NHS
East Surrey
Clinical Commissioning Group

Appendix 2: East Surrey CCG Commissioning Intentions

Indicative Commissioning Intentions

This letter sets out the initial commissioning intentions from East Surrey CCG for commissioning services from your organisation. As it is very early in the process this appendix provides a high level perspective only, with further work and discussion required over the coming weeks to finalise plans and approaches for 2018/19 and 2019/20. We do however wish to bring your attention to the following initiatives which will impact on commissioned levels of activity in 18/19 and, we expect, reduce demand on SASH.

These are:

Prevention	Access To Services
• Poor diet • Lack of physical activity • Alcohol • Mental health • Loneliness • Social prescribing • Wellbeing Advisors • Active Surrey Programme • Smoking cessation • Cancer screening • Diabetes screening	• 111 Pathways • Clinical Assessment Service • Directory of Services • Functional integration • Direct booking to Primary and Community Care • Community access
Emergency & Acute Care	**Multi-specialty Community Partnership**
Ambulances **Hospitals** • GP Front Door Streaming • Frailty Unit • Ambulatory care pathways • Assessment units **Hospital to Home** • IRU • Integrated Discharge Team • CHC • Psychiatric liaison **Acute elective care** • Advice & Guidance • Right Care programmes • Independent sector	• Primary Care Delivery – GP extended access • Primary Care Networks and resilience • Self care • Urgent Treatment Centre • Elective Referral Management • Diabetes • Cancer • Mental Health • Cardiology • Stroke • Maternity • Respiratory • MSK (Orthopaedics / Rheumatology / Pain Management) • Dermatology • Right Care programmes • >65 Flow Programme - Community nursing • Enhanced Medical Care for Nursing & Residential • Fractures and Falls Pathway • Out Patient impact- referral review (reducing OP referrals that result in a discharge from first appointment with no diagnostics or treatment

In addition there are mental health initiatives through the Surrey collaborative, which could reduce SASH demand. These include:

- Manage crisis well: through development of psychiatric Liaison, 24/7 crisis home treatment teams, safe havens, single point of access, mental health practitioners working with the police and ambulance services.
- Extension of the HOPE day service
- SABP: 2 community mental health workers dedicated to south-East surrey to provide additional crisis support over extended hours on weekdays and 9-5 on weekends.
- Extended Hope: MH crisis beds at Hope House available for up to 7 day stays.
- Havens: drop in café with healthcare professionals specialising in MH, Scoping options for East Surrey.

Contracting Approach

It is essential that our contracting approach and commissioning Intentions for 2018/19 reinforce **system sustainability.** To that end we will:

- align commissioner and provider plans and where possible ensure plans are jointly developed
- ensure all plans are consistent with the 11 Carnall Farrar local care interventions
- contract with providers at a level and mix of care that is affordable
- seek to maximise opportunities to align incentives in contracts shifting the focus to value, cost efficiency and quality and incentivising different behaviours.

New Models of Care

East Surrey CCG is striving to develop more effective ways to commission high quality services at optimal cost in order to manage the increasing demand on resources driven by a growing and ageing population and continuing financial challenges. This includes moving to a block contract and exploring a Programme Budgeting Approach, in particular, for the 65 Flow Programme so we can understand how much the whole pathway costs.

The new delivery models are set out in the CCG's commissioning strategy and illustrate a new vision of how health care will be provided differently in East Surrey.

Rather than developing the traditional model for planned and urgent care pathways, East Surrey CCG will move to a commissioning model aligned to managing patients' health (physical and mental) and social care needs, recognising interdependency is inevitable within complex systems.

The commissioning model is based on four Strategic Change Programmes. These cover:

Prevention, Screening and Immunisation

Our vision is to increase the number of years people live in good health, by encouraging individuals to make healthy lifestyle changes to prevent disease from developing, as well as preventing complications of existing disease. Prevention will be included as part of the clinical care pathway redesign, recognising primary, secondary and tertiary prevention. This work includes:

- Supporting maternity providers to ensure early antenatal booking, smoking cessation, breastfeeding promotion (in line with UNICEF guidelines) and implementation of the outcomes of the Maternity Services Review.
- Embedding early identification of alcohol misuse and brief interventions across primary and secondary care services and Alcohol Liaison services in secondary care

Access to services

The vision is to deliver a service model which enables integration between NHS 111, Primary Care, Community and emergency and acute care services. A core element of this vision is the commissioning of a functionally integrated urgent care access, treatment and clinical advice service and the approach to achieving this is outlined in the recently published Commissioning standards for Integrated Urgent Care.

The introduction of Integrated Urgent Care is a proposal for the radical shift in care to a 24/7 functionally integrated access, assessment, advice and treatment service. It is not simply the bolting together of existing services but the introduction of a new functionally integrated service that includes a new 'Clinical Advice Service'.

1. NHS 111/Integrated Urgent Care Service

The core vision is for a more closely Integrated Urgent Care service building upon the success of NHS 111 in simplifying access for patients and increasing the confidence that the public have in their services. Central to this will be the development of a Clinical Advice Service (CAS) offering patients who require it access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. The clinicians in the CAS will be supported by the availability of clinical records such as 'Special Notes', Summary Care Record (SCR) as well as locally available systems. In time, increasing IT system interoperability will support cross-referral and the direct booking of appointments into other services.

2. Transformation of the Directory of Services

The Directory of Services (DoS) is a central directory that works alongside NHS Pathways, the clinical algorithm tool used within 111 to provide the NHS 111 call handler with accurate and up to date information regarding the available local services. The services offered can be set in the commissioners preferred order and these are offered first. When operating well, it ensures that patients are directed to the right service, at the right time and in the right place. It is also a fundamental aspect of a patient or other service user's experience of the quality of the service received.

3. Urgent Care Market Research

Ensuring that patients know which option is the right option for their condition and then being able to access that option readily will help to balance the use of capacity across the system and help to alleviate pressures on some functions that currently are more stretched than others. To support this it is vital to understand how the public view the current system and why they make the choices that they do.

4. Direct booking to GP primary care appointments

Oxted Surgery is working with 111 pathways to enable triage and direct booking of GP appointments.

5. Directory of Services Review

We have seen from our case for change that some services are not being accessed through NHS 111 Pathways or do not deliver the service response to meet the needs of the patient. Changes to the Directory of Services and the system response are fundamental to making this change.

The project should be considered in two phases:

1. **Short term DoS changes to test activity shifts**

We will identify priority pathways to test changes to the DoS. SECAmb, in partnership with First Community Heath and Care, to work with 111 pathways to support the clinical triage of patients directly to community and primary care services, through the effective use of the Directory of Services.

We will also put in place a robust process to ensure the maintenance elements of the DOS are fulfilled with all projects in the CCG taking into account the implications to NHS 111 and the DoS.

2. **Process/capacity identified for ongoing DoS maintenance and management.**

While testing the concepts of DoS changes we will be working to ensure a longer term system wide process is in place with sufficient capacity to manage both elements of the DoS. There is a national expectation for capacity and expertise and we will be using our learning from the first phase and working with neighbouring CCGs to create a future proofed DOS management system.

Emergency and acute care

Patients with more acute or life threatening emergency care needs, will be treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

The emergency acute care system will be commissioned as a collaborative partner in the delivery of complex acute and emergency care pathways and needs. Clinical decision making will be enabled through the 999 and 111 pathways system allowing patients to be directed to the level of clinical expertise that their need requires. It will be built upon:

- Shared decision making
- Shared resources
- Networked model of care
- Obtain earlier personalised outcome by faster access to right clinician
- Electronic transfer of patient information
- Significantly reduced touch points

The elective acute care system will be commissioned around care pathway designs that, where appropriate, provide the care in the community but recognising those referrals requiring specialist consultant care in an acute setting.
The CCG have a number of projects in place which enable the fast assessment of patients to direct them to the care they need as they arrive in the acute setting. We continue to co-design across the acute pathways to achieve effective discharge planning which includes maximising rehabilitation potential for patients where required. Current projects include:

Ambulances

Patients will receive a more equitable and clinically focussed response through the introduction of alternate referral pathways both within the acute hospital and community based services. This will be supported through the adoption of the national Ambulance Response Programme and easier access to local community provision.

Hospitals

1. **Front Door Streaming -** The GP in SaSH A&E supports a single front door streaming service which ensures patients receive a consistent and rigorous assessment of the urgency of their needs and an appropriate and prompt response. This will be further strengthened through the introduction of a new triage unit in October 2017 and extension of the GP in A&E role to deliver a full GP streaming model.
2. **Frailty Unit –** from December 2016 care is provided for frail elderly patients in an ambulatory setting through the Pendleton Unit at SaSH, supported by a multi-provider approach to avoid unnecessary admission.
3. **Ambulatory Care Unit –** the unit will be a patient focused service where conditions may be treated without the need for an overnight stay in hospital. The patient will receive the same medical treatment you would previously have received as an inpatient at an agreed locally derived tariff.
4. **Assessment units –** supporting ambulatory urgent assessment without the need for admission. The work spans across children and young people, working age adults and the elderly population.

Hospital to Home

Too many patients admitted to hospital remain in hospital when they no longer require acute care. We will support local delivery, linking to the wider system through the Better Care Fund, to implement the 8 High Impact Changes for discharge, to ensure that patients are sent home as soon as possible or transferred to the most appropriate care setting. The delivery will be achieved through the following projects:

1. **Early discharge planning** – the CCG has established plans in place that build on system resilience and planning with the focus on system integration. Delivery will be underpinned by the development of a discharge to assess patient pathway, with Surrey County Council and Surrey Downs Continuing Healthcare teams, resulting in timely continuity of care throughout the pathway.

   October 2017 will see investment to deliver the 24/7 community care model, increasing community capability to take more sub-acute patients to the community. Community teams will in reach to highlight patients earlier in their stay and proactively manage their discharge, to achieve a reduction in the Delay Transfer of Care (DToC).

   Longer term will see the implementation of the 'Let's get you home' programme to reflect community pathways and CCG capacity plans, helping patients avoid long stays in hospitals and normalising timely and effective discharge.

2. **Systems to monitor patient flow –** the CCG are working with partners to maximise the use of system monitoring to map and understand patient flow. Manual processes will be replaced by automated reporting and uploads where possible, including daily live feeds.

3. **Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector**

   Integrated Discharge Team – ensuring patients only stay in hospital as long as they need to be, enabled by earlier planning of discharge and liaison across sectors resulting in co-ordinated and timely transfer of care from hospital to the most appropriate setting.

   Integrated Reablement Unit – the unit provides an improved process for discharge from hospital and enable Surrey and Sussex Healthcare NHS Trust (SaSH), East Surrey Clinical Commissioning Group (ES CCG) and Surrey County Council (SCC) to make better use of their available resources.

   Integrated Stroke Pathway - an effective whole system approach for primary care prevention, rapid assessment, brain imaging, treatment and seamless transfer to local stroke services, rehabilitation and longer term on-going support.

4. **Home first/discharge to assess –** the CCG will continue with the integration agenda for Adult Social Care reablement, community health rehabilitation and rapid response. The result within the next twelve months will be all individuals return home for assessment, reducing the need for hospital stay.

Continuing Healthcare out of hospital community beds are in place to allow for maximised rehabilitation and continuing healthcare assessment in a more appropriate setting.

5. **Seven-day services –** health and social care teams provide seven day working in acute services. This will be strengthened by improved access to a local CHC pathway and additional investment in additional community capacity and capability to deliver seven day services to patients in the community.
6. **Psychiatric Liaison –** providing specialist, compassionate assessment, detection and treatment of mental ill health in general acute hospitals 24 hours a day, with further work planned to consider funding to meet the Core 24 service for adults and older adults. Comprehensive links need to be established

between the community services being developed and the Psychiatric Liaison team within the acute Hospital to ensure anyone experiencing a mental health crisis has access to support at any time.

7. **Trusted assessors -** there are trusted assessments in place between partners, which will support the move to trusted assessor roles. Work is being undertaken to enable community providers to deliver assessments. Within twelve months there will be integrated assessment teams, working within pooled budget arrangements, including resources for CHC. The result, no duplication of assessment processes, and timely responses and community providers are equipped and authorised to act as Trusted Assessors.

8. **Focus on choice –** the CCG will continue to enhance good practice in this area. They will ensure that Patients and Carers are informed and empowered. They know how systems work across health and social care and can access and understand the information and advice available to them.

   Voluntary sector provision has expanded and grown – offering pre and post admission support, providing continuity of care along the patient pathway.

9. **Enhancing health in care homes -** the CCG's successful multi-disciplinary management of patients will be extended further to ensure full compliance with the national guidance.

   Patients are managed in partnership by primary and community care, with additional support through medicines management team members. Each patient has an up to date careplan helping health care professionals and ambulance crews to manage the patients care more affectively and reduce the need for conveyance to an acute setting.

   This element is delivered through the **Out of Hospital Care – Multispecialty Community Partnership** component.

Using the RightCare approach to look at unwarranted variation

As a wave one RightCare site East Surrey CCG adopted the RightCare approach in 2016/17, identifying areas of opportunity to improve patient outcomes, reduce variation and pathway spend in the areas of Frailty (including Care Homes), Cardiology and Cancer.

The RightCare tools have informed a menu of opportunities and supported the prioritisation of a 17/19 work programme for the CCG. The methodology is now embedded within every aspect of the CCG transformation and service redesign, including supporting the identification of quick wins and the use of a decision tree.

Additional RightCare offerings for 17/19 include two cross-cutting schemes–

- Discharge Pathways which covers Continuing Healthcare, Discharge to Assess and the Integrated Discharge Team
- Urgent Care Flow which includes enhancing the current Minor Injuries Unit to reach the new 2017 Urgent Treatment Centre Standards, Directory of Service redesign, enhanced Primary Care access and 111 re-procurement.

Elective care

Patients will continue to require planned acute intervention and treatment. It is however recognised that there is a significant opportunity to manage patients in an out of hospital setting.

1. GP access to online specialist advice

Advice and guidance – the clinical decision making is being strengthened by acute consultants through the commissioned advice and guidance service, giving GP's access to an acute opinion. Surrey and Sussex Healthcare Trust currently have twelve live specialties in place with a further six ready to go live.

This enables GPs to access non-urgent advice before a referral decision is made. It required capacity to be made available within the provider, and arrangements put in place to pay providers for the service.

2. Commissioning standardised clinical pathways

Clinical pathway audits are taking place in specialties within the acute hospital setting to inform how the services should be commissioned going forward in a standardised way to remove steps that do not add value.

The Getting It Right First Time programme based in Department of Health is aiming to do just this for certain major elective surgical pathways. Part of this involves implementation of enhanced recovery programmes that include pre-op, peri-op and post-operative interventions to deliver better patient experience, better clinical outcomes and shorter length of stay.

Elective Procedures – work will be undertaken to understand the effectiveness of the procedures we commission with a view to moving to top decile performance.

Cancer Care - we are committed to improving on both the prevention of cancer and caring for those with the disease through a cancer strategy developed with primary care. This includes:

- Delivery of the constitutional standards for 2ww/31d/62d
- Increasing 1yr survival and increase % of patients diagnosed at Stage 1 and Stage 2
- Increasing diagnostic capacity and making progress towards achieving 6wk from referral to test standard
- Reducing the number of patients diagnosed via an emergency admission

More longer term (2020) we are looking to deliver on:

- Improve 1 yr survival to 75% (currently 68% at ESCCG)
- Patient given definitive Cancer diagnosis or all clear within 28d of referral by GP

Out of hospital care/multispecialty community partnership

An MCP is about integration. As a patient or a clinician, you would not choose to recreate from scratch the historical partitions between primary, community, mental health and social care and acute services. The boundaries make it harder to provide joined-up care that is preventative, high quality and efficient. The MCP model dissolves the divides. It involves redesigning care around the health of the population, irrespective of existing institutional arrangements. It is about creating a new system of care delivery that is backed up by a new financial and business model.

At **network level**, we will build primary care at scale, continuing to develop integrated multidisciplinary teams, to support people more effectively with long term conditions and coordinate care for people with the most complex needs.

The priorities will be delivered through a number of out of hospital components.
(Carnall Farrar intervention 2,3,4,7)

1. **Integrated health & social care into the home -** the model of a single integrated health and social care team providing support to those individuals with needs at home has been developing for some time in East Surrey. The move to trusted assessors and a shared single record will avoid the need for multiple visits from different agencies, with the teams structured in localities aligned around our GP practices.

2. **Rapid response –** the CCG community provider has an MDT team in place able to respond rapidly to people with complex needs who are experiencing a health or social care need. This is further supported by a Proactive Care Team who can support practices to manage patients who would result in a possible hospital admission.
3. **Falls prevention –** work is underway in the prototype pathway development, working closely with clinicians, patients and wider partners including Surrey Fire and Rescue.

   Some aspects such as fracture liaison pathways in and out of SASH will benefit from system programmes of work, coordinated across all commissioners.

4. **Care coordination, planning and management –** the CCG are in the final stages of development of our model for care navigators and case managers, working to support practices to coordinate care and support, with over 5000 careplans in place.

   Care navigation is proposed to be at network level, provided through primary care and forming the focal point for the integration of wider services.

   Case managers are provided at East Surrey level but allocated to each network (currently known in East Surrey as the Proactive Care Team, or Community Matrons).

   As well as comprehensive assessment people will be connected with community resources to keep them well and retain independence.

Social Prescribing

Social prescribing and similar approaches have been used in the NHS for many years, more recently, the General Practice Forward View (2016) has also emphasised the role of voluntary sector organisations – including through social prescribing specifically – in efforts to reduce pressure on GP services. In addition, social prescribing contributes to a range of broader government objectives, for example in relation to employment, volunteering and learning.

East Surrey CCG with the support of local partners will build on local work to implement a system-wide asset based community development approach to connect people through social prescribing i.e. Wellbeing Prescribing Service and other approaches to non-medical and community support.

Urgent Emergency Care Delivery Plan

1. GP Access

The CCG is working with GP Practices and the GP Federation to design the provision of urgent services by general practice outside of core hours, with extended access being offered within locality hubs by October 2017.

This includes the expansion of capacity and services to offer pre-bookable and same day appointments to general practice during evenings and weekends, with Oxted Surgery working with 111 pathways to pilot enabling triage and direct booking of GP appointments.

2. Urgent Treatment Centre

East Surrey CCG patients will be able to access an Urgent Treatment Centre at Caterham Dene that will be open at least 12 hours a day and staffed by nurse and doctors. This will be achieved through the consolidation of the activity currently undertaken at Caterham Dene Hospital in the Rapid Access Clinic (RAC), Minor Injuries Unit (MIU) and GP improved access service into a single UTC model to;

- meet mandated requirements from the Urgent and Emergency Care Delivery Plan
- direct patients to the most cost effective part of the system which is appropriate to the care they require
- reduce attendances at acute hospitals

The implementation will take place during September and October with a view to moving to a full UTC by December 2017.

3. GP Streaming

Every hospital must have comprehensive **front-door clinical streaming** by October 2017, so that A&E departments are free to care for the sickest patients, including older people.

The GP in SaSH A&E supports a single front door streaming service which ensures patients receive a consistent and rigorous assessment of the urgency of their needs and an appropriate and prompt response. This will be further strengthened through the introduction of a new triage unit in October 2017 and extension of the GP in A&E role to deliver a full GP streaming model.

4. Enhancing health in care homes

The CCG's successful multi-disciplinary management of patients is being extended further to ensure full compliance with the national guidance. Patients are managed in partnership by primary and community care, with additional support through medicines management team members. Each patient has an up to date careplan helping health care professionals and ambulance crews to manage the patients care more affectively and reduce the need for conveyance to an acute setting.

5. Elective Care Good Practice

Patients will continue to require planned acute intervention and treatment. It is however recognised that there is a significant opportunity to manage patients in an out of hospital setting, with national benchmarking suggesting that we may further reduce referrals by 10% to reach top quartile and 27% to reach top decile performance.

Elective Procedures – work is being undertaken to understand the effectiveness of the procedures we commission with a view to moving to top decile performance.

Referral management and peer review will be delivered through component four - **Out of Hospital Care – Multispecialty Community Partnership** alongside a number of specialty pathways. These include:

MSK – 2018/19 will see the continued expansion of the Integrated Community Assessment and Treatment service providing a single point of access to all MSK services to all seventeen practices. The work will be extended to incorporate fracture liaison, rheumatology and pain services ensuring the patient gets the right care in the right place first time.

Dementia- the work around dementia is being conducted at a county and local wide level. The focus is centred on continuing to increase the number of GP Practices that are dementia friendly, establishing dementia leads in Practices, mapping the dementia pathway in East Surrey and increasing knowledge across the system about dementia resources. Other programmes of work are centred on developing actions around what further actions and resources can be provided for carers and people with early on-set dementia, to ensure the support is available within the community and nursing homes.

Dermatology – the CCG will develop the scope of a community dermatology service with a view to the future procurement of the service. The principle aim of the service will be to deliver diagnostic, management and treatment of dermatology problems for children of all ages and adults, which compliments and works in partnership with other dermatology services. We will be de-commissioning completely the service provided at the hospital.

Diabetes – the CCG will continue with the on-going development of a best practice pathway, including a tiered community based model of care. An aspect of this will include engaging Health and Wellbeing Advisors to support patients with diabetes around diet and exercise and also sign posting them to mental health support where required.

Cardiology – to review the triage pilot and agree next steps, linking in to the next phase of the MCP prototype developments.

Respiratory – highlighted as an area for review through the RightCare programme the current pathway will be reviewed with a view to managing more patients in an out of hospital environment.

Quality Innovation Productivity and Prevention (QIPP)

As in previous years, a key component of our subsequent negotiation will be to secure a mutual understanding of our QIPP plans, including the respective contributions of CCGs and Trusts to the delivery of these plans, with a key focus on the plans of local commissioners for their local provider. East Surrey CCG recognises that further work and discussion is required to develop detailed plans, as part of local strategic partnerships.

As in previous years, some of the CCG's QIPP plans will focus on reducing acute activity and deliver of alternative pathways within the community.

Implementing Right Care opportunities

Improvements in outcome and spend through the successful implementation of reforms to patient care at Acute, Primary, Secondary and Community care levels across three key programmes, namely,

- **Cardiovascular**: Introduction of interventions aimed at coordinating current primary care with existing
- **Cardiology:** Intravenous Diuretics- aims to improve the pathway of care for patients with Chronic Heart Failure experiencing symptoms of fluid overload.
- **Cancer:** A Cancer Steering Group is in place to explore the reasons for the high spend and identify opportunities to reduce the current level of spend and improve outcomes. This is likely to impact on service provision and pathways

Focus on the Key Clinical Priorities

The CCG will continue to focus on the six key clinical priorities stated in the Forward View and forming part of the CCG Improvement and Assessment Framework, namely;

- diabetes
- cancer
- maternity
- dementia
- learning disabilities
- mental health

The right enablers to accelerate transformation, including

- Pooling our expertise and solutions for workforce transformation
- Using our STP forum and workstreams to drive collaboration and networking
- Estates that enable efficient care and implementation of locality teams
- Digital improvements that enable self-care and interoperability

Impact of Transformation and Change Programmes

The impact of the above is likely to reduce acute sector activity across all major points of delivery (PODS), namely:

- Outpatient First and Follow Up Attendances
- Outpatient Procedures
- Day case activity
- Admitted Elective activity
- Non-elective admissions
- A&E attendances
- Length of stay/excess bed days

The cancer programme however is likely to result in an increased need for acute sector outpatient first appointments and increased need for diagnostics in both the acute and Any Qualified Provider sectors.

The CCG will work with its co-commissioners and providers within the STP and place based planning footprints to develop and deliver new contractual models to deliver the new models of care in line with the Five Year Forward View. The CCG expects all its providers to work collaboratively through this process, which will include:

- Incentivising community-based prevention and population wellness resulting in a shift in investment towards general practice and community and away from reactive treatment in high cost care settings.
- Encouraging a provider sector that collaborates to network services and share workforce and incentivise collaboration between providers to coordinate care along pathways.
- Working with providers to implement outcome capitation payments or a bundled payments approach, to incentivise the system to work together, towards one balance sheet and one control total.
- Focusing on reducing the costs of commissioning and transacting the business, as well as avoiding the pathway fragmentation that undermines integration and adds in transaction costs through operating parallel models. We will seek to achieve our aims through collaboration in the way that we procure new models. The STP-wide work on digital interoperability and estates planning and management is critical to this principle.

Better Care Fund

The Better Care Fund (BCF) will continue to be of relevance to the acute contracts for 2018/19 and 2019/20 as this will be one of the main drivers of the transformation agenda highlighted above. We will need a joint understanding of local health economy BCF submissions and agreements to ensure these are appropriately reflected in acute contracts for 2018/19 and 2019/20. Key issues for 2018/19 and 2019/20 contracts will be:

- To ensure there is a collective understanding of health economy BCF plans, as relevant to each provider.
- To ensure there is a collective understanding of the services that are funded through the BCF.
- To ensure there is a collective understanding of the expected impact on emergency admissions of BCF plans and investments and that these are reflected in 2018/19 and 2019/20 signed contracts.
- To ensure there is a clear understanding and agreement of BCF activity assumptions and other relevant national guidance in relation to emergency care, including the emergency baseline rules and the marginal rate emergency threshold rules.

Operating Plans

National operational planning guidance has yet to be issued for 2018/19 and we will need to jointly review our 2018/19 plans in the context of this guidance when it is available.

It would be our intention to reflect any national guidance and priorities in our agreed contracts for 2018/19 and 2019/20 and jointly review the implications of national guidance when it is available. The same approach will be

taken in relation to any Surrey and Sussex wide priorities and requirements. At this stage of the process there are a number of issues that will require detailed discussion, modelling and agreement with and between providers.

Patient Rights

Constitutional Standards

Where national performance standards have been breached in 2017/18 and challenges are expected to continue in to 2018/19 and 2019/20., Commissioners will seek to agree an improvement trajectory and Recovery Plan as part of the 2018/19 and 2019/20 contract, subject to the agreement of other system regulators.

Patient Choice

The CCG will have regard for patients' constitutional right to choice

Clinically Effective Commissioning Programme

Clinically effective commissioning and the review of all clinical procedures aligned to the CCG clinical policy will continue to introduce changes to pathways, thresholds and some services throughout 2018/19.

Appendix 3: Medicines Management and Pharmaceutical Commissioning Intentions

This section sets out the expectations for 2017/18 and 2018/19 with regard to pharmaceutical commissioning for the Coordinating Commissioner on behalf of itself and Associate Commissioners. It is intended to ensure parity in quality of services across different providers although it is recognised that different providers deliver a range of services and not all requirements may be applicable.

- Adherence to all medicines management specification documents, i.e. 'Interface Prescribing Policy' (IPP) and 'Drugs and Devices Excluded from the National Tariff'.

- All existing and new drugs and technologies will be provided within the scope of National Tariff guidance unless:
    - Explicitly excluded through the published National Tariff and funding agreed with commissioners; or
    - As part of excluded services; or
    - Through local arrangement agreed with the commissioners

- The 'Drugs and Devices Excluded from the National Tariff' document will contain all drugs and indications that are commissioned in line with the scoping horizon work undertaken between October 2017 and December 2017. Horizon scanning of drugs and respective business cases to support their use will be submitted to commissioners in order that decisions and finances are aligned.

- A full data set will be submitted for all drug charges and any subsequent challenges. This will be aligned to NHSE requirements and include as a minimum:
    - NHS number
    - Drug name – generic and brand name e.g. etanercept (Benepali)
    - Quantity supplied e.g. 4x50mg pre-filled pen
    - Date of issue
    - Acquisition costs of drug as charged on the invoice (sight of which may be requested by CCG) N.B. Additional costs must be shown on a separate line
    - Specialty/Clinical Department
    - Indication (preferred but not mandatory if speciality/clinical department provided)

- The CCGs will review the challenge process in relation to data flow guidance expected from NHS Digital (formerly HSCIC) and will agree with providers any necessary changes in data requirements. Current data flow will remain in place until further guidance is published.

- Drug charges will be for the drug only and at acquisition cost or at Local Procurement Partnership (LPP) agreed price, whichever is lower. There will be no additional charges automatically added to drug prices without prior discussion and agreement with commissioners and in accordance with National Tariff rules.
- Locally approved homecare service charges cannot be amended without prior discussion and agreement with commissioners, even if the total patient cost (drug + homecare fee) per annum remains unchanged.

- Price lists will be shared with the CCG prior to that drug being used (and price changes should also be notified) to aid invoice validation

- All providers must have and use an nhs.net email account to communicate electronically with the CCG (including for invoice reconciliation).

- Providers will comply with monitoring arrangements in line with NICE or local agreement and/or Summary of Product Characteristics. CCGs will withhold payment if it is found on validation that required monitoring has not been reported to the CCG as per Blueteq continuation. Payment will be made on submission of up to date monitoring information.

- It is the responsibility of the provider to ensure that all national/regional wide agreed patient access schemes (PAS) are in put in place within the provider and all such drugs will be charged as per the detail of the PAS

- Providers will prescribe and supply in a manner that minimises the potential for waste: examples of prescribing practices that could lead to financial waste include dispensing very large supplies of drugs in particular high cost drugs with each issue.

- Where potential cost-savings are identified by either the provider or commissioners, any reimbursement and incentivisation paid to the provider will be agreed on a case by case basis and will be time limited and reviewed regularly – payment will only be considered if savings result from direct efforts of the provider and will not be incidental or result from factors outside of the direct control of the provider.

- Challenges to drug interventions will be responded to within the prescribed timeframe for all challenges as per national timetable.

- If specialised services/chemotherapy commissioning is transferred back to CCGs, robust systems and processes will be put in place to manage the entry of new drugs/chemotherapy protocols onto formularies to ensure that there is appropriate governance in place and that evidence based, clinically safe, cost-effective decisions are made.

- The provider will work with the commissioner when contracts are negotiated for the procurement or supply of items such as continence or stoma devices, glucose monitoring devices or feeds which may require on-going prescription in primary care.

- In the case of Oral Nutritional Supplements (ONS) the provider will only supply enteral feeds on discharge if accompanied with a nutritional management plan including a MUST score.

- The provider will work with commissioners to fully implement the Hackett report and the professional standards issued by the Royal Pharmaceutical Society of Great Britain, including clinical and cost effectiveness review and audit of home care medicines.

- The prescribing of two care pathways will be reviewed in each financial year. The areas to be audited will be agreed with providers as part of the commissioning round.

- The provider will work with commissioners to implement a repeat dispensing scheme.

- The provider will work with commissioners to support information transfer for 'hospital only medicines' for inclusion onto the GP held medication record.

- **Medication Compliance Aids**

  Surrey Downs CCG is working with colleagues in Local Authority and providers to ensure medication compliance aids are only provided for individuals where it is appropriate to do so in line with the latest guidance from NICE and the Royal Pharmaceutical Society. This work will also apply to East Surrey CCG.

  By way of reminder the following remain expectations for 2017-19:

  - A two week supply of medicines will be supplied on discharge for all patients, including those who require a medication compliance aid to discharge safely and without delay.

  Primary care must not be requested by the provider to convert hospital prescriptions to FP10s to circumnavigate Pharmacy waiting times or formulary restrictions. Any requests to do so will be highlighted to the Chief Pharmacist.

- **New PRSB standards for outpatient letters**

  The CCG will be working with local providers to standardise the format and contents of outpatient clinic letters based on the Professional Record Standards Body for health and social care (www.theprsb.org) recommendations.

  These standards will improve continuity of care and patient safety by helping clinicians to communicate relevant information more clearly, reducing medication errors by enabling recording of key information in the GP system.

- **Insulin Pump consumables**

  The commissioners will be working with providers in 2017/18 to investigate routes with which to gain control of the rising spend in the consumables associated with insulin pump use.

- **CGMS and Flash Glucose Meters**

  Providers are reminded that CGMS is NOT excluded from National Tariff and cannot be charged to CCGs.

- **Prescribing Clinical Network (PCN) fitness for purpose review**

  The recommendations of the fitness for purpose review of the PCN will be implemented across the local SASH economy.

- **Business cases**

  Requests for new funding must be accompanied by a robust business case demonstrating the benefits and costs, which must be approved by the CCG before implementation.

- **Homecare**

  Providers using homecare will be expected to invoice CCGs in a timely manner.

- **Medicines costs**

  Providers are reminded that CCGs should not be charged for aseptic preparation (including from external sources).

- **Biosimilars**

  As providers will be aware from previous communications, the Lead Commissioner is keen to make costs savings through the purchase of biosimilar drugs whenever they are available. From 1st April 2017, the Lead Commissioner will only fund the cost of the cheapest biosimilar drug available on the market. If following a switch programme a cheaper biosimilar enters the market or is included on the contractual framework, then a conversation between provider and commissioner should take place to determine whether the cost savings to the NHS warrants further switches.

- **End of QIPP incentive for rituximab**

  Providers must treat this as formal notice that the Lead Commissioner will cease paying for the originator price of rituximab and will only reimburse the price of the cheapest alternative biosimilar from the 1st May 2018 when the QIPP incentive will end.

- **Etanercept in Dermatology**

  Providers must treat this as formal notice that the Lead Commissioner will cease paying for the originator price of etanercept in dermatology and will only reimburse the price of the cheapest alternative biosimilar from the 1st April 2018.

- **New Biosimilars**

  Providers will work with their patients, clinicians and CCGs to develop a policy on how prescribers can implement the use of biosimilars in new and existing patients and support them in making informed choices to save valuable resources.

  Exceptions

  Any new patients requiring drugs for which a biosimilar is available must be prescribed the cheaper biosimilar; exceptions will ***not be accepted*** for new patients.

  Any agreed exceptions to the use of biosimilars for existing patients will require an exception request form on Blueteq to be completed.

  The terms described above will be incorporated into the 17/19 provider contract from 1st April 2017 and will therefore be contractually binding on both parties from that date.