of the national work which include aspects of the specialised cardiac and vascular pathways.

### **5.5.3 Tariff / Currency / Pricing Developments**

#### **Complex Invasive Cardiology**

Consolidation of the procurement process following national review of the ICD / CRT devices for procedures within cardiology.

#### **Intestinal Failure**

Tariff arrangements remain under review, in parallel to the procurement exercise.

#### **Home Parenteral Nutrition**

The national framework was re-procured from 1 April 2016. The specification will be implemented fully with clearer criteria on the services provided for delivery of HPN services.

## **Renal Services**

The two work streams on renal dialysis and transplant tariffs will continue. For renal Transplant the aim is to recommend a tariff from 17/18 together with benchmark ref cost guidance to better reflect these costs by Nov 16.

## **CQUINS**

Internal Medicine Programme will be focusing on further development of the schemes for Rheumatology networks, appropriate use of cardiac devices, and enhanced supportive care for patients with advanced hepatopancreatobiliary disease, heart failure, respiratory disease and idiopathic pulmonary fibrosis. The programme will also be promoting Patient Activation in Cystic Fibrosis linked to the NIHR clinical trial and Shared Decision Measures as a tool to promote increasing patient engagement in service change and self-management.

## **Opportunities to work with STP footprints & Collaborative Commissioning**

The programme of care team will work with STP footprints and specifically with the four STP areas in Greater Manchester, SE London, Worcestershire/Gloucestershire and Cornwall to agree service priorities and support what they want to do to achieve those priorities for local populations over the next two years.

## **5.6 Blood and Infection Programme of Care**

### **5.6.1 Planned commissioning changes**

Work to enable progress on implementing changes in currency and pricing is a priority in Blood and Marrow Transplantation and HIV.

Work will continue to extend changes in drug procurement, stewardship and medicines optimisation across all of the clinical areas in the programme, with changes in commissioning arrangements as required. This will focus on algorithms for use of lowest acquisition cost clinically appropriate drugs (Hepatitis C, Haemophilia), switch programmes to allow greater use of generic drugs (HIV) and enhanced prior approval and outcomes reporting (immunoglobulin). In relation to immunoglobulin (IVIg), a comprehensive review of evidence of effectiveness in multiple indications will be undertaken to bring IVIg commissioning policy into line with NHS England's overall policy approach. In 2017/18, there will be a requirement to revise and enhance the role of provider IVIg Assessment Panels to demonstrate effective clinical oversight of usage in line with existing guidance. There will be changes to the mandatory requirements for reporting usage, such as weight related dosing, as well as outcomes data reporting via the national database. In line with previous years providers will be required to record all use of IVIg on the database. As a mandatory data requirement, non-payment for failure to comply will be enforced.

Pathway and network development will continue to ensure appropriate delineation of specialised and non-specialised activity, improve care for patients and improve value overall. This is particularly relevant to CRG areas such as Infectious Diseases, Immunology and Allergy and Haemoglobinopathies.

Supporting the implementation of treatments which improve outcomes and efficiency will be supported, such as automated exchange transfusion for people with sickle cell disease and thalassaemia.

Work will be completed to enable the transfer of commissioning responsibility for Thrombotic Thrombocytopenic Purpura (TTP). This is a very rare blood disorder and a service specification is being developed in 2016/17. Transfer to NHS England is expected to require a national procurement in 2017/18.

The Programme will continue to focus on using data on variation and outcomes to drive its work plan to secure improvements for patients and to drive improvements in value.

A work programme of policy and service specifications will be undertaken.

## **5.6.2 Transformation and Strategic Service Reviews**

### **Haemaglobinopathies**

This review aims to ensure the full implementation of networked care to address variations in access to specialist care for people with sickle cell disease and thalassaemia.

### **Infectious Diseases**

Building on and linked to the review of High Consequence Infectious Diseases, and taking into account the link with specialised HIV inpatient care, this review aims to better define tiers of infectious diseases care and improve the commissioning of specialised infectious disease centres.

### **Hepatitis C**

The implementation and development of Operational Delivery Networks supporting access to specialist care and treatment with new oral direct acting antiviral drugs will continue. With leadership from the Quality Surveillance Team, a programme of peer review visits is planned.

### **HIV**

At a national, regional and local level, work will continue to work collaboratively with local commissioners and providers to manage changes in sexual health and HIV pathways to safeguard improvements in outcomes. In terms of specialised HIV inpatient care, collaboration with specialised infectious disease is required to ensure pathways of care and sustainability of services and work force. The London HIV Service Review will continue.

Haemophilia care and BMT have also been identified by the Programme of Care as likely areas for service review in 2017/18 and further work is currently underway to confirm the scope and timing.

## **5.6.3 Tariff / Currency / Pricing developments**

### **HIV**

All Providers and commissioners must use the mandatory currency for HIV outpatient activity in contracts from April 2017. This will support the work to develop and begin the implementation of shadow pricing.

## **BMT**

Workshops with providers will be held to confirm the issues of variation to be addressed by moving to a mandatory currency.

## **Haemoglobinopathy**

With effect from April 2017 all providers will be required to use new procedure coding to distinguish automated and manual red cell exchange, which will be used to deliver new prices which are intended to replace the CQUIN in April 2019. This will ensure the NHS promotes best practice in the use of automated red cell exchange, within available resources.

## **CQUIN**

The Blood and Infection Programme expect to implement the following CQUINs across relevant providers in 2017/18. These are an extension of existing multi-year CQUINs, the promotion of national generic CQUINs or the national roll out of relevant locally developed CQUINs:

- Hepatitis C Operational Delivery Networks;
- Haemtrack reporting for haemophilia patients;
- Haemoglobinopathy Networks;
- Automated red cell exchange;
- Patient Activation at existing providers extended to blood and infection patients, along with Shared Decision Making as a tool to promote increasing patient engagement in service change and self-management; and
- HIV drug switching for improved value within medicines optimisation CQUIN.

## **Opportunities to work with STP footprints**

The programme of care team will work with STP footprints to agree service priorities and support key initiatives planned for local populations over the next two years. HIV, Hepatitis C, infectious diseases and haemoglobinopathy pathways would benefit from stronger links with commissioners of the non-specialised service elements. This may include supporting:

- Provider configurations – setting out the provider model and configuration required to deliver shared STP and NHS England priorities;
- Development of new service standards linked to outcomes; and
- Contract approaches such as multiyear contract options, collaborative commissioning arrangements with CCGs.

## **5.7 Highly Specialised Services**

### **5.7.1 Planned commissioning changes**

Building on the changes notified in the 2016/17 Commissioning Intentions, the Highly Specialised Commissioning Team (HSCT):

- Is considering the development of specifications for new models of care, which will likely involve provider selection to concentrate clinical expertise for: *in utero*

spina bifida surgery, urinary fistulae, thrombotic thrombocytopenic purpura and the management of corporea arteriovenous malformations in children;

- Is developing clinical commissioning policies, which will likely involve provider selection, to concentrate clinical expertise for: mechanical assist devices as destination therapy, balloon pulmonary angioplasty and interleukin 1 blockers.
- Is revising the service specification for the Vein of Galen malformation service in order to select a new, second provider of the service;
- Is revising the service specifications for the small bowel transplantation service to adequately describe the requirement to transition patients from paediatric to adult services;
- Will select provider(s) to deliver a service for patients with hypophosphatasia should NICE recommend the use of the drug asfotase alfa; and
- Is working with the Infectious Diseases CRG and other partners to scope the requirements for the treatment of high consequence infectious diseases (HCIDs). In particular, this will include the development of service specifications for airborne HCIDs and the selection of providers to deliver these services.

### **5.7.2 Developing payment approaches to best support patient care**

The HSCT is:

- Developing proposals for the reprocurement of homecare for patients with lysosomal storage disorders. This will include the delivery of sebelipase alfa should this be recommended for use by NICE;
- Developing a market engagement process for potential providers of highly specialised services to ensure that clinical expertise, access, quality and value for money are optimised;
- Working with colleagues in the Department for Work and Pensions and the Department of Health to ensure that income from patients from other EU member states accessing highly specialised services in the UK is maximised; and
- In the extra corporeal membrane oxygenation (ECMO) service: is benchmarking existing services and reviewing variation in the contracting mechanisms and tariff; and continuing development of the integrated referral pathway, as part of the improving value programme.

### **5.7.3 Other service changes**

The HSCT is identifying and developing a sustainable position for the commissioning of transplant-aligned services such as cardiac ECMO and mechanical assist devices.

## **6 Section 3: Regional Intentions**

### **6.1 The South Regional Service Programme**

#### **6.1.1 South - Service Quality and Strategic Change**

The NHS South Specialised Commissioning team will work closely with STPs to ensure that services are planned at optimal population level.

We will continue to reduce pathway variation and will use the results of audit of NICE TA and commissioning policy audits to support reconfiguration through consolidation and networking.

#### **6.1.2 South - Internal Medicine**

Review of complex cardiology services with a view to consolidation of specialist work in fewer higher volume centres.

Working with providers to extend the enhanced supportive care approach beyond cancer to other life limiting conditions.

#### **6.1.3 South - Cancer**

We will work with regional cancer alliances to implement the recommendations of the national review of radiotherapy. We are aware of the time pressure to replace aging Linacs but need to ensure a consistent approach to assumptions about future capacity requirements to avoid a proliferation of services which may not be financially viable over the lifetime of proposed new Linacs.

We will be encouraging providers to adopt a number of levers to improve access, quality and efficiency including CQINS for Enhanced Supportive Care and Chemotherapy Dose Standardisation.

#### **6.1.4 South - Mental Health**

We will collaborate with providers to develop new contracting models and will be working to extend the New Models of Care Mental Health pilots to CAMHs services.

The NHS South team will explore the potential to develop a forensic outreach service in the Kent area, to support a diversion away from admission and an accelerated discharge pathway from secure care.

#### **6.1.5 South - Trauma**

Against a backdrop of high benchmarked reference costs and prices, we will work with providers and CCGs to consider new approaches to commissioning Critical Care services. Our intention is to move with a number of key contracted centres to a fixed facility payment from 2017/18 covering the bulk of costs, with a supplementary payment to cover variable costs and to work with providers to inform the national future work in this area. We will consider alternative proposals put forward by providers which contribute to a consistent regional pricing approach which incorporates the national approach to zero organs supported and delayed discharge from critical care to ensure funding flows facilitate improvements for patients.

#### **6.1.6 South - Women and Children**

We will work collaboratively with Neonatal ODNs to ensure consistent admission thresholds to avoid term admissions into Neonatal Units.

In anticipation of revised BAPM guidance we will review neonatal unit designation to ensure quality standards are met.

We will performance manage L1 Congenital Heart Disease centres and associated networks to ensure that standards relating to L1,2 and 3 congenital heart disease are met.

Linked to the IR exercise we will only commission Paediatric HDU services where there is a PICU on site.

#### **6.1.7 South - Blood and Infection**

Please see National section.

#### **6.1.8 South - Pharmacy**

We will be working, as part of the population based budgeting exercise, to identify variation in use and spend of specific National tariff excluded drugs and will work with providers to understand the variation.

We will continue to work towards improvements in the management of the use of immunoglobulin treatment with peer review supported IVIG Panels.

We will continue to support the work of clinical trials and to develop consistent processes for the agreement of any excess treatment costs which must be agreed with commissioners.

We will continue to review the role of the embedded pharmacist as a position that supports both provider and commissioner organisations.

We will work to support delivery of clinical treatment pathways utilising the most cost efficient drugs.

#### **6.1.9 South - 2017-19 Contracts**

We will review remaining block elements in contracts, particularly those supporting staffing only and will use price x activity contracts for 2017/18.

We will adopt a range of new contracting models, alongside CCGs and STPs, including prime provider models, supported by sub-contracting or partnership arrangements. We intend to pilot this approach with providers in 2017/18 and to roll these out across the South in 2018/19. Possible services include Cardiothoracic, Cancer, Cochlear Implants and BAHAs and specialist paediatric services. We welcome proposals from providers for other services and contracting models.

Linked to our strategic approach to reconfigure pathways and consolidate the supplier base, we will look to introduce differential funding approaches to support the changes we wish to see, including marginal rates or local tariffs where activity is consolidated or steps and costs are removed from pathways, which are covered by national tariffs.

We will review prices and costs for neonatal services, which compare highly with national benchmarks and will address high prices in the 2017/18 contract.

We will continue to strengthen our closed loop IFR process and will review the arrangements which providers have in place for ensuring that charges for overseas and private patients are not inappropriately passed on to commissioners.

We will not be funding in-year pathway changes without prior approval through an agreed process.

## **6.2 The London Regional Service Programme**

### **6.2.1 London – Service Quality and Strategic Change**

London Region will focus on improving the quality and effectiveness of services for patients, and ensuring resilient provision, by concentrating on five key themes which account for the majority of the financial sustainability challenge facing specialised services:

- Pathway inefficiencies;
- Ineffective prevention;
- Operational inefficiencies;
- Fragmented service provision landscape; and
- Inefficiencies due to patient flows.

London Region has established a Specialised Commissioning Planning Board, bringing together representatives from the 5 STPs, providers, NHS Improvement, the national specialised commissioning team and the two neighbouring NHS England regions. The Planning Board will identify and agree priorities for transformation in specialised services where there are significant patient flows across London and beyond. The initial improvement priorities for work across London and beyond are:

- Paediatrics;
- Cardiovascular;
- Specialist cancer; and
- Renal (led by each STP).

In addition, there is a programme of work focussed on options for the future configuration of specialised acute services across South London, and the patient flows into London from the South East.

We will continue to monitor all services against compliance with the service specifications. Work will continue in 17/18 on ensuring compliance, using information from the quality dashboards as well as the new quality information system (QSIS) and reviews of the quality surveillance teams.

We will undertake a number of audits to ensure compliance with national policy for the use of high cost drugs and devices.

### **6.2.2 London - Internal Medicine**

London - Internal medicine - Undertake a review of paediatric cystic fibrosis services provided in London, working jointly with the South region.

### **6.2.3 London – Cancer**

We will work with the two cancer vanguards in London, and the cancer alliance in South East London, to ensure delivery of commitments for improved quality and cost effectiveness in relation to specialised services.

We will continue to address non-compliant cancer pathways which do not meet agreed activity thresholds.

We will work within the framework of the national strategy to address paediatric cancer services in London.

### **6.2.4 London – Mental Health**

We will support the implementation of the two new models of care pilots in London: North West London, focussed on CAMHS, and South London, focussed on adult secure.

We will continue our work with CCGs, providers and local authorities to improve the integration of CAMHS pathways.

We will continue our work with the London Transforming Care Partnerships to increase care and support provided to people with learning disability and autism in the community.

We will continue to work with the providers of Gender Identity services in London to improve waiting times, moving towards meeting constitutional standards; working with the national team and the other regions, we will reprocure gender surgery and Gender Identity services in London.

### **6.2.5 London – Trauma**

Adult ECMO: we will undertake procurement for the adult ECMO service covering West London and the South West, working jointly with South Region.

We will progress implementation of the London neuro-rehabilitation review to improve patient flow and joint working across the pathway.

### **6.2.6 London – Women and Children**

Congenital Heart Disease: we will ensure that contracts with all relevant providers include the new service specification and time limited derogations as necessary and work with providers to implement the outcome of the national review following public consultation.

We will progress implementation of the 2016/17 review into paediatric and neonatal transport services in London.

### **6.2.7 London – Blood and Infection**

We will progress implementation of the London HIV review.

We will continue to work with the National team to secure benefits from the new Hepatitis C Networks.

### **6.2.8 London – 2017-19 contracts and enablers**

We will assess what we need to do with respect to information sources and regular reporting to evidence changes and benefits of the above service changes. We will reflect these requirements into contract.

As in all regions CQUIN continues to be strategic enabler of change and quality improvement.

We will work across London with providers to address problems caused by referrals made without the required minimum data sets.

## **6.3 The Midlands and East Regional Service Programme**

### **6.3.1 Midlands and East – Service Quality**

We will continue to monitor all services against compliance with the service specifications. Work will continue in 17/18 on ensuring compliance, using information from the quality dashboards as well as the new quality information system (QIS) and reviews of the quality surveillance teams.

We will undertake a number of audits to ensure compliance with national policy for the use of high cost drugs and devices.

### **6.3.2 Midlands and East Internal Medicine**

Vascular Surgery: implementation of the outcome of the Midlands and East stocktake and complete designation of vascular networks and address non-compliant vascular service configurations.

### **6.3.3 Midlands and East – Cancer**

We will work with the new cancer alliances to deliver the national cancer strategy objectives relating to specialised services

We will continue to address non-compliant cancer pathways including:

- Complete the commissioning of IOG complaint specialised urology surgical centre for Essex;
- Complete the work to identify the optimal model for upper GI services in the East Midlands;
- Review of hepatobiliary pathways in the West Midlands;
- Review skin cancer pathways in the West Midlands to meet IOG standards; and
- Ensure oncology services for the Sandwell and West Birmingham population are compliant with service specification and peer review.

Review access to radiotherapy services for the Hertfordshire population.

### **6.3.4 Midlands and East – Mental Health**

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We will reduce the capacity of Learning Disability/Autistic Spectrum Disorder secure services across the Midlands and East by a minimum of 10% in 2017/18. We will support the implementation of the Fast Track Programme to reduce reliance on inpatient beds in Coventry and Warwick, Nottinghamshire and Hertfordshire.

We will undertake a review of high cost packages of care and move towards a consistent pricing /banding structure across the ME.

We will complete the procurement of an additional perinatal service in the East of England.

We will increase the capacity of Gender Identity services in the East Midlands to improve waiting times, moving towards meeting constitutional standards.

We will undertake a review and reduce non-therapeutic lengths of stay.

We will work with and support the implementation of the New Models of Care pilot in the West Midlands.

We will complete the review of CAMHS and secure services looking to work with new models of commissioning collaboratively with CCGs and providers.

### **6.3.5 Midlands and East - Trauma**

Implement the national spinal pathfinder and improved RTT. Improve access to spinal services and reduce waiting lists in the West and East Midlands.

### **6.3.6 Midlands and East – Women and Children**

Congenital Heart Disease: we will ensure that contracts will all relevant providers include the new service specification and time-limited derogations as necessary and work with providers to implement the outcome of the national review following public consultation.

Complete the review neonatal services to ensure we have sufficient capacity in the most optimal network configurations.

Consideration of a new model of care to combine the commissioning and provision of neonatal and maternity services.

### **6.3.7 Midlands and East – Blood and Infection**

We will continue implementation of year of care tariff for HIV services.

We will complete the procurement of HIV services in the East of England.

## **6.4 The North Regional Service Programme**

### **6.4.1 North - Service Strategy**

In order to improve the quality and outcomes of specialised services across the North of England, we will focus on:

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- Linking with STP footprints to develop a whole system, pathway led, approach to provision and commissioning of services, particularly where transformational change is required;
- Understanding the variation that currently exists across the region and identifying opportunities to challenge this in order to ensure equity of access, outcomes and experience for all patients. This will include working with other commissioners to ensure that care pathways work in a consistent way to support this in all areas;
- Building upon our knowledge of patient flows and the functional relationship between services to work with commissioners and providers to determine new and innovative ways of commissioning and providing services, in order to improve quality, safety and cost effectiveness;
- Piloting new innovations and evaluating the impact, where this is positive we will seek to spread best practice as quickly as possible; and
- At an STP level we will look at adopting one of the following with each footprint, depending on what is most appropriate in any given system:
  - New contracting model – Lead Provider / Alliance Contracting
  - Commissioning for one of the regional strategic clinical bundles
  - Pooling / delegating budgets for a particular pathway

As part of this work, during 2016/17 we undertook a specialised services sustainability audit in each of the North STP footprints. We will work with providers and CCG partners as part of STPs to address the findings of these audits and inform STP workstreams around future hospital configuration.

For 2017/18 and 2018/19, we will pilot new delivery models which will inform future contractual approaches to support our regional 2020 Vision of:

- Establishing one contract per strategic care bundle, per STP area (with the exception of for the West, North and East Cumbria STP);
- Moving to an approach that all Tier 1 (health economy) service lines for each bundle should be provided through a Lead Provider arrangement; and
- Establishing mechanisms so that Lead Providers in each STP area work across the sub region to coordinate access to Tier 2 (sub-regional) services.

In this way sustainability will be enhanced by:

- Reduced variation in cost and outcomes, driven by greater consistency of care and a coordinated pathway;
- Greater links to CCG commissioned pathways and prevention work;
- Better coordination and flexible use of scarce workforce;
- Improved access for all patients regardless of where they reside; and
- Potential for leveraging backroom costs and contributing to provider CIPs, as well as closing the financial gap across the health systems in the North of England.

### **6.4.2 North - Mental Health**

We will work with CCGs and other partners to better integrate Specialised Mental Health services into place-based commissioning approaches and pathways.

We will reduce the capacity of Learning Disability secure services across the North of England, working in conjunction with CCG partners. In the North West, subject to consultation, we will commission a new service configuration of secure learning disability services. The North is aiming to reduce the numbers of patients in a specialised inpatient bed by 187 by March 2019. Trajectories have been set to achieve this as follows:

March 2016 Starting point	16/17	17/18	18/19
468 inpatients	411	349	281

We will undertake work to consider how best to meet the needs of patients requiring gender identity services in the North West.

#### **6.4.3 North - Cancer**

We will work with the new cancer alliances to deliver the national cancer strategy objectives relating to specialised services.

We will undertake local reviews of Pancreatic Cancer and Head and Neck Cancer services in Yorkshire and the Humber.

We will move towards a single MDT and subsequently single site of surgery for Upper GI Cancer in Merseyside.

We will review Specialised Kidney, Bladder, Prostate Cancer; Testicular Cancer; and Malignant Mesothelioma services in Cumbria & the North East.

#### **6.4.4 North - Blood and Infection**

We will address service specification and network issues in HIV services. Work will also be undertaken to harmonise contractual and pricing arrangements for this service; and in Lancashire and South Cumbria we will re-procure a single county-wide HIV service.

#### **6.4.5 North - Internal Medicine**

During 2016/17 we have undertaken work to examine variation across the North in Dermatology; Rheumatology; Respiratory; and Hepatobiliary services. We will implement changes that address these areas of variation.

We will undertake local reviews of Severe Asthma; ILD; and Cardiology services in the North West.

We will undertake local reviews of the Implantable Cardioverter Defibrillator and Cardiac Resynchronisation Therapy and Inherited Cardiac Conditions (All Ages) elements of Cardiology; and Endocrinology Services; Vascular Services; Colorectal: Complex Inflammatory Bowel Disease; and Faecal Incontinence services in Cumbria and the North East.

#### **6.4.6 North – Trauma**

We will implement a case-management model for Neuro-rehabilitation services, working with providers on complex rehab cases across the North.

We will undertake a regional review specialised Orthopaedics Services.

We will undertake a review of the National Artificial Eye Service hosted by Blackpool Teaching Hospital.

We will undertake a local review of Specialist Rehabilitation for Complex needs in Yorkshire & Humber.

#### **6.4.7 North – Women and Children**

Congenital Heart Disease: we will ensure that contracts will all relevant providers include the new service specification and time-limited derogations as necessary and work with providers to implement the outcome of the national review following public consultation.

We will implement a single Neonatal Transport service in the North West.

We will undertake local reviews in Yorkshire & Humber on Paediatric Medicine; Paediatric Oncology; and Paediatric Neurosciences services.

We will undertake local reviews in Paediatric Ophthalmology; Paediatric Gastroenterology, Hepatology & Nutrition; and Paediatric Palliative Care service in Cumbria and the North East.

#### **6.4.8 Devolved Specialised Services in Greater Manchester**

In Greater Manchester, Tier 1 (Health Economy) specialised services area commissioned on behalf of the Greater Manchester Health and Social Care Partnership. Jointly agreed priorities for Greater Manchester service reviews include:

- Vascular Surgery;
- HIV;
- Neurorehabilitation;
- Specialised Ophthalmology; and
- Specialised Orthopaedics.

## Annex A

The policies and specifications included within the work programmes are correct as of September 2016 but may be subject to change.

### Clinical commissioning policies as per 2016/17 work programme

Programme of Care	Intervention	Indication
<b>Internal Medicine</b>	Balloon pulmonary angioplasty	Non operable chronic thromboembolic pulmonary embolism
	Inhaled therapy levofloxacin	People with cystic fibrosis chronically colonised with pseudomonas aeruginosa
	Lung volume reduction	Severe emphysema
	Total pancreatectomy with islet autotransplant	Pancreatitis
	Rituximab	Systemic lupus erythematosus in adults
	Rituximab	Interstitial lung disease associated with connective tissue disease
	Infliximab	Refractory sarcoidosis
<b>Cancer</b>	Bortezomib	Relapsed Waldenstroms Macroglobulinaemia
	Clofarabine	Acute myeloid leukaemia as a bridge to transplant
	Stereotactic radiosurgery and radiotherapy	Pituitary adenoma
	Bendamustine	Relapsed mantle cell lymphoma
	Bendamustine	1 <sup>st</sup> line low grade lymphoma with rituximab
	Bendamustine	Relapsed chronic lymphatic leukaemia
	Bendamustine	Relapsed low grade non-Hodgkin's lymphoma
	Bendamustine	Relapsed multiple myeloma
	Dexraoxane for the prevention of cardiomyopathy	All children receiving cardiotoxic therapy with anthracyclines
	Arsenic trioxide	Primary therapy for acute promyelocytic leukaemia in children
	Bortezomib	Relapsed/refractory mantle cell lymphoma
	Bendamustine	1 <sup>st</sup> line mantle cell lymphoma
	Hypofractionated external beam radiotherapy	Prostate cancer
	Stereotactic ablative body radiotherapy	Non-small cell lung cancer
	Surgical correction	Pectus deformity (all ages)
Dasatinib	Chronic myeloid leukaemia	

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Programme of Care	Intervention	Indication
<b>Trauma</b>	Total distal radio-ulnar joint replacement	Management of symptomatic instability and arthritis of the distal radio-ulnar joint
	Adalimumab	Adults patients with severe refractory uveitis
	Boston keratoprosthesis	Patients who are no longer suitable for a corneal transplant
	Deep brain stimulation	Tourette's Syndrome
	Intra-arterial thrombectomy	Proximal occlusion of the middle or anterior cerebral arteries
	Osseointegration	Transfemoral amputation
	Deep brain stimulation	Refractory Epilepsy
	Rituximab	Chronic inflammatory demyelinating polyneuropathy
	Hyperbaric oxygen therapy	Multiple indications
<b>Women &amp; Children</b>	Triethylenetetramine	Hepatic, neurological and neuropsychiatric sequelae of Wilson's Disease
	Rituximab	Acute and relapsing paediatric autoimmune encephalitis
<b>Blood &amp; Infection</b>	Anakinra and tocilizumab	Adult onset still's disease
	Canakinumab and anakinra	Hereditary periodic fever syndromes
	HSCT	Lymphoblastic lymphoma
	Immediate initiation of anti-retroviral therapy	HIV positive, any CD4 count, anti-retroviral therapy naive
	Lenalidomide	POEMs syndrome

**Service specifications as per 2016/17 work programme**

Programme of Care	Title
<b>Internal Medicine</b>	Respiratory: Complex Home Ventilation
	Adults with Primary Ciliary Dyskinesia
	Specialised Colorectal: Selected Specifications
	Neuroendocrine Tumour Networks
	HSS Renal: Cystinosis
	HSS Small Bowel (Adults)
	Specialised Endocrinology
	Cardiac Surgery
<b>Cancer</b>	Service specifications will be revised as required through the Service Review programme and may involve: OG, Head and Neck, Chemotherapy, Radiotherapy, Paediatric Cancer, TYA Cancer
<b>Trauma</b>	Neurosciences - Neuropsychiatry
	Specialised Ears and Ophthalmology - Adult
	Specialised Ears and Ophthalmology - Children

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Programme of Care	Title
	Neurorehabilitation
	Neurosciences
	Adult Critical Care
	Stevens-Johnson syndrome and toxic epidermal necrolysis (SJS-TEN), all ages
<b>Women &amp; Children</b>	Clinical Medical Genetics
	DNA Repair
	Recurrent prolapse
	Recurrent Urinary Incontinence
	Urogenital and anorectal conditions
	Abnormally Invasive Placenta
	Urinary Fistulae / Vesico Vaginal Fistulae
	Congenital Anomalies
	Ciliopathies
	Leukodystrophy – Inherited White Matter Disorders
	Rare Hereditary Neuropathy
	Paediatric Onset Multiple Sclerosis
	ECMO for neonates, infants and children with respiratory failure
	Vein of Galen
Small bowel transplantation (children)	
<b>Blood &amp; Infection</b>	HSS: Thrombotic Thrombocytopenic Purpura
	Infectious Diseases
	Haemoglobinopathies
	Other service specifications will be revised as required to reflect changes in policy or pricing and may involve: HIV and BMT.

## Annex B: Commissioning Levels to support Place based STP planning

Commissioning Level	Service
National/Regional	Cryopyrin associated periodic syndrome service (adults)
	Diagnostic service for amyloidosis (adults)
	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)
	Severe combined immunodeficiency and related disorders service (children)
	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)
	Breast radiotherapy injury rehabilitation service (a discrete cohort of adult females)
	Choriocarcinoma service (adults and adolescents)
	Ex-vivo partial nephrectomy service (adults)
	Primary malignant bone tumours service (adults and adolescents)
	Proton beam therapy service (adults and children)
	Retinoblastoma service (children)
	Adult ataxia telangiectasia services
	Adult specialist pulmonary hypertension services
	Autologous intestinal reconstruction service for adults
	Behçet's syndrome service (adults and adolescents)
	Chronic pulmonary aspergillosis service (adults)
	Complex Ehlers Danlos syndrome service (adults and children)
	Encapsulating peritoneal sclerosis treatment service (adults)
	Epidermolysis bullosa service (all ages)
	Heart and lung transplantation service (including mechanical circulatory support) (adults)
	Insulin-resistant diabetes service (adults and children)
	Islet transplantation service (adults)
	Lymphangiomyomatosis service (adults)
	Pancreas transplantation service (adults)
	Pseudomyxoma peritonei service (adults)
	Pulmonary thromboendarterectomy service (adults and adolescents)
	Small bowel transplantation service (adults)
	Xeroderma pigmentosum service (adults and children)
	Atypical haemolytic uraemic syndrome service (adults and children)
	Adult highly specialist oesophageal gastric services in the form of gastro-electrical stimulation for patients with intractable gastroparesis

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Commissioning Level	Service
	Liver transplantation service
	Mental health service for Deaf children and adolescents
	Secure forensic mental health service for young people
	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)
	Specialist mental health services for Deaf adults
	Veterans' post-traumatic stress disorder programme
	Diagnostic service for rare neuromuscular disorders (adults and children)
	Extra corporeal membrane oxygenation service for adults
	Hyperbaric oxygen treatment services (adults and children)
	Neuromyelitis optica service (adults and adolescents)
	Neuropsychiatry services (adults and children)
	Ocular oncology service (adults)
	Ophthalmic pathology service (adults and children)
	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)
	Spinal cord injury services (adults and children)
	Hand transplantation service (adults)
	Adult congenital heart disease services
	Alkaptonuria service (adults)
	Alström syndrome service (adults and children)
	Ataxia telangiectasia service for children
	Autoimmune paediatric gut syndromes service
	Bardet-Biedl syndrome service (adults and children)
	Barth syndrome service (male adults and children)
	Beckwith-Wiedemann syndrome with macroglossia service (children)
	Bladder exstrophy service (children)
	Complex childhood osteogenesis imperfecta service
	Complex neurofibromatosis type 1 service (adults and children)
	Complex tracheal disease service (children)
	Congenital hyperinsulinism service (children)
	Craniofacial service (adults and children)
	Diagnostic service for primary ciliary dyskinesia (adults and children)
	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure
	Gender identity development service for children and adolescents
	Highly specialist metabolic disorder services (adults and children)
	Lysosomal storage disorder service (adults and children)

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Commissioning Level	Service
	McArdle's disease service (adults)
	Neurofibromatosis type 2 service (adults and children)
	Paediatric cardiac services
	Paediatric intestinal pseudo-obstructive disorders service
	Primary ciliary dyskinesia management service (children)
	Pulmonary hypertension service for children
	Rare mitochondrial disorders service (adults and children)
	Severe acute porphyria service (adults and children)
	Specialist genetic services (adults and children)
	Specialist paediatric liver disease service
	Stickler syndrome diagnostic service (adults and children)
	Vein of Galen malformation service (adults and children)
	Wolfram syndrome service (adults and children)
	Surgery for complex obesity in children
Sub Regional	Blood and marrow transplantation services (adults and children)
	Highly specialist services for adults with infectious diseases
	Specialist haemoglobinopathy services (adults and children)
	Specialist services for haemophilia and other related bleeding disorders (adults and children)
	Specialist services for children with infectious diseases
	Adult thoracic surgery services
	Radiotherapy services (adults and children)
	Specialist cancer services for children and young people
	Highly specialist adult urological surgery services for men
	Adult highly specialist respiratory services
	Adult highly specialist rheumatology services
	Adult specialist endocrinology services
	Cystic fibrosis services (adults and children)
	Highly specialist dermatology services (adults and children)
	Severe intestinal failure service (adults)
	Specialist cancer services (adults)
	Specialist services for complex liver, biliary and pancreatic diseases in adults
	Adult secure mental health services
	Adult specialist eating disorder services
	Child and adolescent mental health Tier 4 services
	Gender identity disorder services
	Specialist perinatal mental health services (adults and adolescents)
	Specialist services for severe personality disorder in adults
	Adult highly specialist pain management services

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Commissioning Level	Service
	Bone conduction hearing implants (adults and children)
	Cochlear implantation services (adults and children)
	Specialist burn care services (adults and children)
	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)
	Cleft lip and palate services (adults and children)
	Fetal medicine services (adults and adolescents)
	Highly specialist adult gynaecological surgery and urinary surgery services for women
	Highly specialist pain management services for children
	Highly specialist palliative care services for children and young adults
	Mitochondrial donation service
	Paediatric and perinatal post mortem services
	Reconstructive surgery service for adolescents with congenital malformation of the female genital tract
	Specialist dentistry services for children
	Specialist ear, nose and throat services for children
	Specialist gastroenterology, hepatology and nutritional support services for children
	Specialist gynaecology services for children
	Specialist haematology services for children
	Specialist neuroscience services for children
	Specialist orthopaedic surgery services for children
	Specialist paediatric intensive care services
	Specialist plastic surgery services for children
	Specialist renal services for children
	Specialist surgery for children
	Specialist urology services for children
	Specialist immunology services for children with deficient immune systems
	Specialist maternity care for women diagnosed with abnormally invasive placenta
<b>STP/Multi STPs</b>	Adult specialist services for patients infected with HIV
	Specialist immunology services for adults with deficient immune systems
	Highly specialist allergy services
	Positron emission tomography-computed tomography services (adults and children)
	Adult specialist cardiac services
	Adult specialist intestinal failure services
	Adult specialist renal services

OFFICIAL

Commissioning Level	Service
	Adult specialist vascular services
	Specialist colorectal surgery services (adults)
	Adult specialist neurosciences services
	Adult specialist ophthalmology services
	Adult specialist orthopaedic services
	Complex spinal surgery services (adults and children)
	Major trauma services (adults and children)
	Specialist ophthalmology services for children
	Specialist rehabilitation services for patients with highly complex needs (adults and children)
	Specialist endocrinology and diabetes services for children
	Specialist neonatal care services
	Specialist respiratory services for children
	Specialist rheumatology services for children