LEICESTER, LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUPS

COMMISSIONING INTENTIONS 2017 – 2019

East Leicestershire and Rutland Clinical Commissioning Group

Leicester City Clinical Commissioning Group

West Leicestershire Clinical Commissioning Group

Introduction

Within Leicester, Leicestershire and Rutland there are three Clinical Commissioning Groups, East Leicestershire and Rutland, Leicester City and West Leicestershire. Since formation, the CCGs have worked collaboratively together and with the wider health and social care economy. This collaboration has been further developed through our Better Care Together programme, an LLR health and social care economy wide change programme, and more recently, the development of the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (LLR STP).

The commissioning intentions set out in this document are joint commissioning intentions of the three CCG's. Where commissioning intentions are only specific to one or two LLR CCGs this will be indicated.

The CCGs have been commissioning services on behalf of its patients and public since April 2013. Each year it reviews the local health needs of its population and commissions accordingly in conjunction with local councils, public health, local hospitals and community service providers.

Commissioning intentions reflects what the CCG considers are the health needs of the local population, incorporating the key health challenges and ensures that its plans align to key strategic documents such as, the NHS Five Year Forward View, the Joint Strategic Needs Assessment and System Sustainability Transformation Plan (STP).

Commissioning intentions outline to our current and potential new providers how, as a commissioning organisation, we intend to shape the local healthcare system in the coming year and ensuring we deliver the CCG's strategic aims whilst managing the complexity of the continued challenging financial environment where we have limited growth in resource and an increasing aging population with multiple co-morbidities. Commissioning intentions allow us to outline how we will respond to the publication of changes to national priorities set out by NHS England (NHSE).

These commissioning intentions will reflect our delivery of years 1 and 2 of our LLR STP and how they will enable the CCGs to deliver financial balance and sustainability during 2017/18 and 2018/19. They also respond to the integration agenda and will support our implementation through the Better Care Fund (BCF).

We will be entering into two year contracts for 2017/18 and 2018/19 hence the need for our commissioning intentions to span across a 2 year plan.

The purpose of these commissioning intentions is to seek to inform providers and stakeholders of:

- The changes in services or pathways that LLR CCGs wish to commission for 2017/18 – 2018/19

- Any services within existing contracts which LLR CCGs are giving notice on or intend to give notice on in advance of undertaking a procurement for that service or of disinvesting in that service.

- Early consideration of any required or likely changes to contracts within this two year period

- Anticipation of likely emerging themes as per NHS England guidance and specifically the NHS Planning Guidance.

The economic climate in which we operate remains a challenge for all NHS organisations. Maintaining financial balance is central to our plans for next year. Living within our means will support this but we have to ensure that we commission high quality care and promote continue positive patient experience. We will continue to have minimum growth within our financial allocation, and therefore our commissioning intentions are modelled primarily on this basis.

We recognise the need for service improvements to deliver better quality of patient care and experience in the long-term, whilst reducing clinical variation, eliminating waste and delivering better value for money. This we will achieve through delivery of our QIPP (Quality, Innovation, Prevention and Productivity) programme.

Local Overview

LLR CCGs are GP membership organisation. In East Leicestershire and Rutland (ELR CCG) there are 32 practices serving around 329 000 registered population; in Leicester City (LC CCG) there are 59 practices serving a registered population of 391,000; and in West Leicestershire (WL CCG) there are 48 practices serving a registered population of 380,415. Each CCG is led by a Governing Body comprising elected GP members, a secondary care clinician, lead nurse, independent lay members, representatives of Healthwatch and chief officers. It is supported by a team of staff overseeing the daily business of the CCG.

The following are known demographics:

- Increase in ageing population.
- High cancer prevalence
- Increasing dementia prevalence
- High diabetes prevalence
- High levels of cardio vascular disease (Leicester City)
- High levels of COPD (Leicester City)
- Increase in circulatory problems (West Leicestershire)
- High numbers of people with multiple long term conditions (West Leicestershire)

ELR CCG receives an allocation of £409 million, LC CCG £490 million and WL CCG £450,661 million to plan and manage healthcare for the local population. We hold contracts ranging from small grants with the voluntary sector, to our largest contract with our main acute provider, University Hospital Leicester (UHL).

We commission acute services from out-of-county NHS trusts and a range of independent sector providers such as Spire Leicester Hospital, Nuffield Leicester Hospital and Circle Nottingham Treatment Centre.

Across the LLR CCGs we have a co-ordinating commissioner approach to contracts where each CCGs leads on a portfolio of contracts on behalf of all three Leicester, Leicestershire and Rutland (LLR) CCGs. The following identifies which CCG leads on which contracts:

East Leicestershire and Rutland CCG

- LPT – Mental Health and Community Health services
- Out-of-county contracts (mental health)
- LLR Continuing Healthcare (CHC)
- LLR Voluntary Sector arrangements

Leicester City CCG

- Acute contracts including out of county
- Independent Sector Contracts
- Alliance (Community based planned elective care

West Leicestershire CCG

- Ambulance services
- NHS 111
- Patient Transport
- Out of Hours
- AQP

Our Strategic Aims

The LLR CCGs are committed to involving patients and carers, partner organisations and the general public in our work. To ensure that our commissioning priorities meet the needs of local people, we have undertaken a period of engagement with a wide range of stakeholders. This engagement will be on-going as we continue to evolve and develop as a commissioning organisation.

Feedback from all of our stakeholders – patients and carers, member practices, clinicians, staff and partners - has informed the development of our vision, values and strategic aims; our Better Care Together Programme and the Sustainability and Transformation Plan. These include the elements of local healthcare that we wish to transform most significantly in the longer-term, and are as follows:

- Transform services and enhance quality of life across our Better Care Together workstream priorities:

- Ensure that we have a resilient primary care sector
- Improve the quality of care
- Reduce inequalities in access to healthcare
- Improve integration of local service
- Listening to our patients and public
- Living within our means

In the context of above and with the development of our LLR STP Plan our key strategic priorities are as follows:

- Increasing prevention and self-management
- Developing accessible and responsive unscheduled and community care
- Transforming primary care
- Delivering integration
- System resilience

Our draft commissioning Intentions are thus structured within the above strategic priorities. This is not a complete list of all initiatives, projects or service changes that are either underway or in the pipeline. However it is an attempt to summarise the key priorities for the years ahead and that we will work closely with providers and other key stakeholders to agree and deliver our commissioning and operational plans for 2017/18 and 2018/19.

Challenges Facing the Health Economy

There are some continued challenges that we face as CCGs and as a health and social care system and our Sustainability and Transformation Plan starts to address these and they will be operationalised through our Operational Plan for 2017 - 2019:

- Variation on health outcomes and health inequalities still exist
- Significant number of adult mental health patients continue to be placed out of county.

- Lack of integration between mental health services and physical health
- Duplication in diagnostic tests
- Lack of continuity for patients when moving through different settings of care.
- Fragmented end of life services
- High non-elective avoidable admissions
- Challenges within the urgent care system
- Mortality from cardiovascular disease remains high

LLR CCGs Strategic Priorities

Increasing Prevention and Self –Management

- Support many more people to make healthy lifestyle choices by making every contact with health and social care services count
- Tackle underlying risk factors that are associated with premature death and mortality (smoking, obesity, alcohol etc.)
- Link screening and problem identification seamlessly into what people do day to day
- Ensure early assessment and treatment of illness
- Develop asset based approaches to working with local communities

Developing Accessible and Responsive Unscheduled and Community Care

- Proactive health and social care services arranged around growing needs of people with multiple long term conditions and frailty in their homes and community settings, shifting care, where appropriate, away from hospital settings
- Evidence-based care pathways which provide the best possible outcomes for people, reducing variation in care interventions, improving safety, & experiences.
- Mental health - Community Mental Health Team redesign and development of locality based recovery hubs.
- Develop an integrated urgent care offer that reduces the number of avoidable attendances to the acute sector

Transforming Primary Care

- Embed contract management, workforce solutions, IT and estates initiatives to shape sustainable services.
- Develop a model for general practice that ensures sustainability for example sharing resources, working within networks, super-partnerships/federations around locality hubs.
- Close working with social care, specialists, third sector, pharmacies etc. to deliver care in a more integrated and coordinated manner.
- Develop wider primary care at scale (risk stratification, care planning, case management) to proactively support people with LTCs
- Ensuring that there is the workforce available to deliver new models of general practice and emerging care models

Delivering Integration

- Develop integrated health and social care teams, supported by specialists and the voluntary and community sector, clustered around groups of general practices within identified placed based communities to enable significant shifts of care away from hospitals and embeds our Better Care Fund programmes. The initial focus of these teams will be on over 18's with five or more chronic conditions; all adults with a "frailty" marker; and adults whose secondary care costs are predicated to cost three or more times the average cost
- Through the integrated teams programme general practices, social care, acute and community teams will work with commissioners to introduce a new model of care that focuses on:
  - Increasing prevention and self-management
  - Developing accessible and responsive unscheduled primary and community care
  - Developing extended primary care and community teams
  - Securing specialist support in non-acute settings

System Resilience

- Implement plans for the redesign of simplified, streamlined urgent care pathways
- Local leadership of the LLR System Resilience Group, including development of system planning for periods of surge in demand for health and social care services
- Operational management of Emergency Planning, Preparedness and Resilience, developing core standards of planning across LLR
- Operational management of response to states of emergency and/or escalation e.g. business continuity during periods of surge in demand for services, response/escalation in significant/major incidents, including management of on call systems

Increasing Prevention and self- management	
Commissioning Intention description	**Provider Impact**
1. Work with providers to support self-management for people diagnosed with long term conditions and prevention initiatives such as 'making every contact count'. Patient and carer education and access to the right support at the right time will be critical to success.	**ALL**
2. Include measurable prevention initiatives such as diabetes prevention programme, Cancer Screening – utilising information technology to simplify pathways – increase early detection and improve survival rates.	**ALL**
3. Continue to support the implementation of NICE Guidance for Antimicrobial Stewardship published in August 2015 – ensuring robust management throughout the whole health community including urgent care, community pharmacies	**ALL**
4. Development of self-management support for people with increasing complexity and frailty to prevent further escalation and improvement management – in line with STP. This patient group will be supported by access to the right community-based services at the right time.	**ALL**
5. Review of Carer support and wellbeing services – with a view to redesign and commission linking better with the third and voluntary sectors to maximise community capacity and resilience	**Vol Sector**
Developing accessible and responsive unscheduled and community care	
Commissioning Intention description	**Provider Impact**
1. Develop the frailty pathway including reviewing the outputs from the 'test beds', forming our urgent care and community service offers for our changing population	**ALL**
2. Implementation of Integrated points of access, reducing confusion and preventing crisis where possible.	**ALL**
3. Review and redesign of integrated care team – mapping to the functional Frailty Model – linked to the STP and building the right	**ALL**

community services model for the future.	
4. Review of the ICRS Model to evaluate its effectiveness and redesign to fit within the integrated care model	**LPT and ASC**
5. Review of ICS Model to evaluate its effectiveness and redesign to fit within the integrated care model	**LPT**
6. Integrated 7-day community care – as part of the extended primary care and urgent care in the community transformation and integrated care model, delivering real choice and alternatives to Acute service access	**ALL**
7. Intensive Community Service – review and redesign in line with the Integrated Care Model work	**LPT**
8. Mental Health – Liaison Psychiatry, complete implementation of all age model in ED and develop new model based on Core 24 to support other UHL services.	**UHL/LPT**
9. Reduce short stay admissions – improving GP/OOH/Urgent Care model including an urgent care home-visiting service for house-bound patients, reducing the need to convey to Acute sites for assessment and treatment	**UHL/LPT**
10. CAMHS – deliver a service that meets the needs of young people at a time of crisis and support longer-term well-being in the community.	**LPT**
Transforming Primary Care	
Commissioning Intention description	**Provider Impact**
1. Primary Care Federation development/implementation to develop clinical and innovation capacity within our primary care services to deliver a more responsible and	**Primary Care**
2. GP IT Prioritisation **–** integrated systems – enabling shared electronic records**.** This is a particular focus for new services being procured as part of our urgent and integrated service officers and intraoperability remains a clinical and safety priority	**Primary Care**
3. Review of Community-based services in line with the integrated care model. The review will enable us to work with providers to develop new ways of delivering integrated care, improving access and clinical outcomes	**Primary Care & LPT**

4. Deliver Medicines optimisation with a focus on patient safety and ownership in addition to value creation and duplication reduction.	**Primary Care**
5. Case management and care planning to support the integrated services models of care, enabling patients to come into contact with different services all working to deliver the same and agreed individualised care plan.	**Primary Care & LPT**
6. Reducing variation in referral practice and embedding a more robust referral management system within primary care	**Primary Care**
Delivering Integration	
1. Review of post-diagnostic memory support services – integrating service provision and procurement of new model.	**Vol Sector**
2. Review of Assistive Technology where clinically appropriate	**ALL**
3. Implementation of integrated reablement pathways that support safe and effective discharge from hospitals**.**	**ALL**
4. Falls Pathway – deliver an optimised and redesigned falls prevention model	**ALL**
5. Reablement – support in-reach and integrated discharge model	**ASC & LPT**
6. Integrated commissioning of domiciliary Care	**ALL**
7. Care Navigation **–** consolidation of varying models to implement an integrated and singular approach to case management, clinical navigation and advisory services flowing into and out of the third sector	**ALL**
8. Review Integrated Community Equipment arrangement	**S75 Arrangement**
9. Delivering End of Life Pathway that supports people in their last few days of life and provides palliative care.	**ALL**
10. Commissioning of locality mental health resilience and recovery hubs	**Vol Sector**
11. Bid to become an early adopter site for Integrated Personalised Commissioning (IPC)	**ALL**

System Resilience	
Commissioning Intention Description	**Provider Impact**
1. Reducing ultra-short stay admissions by delivery improved ambulatory pathways and quality community based alternatives to Acute services	**UHL**
2. A&E Urgent Care, offering extended primary care services at the UHL Front Door, reducing Ed attendances and short stay admissions	**UHL & Urgent Care Centre**
3. Urgent Care Review and procurement – Vanguard, delivering an integrated urgent care model across LLR based around a clinical navigation hub to ensure patients access the right service, first time	**Urgent Care Centres**
4. Implementation of Vanguard – linked to STP	**ALL**
5. Procurement of the Non-Emergency Patient Transport – new contract to commence 1st July 2017	**ARRIVA**
6. Implementation of an Integrated Discharge to Assess Process with LA	**ALL**
7. Joint commissioning of care home provision	**Care homes**
Planned Care	
Commissioning Intentions Description	**Provider Impact**
1. Thresholds / Procedures of limited clinical value review (Prior approval process) Re-clarification with general practice and secondary care those procedures that have a threshold attached to them. – continual review	**ALL Acute**
2. Decommissioning in Planned Care	**ALL Acute**
3. Implementation outcomes from the Clinical Priorities Implementation Group	
4. MSK – implementation of referral assessment and support/triage	**MSK**
5. Audiology Pathway review and procurement	**UHL**
6. Decommissioning of community based ultrasound service – current AQP	**AQP**
7. Decommissioning of Acupuncture for chronic pain management	**UHL**
8. Decommissioning of Physiotherapy contracts (historical arrangements)	**AQP**

DRAFT Contracting Intentions 2017/18 – 2018/19

Provider	Title	Summary	Expected Outcomes	Timeline
ALL Providers	Non-recurrent investments	Commissioners will review all non-recurrent investments and will notify intention to decommission non-recurrent investments that are not supported	Ensuring that robust process is in place to make changes to and free up capacity within contracts to cover core provision.	Review over Q1 of 2017/18 with notices served in Q2 of 2017/18 – services cease in 2018/19
ALL Providers	Service Changes & Developments	Commissioners expect that any service change or development is supported by a business case and approved relevant CCG with a contract variation in place before any service commences	As a result commissioners do not expect to receive requests for payments for additional costs or charges incurred as a result of service changes or developments implemented by the provider where the process outlined is not followed	Changes to be notified over Q1 and Q2 of 2017/18 with implementation Q3 onwards of 2017/18 – 2018/19
Any Provider paid in line with national tariff payment systems	National Tariff (awaiting guidance for 17/18)	To complete once guidance is received	TBC	TBC
Community Services LPT	Re-design of community services	Review and redesign of community services including commissioning of services in line with the LLR STP and Integrated Care Model	Local development and delivery of an MSCP Model to deliver integrated care	TBC
ALL Providers	NICE Technical Appraisal	Providers are reminded to provide quarterly uptake of treatments approved via a NICE technology appraisal Providers are reminded that a business case must be submitted to the co-ordinating commissioner for any change in service anticipated due to the publication of NICE technology appraisal. – For planned care we anticipate that this would be considered and reviewed at the Clinical Priorities Implementation Group. 90 days standstill for NICE approval by commissioners and role of LMSG (Leicestershire Medicines Strategy	Only approved and agreed NICE TA are implemented – CCGs will use an audit process to pinpoint evidence that the guidance is being followed.	Ongoing

Provider	Title	Summary	Expected Outcomes	Timeline
		Group) in approving NICE Guidance 90 Days standstill is required by the CCG even if LMSG approve NICE TA. LMSG will scrutinise affordability and undertake horizon scanning for any potential impacts. If the provider starts to prescribe outside of these principles this will be at their own financial risk.		
Any Provider paid in line with national tariff payment system or CCG local priorities	Outpatient Tariff/s	**New to follow-up ratios –** will be benchmarked with target reduction reflected in contractual discussions **Intrafirm referrals** – where a member of a group of clinicians under the direction and control of a consultant requests an opinion or help from a colleague within the same provider which leads to an outpatient appointment should be charged and counted as a follow-up appointment.	Efficient patient pathways and value for money	To be in place for 2017/18 contract
ALL	Policies & Protocols	Notwithstanding the NHS Constitution the CCGs will only contract with providers that abide by our policies and protocols. These include, but are not limited to local clinical policies and access criteria (including procedures of limited clinical value and effectiveness, prior approval thresholds and pathways for BMI and Smoking) as determined by the CCGs, which may be different to the providers Lead Commissioner. Referrals will clearly specify when patients are being referred for clinical opinion and	In accordance with 'who pays' guidance para 41D – should a provider receive a referral for a clinical opinion only and then choose to accept the patient for treatment without requesting prior approval from the CCG, the CCG reserves the right to refuse payment to the provider in accordance with (SC29.26) for any treatment undertaken or associated costs. In addition, where prior authorisation is not granted commissioners are under no obligation to pay for activity which is carried out by providers on a non-	To be in place for 2017/18 contract

Provider	Title	Summary	Expected Outcomes	Timeline
		patients will only be treated if they meet the CCG's criteria for treatment.	contracted basis.	
UHL	Block arrangements within UHL Contract	To review all block arrangements within the UHL contract ensuring that they deliver the right outcomes and value for money	Where block arrangements are counter-productive or duplicate with tariff based services then these will be ceased in order to ensure that commissioners are only paying for activity that is commissioned once.	Review of block arrangements during Q1 and Q2 of 2017/18
UHL	Locally agreed Tariffs	To review locally agreed tariffs with UHL – where these are higher than national tariff the intention is to move to the national tariff as a minimum depended upon the service line, level of activity, complexity and any requested additional elements	To improve cost control and efficiency which links to affordability of plan	To be agreed as part of the 2017/18-18/19 contract
ALL	Information Requirements	It is intended that the following information principles are followed by all providers: • Specialised Services – ensure that all specialised services activity as defined by NHSE are clearly identified as such and thus are not included in CCG activity or paid for by the CCG. All parties will ensure that the rules are applied consistently • Block elements of contracts – where these are continued – the rules around which activity is included must be made fully available and where appropriate must be supported by patient level data • Unbundled diagnostics – providers provide this data flow via SLAM with backing data to validate unbundles diagnostics. Commissioners require that in addition to this it must be	Robust and efficient information schedules will be in place across all providers. Compliance will be measured in accordance with the contractual terms and conditions.	To be in the 2017/18 contract agreement

Provider	Title	Summary	Expected Outcomes	Timeline
		submitted via SUS according to the rules for identification of such activity as outlined in the national SUS submission guidance. Providers will be required to fully encode this data within the national SUS data in line with national guidance. Therefore commissioners will only pay for DA diagnostics which is recorded correctly in SUS and SLAM Activity in 2017/18 and 2018/19.		
ALL	Non-Contracted Activity	We expect all providers with the CCG before any changes that are likely to have a material before any changes that are likely to have a material impact on cost or quality are made. Invoices must be submitted in accordance with 'Who Pays Guidance' and NHS National Tariff Payment System Rules and the Terms and Conditions set out in the 2017/18 NHS Standard Contract Template	Commissioner's regulatory responsibility is to commission population based services from providers capable of delivering safe effective healthcare. Where non-emergency non-contract referrals are made other than by the patient's GP, dentist or optometrist, including self-referrals, the provider must seek prior authorisation from the responsible commissioner before assessing and treating the patient. Where prior authorisation is not granted, notwithstanding the NHS Constitution (TG37.22) commissioners are under no obligation to pay for activity which is carried out by providers on a non-contract basis. Arrangements for submission of activity datasets, invoicing and payment reconciliation should follow National Tariff guidance (National tariff Payment Services guidance in 2015/16) and the terms and conditions set out in the NHS Standard Contract. Commissioners will	Ongoing

Provider	Title	Summary	Expected Outcomes	Timeline
			be under no obligation to pay for activity where activity datasets and invoices are not submitted in line with these requirements.	
UHL & LPT	Improved Discharge Procedures	Require continued improvement in the quality and timeliness of electronic discharge summaries and clinic letters to Patients and GPs in line with set performance indicators included in contracts. Providers are required to adhere to the newly developed pathways for discharge ensuring that patients are appropriately identified and then clear MDT working in place to discharge patients within the appropriate timescales and onto appropriate pathways	Sanctions will be applied to Providers where compliance is not met.	2017/18 Contract agreement
ALL	Growth and efficiency application	Will be applied to contracts, where relevant, in line with 2017/18 – 2018/19 planning guidance and published operating mandates. This will apply to all elements of the contract but not pass-through costs as identified in contracts.		
ALL	Non-tariff services	Any nationally mandated deflators/inflators will be applied to non-tariff prices in line with the 2017/18	No other changes will be accepted without the explicit consent of the co-ordinating Commissioner on behalf of all Associate	2017/18 contract

Provider	Title	Summary	Expected Outcomes	Timeline
		NTPS Guidance.	Commissioners. Block items paid without backing Minimum Data Set (MDS) are not appropriate for a contract set using NTPS and local tariffs on a cost and volume basis. Therefore any block items remaining in the contract that are not provided with an robust MDS are assumed a double count of activity and price and will not be included in 2017/18 contracts as the default position.	
ALL	Data Quality	To have locally agreed DQIP in place that is signed off and agreed with commissioners.		Ongoing
ALL	Contract changes	To ensure all newly agreed legal requirements with regards to the NHS standard Contract for 17/18 and 18/19 are incorporated in to the relevant contract discussions	Sanctions will be applied to Providers where compliance is not met.	17/18 Contract agreement

Further feedback from patients, carers, clinicians and wider stakeholders to enable us to further develop our Plan is welcome and sought. Please contact the CCGs at the following email addresses to provide comment and feedback:

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